

# Marking sutures to orientate specimens of basal cell carcinoma: do they really make a difference?

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## Abstract

Traditionally, marking sutures have been used to orientate specimens of non-melanomatous skin cancers, and they provide an identifiable point as a reference for monitoring and further treatment. For histopathological purposes, the orientated specimen is marked with different inks, which enables measurement to the nearest lateral and deep margins, and if invaded, guides further excision. We retrospectively analysed 688 specimens of basal cell carcinoma (BCC) from the head and neck from two separate years: 2010 and 2012. Marking sutures were used in 663 (96%) cases. There were 21 invaded margins (3%), 17 (81%) at the lateral margin and 4 (19%) at the deep margin. Of the 17 with invaded lateral margins, 10 were from the nose, and the remaining 7 from other sites including the ear ( $n=2$ ), and neck, forehead, temple, eyelid, and cheek ( $n=1$  each). Of the 663 marked specimens, the marking stitch was useful in only one patient who needed another operation (0.2%). We suggest that routine orientation of BCC, even from high risk areas, is not necessary. If the operating surgeon questions the size of the margin when a lesion is ill-defined or of a high-risk histological subtype, then excision with monitored en-face margins should be considered with traditional Mohs surgery or a reliable modified version.

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## Introduction

The treatment of non-melanomatous skin cancers accounts for much of the work done by oral and maxillofacial surgeons and their colleagues. The incidence of these lesions is often not accurate on cancer databases and is under-reported by between 30% and 50% for many reasons, but primarily because basal cell carcinoma (BCC) is not reported in the same way as squamous cell carcinoma (SCC) and melanoma (MM).<sup>1</sup> Although BCC have a relatively benign course and rarely metastasise, they can cause morbidity because of a propensity to invade locally. Lesions

at high-risk sites (ear, lip, periocular region, and nose), those greater than 20 mm in diameter, and those with perineural invasion, can be aggressive. Histological subtypes (such as infiltrative, sclerosing, or micronodular tumours) and those with atypical squamous components may also spread.<sup>2</sup>

There are many treatments for BCC, but the aims are the same: to eradicate the tumour and provide the best cosmetic result. Guidelines published by the British Association of Dermatologists<sup>3</sup> outline the methods currently in use, but the gold standard, which has the best prospect of complete removal, is excision. Most excised specimens should have a clear margin, and one of 4 mm means that excision has been complete in 95% to 96% of cases. When this is not possible, en-face monitoring with Mohs micrographic surgery (MMS) has been reported to have a 5-year cure rate of up to 100%

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Fig. 1. Differential inking.

for primary BCC, and 92.2% for recurrent BCC in the periocular region.<sup>4–7</sup>

Traditionally, the orientation of specimens has been considered necessary to enable the assessment of margins and to direct further operations or treatments.<sup>8</sup> We wanted to establish the clinical value of routine marking and differential inking of specimens of BCC of the head and neck after clinical diagnosis or previous incisional biopsy examination.

## Methods

We retrospectively analysed the details of all patients who had BCC excised from the head and neck at the Department of Maxillofacial Surgery, St Richard's Hospital, Chichester, in 2010 and 2012, most of which were done under local anaesthesia. Lesions were excised with a 3–4 mm clinical margin.

We macroscopically measured the distance from the edge of the tumour to the margins of the orientated samples. After the specimen had been inked in at least one colour to indicate a margin with respect to the orientation (3 o'clock and 9 o'clock, or 12 o'clock and 6 o'clock, depending on which margins were closest macroscopically) (Fig. 1), we cut transverse sections. The polar margins were embedded only if they were macroscopically close (Figs. 2 and 3). Cruciate sections were often taken at each surgical margin of larger lesions to assess clearance. The histopathological reports included subtype, depth of invasion, and distance to the excision margins.

Patients who had incisional biopsies, shave excisions, or excisions of recurrent lesions were excluded.



Fig. 2. Transverse slicing.

## Results

A total of 688 BCC were excised from the head and neck during the years studied. The mean age of the patients was 76 years (range 32–100), and there were slightly more men than women (ratio 1.38:1 men:women). The most common sites were the nose, cheek and forehead (Table 1). A total of 663 (96%) specimens had orientation sutures (Table 2). Twenty-one cases (3%) had invaded margins (17 lateral and

Table 1  
Site of basal cell carcinoma.

Site	No. (%)
Nose	139(20)
Cheek	132(19)
Forehead	89(13)
Temple	82(12)
Ear	53(8)
Not head and neck	47(7)
Eye lid	30(4)
Lip	27(4)
Mastoid	19(3)
Scalp	22(3)
Eyebrow	14(2)
Canthus	16(2)
Nasolabial fold	11(2)
Chin	7(1)

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