

Recurrence rates of primary basal cell carcinoma in facial risk areas treated with curettage and electrodesiccation

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Background: The incidence of basal cell carcinoma (BCC) is increasing. Curettage and electrodesiccation (CE) are not recommended for BCC treatment at medium- and high-risk facial sites. Surgical excision has been proposed as the treatment of choice.

Objective: We sought to evaluate the cumulative recurrence rate (RR) of primary BCC in facial areas of medium and high risk after CE.

Methods: This nonrandomized, clinical trial enrolled 257 patients with primary BCC located in medium- and high-risk facial areas, and treated with 4 or 5 cycles of CE by a single operator from a section specializing in BCC CE in a tertiary teaching hospital in Oviedo, Spain. Exclusion criteria for study entry included: recurrent BCC, fibrosing BCC, ill-defined BCC, and BCC larger than 10 mm in diameter (high-risk facial sites) or larger than 15 mm in diameter (medium-risk sites); BCC smaller than 4 mm; and nonbiopsy-proven BCC. BCCs included in the study were from the nose, and paranasal and nasal-labial fold (n = 105); eyelids and canthi (n = 48); perioral areas (n = 12); ears (n = 11); forehead and temples (n = 48); periauricular areas (n = 14); and malar areas and cheeks (n = 19). The primary outcome was recurrence of carcinoma, which was clinically evaluated by at least two observers in consensus. Data were analyzed using both a life table method and Kaplan-Meier analysis. The statistical analysis included best- and worst-case scenarios (which means that all cases lost to follow-up were considered as recurrences).

Results: The 5-year cumulative non-RR in the best-case scenario was 98.80% (SE 0.70, 95% confidence interval 97.40%-100%); thus, a 5-year cumulative RR of 1.20% was found after CE in our medium- and high-risk BCCs of the face (best case). The 5-year cumulative non-RR in the worst-case scenario was 79.40% (95% confidence interval 78.90%-79.90%); thus, a 5-year cumulative RR of 20.60%.

Limitations: Retrospective design with a relatively small number of patients lost to follow-up is a study limitation.

Conclusion: High 5-year cure rates can be obtained after CE of primary, nonfibrosing BCCs of medium- and high-risk areas of the face performed in a specialized section. (J Am Acad Dermatol 2007;56:91-5.)

Nonmelanoma skin cancer is the most common form of cancer in the world; basal cell carcinoma (BCC) accounts for approximately 80% of these neoplasms, and its incidence is

Abbreviations used:

BCC: basal cell carcinoma
CE: curettage and electrodesiccation
CI: confidence interval
RR: recurrence rate

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increasing. Excisional surgery, Mohs micrographic surgery, curettage and electrodesiccation (CE), radiotherapy, cryotherapy, and, more recently, photodynamic therapy and imiquimod are the main treatments used. Surgical excision has been recently indicated as the treatment of choice for most BCCs,

and is considered superior to CE in terms of recurrence rate (RR),¹ although critics note that evidence for this statement is lacking.^{1,2} In the long experience of one of the authors (T. R-V.), the clinical impression in an academic center is that recurrences after CE for BCC are low, even when located at medium- and high-risk facial sites, where it is generally recommended that CE be avoided. Because CE is a simple and low-cost procedure that can be performed in an ambulatory setting, we consider CE for BCC worthy of further statistical analysis. The premise of CE is that by using a curette the clinician can distinguish precisely between nodular and superficial BCC (soft, less cohesive, yielding, easily dislodged structures) and a normal dermis (hard, unyielding, and difficult or impossible to dislodge except by cutting, which the curette does not do).

The main objective of this study was to evaluate the cumulative RR after CE of BCCs of medium- and high-risk facial areas. The special characteristics of this study include the fact that CE was performed by a single operator.

PATIENTS, METHODS, AND DEFINITIONS

CE section

All patients were treated in a tertiary teaching hospital in Oviedo, Spain, by a single dermatologist (T. R-V.) with more than 30 years of experience in the procedure, in a section specializing in BCC CE.

CE technique

The same type of curettes (standard round and oval head Fox, 4-10 mm in longest diameter, Aesculap, Tuttlingen, Germany) and electrodesiccation equipment (Erbotom T400C model, Erbe, Tübingen, Germany) (level 4 was the power setting used for electrodesiccation, with approximately 40-55 W) was used on all patients.

The general principles of CE for primary BCC are well established.³⁻⁶ In summary, the main basis of the procedure is how meticulously and carefully it is done. Briefly, the procedure protocol is as follows. (1) Tense and fix the intradermally anesthetized skin around and at the base of the tumor between the index and middle finger. (2) Make a horizontal, tangential, shave biopsy specimen and carefully apply light electrodesiccation just to stop any bleeding. (3) Meticulously scrape the bulk of the tumor off with the edge of a sharp spoon curette until a smooth surface remains. (4) Repeat electrodesiccation. (5) Repeat curettage using a smaller curette to search for residual tumor pockets. At this stage, the curette should be partially scraping against the normal dermis and less material will be removed. Avoid slicing down through the underlying dermis to the

hypodermis. (6) Repeat the electrodesiccation. (7) If there is any undermining by curettage of peripheral skin around the lesion, use scissors to cut off the overhanging tissue. (8) In contrast with other authors,³ constantly repeat 4 or 5 cycles of CE. (9) The procedure is finished when soft and friable (tumoral) material is not obtained with the curette and when the (normal) tissue appears resistant and not bleeding. After this procedure, the total treated area is that of the tumor plus some millimeters of the apparently normal surrounding skin, which varies between 3 and 5 mm. This margin has not been previously established.

Special care needs to be taken in auricular BCC, and with tensing and fixing the eyelid skin. During CE of BCC of the ear, the exposed cartilage is excised to reveal the opposing perichondrium.

Selection of patients

A total of 257 BCCs from 256 patients (136 men, 120 women) were included in the study. The mean age of the patients was 66.49 years (SD 8.49; range 24-84 years). Patients were treated with 4 or 5 cycles of CE and evaluated from 1997 to 2004.

BCC inclusion criteria were as follows: primary, facial, biopsy-proven BCC treated by CE by a single dermatologist. According to the stratification of Silverman et al,⁷ locations were evaluated as: (1) high-risk (nose, paranasal areas, nasal-labial fold, eyelids and canthi, perioral area, and ears); and (2) medium-risk (forehead and temples, preauricular areas, and malar areas and cheeks). Arbitrarily, but, according to our previous experience, only BCCs of 15 mm or less in diameter were included. A diameter of 10 mm was established as the cut-off point for size in high-risk sites and 15 mm in medium-risk sites. Exclusion criteria for study entry included: recurrent BCC, clinically or histologically fibrosing BCC, ill-defined BCC, BCC larger than 10 mm in diameter (high-risk facial sites) or larger than 15 mm in diameter (medium-risk sites); BCC smaller than 4 mm; nonbiopsy-proven BCC; BCC where an incisional biopsy was performed; BCC on which CE was abandoned because of slicing of the curette to the hypodermis in the course of the procedure, except in areas with minimal or no fatty layer such as the eyelids, canthi, or the front side of the ears; BCC originally treated with other techniques or by other dermatologists; patients without complete clinical information; patients without follow-up clinical examination performed by at least two observers; and BCC located on the scalp, neck, and other nonfacial areas.

Follow-up

The recurrence data were not obtained from the patient files. Only patients with available follow-up

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