

## Locally Advanced Basal Cell Carcinoma: Management Challenges and Role of Multidisciplinary Approach

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### Clinical Practice Points

- Collaboration between Mohs micrographic surgery and head and neck surgery can be used for peripheral and deep margin control, maximizing the functional and cosmetic outcomes.
- A 75-year-old woman with recurrent morpheaform basal cell carcinoma of the left nasolabial fold presented to a tertiary cancer center.
- A multidisciplinary approach was implemented, and surgery, radiation, and/or systemic therapy were considered.
- The peripheral margins were cleared using Mohs micrographic surgery, followed by deep margin resection by head and neck surgeons and reconstruction by plastic surgeons.
- The present case highlights the challenges and benefits associated with multidisciplinary care.
- Optimal margin clearance is imperative in the treatment of large, complex, or recurrent basal cell carcinoma. Mohs micrographic surgery can evaluate the entire peripheral margin with maximal tissue conservation, leading to high cure rates and preserved functional/cosmetic outcomes. Mohs micrographic surgery is an underused, yet highly effective, management option when used as part of a multidisciplinary collaborative approach.

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### Introduction

Basal cell carcinoma (BCC) is the most prevalent form of cutaneous cancer, with > 2.8 million new cases diagnosed in the United States annually.<sup>1</sup> Most BCCs are at a low risk of local recurrence and metastasis, and the treatment options include nonsurgical modalities such as electrodesiccation and curettage or topical

chemotherapeutic agents.<sup>2</sup> BCCs deemed at high risk according to the histologic findings, location, size, and/or recurrence should be treated surgically with wide local excision or Mohs micrographic surgery (MMS). MMS is a tissue-sparing technique in which thin layers of tissue are removed, and the pathologic features traced out until the peripheral and deep margins are clear. However, a small number will require multiple treatment approaches, including surgery, radiation, and/or adjuvant therapy. Locally advanced BCC presents a particular management dilemma if standard surgical excision is not possible owing to the depth of invasion or when surgery will result in excessive morbidity or disfigurement.<sup>3</sup> These complex tumors can involve > 1 cosmetic unit and often require multiple layers, prolonged operative times, and general anesthesia, making office-based management unfeasible.<sup>4</sup> The face is divided into cosmetic subunits according to the color, texture, and thickness of the skin. Thus, involvement of multiple subunits makes reconstruction more difficult. Moreover, these complex cases have been associated with a greater rate of local recurrence and local tissue invasion, leading to significant morbidity. Metastasis is uncommon, with rates ranging from 0.0028% to 0.55%. The risk factors

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associated with metastatic disease are the same as those for recurrent disease and include an aggressive histologic pattern, size > 2 cm, perineural and/or perivascular involvement, location on the central face and ears, and duration.<sup>5</sup> The 5-year survival for patients with metastatic disease has been approximately 5%.<sup>6</sup>

Clearance of the tumor margins is essential to improve the outcomes among patients with large, complex, or recurrent BCC. The guidelines for conventional excision have recommended 4- to 15-mm margins for a large BCC to achieve clearance in 95% of tumors.<sup>4,7,8</sup> However, standard surgical frozen sectioning only samples a small percentage of the tumor margin. Tumor present in unsampled areas can lead to local recurrence and metastasis, but the wide margins recommended for conventional excision can unnecessarily disfigure the patient and complicate reconstruction.<sup>4,9</sup> A collaborative approach between MMS and head and neck surgery might improve the functional and cosmetic outcomes in locally advanced BCC located on the head and neck. The frozen section specimens obtained during MMS can facilitate circumferential identification of the tumor margins and precise planning for deeper resection.<sup>3</sup> This would allow for maximal tissue conservation and minimization of the risk of recurrence. In the present study, we report the multidisciplinary management of a locally advanced BCC on the face and discuss the diagnosis, imaging, surgery, and reconstruction.

## Case Report

A 75-year-old healthy woman presented for evaluation of a recurrent BCC of the left nasolabial fold. She had first undergone MMS at an outside hospital 9 years before her presentation to our center. She had required 4 layers to clear the surgical margins, and reconstruction was performed using a cheek advancement flap. Given that all margins were clear, no adjuvant radiation therapy was given at the initial presentation. We were unable to obtain the original pathology report. During a several-month period before representation, the patient had noted progressive skin changes at the previous surgical site that eventually resulted in retraction of the upper lip. Examination of a biopsy specimen at that time confirmed the presence of recurrent BCC.

On physical examination, an ill-defined, firm, indurated plaque measuring  $2.5 \times 2.3$  cm was noted along the left nasolabial fold that had caused notable retraction of the left upper lip and had extended onto multiple cosmetic subunits, including the left medial cheek, left nasal ala, and left upper cutaneous lip (Figure 1). Anterior rhinoscopy and intraoral examinations showed that this lesion did not extend onto the mucosal surfaces. No sensory or motor deficits were appreciated, and the facial nerve function and trigeminal nerve function were specifically normal. She denied the presence of pain, paresthesia, pruritus, or formication. No palpable adenopathy was present in the parotid or mandibular beds or in the jugular chains bilaterally. Histopathologic review of the biopsy specimen confirmed BCC with infiltrative and morpheaform (sclerosing) features (Figure 2). Magnetic resonance imaging (MRI) showed a  $2.1 \times 0.9 \times 2.5$ -cm subcutaneous soft tissue mass at the left nasolabial fold and upper lip, with no evidence of perineural spread (Figure 3).

We performed confocal microscopy and mapping biopsies to guide the overall management before the patient went to the

**Figure 1** Recurrent Basal Cell Carcinoma Causing Upper Lip Retraction



operating room. Next, full-thickness incisional biopsies were taken along the critical anatomic and cosmetic locations, including the left medial cheek, left lateral cheek, left superior cheek, left central cheek within the previous scar, left upper cutaneous lip, and left lateral oral commissure (Figure 4). Residual BCC was only identified in the left cheek specimen at the site of the previous excision. Pathologic examination showed an aggressive pattern of growth consisting of single cells, cords, and strands of cells invading deeply throughout the dermis, scarring fibrosis, and underlying skeletal muscle with perineural invasion and intrafascicular growth. The tumor extended diffusely to the side and had deep margins.

Because the mapping biopsy specimens indicated that the residual BCC was confined to the nasolabial fold area, we selected surgery, with the option for adjuvant or salvage radiation therapy or an oral hedgehog inhibitor such as vismodegib in the future, if needed. A multidisciplinary approach was designed using MMS to clear the peripheral margins, head and neck surgery to resect the deep soft tissue margins, and delayed reconstruction with plastic surgery once clear histologic margins had been achieved.

On day 1 of MMS, the initial surgical margins around the BCC were marked using palpation, MRI, and the mapping biopsy specimens as guides. After infiltration of local anesthesia, the peripheral margins were excised using a double-bladed “spaghetti technique” that consisted of removing a 2-mm strip of skin approximately 3 mm beyond the clinical borders of the tumor.<sup>10</sup> The excision depth extended through the subcutis and muscularis to the level of the periosteum on the cheek and muscularis on the lip. The first MMS excision showed extensive BCC along the subcutis and muscle, with perineural invasion (Figure 5). Two additional MMS excisions were required, extending laterally, to achieve histologic clearance of the peripheral margin using frozen section analysis. Given the pitfalls of skip areas with recurrent BCC, an additional 2-mm peripheral full-thickness excision down to the periosteum was performed, and the specimen was sent for permanent section analysis, which showed no BCC. The post-MMS surgery defect measured  $4.8 \times 5.0$  cm (Figure 6), with the central tumor island preserved for later removal by the head and neck surgeons. The patient was admitted to the hospital for

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