Basal Cell Carcinoma (BCC) Management Guidelines
There is a dearth of well conducted RCTs in this area. A number of guidelines have been published but most rely on expert opinion for the majority of recommendations. This guideline should be read in conjunction with those published previously and should be tailored to the individual patient. Low risk BCCs may be managed in the community by practitioners meeting recognized standards.

MANAGEMENT
Surgical approaches often offer the most effective and efficient means for accomplishing cure, but considerations of function, cosmesis and patient preference will ultimately guide treatment choice.

Surgery
Surgical Excision
- Surgical excision is usually the treatment of choice for the majority of BCCs, usually with a 4mm clinical peripheral margin. If there is diagnostic uncertainty, and the preferred treatment option is excision, then an incisional biopsy or diagnostic shave, without removing the entire lesion, should be performed rather than C+C as the latter can make it very difficult to identify residual tumour margins.
- Recurrent or morphoeic BCC may require a larger margin and may be best treated with Mohs micrographic surgery.
- Re-treatment of incompletely excised BCCs should be considered particularly on midfacial sites, deep surgical margin involvement, aggressive histological subtype, flap/graft repair. Re-excision or Mohs surgery are treatments of choice. Radiotherapy may have a role in preventing recurrence of incompletely excised BCC.

Curettage and cautery (C+C)
May be used for low risk primary BCC - small, well- defined, non-aggressive histology, usually at non-critical sites (for high-risk BCC see below). If fat reached, surgical excision should be performed.

Mohs Micrographic Surgery
Indications include high-risk BCC which include the variables below:
- Recurrent tumours
- Tumour site: especially central face, periocular, nose, lips, ears
- Tumour size: especially >2cm
• Histological subtype: especially infiltrative, morphoeic, micronodular, basosquamous
• Poor clinical definition of tumour margins
• Perineural or lymphovascular invasion

Radiotherapy
Suitable for:
• Patients unwilling or unable to tolerate surgery
• Primary BCC
• Surgically recurrent BCC
• Adjuvant therapy

Unsuitable for:
• Post radiotherapy recurrent BCC
• Gorlins Syndrome

Patients with a histologically confirmed BCC for consideration of radiotherapy should be referred to Dr Catriona McLean, Consultant Radio-oncologist at the Western General hospital.

Cryotherapy
Is a suitable treatment for low risk BCCs by an experienced practitioner.

Topical therapy
Imiquimod
Has a role in the treatment of small primary superficial BCCs – usually under the supervision of dermatology

Topical 5-fluorouracil
Has a role for low-risk superficial BCC at non-critical sites

Photodynamic therapy (PDT)
Suitable for treating low-risk primary superficial BCCs

FOLLOW UP
If adequately excised then risk of BCC recurrence is low. Patients should be advised on sun protection measures and counseled on the risk of developing a second primary. Self monitoring or follow up in primary care or secondary care will depend on discussion between the patient and Consultant.

Patients should be given appropriate verbal and written information on their diagnosis and management.
References


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