Staged surgical therapy of basal cell carcinoma in the head and neck region

To the Editor:

I refer to the interesting article by Dr Hüsler et al. [1]. In it the authors attempt to compare two different techniques and unfortunately their vague notions of Mohs micrographic surgery involve them in essential errors and claims. In consequence, the pros and cons of the two procedures are not well balanced and therefore lack any basis for comparison. The authors have chosen a framework by which to obtain optimal results, but several of their findings and interpretations are incorrect and lead to faulty conclusions.

1. Although the authors mention 500 procedures in fact they treated 228 patients with 281 lesions and counted each reexcision as a procedure. In consequence I think the title is misleading, as the authors present two-staged surgery, meaning that each second stage is a continuation of the first and therefore should be counted as one procedure. Since the authors wish to compare their work to publications on Mohs surgery, they should use the same terminology and, as we shall see, identical framework conditions.
2. The total number of cases is quite low for a period of 5 years in a university hospital. This may be due to the strict inclusion criteria applied by the authors. To exclude genetic disorders, BCC of more than 6 cm, BCC after radiotherapy, multiple lesions and metatypic BCC is contradictory, since these constitute the major portion of the criteria for selection of MS. In consequence, these data cannot be compared to MS because the lesions with high risk of recurrence are excluded.
3. The authors have used – in conformity with the international standard for surgery of epidermal carcinomas – a security margin of 3–5 mm in the first excision. The authors seem not to have understood the advantage of Mohs surgery. The aim is to ensure minimal defect and a maximum of total excision, to keep reconstruction easy and – as a result – costs low. The authors painstakingly compare their number of reexcisions with studies on Mohs surgery – where often a 1 mm, rarely 2 mm security margin is taken; this is a misleading methodological error.
4. What does serial transverse blocking mean? Every 100 microns, 200 microns? When comparing this procedure with Mohs surgery it is necessary to be precise. If the authors wish to have a control of approx. 80% of the excision margin, the number of slides would overstrain the capacity of any laboratory, not to mention the time-consuming part of pathological analysis. Mohs surgery is surgery and pathological correlation of horizontal slides every 100 microns means histological control of 80% of the excised tissue compared to 5% tissue control in normal histology. It is surely not correct to compare just one part of a procedure.
5. A 1-hour real operation time does not reflect the reality of patient comfort; at each passage the patient has to come in, undress, be installed in the operating theatre, be given a new local anaesthesia, wait for a few days for the results and with a 2% infection rate (much too high compared with my personal experience in Mohs surgery). In this context, and in correlation with what was said under point 3, there is no reflection on quality of life index (QLI) and quality of results (QRI), unfortunately a major issue in the whole discussion surrounding Mohs surgery.
6. The authors *suppose* that any recurrence would have been sent to their hospital: have they, before or during the study, contacted the dermatologists to inquire about cases of recurrence? With this low number of cases (292), two or three non-notified cases would amount to 1%.
7. The authors mention 1.8 reexcisions with a primary security margin of 3–5 mm, and try to compare this with studies which start with a primary margin of 1–2 mm, which is unfortunately unrealistic.
8. The authors compare their results with a UK study carried out in two centres (which is not the ideal example) and showing 3.8% tumour recurrence. Both UK centres show larger mean tumour size (1.5 cm and 2.3 cm compared to 1.3 cm in Bern), the largest tumour in the UK study being more than 10 cm in diameter, where this study has limited the maximum tumour size to 6 cm. In one of these centres which contributed ⅔ (156 out of 228) of the patients, 80% of the tumours were recurrent after previous surgery. This is a potentially high risk group which even in MS shows a risk of some 5% recurrence (according to various studies). In the present study from Bern only 21% had been previously operated on. It is difficult to understand why the authors should have forgotten to discuss this point.
9. Since there would have been sufficient much larger studies to compare with recurrence rates between 1 and 1.5%, why have the authors chosen the UK study? The low number of patients is not a scientific argument.

This study – although statistically probably correct – has some major errors in its methods. It is like comparing apples and pears. Mohs surgery has now been accepted by Medicare – one of the major actors in the American health system – as the primary surgery for epidermal tumours. One cannot deny the fact that this is a health insurance and the people involved have all the necessary resources with which to evaluate the economic factor. For the QLI and QRI Mohs surgery no doubt has the advantage. To conclude, one might say staged surgery is better than "classic" surgery but as such unfortunately not comparable to Mohs surgery.

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Reference

1 Hüsler R, Schlittler FL, Kreutziger J, Streit M, Banic A, Schöni-Affolter F, Hunger RE, Constaninescu MA. Staged surgical therapy of basal cell carcinoma of the head and neck region: an evaluation of 500 procedures. Swiss Med Wkly. 2008;138:746–51.

Author's reply

We were surprised at the reviewer-like comments in Dr. A. M. Skaria's letter, which not only fall just short of being offensive but also show that he may have misunderstood the basic message and some important details of this original, peer-reviewed article which reflects a long-term interdisciplinary approach at an university hospital.

Firstly, the focus of the paper relates – as clearly stated in the title, patients and methods and result sections – to the retrospective outcome *evaluation of staged surgical therapy* of basal cell carcinoma in the head and neck region alone. It is unclear why Dr. Skaria is led to believe that the article "tries to compare two different techniques" when in fact the discussion/limitation section makes it clear that "no direct comparison of different techniques could be performed" due to the retrospective single centre analysis design. Our discussion section further includes – "assessing the available literature" – reported outcome results of various other surgical and non-surgical therapeutic modalities of basal cell carcinoma, acknowledging their individual strengths and weaknesses and particular indication areas.

The article does not focus on a "painstaking comparison" between "apples and pears" in two techniques. The reader's letter contains, in contrast, a long and reiterative description of Mohs micrographic surgery technique and its particular strengths (which are common knowledge) which contributes nothing to the technique and findings presented in the article on staged surgical therapy.

Secondly, neither the title nor the findings presented are misleading. The semantic discussion (under point 1 of the reader's letter) lacks a basis since the chosen terminology of the article relates clearly to *common surgical nomenclature*, even if Dr. Skaria's personal comprehension here may be different.

Thirdly, *the strict inclusion criteria are a major strength of this study*. They help in delineating and evaluating the very precise indications for staged surgical therapy in keeping with international standards for surgery of epidermal carcinoma. The findings in terms of low recurrence and infection rates using staged surgical therapy underline the correct choice of indications for this technique.

Finally, as stated in the introduction and in the conclusions of the article, the treatment of malignant cutaneous lesions of the face, head and neck area is of importance to various medical disciplines which may adopt – alone or on an interdisciplinary basis – staged surgical therapy for the indications described. These initial retrospective single-centre findings warrant, in our opinion, further evaluation in a future prospective multi-centre setting.

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