Clinical practice guidelines

Management of basal cell carcinoma in adults

March 2004
# Synopsis

<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Management of basal cell carcinoma (BCC) in adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Publication date</strong></td>
<td>March 2004</td>
</tr>
<tr>
<td><strong>Requested by</strong></td>
<td>Société Française de Dermatologie</td>
</tr>
<tr>
<td><strong>Produced by</strong></td>
<td>ANAES – French National Agency for Accreditation and Evaluation in Healthcare (Guidelines Department)</td>
</tr>
<tr>
<td><strong>Intended for</strong></td>
<td>Health professionals involved in the management of BCC in adults</td>
</tr>
</tbody>
</table>
| **Assessment method** | - Systematic review of the literature (with evidence levels)  
- Discussion among members of an *ad hoc* working group  
- External validation by peer reviewers (see ANAES guide “Recommandations pour la pratique clinique – base méthodologique pour leur réalisation en France – 1999” available at www.anaes.fr) |
| **Objectives** | (i) To classify BCC subtypes according to their prognosis and simplify BCC terminology  
(ii) To propose diagnostic tests and treatment modalities suited to each situation. |
| **Literature search** | Jan 1993 – Dec 2003  
153 articles selected among 378 analysed |
| **Economic study** | See full report available at www.anaes.fr |
| **ANAES project leader(s)** | Dr. Philippe Martel (Department head: Dr. Patrice Dosquet)  
(Literature search: Emmanuelle Blondet with the help of Laurence Frigère (Department head: Rabia Bazi)); secretarial work: Elodie Sallez. |
| **Authors of draft report** | Dr Michel Dandurand, dermatologist, Nice  
Dr Thomas Petit, pathologist, Paris |
| **Collaborations and participants (annex 1)** | - Learned societies  
- Steering committee  
- Working group (Chair: Professor Bernard Guillot, dermatologist, Montpellier)  
- Peer reviewers |
| **Internal validation** | ANAES Scientific Council (Referees: Professor Maryse Gadreau, Professor Muriel Rainfray)  
Validated in March 2004 |
I. Introduction

I.1 Objective

There are many clinical and histological subtypes of basal cell carcinoma (BCC), with many different treatment modalities i.e. many situations for the physician to consider. The aims of these guidelines are:
(i) to classify BCC subtypes according to their prognosis and to simplify BCC terminology,
(ii) to propose diagnostic tests and treatment modalities suited to each situation.

I.2 Scope of the guidelines

These guidelines do not cover:
- BCCs developing during genodermatosis and immunosuppression
- multiple BCC
- BCC in children
- primary prevention and screening.

II. Assessment method

The guidelines were produced using a three-step method (Annex 2) comprising:
(i) a critical appraisal of the literature published from Jan. 1993 to Dec. 2003
(ii) discussions within a working group (3 meetings)
(iii) comments by peer reviewers.

They were graded on the basis of the level of evidence of the supporting studies (Annex 2). If no grade is given, they are based on agreement among professionals within the working group after taking into account the comments of peer reviewers.

There is a vast amount of published data on BCC but it provides low levels of evidence. This is largely because of the wide variety of tumours, diagnostic techniques, treatment modalities and endpoints (and ways of calculating recurrence rates). Several guidelines are therefore based on agreement among working group members. They were keen to provide healthcare professionals with a practical decision-making tool suited to most clinical situations, while emphasising that guidelines can be adapted to specific circumstances.
### III. Clinical and histological subtypes of BCC

According to the working group, BCCs should be divided into 3 clinical and 4 histological subtypes (Table 1). This is a convenient classification for routine use that is relevant to the management of the disease and that should help communication between health professionals.

<table>
<thead>
<tr>
<th>Clinical subtypes</th>
<th>Histological subtypes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nodular</strong></td>
<td>Presence in the dermis of one or more large and well-circumscribed masses or lobules consisting of basaloid cells with peripheral palisading of the nuclei. Retraction features are usually present.</td>
</tr>
<tr>
<td><strong>Superficial</strong></td>
<td>Presence of a tumour nest attached to the epidermis and/or hair follicles, consisting of basaloid cells with peripheral palisading of the nuclei. Retraction features are usually present and separate the tumour cells from the stroma. Usually there appear to be multiple tumour foci, separated by areas of normal skin.</td>
</tr>
</tbody>
</table>
| **Infiltrating**   | To be used only for:  
|                   | - **Trabecular pattern**: presence of small, intradermal or occasionally dermal-hypodermal tumour foci. These have few cells arranged in irregular islands or networks. There is often little or no palisading of the peripheral nuclei. Tumour proliferation infiltrates into the dermis, with fluid margins.  
|                   | - **Micronodular pattern**: large number of small tumour foci (no validated values for size) forming well-defined lobules. There may be some palisading of peripheral nuclei. |
| **Morpheiform**   | The tumour foci are thin strands, sometimes consisting of a single cell layer. The tumour cells are poorly differentiated and there is no peripheral palisading. The tumour infiltrates a very sclerotic tumour stroma. Tumour elements normally occupy the whole height of the dermis, sometimes extending to the hypodermis. |

*a* These 3 clinical subtypes may be pigmented and/or may ulcerate.  
*b* There may be other histological features concerning the epithelial and/or stromal component (see full report).  
*c* Also called “pagetoid” BCC but this term should no longer be used.

A combination of histological subtypes may be present, in which case the subtype of the least favourable component is the one to be adopted.
There was no agreement among working group members on how to classify fibroepithelioma of Pinkus. Some authors consider this to be a rare anatomical and clinical form of BCC.

Two specific histological forms have also been identified:
- **Metatypical BCC**: This is defined as BCC which includes squamous carcinomatous differentiation. Classifying this lesion as a histological subtype of BCC or as a transitional form with squamous cell carcinoma remains controversial.
- **Mixed or composite carcinoma**: This is defined as a combination of a BCC with a squamous cell carcinoma, each component being histologically well distinct.

### IV. Prognostic factors and prognosis groups

The objective criterion for assessing prognosis is risk of recurrence. Risk of local invasion, and difficulty in treating the lesion in the event of recurrence, should also be considered. Recurrence rate is influenced by the clinical and histological factors given in Table 3.

**Table 3. Risk factors for recurrence**

<table>
<thead>
<tr>
<th>Clinical Factor</th>
<th>Clinical Description</th>
<th>Histological Description</th>
</tr>
</thead>
</table>
| Location (grade C) | - low risk area: trunk and limbs  
- intermediate risk area: forehead, cheek, chin, scalp and neck  
- high risk area: nose and periorificial areas on the head and neck. | Aggressive forms* _i.e._:  
- morpheaform subtype  
- infiltrating subtype  
- metatypical form (grade C) |
| Size (largest tumour diameter) (grade C) | > 1 cm for high risk area  
> 2 cm for low or intermediate risk area |  
Ill-defined or morpheaform subtypes  
Recurrent form |
| Clinical aspect (grade C) |  |  |
| Primary/Recurrent forms (grade C) |  |  |

* When several subtypes are associated, the global prognosis depends on the component with the poorest prognosis.

Age, lesion duration and sex are not risk factors for recurrence (grade C).
Data are inconclusive on whether the following are risk factors for recurrence:
- immunosuppression and previous radiotherapy
- perineural spread and aspects of the stromal or epithelial component other than those defining the subtypes cited above.

For practical purposes, BCCs can be classified into 3 prognosis groups (Table 4) according to risk of recurrence and, in the event of recurrence, to the risk of local invasion and the difficulty of treatment. These groups should be used to decide on treatment options.
Table 4. Prognosis groups

<table>
<thead>
<tr>
<th>Poor prognosis</th>
<th>Good prognosis</th>
<th>Intermediate prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>* clinical forms: morpheaform or ill-defined</td>
<td>* superficial primary BCC</td>
<td>* superficial recurrent BCC</td>
</tr>
<tr>
<td>* histological forms: aggressive</td>
<td>* Pinkus tumour</td>
<td>* nodular BCC</td>
</tr>
<tr>
<td>* recurrent forms (apart from superficial BCC)</td>
<td>* nodular primary BCC:</td>
<td>&lt;1 cm in high risk area</td>
</tr>
<tr>
<td>* nodular BCC &gt;1 cm in high risk zone</td>
<td>&lt;1 cm in intermediate risk area</td>
<td>&gt;1 cm in intermediate risk area</td>
</tr>
<tr>
<td></td>
<td>&lt; 2 cm in low risk area</td>
<td>&gt; 2 cm in low risk area</td>
</tr>
</tbody>
</table>

V. Available treatments

The main criterion for assessing treatment efficacy is recurrence rate. Different calculation methods and durations of follow-up are used to determine rates, making it difficult to analyse published results. The life-table cumulative 5-year recurrence rate should be used.

For primary BCCs, life-table cumulative 5-year recurrence rate is approximately:
- 1% with Mohs micrographic surgery (MMS) and classical surgical excision with frozen section
- 5-10% with classical surgical excision, radiotherapy and cryosurgery
- 7-13% for curettage and cautery.

For recurrent tumours, it is approximately:
- 5% with MMS
- 10-20% with classical excision and radiotherapy
- 40% with curettage and cautery.

V.1 Surgery (excluding Mohs micrographic surgery)

Surgery is the treatment of choice to which other techniques should be compared. It has a high cure rate as margins are controlled histologically. The criteria governing excision should be based mainly on prognosis (see recommended lateral excision margins in Table 5).

Table 5. Recommended lateral margins for excision

<table>
<thead>
<tr>
<th>Prognosis</th>
<th>Recommended margin</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>3-4 mm (grade C)</td>
<td>Statistically speaking, with this margin, excision is incomplete in &lt;5% of cases</td>
</tr>
<tr>
<td>Intermediate</td>
<td>At least 4 mm</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>From 5 mm for some well-circumscribed tumours to</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If these margins cannot be complied with for functional or</td>
</tr>
</tbody>
</table>
In all cases, the deep margins are located in subcutaneous fat tissue. The margins should reach (and in case of non-invasion spare) the fascia (forehead), the perichondrium (ear, nose), or the periosteum (scalp). For superficial BCC they may be less deep.

- **Frozen section**
  During classic surgery, frozen sections may be taken. These fragments, as well as the rest of the operative specimen, may be examined postoperatively. Frozen section should be reserved for BCCs with a poor or intermediate prognosis (see Section VI.2 on Treatment). In contrast to Mohs surgery, they allow examination of only a very small proportion of margins. They should therefore be taken as meticulously as possible from zones at risk of invasion. When relevant, these zones should be indicated by the surgeon.

- **Two-stage surgery**
  Two-stage excision surgery is an alternative to frozen section as the margins of paraffin-embedded specimens can be examined before closing. Tissue morphology is better preserved but there are no published data indicating that two-stage surgery is more effective than frozen section. The efficacy of both methods depends on the technique used to examine the surgical margins. As for frozen section, the histological examination should focus, as meticulously as possible, on zones at risk of invasion. Two-stage excision is particularly indicated if closure will require a graft or flap, which makes surgical revision difficult if excision is incomplete.

**V.2 Mohs micrographic surgery (MMS)**

MMS is the technique with the lowest reported recurrence rates, particularly for the treatment of BCC with a poor prognosis (grade C) and should be reserved for this indication. Recurrence rates for alternative treatments of poor prognosis BCC are little documented (surgery with frozen section) or not documented at all (two-stage surgery). Comparative trials are needed.

MMS requires a specialist team and good coordination to allow slides to be prepared and read during the surgical procedure. Today, only a few centres in France offer MMS, while it is current practice in countries such as the United States. The technique needs to be thoroughly assessed so that its use can be developed in France, if appropriate.

**V.3 Radiotherapy**

Radiotherapy gives good local control results for many clinical and histological forms of BCC. It requires prior histological confirmation of the diagnosis. It may use low energy X-rays (contact radiotherapy, which is particularly suitable for treating BCC), brachytherapy, or high-energy radiotherapy (photons or electrons), depending on the clinical presentation.

Radiotherapy is contraindicated or not recommended in the following cases:
- It is contraindicated in genetic syndromes predisposing to skin cancers such as basal cell naevus syndrome and *xeroderma pigmentosum*.
- It is not recommended as first-line treatment if excision surgery is possible.
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- It is not recommended:
  - in subjects aged under 60 years
  - as treatment for morpheaform BCC
  - on areas such as ears, hands, feet, legs or genital organs.

Radiotherapy should be reserved for cases where surgery is not possible (contraindication to surgery, surgical problems, patient's refusal). In these circumstances, the best indications are:
- BCC with incomplete excision
- recurrent BCC
- nodular BCC of the head and neck, under 2 cm
- BCC with invasion of bone or cartilage.

Minimum safety margins of 5-10 mm should be applied to the irradiated volume depending on tumour prognosis.

V.4 Cryosurgery

Cryosurgery gives satisfactory results in terms of recurrence when performed under optimum conditions in rigorously selected patients (grade C). Biopsy is required prior to treatment. It is an alternative when surgery is not possible, for:
- superficial BCC in a zone with low risk of recurrence
- well-defined nodular BCC smaller than 1 cm, irrespective of location.
There is a risk of delayed healing on the legs.

V.5 Curettage and cautery

Curettage and cautery is a blind technique requiring a definite clinical diagnosis, histological confirmation on the material removed and an experienced operator. Under these conditions and for the right indications, its efficacy is acceptable (grade C). It is not a recommended technique as other treatments are available but it may be considered for an area with low risk of recurrence in the case of small (< 2 cm) nodular BCC and superficial BCC.

V.6 Laser

There is insufficient data to support the use of CO$_2$ laser in the treatment of BCC.

V.7 Dynamic phototherapy

Dynamic phototherapy cannot be recommended for BCC treatment on the basis of available data and because the photosensitising agent has no marketing authorisation in France. Published data suggest that superficial BCC may benefit from dynamic phototherapy (grade B).

V.8 Drug treatments

No drug treatment can be recommended at present.
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- **5-fluorouracil** has no marketing authorisation in France for treatment of BCC. According to the working group, its efficacy in BCC treatment cannot be assessed from published data.
- **Imiquimod** is not sufficiently documented and has no marketing authorisation for BCC treatment. The data suggest that superficial BCC may benefit from Imiquimod (grade B).
- **Interferon** has many side-effects and limited efficacy (grade C).

VI. Diagnosis

VI.1 Role of biopsy

A biopsy should always be done:
- when the clinical diagnosis is not certain
- when a non-surgical treatment is proposed
- for all clinical forms with a poor prognosis
- when the surgical procedure requires major reconstruction.

Immediate excision may be performed for clinically very probable BCC with a good prognosis if recommended safety margins (3 or 4 mm) are complied with. The diagnosis must be confirmed histologically after excision.

The biopsy may be incision or punch biopsy. It should be sufficiently deep to include the reticular dermis to detect any infiltrating pattern and define the histological subtype as accurately as possible.

VI.2 Examination of histological samples

Either biopsy fragments or excision specimens may be used for pathological examination. The surgeon should specify the specimen's orientation and ideally provide a diagram. The specimen should be sent fresh (if it can be delivered quickly) or fixed (formol is recommended for excision specimens).

The excision specimen, the lesion (if possible), and the narrowest safety margin should be measured. The lesion should be described macroscopically, the location of the narrowest safety margin should be specified, and the orientation of the specimen indicated.

Recommendations on macroscopic technique vary according to the size, topography and shape of the excision specimen (Table 6).

<table>
<thead>
<tr>
<th>Excised specimen</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 0.5 cm</td>
<td>Cut specimen in half or include whole without cutting</td>
</tr>
<tr>
<td>0.5 - 3 cm</td>
<td>Make parallel slices perpendicular to the main axis of the specimen. To visualise the margins, each side may be examined with one or more slices perpendicular to the other</td>
</tr>
</tbody>
</table>
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VI.3 Pathology report

A standard pathology report should be used, containing at least the information shown in Box 1.

Box 1. Standard pathology report

<table>
<thead>
<tr>
<th>Macroscopic examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour site:</td>
</tr>
<tr>
<td>Specimen:</td>
</tr>
<tr>
<td>Type: Biopsy</td>
</tr>
<tr>
<td>Excision specimen</td>
</tr>
<tr>
<td>oriented</td>
</tr>
<tr>
<td>not oriented</td>
</tr>
<tr>
<td>Size:</td>
</tr>
<tr>
<td>Lesion:</td>
</tr>
<tr>
<td>- Visible on fixed specimen</td>
</tr>
<tr>
<td>- Not visible on fixed specimen</td>
</tr>
<tr>
<td>Pattern:</td>
</tr>
<tr>
<td>Size:</td>
</tr>
<tr>
<td>Other features:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Histology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis: basal cell carcinoma.</td>
</tr>
<tr>
<td>1- Histological subtype:</td>
</tr>
<tr>
<td>- Superficial</td>
</tr>
<tr>
<td>- Nodular</td>
</tr>
<tr>
<td>- Infiltrating</td>
</tr>
<tr>
<td>- Trabecular</td>
</tr>
<tr>
<td>- Micronodular</td>
</tr>
<tr>
<td>- Morpheaform</td>
</tr>
<tr>
<td>Fibroepithelioma of Pinkus</td>
</tr>
<tr>
<td>Metatypical</td>
</tr>
<tr>
<td>Other:</td>
</tr>
<tr>
<td>2- Excision</td>
</tr>
<tr>
<td>Lateral margins:</td>
</tr>
<tr>
<td>- in tumour tissue</td>
</tr>
<tr>
<td>- level with the tumour</td>
</tr>
<tr>
<td>- in healthy tissue</td>
</tr>
</tbody>
</table>

Specimen along a free margin (helix, eyelid, nostril, lip)
Cut tumour and take radial specimens from the areas with the smallest safety margin.
Make parallel slices perpendicular to the free margin. The external surface of the two distal slices should be marked with ink for histological control.

slices
> 3 cm
Specimen along a free margin (helix, eyelid, nostril, lip)
VI.4 Work up to detect disease spread

As metastases from BCC are unusual, systemic disease spread should not be looked for routinely. Suspicion of deep or local or regional invasion warrants imaging examinations such as radiography, ultrasonography and, in particular, CT scan and MRI, depending on the location and the underlying tissue invasion.

VII. Treatment strategy

Treatment is decided on the basis of the tumour prognosis groups defined in Section III.2. However, factors unrelated to the tumour may also be considered. These are:
- patient’s choice
- likely cosmetic and functional outcome
- general health and life expectancy
- concomitant treatment and disease
- availability of techniques
- practitioner’s competence.
Age alone should not be a reason for not treating properly a BCC.

• **Primary BCC**

Treatment strategy for primary BCC is given in Table 7. Restrictions on the use of each technique must be considered. Second- and third-line treatments are offered when first- and second-line treatments, respectively, cannot be used (contraindication to the technique, practical problems with treatment, patient's refusal).

<table>
<thead>
<tr>
<th>Prognosis</th>
<th>First-line*</th>
<th>Second-line*</th>
<th>Third-line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Surgery (margin: 3-4 mm), no frozen section</td>
<td>Radiotherapy</td>
<td>Curettage and cautery</td>
</tr>
<tr>
<td>Poor</td>
<td>Surgery (margin: 5-10 mm or more) 2-stage surgery Surgery with frozen section MMS whenever available</td>
<td>Radiotherapy</td>
<td>Other techniques are contraindicated</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Intermediate</th>
<th>Surgery (margin: at least 4 mm), no frozen section. If margin cannot be complied with, surgery with frozen section or 2-stage surgery</th>
<th>Radiotherapy Cryosurgery</th>
</tr>
</thead>
</table>

* Techniques are not listed in rank order of relevance.

- **Incomplete excision**
  The working group recommended that incomplete excision be followed immediately by revision as the rate of recurrence is approximately 50% and the prognosis for recurrent BCC is poorer than for primary BCC. There is, however, no evidence that this approach is superior to surveillance and treatment of any recurrences. Surveillance therefore remains an option for BCC subtypes with a good prognosis.

There are no published data to recommend excision margins for revision surgery.

**Table 8. Treatment strategy when excision is incomplete**

<table>
<thead>
<tr>
<th>Prognosis</th>
<th>First-line</th>
<th>Second-line[a]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>Surgery with frozen section</td>
<td>Radiotherapy</td>
</tr>
<tr>
<td></td>
<td>2-stage surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MMS whenever available</td>
<td></td>
</tr>
<tr>
<td>Good or Intermediate</td>
<td>Surgery without frozen section[a]</td>
<td>Radiotherapy</td>
</tr>
</tbody>
</table>

[a] Surveillance is an acceptable option for BCC subtypes with a good prognosis

[b] Only if surgery is not possible.

- **Recurrent forms**
  The treatments recommended for recurrent forms are given in Table 9.

**Table 9. Treatment of recurrent forms**

<table>
<thead>
<tr>
<th>Recurrent forms</th>
<th>First-line</th>
<th>Second-line</th>
<th>Third-line</th>
</tr>
</thead>
<tbody>
<tr>
<td>All but superficial BCC</td>
<td>Surgery with frozen section 2-stage surgery MMS whenever available</td>
<td>Radiotherapy</td>
<td>Curettage and cautery and cryosurgery are not recommended</td>
</tr>
<tr>
<td>Superficial BCC</td>
<td>Surgery with a 4 mm margin, no frozen section</td>
<td>Radiotherapy</td>
<td>Curettage and cautery and cryosurgery can be considered</td>
</tr>
</tbody>
</table>

- **Role of multidisciplinary consultation**
  Most cases of BCC do not justify a treatment decision being taken by a multidisciplinary team because the overall prognosis is good and simple surgical treatment is possible. However, BCC types that are more difficult to manage (multiple risk factors, cases requiring complex surgery, local or regional invasion) should be discussed by a multidisciplinary team.
VIII. Follow-up of patients with BCC

Clinical monitoring is recommended because of the risk of recurrence of BCC and because of the increased risk of further BCCs (33-70% at 3 years), squamous cell carcinoma (1-20% at 3 years) or melanoma (incidence doubled) (grade C). The patient should have a check-up at least once a year for at least 5 years, and ideally for life. The frequency may be increased if there are risk factors for recurrence. All the skin surface should be examined in order to diagnose and treat small lesions as early as possible.

IX. Decision trees

The following pages give decision trees on how to: (i) diagnose BCC, (ii) treat BCC with a good prognosis, (iii) treat BCC with a poor prognosis, (iv) treat BCC with an intermediate prognosis, (v) treat recurrences, (vi) follow-up and manage recurrence.
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**DIAGNOSIS OF BASAL CELL CARCINOMA (BCC)**

1. Diagnosis suspected
2. No systemic investigation
3. Biopsy
4. Determination of prognosis
   - Good prognosis
   - Intermediate prognosis
   - Poor prognosis
5. Except for clinically typical BCC with good prognosis
6. Surgery with postoperative control of margins (3-4 mm)
   - Histological confirmation
Primary treatment

**Surgery** with postoperative control of margins (3-4 mm)

Margins

Additional treatment

Negative: see Follow-up

Positive:
Surgery with postoperative control of margins
Radiotherapy (2nd line)
Surveillance possible

See Follow-up

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**TREATMENT OF GOOD PROGNOSIS BASAL CELL CARCINOMA (BCC)**

**Good prognosis BCC**

1st line

**Surgery**

With postoperative control of margins (3-4 mm)

Margins

2nd line

**Radiotherapy**

Patient > 60 years outside sensitive areas

Negative: see Follow-up

Positive:
Surgery with postoperative control of margins
Radiotherapy (2nd line)
Surveillance possible

See Follow-up

3rd line

**Cryosurgery**

Nodular BCC < 10 mm superficial BCC in area at low risk of recurrence

See Follow-up

**Curettage and cautery**

Superficial or nodular BCC < 20 mm from area with low risk of recurrence
Poor prognosis BCC

1st line
Surgery with postoperative control of margins (POCM) ≥ 5-10 mm
Surgery with frozen section (POCM)
or 2-stage surgery (POCM)
or Mohs micrographic surgery

2nd line
Radiotherapy:
> 60 years
outside sensitive zone
except for morpheaform BCC

Primary treatment

Additional treatment

Margins
Negative: see Follow-up
Positive:
Surgery (POCM) with frozen section
or 2-stage surgery (POCM)
or Mohs micrographic surgery
Radiotherapy (2nd line)
See Follow-up
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TREATMENT OF BASAL CELL CARCINOMA (BCC) OF INTERMEDIATE PROGNOSIS

Primary treatment

1st line

Intermediate risk BCC

Surgery with postoperative control of margins (POCM) (≥ 4 mm)

Surgery with frozen section (POCM)
or 2-stage surgery (POCM)

Margins

Negative: see Follow-up

Positive:
Further surgery (POCM)
Radiotherapy (2nd line)

2nd line

Radiotherapy
age > 60 years
outside sensitive zones

Cryosurgery
nodular BCC < 10 mm
from area at high risk of recurrence

See Follow-up

See Follow-up
Follow-up

Recurrence

Treatment

Clinical examination at least once a year for at least 5 years, ideally for life

Local

Regional

Imaging

Surgery with postoperative control of margins (POCM) with frozen section or 2-stage surgery (POCM) or Mohs micrographic surgery

Radiotherapy (2nd line)

Multidisciplinary teamwork
Annex 1 – Participants

Learned societies consulted

Association française des chirurgiens maxillo-faciaux
Collège national des généralistes enseignants
Société de formation thérapeutique du généraliste
Société française de chirurgie plastique, reconstructrice et esthétique
Société française de dermatologie
Société française de gériatrie
Société française de médecine générale
Société française d’ORL et de chirurgie de la face et du cou
Société française de pathologie
Société française de radiothérapie oncologique

Steering committee

Dr. Elie Calitchi, radiotherapist, Saint-Cloud
Dr. Michel Dandurand, dermatologist, Nîmes
Dr. Patrice Dosquet, ANAES
Dr. Christophe Ferron, ENT specialist, Nantes
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Dr. Philippe Martel, ANAES
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Dr. Jacques Wagner-Ballon, general practitioner, Joué-lès-Tours
Dr. Janine Wechsler, pathologist, Créteil
Annex 2 – Assessment method

The ANAES method for producing these clinical practice guidelines comprised the following steps:

Defining the scope of the guidelines (Steering committee). ANAES invited representatives from learned societies concerned by the topic to take part in a steering committee. The committee's job was to define the scope of the guidelines and determine which type of health professionals should take part in a working group or act as peer reviewers.

Literature search (Documentation Department of ANAES): See below

Drafting the guidelines (Working group). The ANAES project manager formed a working group of 16 professionals from a number of disciplines, working in different types of practice, from all over the country. The chair of the working group coordinated the production of the guidelines with the help of the project manager whose job was to ensure conformity with the methodological principles of guideline production. Two members of the working group identified, selected, and analysed relevant studies (from a literature search performed by the ANAES Documentation Department) and wrote a draft report. This draft report was discussed by the working group over 3 meetings and amended accordingly. Proposals for future studies and action were made.

External validation (Peer reviewers). Peer reviewers were appointed according to the same criteria as working group members. They were consulted by post after the second working group meeting, with regard to the readability, applicability and relevance of the guidelines (scores from 1 to 9). The ANAES project manager summarized their comments and submitted them to the working group prior to the third meeting. Peer reviewers were asked to sign the final document.

Internal validation (Evaluation Section of the ANAES Scientific Council). Two members of the Council acted as referees reporting to the Council. The working group finalized the guidelines with due regard to the Council's suggestions.

- Literature search and analysis (general procedure)

The scope of the literature search was defined by the steering committee and the project manager. The search was carried out by the ANAES Documentation Department and focused on searching:
- medical and scientific databases over an appropriate period, with special emphasis on retrieving clinical practice guidelines, consensus conferences, articles on medical decision-making, systematic reviews, meta-analyses and other assessments already published nationally or internationally (articles in French or English)
- specific and/or financial/economic databases, if necessary

1 Full details are given in “Recommandations pour la pratique clinique – base méthodologique pour leur réalisation en France – 1999” (Anaes)
all relevant websites (government agencies, professional societies, etc.)
- the grey literature (documents not identified through the usual information
distribution circuits)
- legislative and regulatory texts

Further references were obtained from citations in the articles retrieved above and
from working group members' and peer reviewers' own reference sources. The
search was updated until the project was completed.

The articles selected were analysed according to the principles of a critical appraisal
of the literature, using a checklist, to allocate a level of scientific evidence to each
study. Whenever possible, the working group based their guidelines on this review of
the literature. Guidelines were graded from A to C as shown in Table 1 depending on
the level of the evidence of the supporting studies. If no grading is given, they are
based on agreement among professionals.

<table>
<thead>
<tr>
<th>Level of published scientific evidence</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>A:</td>
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<tr>
<td>Randomised controlled trials of high power</td>
<td>Established scientific evidence</td>
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<tr>
<td>Meta-analyses of randomised controlled trials</td>
<td></td>
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<tr>
<td>Decision analyses based on properly conducted studies</td>
<td></td>
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<tr>
<td>Level 2</td>
<td>B:</td>
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<tr>
<td>Randomised controlled trials of low power</td>
<td>Presumption of scientific foundation</td>
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<tr>
<td>Properly conducted non-randomised controlled trials</td>
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<tr>
<td>Cohort studies</td>
<td></td>
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<tr>
<td>Level 3</td>
<td>C:</td>
</tr>
<tr>
<td>Case-control studies</td>
<td>Low level of evidence</td>
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<tr>
<td>Level 4</td>
<td></td>
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<td>Comparative studies with major bias</td>
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<td>Retrospective studies</td>
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<td>Case series</td>
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