WPRS

Warrnambool Plastic & Reconstructive Surgery

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this issue

Let us answer some questions you may have

- What are Merkel Cell Tumours?
- What margin should I excise BCC's?

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Basal Cell skin cancers: what margin should I excise?

Basal Cell cancers although relatively benign in their behaviour can sometime be difficult to clear due to their sometime extensive dermal spread which cannot been seen clinically.

There are a number of factors I consider when deciding what margin to excise around a Basal Cell Carcinoma (BCC):

1. Subtype of BCC: BCC are clinically and histologically divided into: circumscribed BCC (Nodular/ adenoid/cystic) and diffuse BCC (superficial/morphoeic/infiltrative/micronodular). NHMRC guideline use a 3mm margin for circumscribed lesions and 5mm margin for diffuse lesions. Using these margins on a primary BCC will result in 96% of excisions having clear histological margins

2. Size of BCC: <2cm BCC 3-5mm margin, >2cm BCC 1 cm margin recommended by NHMRC

3. Location of BCC: Some areas such as the nose and ear are high risk areas for recurrence and in complete margins. These are often also the most difficult areas to place large margins around the BCC. Often in these areas you will need to compromise on margin and risk a slightly higher incomplete excision rate to attempt to maintain function and cosmesis.

It is important to obtain clear histological margins when excising a BCC. 60% BCC's that are incompletely excised will reoccur often in a more aggressive subtype. These recurrences can sometime be very difficult to clear.

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Merkel Cell Tumours: What are they?

Merkel cell carcinomas first described in 1972 are rare primary skin tumour exhibiting neuro-endocrine differentiation. They make up less than 1% of skin cancers however are important as they carry an extremely poor prognosis.

These slow growing tumours present as a red blue nodule commonly on the head and neck (55%) or lower limb (20%). Men aged between 50-80 years old are most commonly affected. Up to 40% of these lesions will have nodal metastasis at initial presentation, and up to 33% of cases will develop distant metastasis.

Histologically they are a small cell tumour and must be differentiated from cutaneous lymphoma, small cell melanoma, and metastatic small cell lung cancer.

Treatment of these tumours involves wide local excision with 2 cm margin and sentinel lymph node biopsy. Merkel cell tumours are extremely radiosensitive tumours and hence radiotherapy is important adjuvant and in some cases primary treatment modality.

Prognosis for Merkel Cell tumour is poor with 5 year survival for stage 1 disease 81%, and stage 4 11%.

Practical Workshop: Suturing techniques and local skin flaps.

Robert Toma will present a Suture Workshop for his regional Colleagues and we invite you to attend…

Wednesday, 19th February 2014
From 6:00pm until 8:00pm
St John of God Hospital
Function Room

Register your interest on 5562 5330 or info@wprs.net.au

**Accreditation towards CPD Points*