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Reply to "Local recurrence of clinically observed basal cell carcinomas following complete saucerization or punch removal with negative margins: Retrospective case series from 2010 to 2020"

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To the Editor: We read with interest the article by Ransohoff et al,[1] suggesting that "biopsy with excisional intent" may be curative for majority of lower-risk basal cell carcinomas (BCCs).[1] As the incidence of nonmelanoma skin cancer continues to increase, we commend the authors for attempting to find ways to mitigate health care costs in the face of a growing epidemic. However, several critical issues arose when we read this article.

The most critical issue is the concept that the margins can be confidently assessed with routine pathology. During standard vertical sectioning, ie, "breadloafing" of tissue for histopathologic evaluation, routine pathology can only examine ~1% of the true margin.[2] In fact, true surgical margin analysis is <0.1% in most standard dermatopathology settings. This means that >99% of the surgical margin is never assessed during a routine pathologic assessment of the biopsied or excised tissue.[2] Thus, to confidently claim complete removal with clear margins with a biopsy, is impossible. This conclusion is corroborated by the fact that nearly 50% of superficial BCCs will demonstrate a previously undetected carcinoma of a different histologic subtype (most frequently higher grade/more aggressive subtype), when exhaustive sectioning or comprehensive margin analysis is used.[3] Furthermore, it has been well documented that nearly 50% of recurrent BCCs are a result of initial tumor misclassification during pathologic assessment of the biopsy specimen.[4] As such, we recommend against calling a biopsied tumor "clear," if it has been grossed and processed in a routine histopathologic fashion.

In practice, routine vertical section aka "breadloaf" pathologic tissue processing of the excision specimens has provided durable tumor cure rates. However, it is important to recognize that the key to its success is the incorporation of a standardized clinical "safety" margin utilized around the tumor during the excision time. In other words, the reason we can clear tumors with success using the traditional wide local excision and standard "breadloafing" is because of a predetermined safety margin of benign-appearing tissue around the tumor, to account for that very shortcoming of margin analysis during routine pathology. Vertical sectioning technique using standard 4-mm sections can only detect approximately 19% of the positive margins.

Additionally, there was no mention or standardization of the clinical margins used for the excisional biopsies. The lack of standardization in prebiopsy margins, ranging from <1 mm to >2 mm, significantly impacts recurrence rates, histopathologic subtype detected, and interpretation of "clear" margins on histology. Surely, performing a "deep scoop" excisional biopsy with a 4 mm clinical margin around a BCC on the arm would produce a vastly superior tumor clearance rate than a scoop excisional biopsy right at the clinical edge of a tumor.

In summary, accurate histopathologic margin assessment defines treatment success or failure in surgical oncology. Numerous studies have demonstrated the risks of interpreting margins from routine biopsies due to the inherent inability to assess > 99% of the true surgical margin. As such, we caution against declaring a tumor "clear" based on biopsy margins alone.

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Conflicts of interest

None disclosed.

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