The major differential diagnosis of sclerosing BCC is scar tissue. Biopsy is necessary to establish the diagnosis.

Recurrence in sclerosing BCCs can be common, and therefore requires regular monitoring. Some recurrence may be due to local incomplete excision, with satellite islands of BCC either having not been visible at the time of surgery, or being distant from the primary lesion, particularly in those with certain genetic syndromes such as Gorlin's syndrome (naevoid BCC syndrome) or those with immunosuppression.

Sclerosing lesions should be reviewed more frequently and may benefit from specialist review.

## 8.2.6 Influence of subtype on prognosis of basal cell carcinoma

Certain BCC subtypes (Table 1) are associated with a poor prognosis.

**Table 1. Tumour-specific factors associated with recurrence of basal cell carcinoma**

| Normal risk | High risk |
|---|---|
| Nodular subtype<br>Nodulocystic subtype<br>Superficial subtype<br>Fibroepithelioma subtype | Infiltrative subtype<br>Sclerosing (morphoeic) subtype<br>Micronodular subtype<br>Basosquamous carcinoma<br>Recurrence<br>Perineural invasion |

**Key point(s)**

- **Consider dermoscopy in the examination of all skin lesions in order to better identify changes in blood vessels and pigmentation.**
- **Biopsy should precede treatment for a single localised erythematous scaling lesion.**
- **Superficial basal cell carcinoma should be considered in the differential diagnosis when reviewing a bright pink, shiny erythematous macular lesion, particularly if well defined.**
- **Nodular basal cell carcinoma should be considered when assessing any lesion that is shiny, translucent (pearly), telangiectatic and has papules or nodules.**
- **Consider the possibility of sclerosing (morphoeic) basal cell carcinoma when assessing scar-like lesions.**
- **Stretching the skin accentuates features in basal cell carcinoma subtypes (eg. nodular subtypes and sclerosing subtype).**

## 8.2.7 References

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