Table V. Recommendations for the biopsy of suspected BCC

The recommended biopsy techniques for BCC are punch biopsy, shave biopsy, and excisional biopsy. The biopsy technique used will depend on the characteristics of the suspected malignancy (morphology, location, etc) and the judgment of the physician.
The biopsy size and depth should be adequate to provide the recommended clinical information and pathology report elements to permit accurate diagnosis and guide therapy.
Repeat biopsy may be considered if initial biopsy specimen is inadequate for accurate diagnosis.

BCC, Basal cell carcinoma.

Table VI. Recommendations for clinical information and pathology report for suspected BCC

Clinical information provided to pathologist
Strongly recommended
• Age
• Sex
• Anatomic location
• Recurrent lesion
Recommended
• Size of lesion
• Immunosuppression
• History (especially radiation burn, organ transplant)
Elements to be included in final pathology report (excision specimens)
Recommended
• Histologic subtype
• Invasion beyond reticular dermis
• Perineural involvement

BCC, Basal cell carcinoma.

CLINICAL AND PATHOLOGIC INFORMATION

Presumptive diagnosis of BCC is based on the physician's interpretation of clinical information, including clinical appearance and morphology, anatomic location, genetic risk factors, and patient-reported history. Clinical diagnosis is routinely confirmed by biopsy findings before treatment. When the clinician is submitting biopsy tissue for histopathologic diagnosis, the work group recommends that whenever possible and appropriate, key elements of patient demographics, clinical presentation, and clinical history should be provided to the pathologist (see Table VI; for level of evidence/strength of recommendations, see Table III). These include patient age and biologic sex,[17-25] anatomic location,[17-20,22-26] and any history of treatment at the same anatomic site.[17,18,22,23] Additional desirable relevant information includes the clinical size of the lesion[17,18,20-26] and whether the patient currently, or previously encountered additional risk factors, such as immunosuppression, radiation treatment, or solid organ transplantation.[21,27]

The pathology report provided to the clinician confirms the diagnosis of BCC and provides additional information to guide therapeutic decision making. Reporting of biopsy specimens may include relevant pathologic features that can help distinguish between low- and high-risk categories, especially histologic subtype. If deeper invasion cannot be ruled out, as in the case of tumor transection (ie, tumor extension to the base of the biopsy), this may be noted. The work group recommends including, when possible, details regarding the specific histologic subtype(s) detected,[17,19,26,28] invasion of the tumor beyond the reticular dermis,[17,19] and perineural invasion,[3,29,30] as these parameters provide prognostic information regarding the potential for recurrence (see Table VI; for level of evidence/strength of recommendations, see Table III).

Pathologic evaluation of skin biopsy specimens is ideally performed by a dermatologist or pathologist who is experienced in interpreting cutaneous neoplasms. Such a physician is most able to collectively interpret the clinical tumor findings and the histologic features (ie, clinicopathologic correlation) to provide the most precise and accurate biopsy diagnosis.

SURGICAL TREATMENT

A broad range of therapeutic modalities is available for the treatment of BCC, which may present with a wide variety of clinical and histologic characteristics. With each treatment option, when appropriately selected, a practitioner is able to achieve outstanding results. For example, C&E of a small, superficial BCC on the back may have an equally high cure rate as MMS for an infiltrative BCC on the nose. When the most appropriate therapy is being chosen, recurrence rate, preservation of function, patient expectations, and potential adverse effects must be taken into thorough consideration.[31]

When studies evaluating the efficacy of various treatment modalities for BCC are reviewed, critical attention must be paid to the length of follow-up. Because of the slow growth rate of BCC, recurrences are frequently diagnosed beyond 5 years following definitive treatment. As an illustrative example, in a