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Efficacy of Curettage-Electrodesiccation for Basal Cell Carcinoma in Medium- and High-Risk Areas☆

Eficacia de la técnica de curetaje-electrodesecación en el carcinoma basocelular en zonas de riesgo medio y alto

To the Editor:

We have read with interest the review by Aguayo-Leiva et al[1] on surgical vs nonsurgical treatment of basal cell carcinoma, recently published in *Actas Dermo-Sifiliográficas* (October 2010). We would like to comment on some of their statements in the light of our experience:

1. In their conclusions, the authors state: ''Despite there being few studies that compare surgical and nonsurgical therapies for BCC [basal cell carcinoma], it is clear that surgery is associated with the lowest recurrence rates.'' We do not agree that this statement is ''clear.'' It is true that surgical excision is generally regarded as the preferred treatment for BCC, but there is still no scientific evidence to support or refute this view.[2] As Thissen[2] pointed out in an excellent meta-analysis, it is not possible to compare the relative risk of recurrence after surgical and nonsurgical treatment of BCCs because of lack of uniformity in the selection of the BCCs and because of differences in the technique, in the experience of the dermatologist or surgeon performing the treatment, in the statistical analysis, and in reporting of the results in the literature. This is still a subject of debate. It is not yet possible to establish general guidelines based on evidence rather than on opinions, however ''clear'' these opinions may be.
2. We agree with the authors that curettage-electrodesiccation (CE) of BCCs ''is a simple and cheap technique that achieves good functional and cosmetic results.'' In their review the authors repeat the data of Silverman[3] published in 1991 and claim that this technique is only recommended in BCCs that ''have a diameter less than 1 cm [...] and are located in a low-risk area.''[1] We were surprised that they did not include in their review the article that we published recently in the ''blue journal'' (*Journal of the American Academy of Dermatology*),[4] which does not agree with this recommendation.

We performed a follow-up study on 257 patients with BCCs (primary, nonsclerosing, and histologically confirmed), who were treated with CE at the Hospital Universitario Central de Asturias, Oviedo in a department specializing in this technique. Eighty-one BCCs with a diameter between 4 and 15 mm were located in medium-risk areas and 176 BCCs with a diameter between 4 and 10 mm in high-risk areas, according to the standard classification.[3] Altogether, 105 BCCs were located in the nasal and paranasal region or in the nasolabial fold, 48 on the eyelid or canthus, 12 in the perioral region, 11 on the ear, 48 on the forehead and temples, 14 in the periauricular region, and 19 on the cheek and in the malar region. The mean (SD) follow-up was 5.34 (1.33) years. The outcomes were analyzed rigorously by calculating the life table and plotting the Kaplan-Meier curves. In summary, we observed only 3 recurrences of BCC treated with CE: 1 on the nose, 1 on the eyelid, and 1 in the periauricular region. The 5-year cumulative nonrecurrence rate of BCCs treated with CE was 98.89% (SD, 0.70; 95% CI, 97.40%-100%). That is, the recurrence of primary and nonsclerosing BCCs

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in medium- and high-risk areas was observed only in 1.20%. Previously published articles have reported a cure rate of more than 95% for BCC treated with CE when it is performed by experts and suitable selection criteria are applied.[4] In summary, our experience is that CE can be a very effective and inexpensive technique for treating BCC, not only on low-risk areas but also on medium- and high-risk areas if: a) it is performed by experts; and b) suitable selection is performed (primary, nonfibrosing BCC with the diameters stated above). As with any other procedure, proper training is a crucial factor in its effectiveness and should always be borne in mind in the comparison of results between different techniques.

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Epidermal Effacement in Malignant Melanoma☆

Adelgazamiento epidérmico en melanomas malignos

To the Editor:

Epidermal effacement, also known as consumption of the epidermis, is a histologic feature that can be seen in a number of malignant melanomas.[1–4] It consists of the thinning or disappearance of epidermal cell layers overlying the melanoma.[1,2] Hantschke et al[1] found epidermal effacement in 88 (86%) of 102 melanomas but in only 12 (9.6%) of 125 Spitz nevi. They also studied 61 spitzoid lesions without a clear diagnosis using genomic hybridization techniques and found epidermal effacement in 6 (14%) of 42 lesions that were reclassified as benign lesions and in 14 (74%) of 19 lesions that were reclassified as malignant lesions. Walters et al[2] found epidermal effacement in 92 (43%) of 213 melanomas but in just 4 (4.2%) of 94 melanomas in situ or high-grade dysplastic nevi. There was no effacement in 146 benign nevi (114 low-grade dysplastic nevi, 8 congenital nevi, and 24 common nevi). In other words, epidermal effacement could be used, with caution, as a diagnostic criterion for differentiating melanoma from Spitz nevus or dysplastic nevus.

Even though epidermal effacement is a relatively common finding in melanomas (found by Hantschke et al[1] and Walters et al[2] in 86% and 43% of cases, respectively), very few studies have analyzed it. Furthermore, we believe that this histologic feature is unfamiliar to the majority of dermatologists.

We recently saw 2 cases of malignant melanoma with epidermal effacement. The first was a superficial spreading melanoma (SSM), located on the right arm, that had entered the vertical growth phase (Breslow depth of 0.95 mm and Clark level III) (Fig. 1). The second was also a SSM in the vertical growth phase (Breslow depth of 1.87 mm and Clark level IV) but located on the abdomen (Fig. 2). The tumors had been removed from a 51-year-old and a 50-year-old man, respectively.

It has been postulated that epidermal effacement is the result of an autoimmune or immunologic process as this histologic feature has also been seen in certain halo nevi (pseudo-epidermal effacement).[1–3] Walters et al[2] do not believe this to be the case as they found no association between epidermal effacement and either tumor regression or inflammatory infiltrates. It might also be a physical phenomenon related to the compression caused by tumor growth[1–3]; this, however, would not explain why epidermal

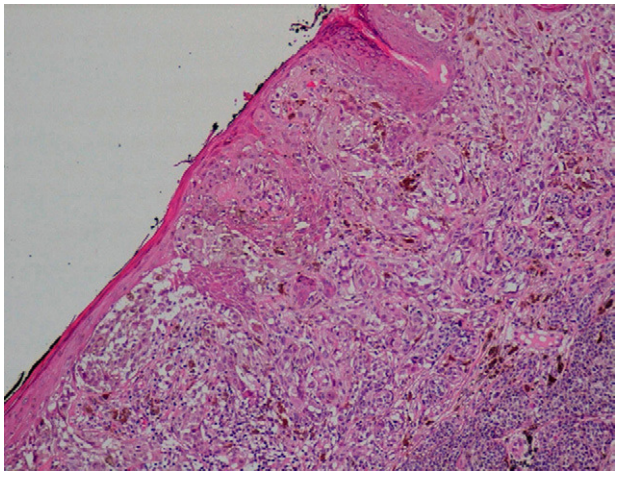

Figure 1 Epidermal effacement overlying malignant melanoma (hematoxylin-eosin, original magnification ×100).

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