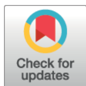

LETTER

Response to Letter: A retrospective 10-year review of cutaneous squamous cell carcinomas of the hand and adherence to British Association of Dermatologists guidelines

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For patients with a low risk for squamous cell carcinoma (SCC), the National Comprehensive Cancer Network (NCCN) guidelines (version 1.0, 2020) recommend excising the area with a 4- to 6-mm margin; however, decisions for high-risk cases should be based on the clinical characteristics of the tumor and the patient's condition. Similarly, the NCCN guidelines for cutaneous melanoma state that "margins may be modified to accommodate individual anatomic or functional consideration and consider histologic margin assessment prior to reconstruction and closure" [1].

Extensive subclinical spreading was found in 14% to 15% of primary SCCs and 23% to 50% of recurrent SCCs. In addition, patients who undergo Mohs microsurgery and have recurrent tumors have a higher risk of recurrence than those treated with wide excision [2]. The probability of spreading is high in cases of recurrent cancer, so freely achieving the maximum possible margin with subsequent aesthetic reconstruction may be the most effective approach for treating skin cancer.

When recurrence takes place due to insufficient margins at the time of primary resection, it is important to consider the patient's discomfort resulting from periodic visits due to positive results along the resection margin, the costs of reoperation and diagnosis, and the invasiveness of the procedure.

The least amount of secondary wound contraction occurs with flaps, followed in order by full-thickness skin grafts and split-thickness skin grafts. A flap is most appropriate reconstructive method because it generates the least scar tissue, which reduces functional issues due to limited joint movement and altered facial expressions [3].

Although skin grafting may promote recurrence in some cases, if the carcinoma is widely and completely removed and an appropriate flap is selected, this simple reconstructive modality generates the least scarring and preserves joint function. Kim et al. [4] used resection margins of 0.5–1 cm for basal cell carcinoma, 1–3 cm for SCC, and 5 cm for malignant melanoma on the face. To reduce the risk of recurrence, the resection of the tumors extended down to the fascia (an anatomical barrier) when the margin was deep. Reconstruction with an appropriate flap was performed depending on the skin laxity at the donor site and considering the facial subunit.

The decision of whether to perform an appropriate flap after the removal of a tumor with a sufficient margin, or skin grafting or perform Mohs surgery should be based on each patient's situation. Pharmacological treatment or simple surgery is preferable for older patients, while younger patients should undergo complete excision with sufficient margins and reconstruction with a functional and aesthetically pleasing flap.

Notes

Conflict of interest
No potential conflict of interest relevant to this article was reported.

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