To Re-excite or Not to Re-excite: Positive Margins After Excision of Non-Melanoma Skin Cancers

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To Re-Excise or Not to Re-Excise: Positive Margins after Excision of Non-Melanoma Skin Cancers

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Introduction:
Non-Melanoma Skin Cancer (NMSC)
• Most common cancer in U.S.
• Greater than 2 million cases treated per year
• Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC) make up majority
• SCC has higher potential for metastases
• Majority occur in Head & Neck region, cosmetically sensitive locations

Purpose:
Management of positive margins after non-melanoma skin cancer (NMSC) excision is controversial. Our goal was to determine the rate of residual tumor in re-excised NMSC specimens after previous excision with positive margins (true-positive). Further, we sought to determine potential factors that could predict a true-positive margin.

• IRB-approved retrospective review
• A total of 2,886 patients were evaluated; 160 patients met inclusion criteria

Results:
• 83 patients (52%) with positive margins on initial excision had no evidence of residual cancer upon re-excision.
• Most common locations for lesions with positive margins on initial excision were on the face.
• Gender and age were not associated with a positive re-excision (p=0.03) (Table 1).
• Patients with a previous history of basal cell carcinoma (BCC) were more likely to have a true-positive margin (p=0.03) (Table 1).
• Larger re-excisions were more likely to harbor residual cancer (Table 1).
• Location of lesion did not predict positive re-excision (Table 2).
• A longer time to re-excision was less likely to find residual cancer (Figure 1).

Discussion:
• Tissue shrinkage after excision – Healthy skin shrinkage occurs more than tumor laden skin
• Host defense clears residual cancer – Longer time to re-excision supports this theory
• Use of electrocautery at excision site could destroy remaining cancer cells

Conclusion:
The absence of residual tumor after re-excision of specimens with positive margins is 52%, similar to that report in the literature. Patients with BCC and larger re-excisions are more likely to have residual cancer upon re-excision. Lesions with positive deep and lateral margins or SCC, are recommended for re-excision. Lesions that require re-excision and are located in cosmetically sensitive areas may best be served by Mohs surgery. For smaller lesions, close observation may be more practical method of treatment.