key points

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Basal cell carcinoma (BCC) is a slow growing, locally invasive malignant epidermal skin tumour. The tumour infiltrates tissue in a three dimensional fashion through the irregular growth of finger-like projections which remain continuous with the main tumour mass. Metastases are very rare and morbidity results from the localised destruction of tissue particularly on the head and neck. Suspected high-risk BCCs on the central face (around the eyes, nose, lips and ears) should be referred for an urgent opinion.

BCCs most commonly present on the head and neck and sun-exposed sites but may occur at any body site. Patients will often report a non-healing wound that recurrently bleeds, crusts and scabs but does not heal. BCCs can present as slow growing papules, nodules, plaques or ulcers with a rolled edge. They can be pearly, red, pink or pigmented and some have a degree of translucency. Surface blood vessels are often visible. Generally, BCCs grow slowly over months to years.

The history should involve a thorough review of the patient's risk factors and consider: the site and size of the lesion; how long the lesion has been present; rate of growth; bleeding, crusting, scabbing; keratotic vs non-keratotic; whether the lesion is painful; history of previous skin cancers; skin type (I-VI); occupational sun exposure (e.g. farming, military, construction); patient's medication particularly anticoagulants and any clotting abnormalities that may influence surgery.

A full skin check should be performed which helps to give a context to the background sun exposure as well as identifying other potential lesions of concern. The lesion itself should be palpated and it may be necessary to remove some of the surface crust with gloved fingers to allow for a more accurate diagnosis. Differential diagnosis includes malignant and benign growths including but not limited to: SCC, melanoma, actinic keratosis, Bowen's disease, trichoepithelioma, sebaceous hyperplasia, chondrodermatitis, fibrous papule of the face and molluscum contagiosum.

Individual patient factors will influence treatment choice including performance status, concurrent medical conditions and the use of anticoagulant medications. A conservative watch and wait approach may be reasonable for low-risk tumours and it is important that the risks of treatment are weighed against the benefits. In certain clinical circumstances clinicians and patients may mutually choose to manage high-risk tumours conservatively where palliation is kinder than curative treatment which may cause significant morbidity. Striking a balance between tumour eradication and acceptable cosmetic and functional outcomes is key. Excision of BCC with intraoperartive or postoperative examination of tissue margins remains the gold standard for treatment of low- and high-risk BCCs and has the highest overall cure rate.