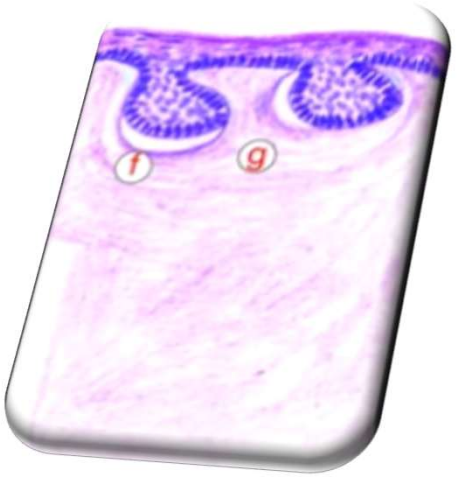
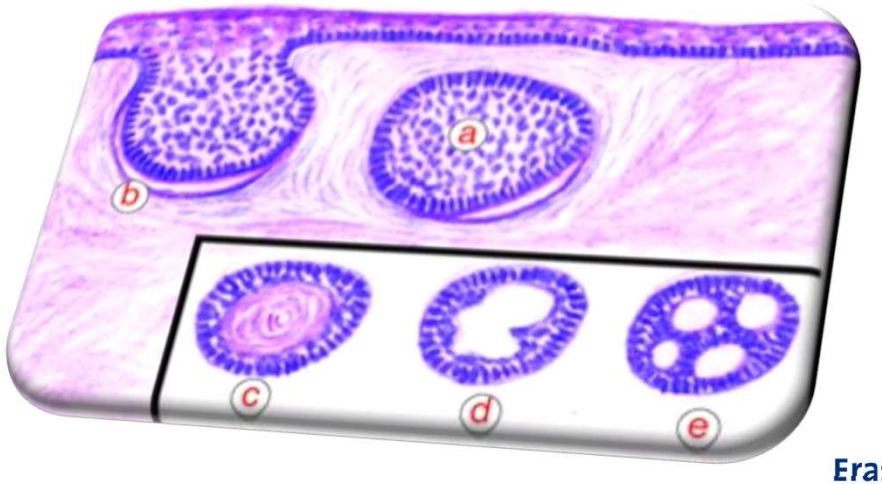
BASAALCELCARCINOOM



Antien Mooyaart

Rosai 29-11



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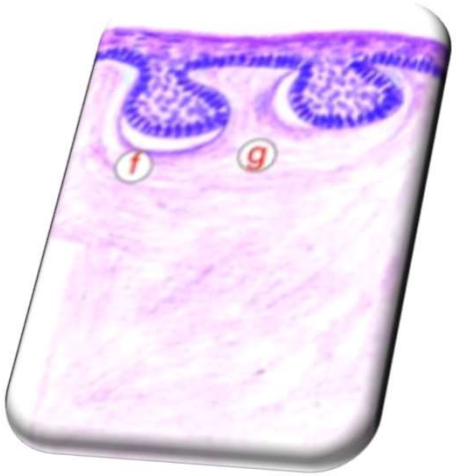
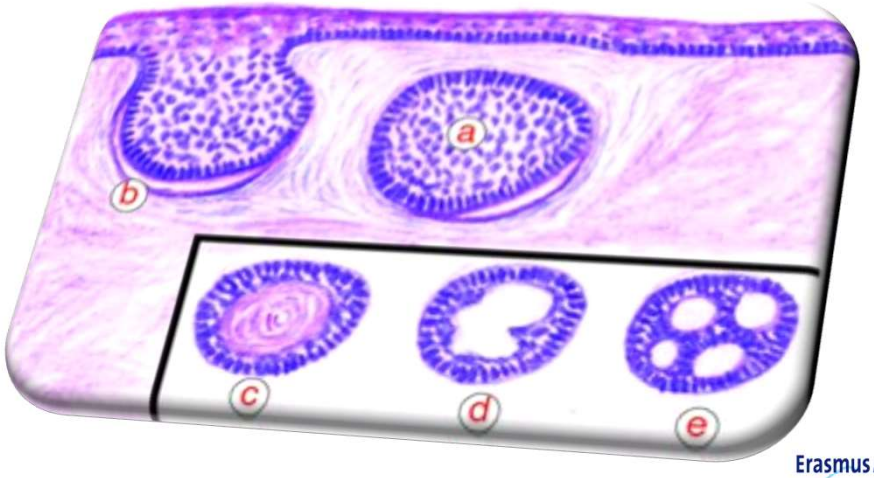
OVERZICHT

- Subtypes
- Coupes kijken
- Literatuur





WHO SKIN TUMORS
SUPERFICIEEL BCC

- Lobules of basaloid cells with peripheral palisading extend from the base of the epidermis, and occasionally adnexal epithelium, into the papillary dermis . Retraction of lobules from surrounding fibromyxoid stroma and a lymphoplasmacytic infiltrate may be seen

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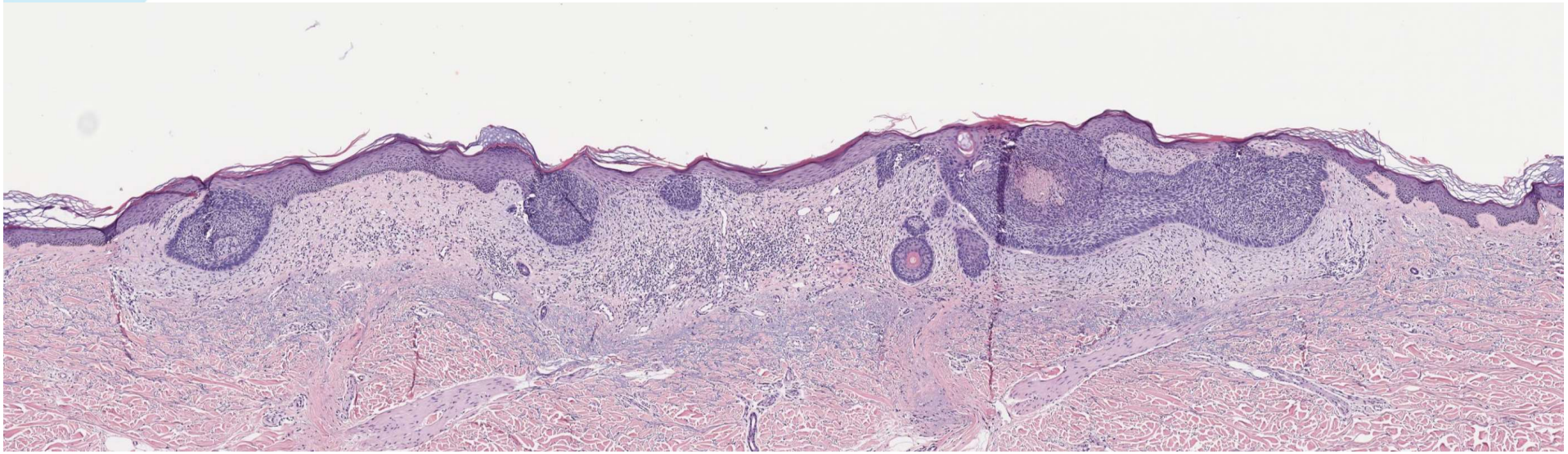
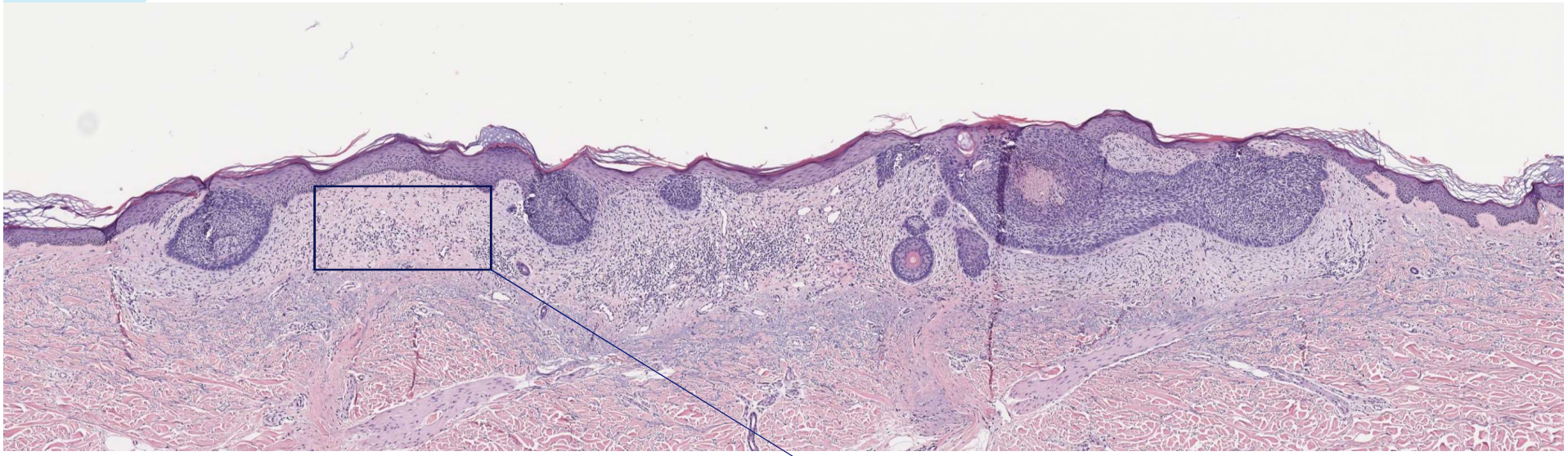
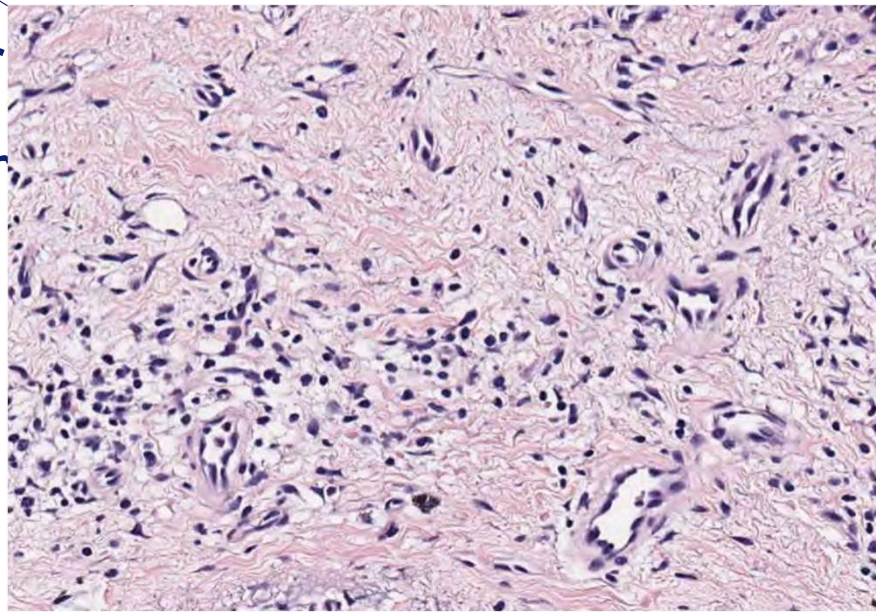


- In contact staat met epidermis
- Groeit in de papillaire dermis
- Fibromyxoid stroma



- In contact staat met epider
- Groeit in de papillaire derm
- **Fibromyxoid stroma**



WHO SKIN TUMORS NODULAIR BCC

- Well-circumscribed, variably-sized nodules of basaloid cells with peripheral palisading and retraction spaces are seen; disorganized nuclear arrangement with apoptosis is frequently observed in the center of the nodules.The tumour is usually connected with the epidermis. The stroma is paucicellular; amyloid deposition or keloidal-type collagenous stroma may be seen, but not desmoplasia.

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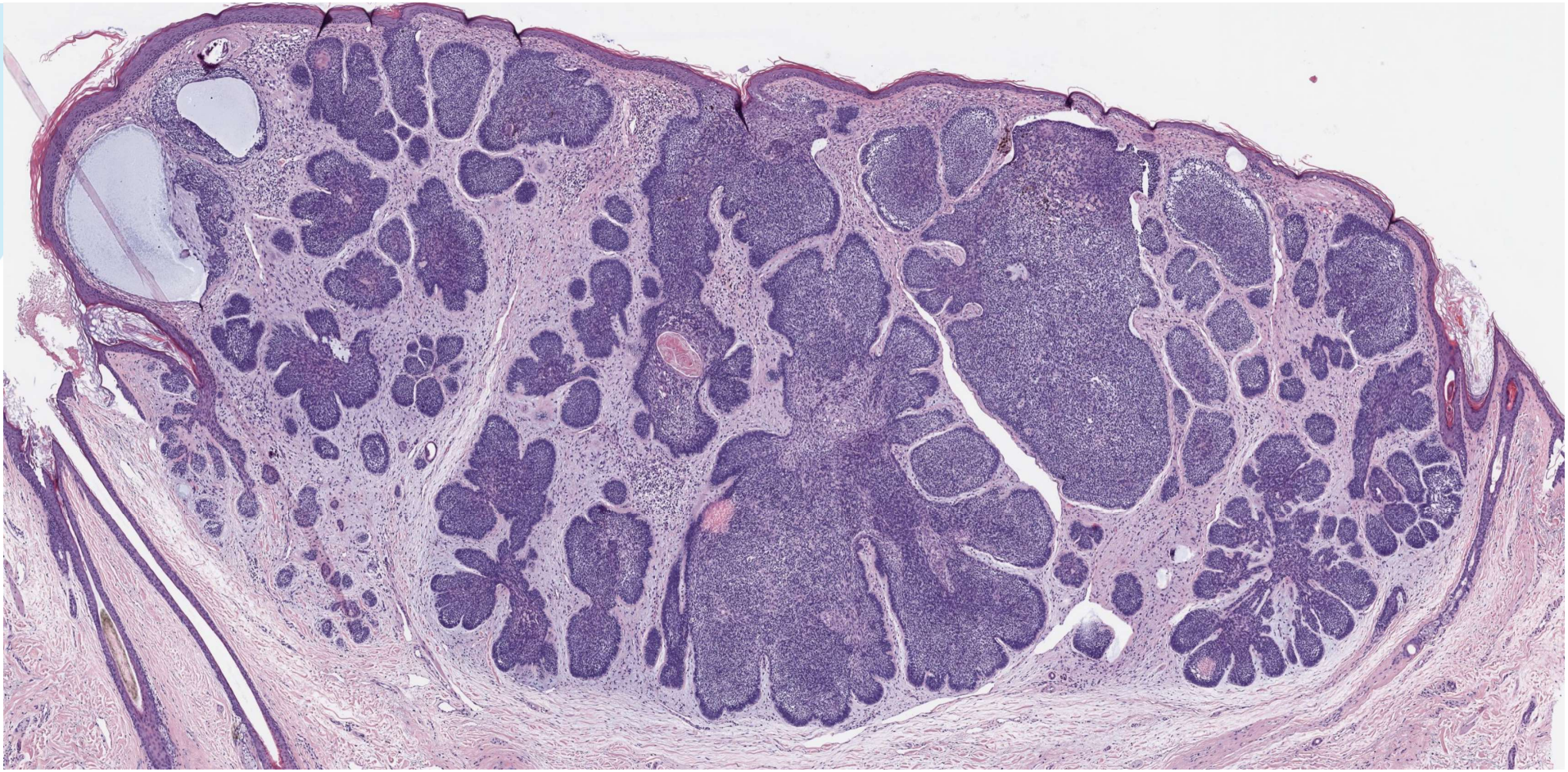

- Nodules in de dermis
- Geen desmoplastisch stroma

WHO SKIN TUMORS - MICRONODULAR

- Micronodular BCC is composed predominantly of **rounded, ovoid or slender groups of basaloid cells often scattered throughout the dermis and subcutis** { 34931722 ; 35885545 }. These may appear as separate satellites outlined by a **thin rim of stroma** and separated by normal dermis. **The tumours have an irregular, tentacular and infiltrative deep or peripheral edge composed predominantly (i.e. greater than 50%) of rounded small discrete groups of cells (less than 0.15 mm in diameter).**

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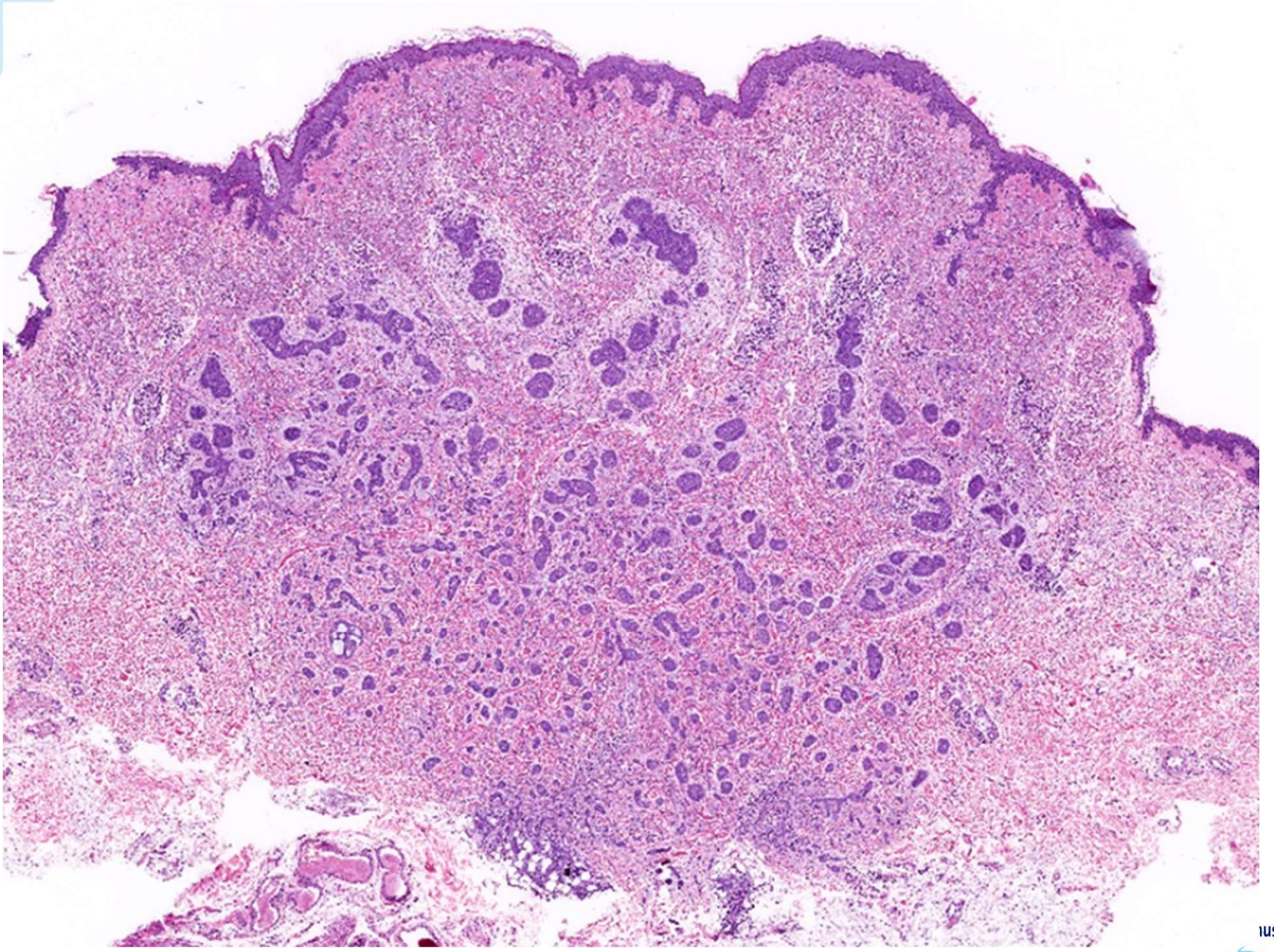
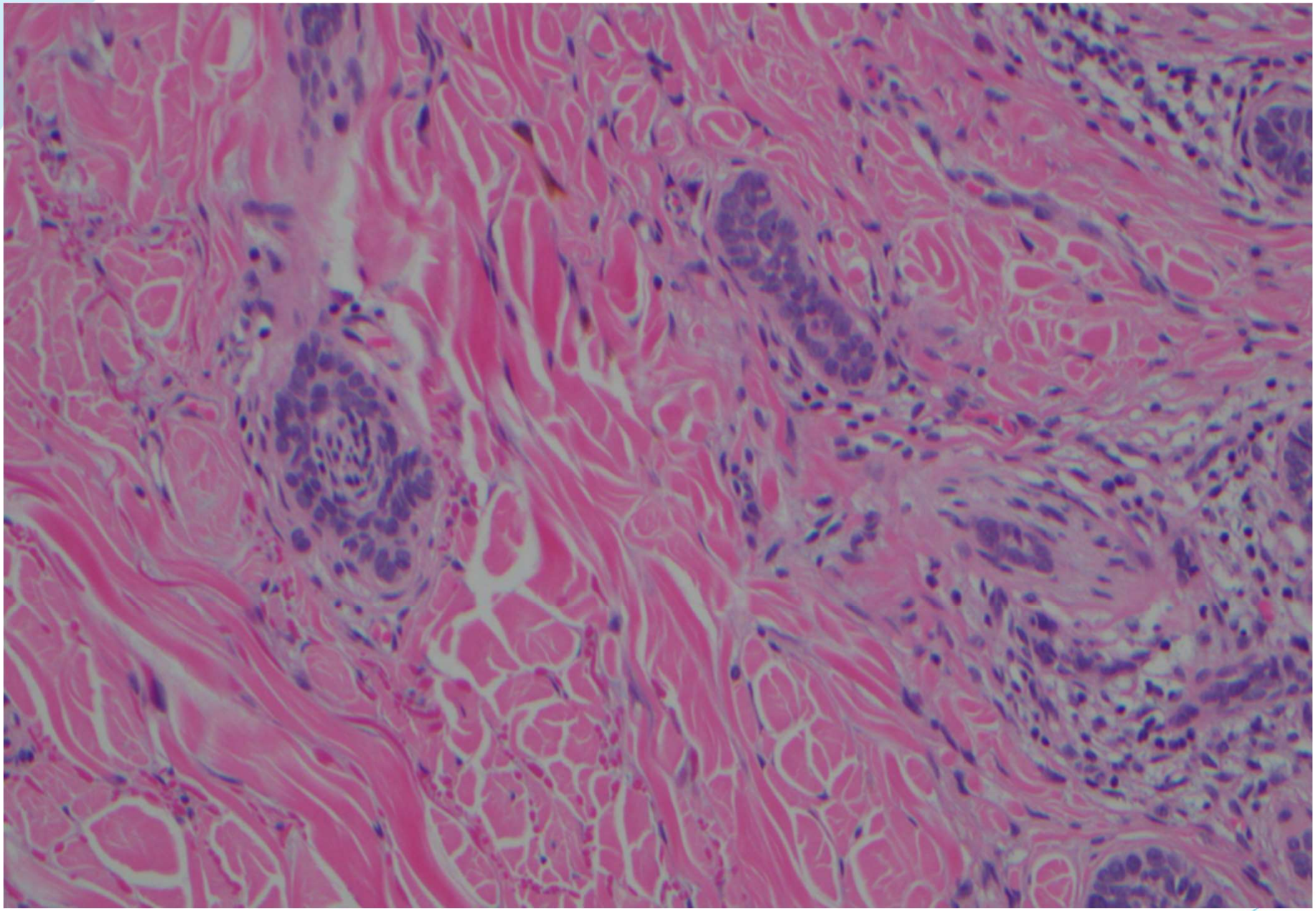
Single nodules may be seen distant from the bulk of the main tumour. The tumours can reach a large size and may demonstrate perineural involvement. This pattern is frequently mixed with other patterns including nodular and infiltrative BCC.

Section misorientation and the lack of strict definitions in terms of the size and number of micronodules may contribute to **poor interobserver reproducibility in the diagnosis** of this variant reported in some studies

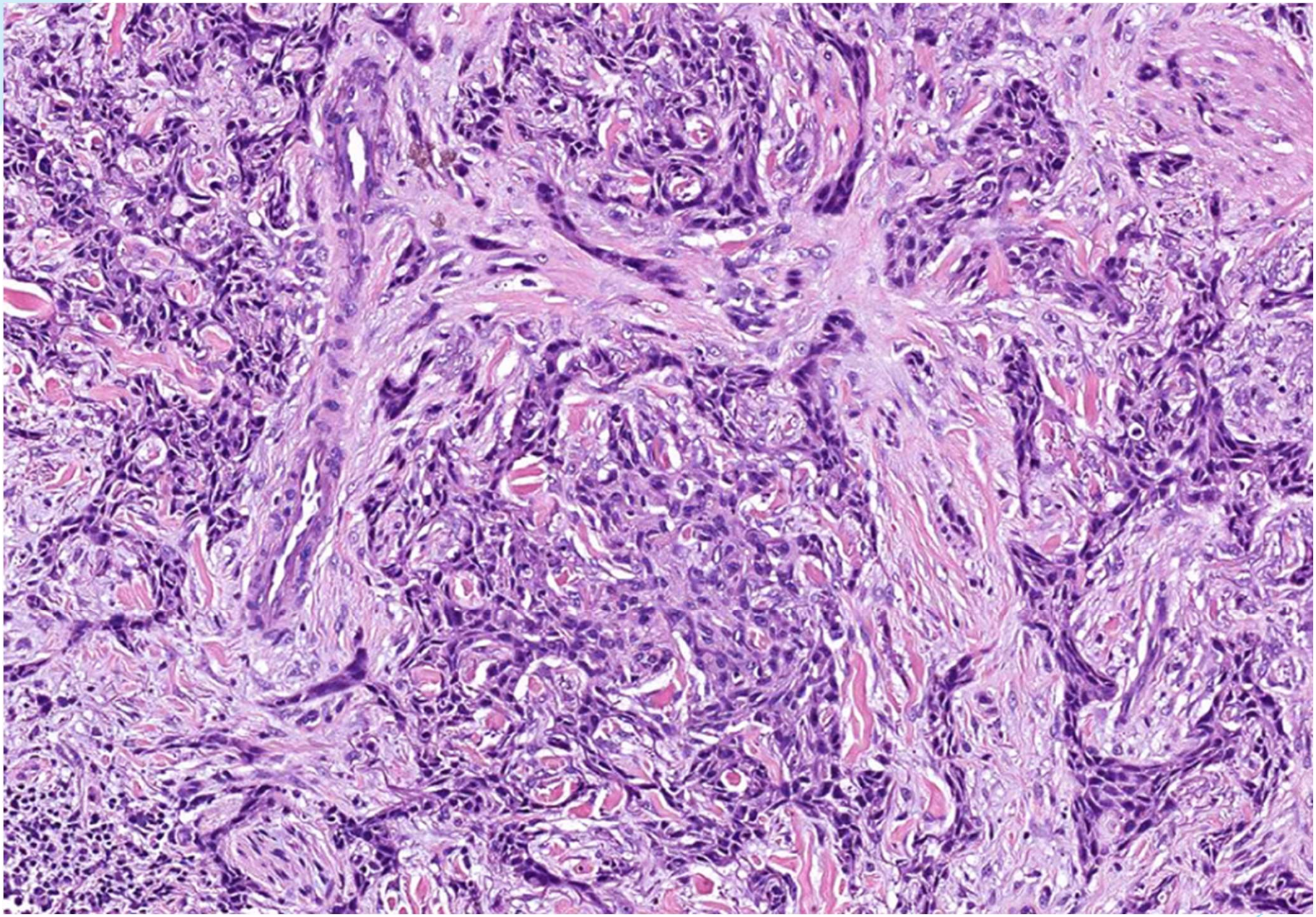




INFILTRATING

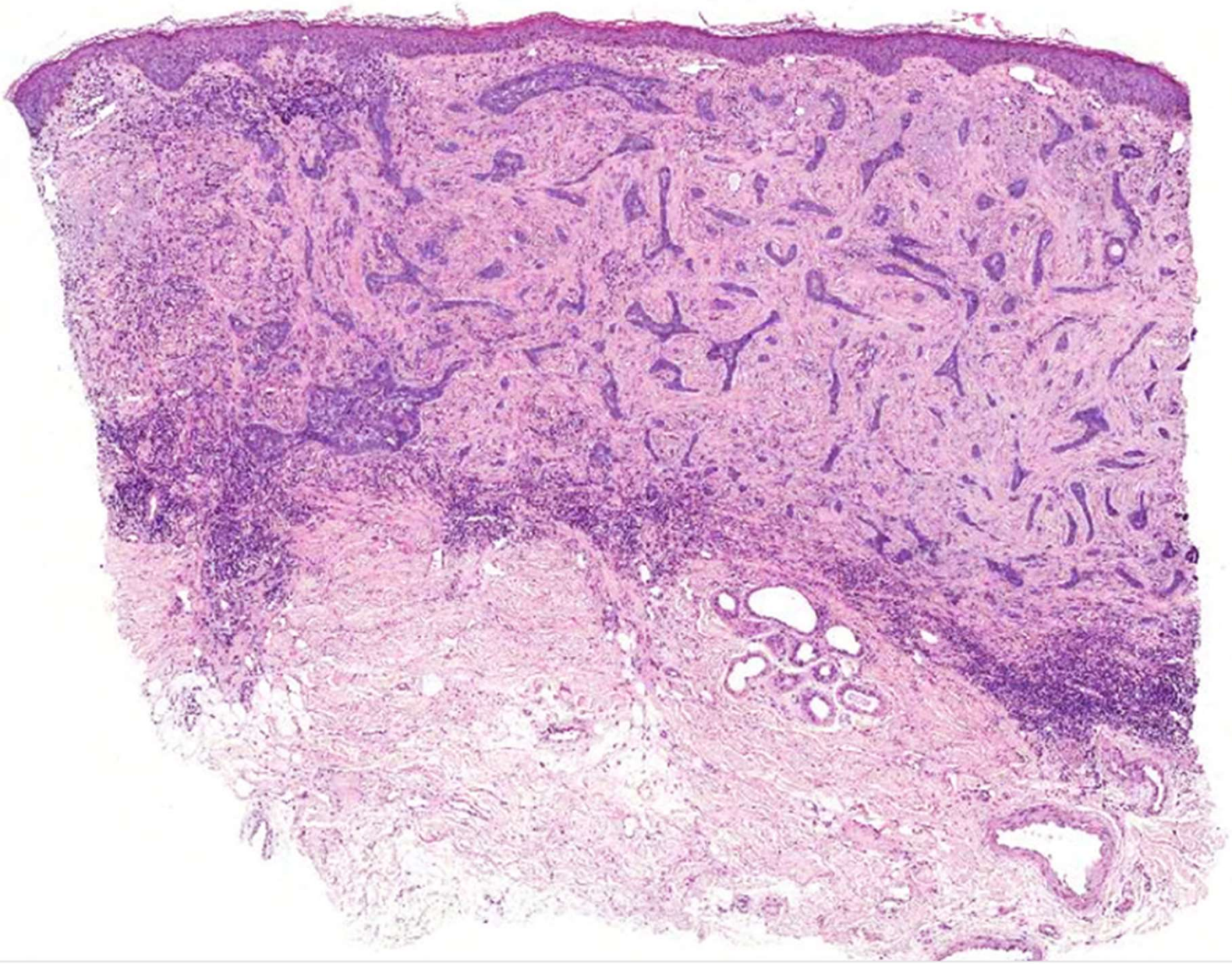
- Variably sized, sometimes jagged nests of basaloid tumour cells infiltrate the normal dermal collagen. The tumour has an **irregular permeating pattern of invasion at the deep tumour edge.**

- Approximately one third of infiltrating BCCs are admixed with a nodular BCC component. Perineural invasion is more frequent in this subtype.



SCLEROSING/MORPHOEIC BASAL CELL CARCINOMA

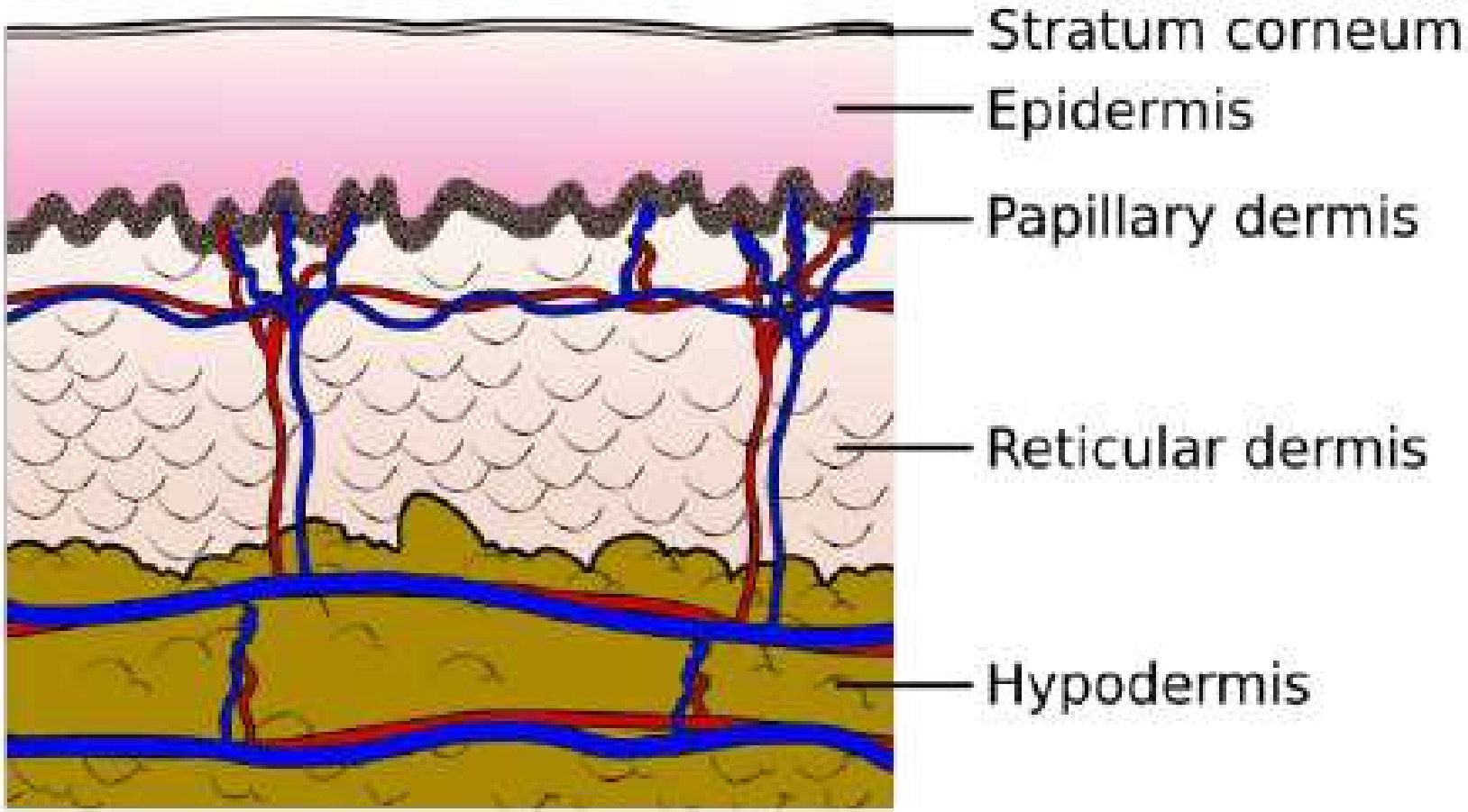
- Narrow cords of tumour (1–5 cells thick) are compressed by induced **sclerotic collagenous stroma**, disrupting the normal dermal architecture. Peripheral palisading and **retraction artifacts are uncommon**. These tumours penetrate deeply and show an irregular/ tentacular, deeply infiltrative border with the surrounding stroma. **There is often overlap with infiltrating BC**C, which **lacks** the **prominent induced collagenous stroma.**

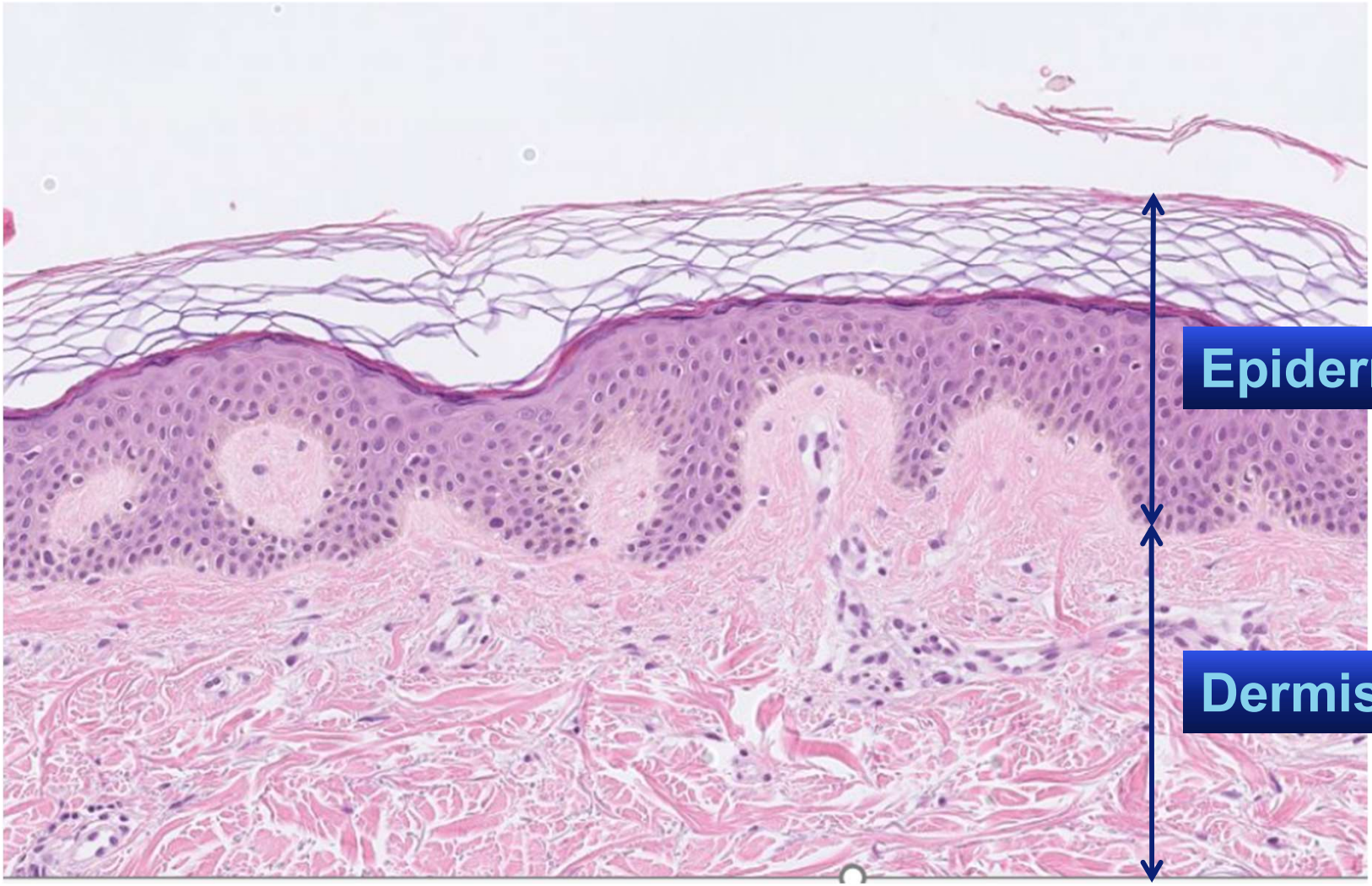


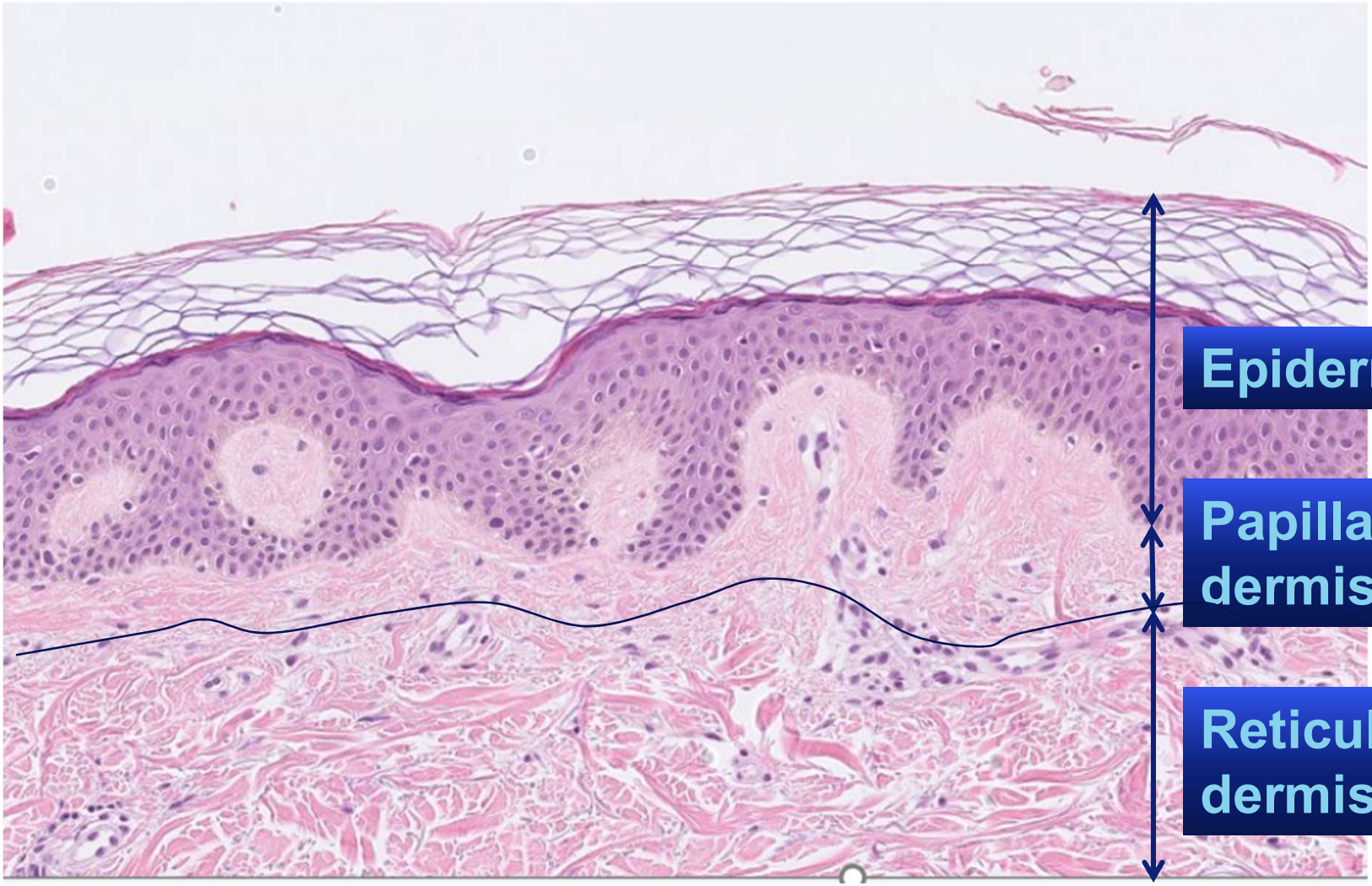
SAMENVATTING

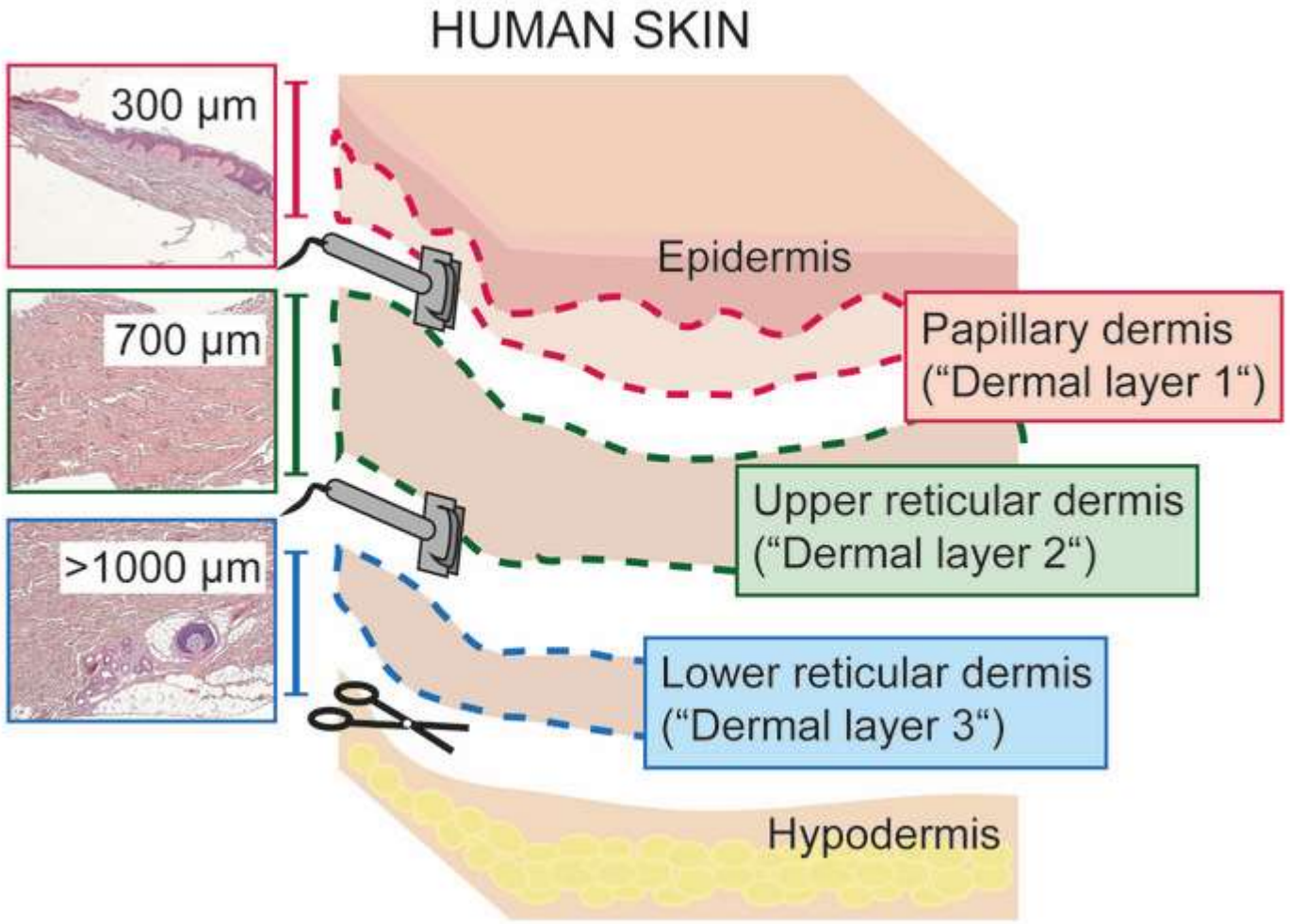
- Superficieel – papillaire dermis
- Nodulair – geen desmoplastische stromareactie
- Sprieterig (infiltrating/sclerosing) – irregulair patroon van invasie, wel desmoplastische stromareactie
- Micronodulair – geen stromareactie

NORMALE HUID




Epidermis
Dermis


Epidermis
Papillaire dermis
Reticulaire dermis


HUMAN SKIN
300 µm
700 µm
>1000 µm
Epidermis
Papillary dermis
("Dermal layer 1")
Upper reticular dermis
("Dermal layer 2")
Lower reticular dermis
("Dermal layer 3")
Hypodermis

COUPES KIJKEN

POSITION STATEMENT

Position paper on a simplified histopathological classification of basal cell carcinoma: results of the European Consensus Project

M.T. Fernández-Figueras,[1,*] J. Malvehi,[2] P. Tschandl,[3] A. Rutten,[4] F. Rongioletti,[5] L. Requena,[6] H. Kittler,[3] K. Kerl,[7] D. Kazakov,[8] B. Cribier,[9] E. Calonje,[10] J. André,[11] W. Kempf,[12,13]
Study Group Collaborators (Validation Group)

[1]Department of Pathology, Hospital Universitari General de Catalunya, Grupo Quironsalud & Universitat Internacional de Catalunya, Sant Cugat del Vallés, Spain

[2]Department of Dermatology, Hospital Clínic de Barcelona (Melanoma Unit), University of Barcelona, IDIBAPS, Barcelona & CIBERER, Barcelona, Spain

[3]Department of Dermatology, Medical University of Vienna, Vienna, Austria

[4]Dermatopathology Practice Friedrichshafen/Lake Constance, Friedrichshafen, Germany

[5]Dermatology Clinic, IRCCS San Raffaele Hospital, Vita Salute University, Milan, Italy

[6]Department of Dermatology, Fundación Jiménez Díaz, Universidad Autónoma, Madrid, Spain

[7]Department of Dermatology, University Hospital Zürich, Zürich, Switzerland

[8]Sikl's Department of Pathology, Medical Faculty in Pilsen, Charles University in Prague, Pilsen, Czech Republic

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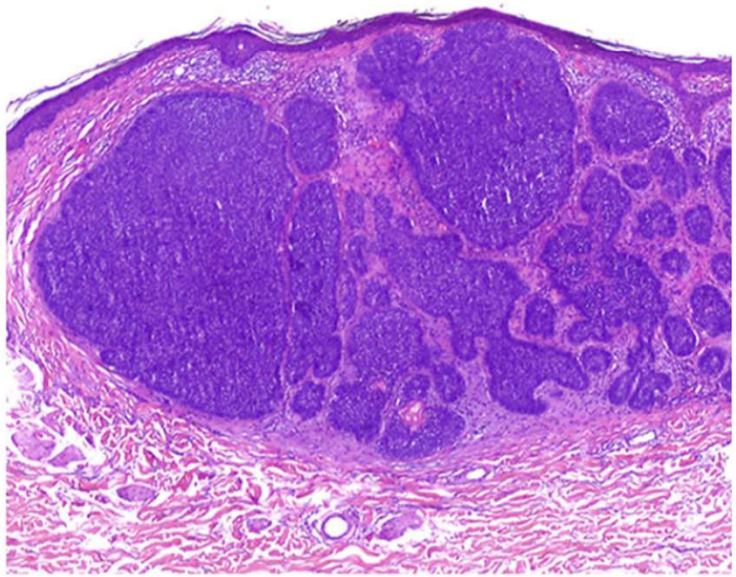
[12]Kempf Pfaltz Histologische Diagnostik, Zurich, Switzerland

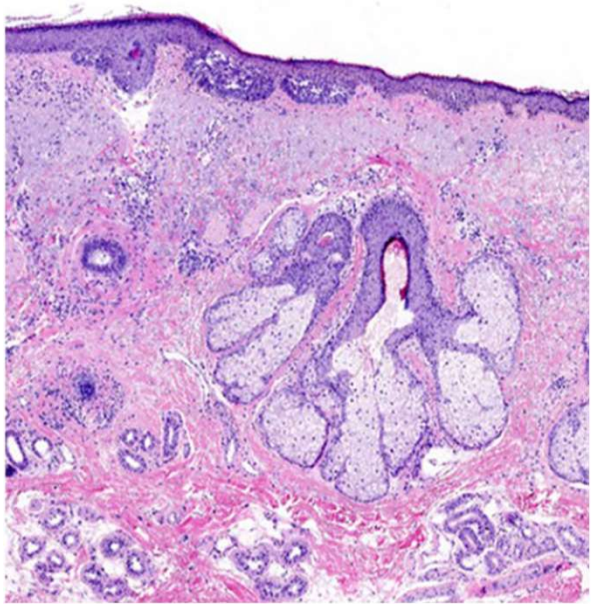
[13]Department of Dermatology, University Hospital Zurich, Zürich, Switzerland

*Correspondence: M.T. Fernández Figueras. E-mail: maiteffig@gmail.com

Nodular



Superficial



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REPRODUCEERBAARHEID

Table 4 Results of Fleiss' kappa (κ) measures of the reliability of agreement corresponding to the different subtype classifications and assessments of 100 BCC cases by 12 panellists (G12) and 10 expert dermatopathologists in the validation group (G10)

BCC subtype	WHO classification (G12) Fleiss' Kappa (95%CI)	Simplified classification (G12) Fleiss' Kappa (95%CI)	Simplified classification (G10) Fleiss' Kappa (95%CI)
Nodular	0.248 (0.219–0.278)	0.431 (0.402–0.461)	0.445 (0.431–0.460)
Infiltrating	0.314 (0.284–0.343)	N/A	N/A
Sclerosing	0.288 (0.259–0.343)	N/A	N/A
Micronodular	0.205 (0.176–0.235)	N/A	N/A
Infiltrative subtype (unified)	N/A	0.515 (0.486–0.545)	0.532 (0.518–0.546)
Superficial	0.611 (0.581–0.640)	0.747 (0.718–0.776)	0.720 (0.706–0.734)
Basosquamous	0.276 (0.247–0.306)	0.342 (0.313–0.371)	0.315 (0.301–0.330)
Other	0.092 (0.063–0.122)	N/A	N/A
Other BCC	N/A	0.589 (0.560–0.618)	0.545 (0.531–0.559)
Other non-BCC	N/A	0.210 (0.180–0.239)	0.142 (0.128–0.156)

Levels of agreement according to Kappa results can be interpreted as follows[25]: Values ≤ 0 indicate no agreement, and 0.01–0.20 indicate none to slight, 0.21–0.40 indicate fair, 0.41– 0.60 indicate moderate, 0.61–0.80 indicate substantial, and 0.81–1.00 indicate almost perfect agreement.
BCC, Basal cell carcinoma; 95%CI, 95% confidence interval; N/A, not applicable.

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Table 1. BCC subtype by observer

Subtype	Observer						
	A	B	C	D	E	F	Total (%)
Nodular	34	52	42	57	54	48	287 (48)
Infiltrative*	21	37	21	22	23	8	132 (22)
Superficial	15	23	22	9	27	8	104 (17)
Pigmented	14	10	17	18	11	9	79 (13)
Morpheaform*	6	0	18	6	11	13	54 (9)
Micronodular*	6	1	7	17	3	4	38 (6)
Fibroepithelial	6	6	4	4	4	3	27 (5)
Infundibulocystic	3	4	0	0	10	0	17 (3)
Nodulocystic	5	0	3	1	0	5	14 (2)
Keratotic	0	0	2	7	3	0	12 (2)
Basosquamous*	0	0	4	0	3	3	10 (2)
Metatypical*	3	0	0	3	0	0	6 (1)
Adenoid	0	0	4	1	0	1	6 (1)
Squamatized	0	0	0	0	0	4	4 (1)
Sclerosing*	2	0	1	0	0	0	3 (<1)
With follicular differentiation	0	0	2	0	0	0	2 (<1)
Clear cell	0	0	0	0	0	2	2 (<1)
Adamantinoid	0	0	1	0	0	0	1 (<1)
With eccrine differentiation	0	0	1	0	0	0	1 (<1)
Adenocystic	0	0	0	0	1	0	1 (<1)
With thickened basement membrane	0	0	0	0	0	1	1 (<1)

*Classified as high-risk in two-tiered analysis.

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Infundibulocystic	3	4	0	0	10	0	17 (3)
Nodulocystic	5	0	3	1	0	5	14 (2)
Keratotic	0	0	2	7	3	0	12 (2)
Basosquamous*	0	0	4	0	3	3	10 (2)
Metatypical*	3	0	0	3	0	0	6 (1)
Adenoid	0	0	4	1	0	1	6 (1)
Squamatized	0	0	0	0	0	4	4 (1)
Sclerosing*	2	0	1	0	0	0	3 (<1)
With follicular differentiation	0	0	2	0	0	0	2 (<1)
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Kappa 0.7

Diagnostic concordance rates in the subtyping of basal cell carcinoma by different dermatopathologists. J Cutan Pathol. 2014

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Surgical excision versus imiquimod 5% cream for nodular and superficial basal-cell carcinoma (SINS): a multicentre, non-inferiority, randomised controlled trial

*Fiona Bath-Hextall, Mara Ozolins, Sarah J Armstrong, Graham B Colver, William Perkins, Paul S J Miller, Hywel C Williams, on behalf of the Surgery versus Imiquimod for Nodular and Superficial basal cell carcinoma (SINS) study group**

	Successfully treated with imiquimod	Successfully treated with surgery	Difference (%, 98% CI)*	RR (98% CI)†‡	p value§
Modified intention-to-treat analysis					
3 years					
Superficial	97/114 (85·1%)	96/98 (98·0%)	12·9% (4·4–21·3)	..	..
Nodular	81/99 (81·8%)	89/90 (98·9%)	17·1% (7·7–26·4)	..	..
All	178/213 (83·6%)	185/188 (98·4%)	14·8% (8·6–21·1)	0·84 (0·78–0·91)	<0·0001
2 years					
Superficial	101/116 (87·1%)	99/100 (99·0%)	11·9% (4·3–19·5)	..	..
Nodular	90/107 (84·1%)	92/93 (98·9%)	14·8% (6·2–23·4)	..	..
All	191/223 (85·7%)	191/193 (99·0%)	13·3% (7·6–19·3)	0·86 (0·80–0·92)	<0·0001
1 year					
Superficial	106/119 (89·1%)	99/100 (99·0%)	9·9% (2·9–17·0)	..	..
Nodular	95/111 (85·6%)	98/99 (99·0%)	13·4% (5·3–21·5)	..	..
All	201/230 (87·4%)	197/199 (99·0%)	11·6% (6·3–17·0)	0·88 (0·82–0·93)	<0·0001
Per-protocol analysis					
3 years					
Superficial	92/109 (84·4%)	96/98 (98·0%)	13·6% (4·8–22·3)	..	..
Nodular	76/93 (81·7%)	88/89 (98·9%)	17·2% (7·5–26·8)	..	..
All	168/202 (83·2%)	184/187 (98·4%)	15·2% (8·7–21·7)	0·83 (0·77–0·90)	<0·0001

Data are n/N (%), unless otherwise indicated. RR=relative risk. *Surgery–imiquinod. †Imiquinod relative to surgery. ‡Relative-risk analysis covariates: centre, tumour type (nodular or superficial), tumour size, tumour site, and immunosuppression. §From likelihood ratio test.

Eligible participants of any age had histologically confirmed, primary, previously untreated, nodular or superficial basal-cell carcinoma not arising at sites at

INVASIE DIEPTE

CLINICAL AND LABORATORY INVESTIGATIONS

BJD
British Journal of Dermatology

Thickness of superficial basal cell carcinoma (sBCC) predicts imiquimod efficacy: a proposal for a thickness-based definition of sBCC

K.M. McKay,[1] B.L. Sambrano,[2] P.S. Fox,[3] R.L. Bassett,[3] S. Chon[4] and V.G. Prieto[4,5]

[1]Departments of Dermatology and Pathology, The University of Alabama at Birmingham, Birmingham, AL, U.S.A.
[2]University of Texas School of Medicine, Houston, TX, U.S.A.
Departments of [3]Biostatistics, [4]Dermatology, and [5]Pathology, The University of Texas MD Anderson Cancer Center, Houston, TX, U.S.A.

- Superficieel basaalcelcarcinoom: definitie volledig vastzittend aan de epidermis

- Kanttekening: diagnostische shave-excisies

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Table 2. Univariate analyses of predictors for tumour recurrence

Variable		Lesion recurrence		*N*	*P*-value
		No	Yes		
Biopsy margin	Negative	25 (100)	0 (0)	25	0·1199
	Positive	91 (89)	11 (11)	102	
Tumour thickness (mm)		0·26 (0·09–0·61)	0·57 (0·41–1·41)	127	< 0·0001
Thickness	≤ 0·4 mm	108 (100)	0 (0)	108	< 0·0001
	> 0·4 mm	8 (42)	11 (58)	19	

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Table 2. Univariate analyses of predictors for tumour recurrence

Variable		Lesion recurrence		*N*	*P*-value
		No	Yes		
Biopsy margin	Negative	25 (100)	0 (0)	25	0·1199
	Positive	91 (89)	11 (11)	102	
Tumour thickness (mm)		0·26 (0·09–0·61)	0·57 (0·41–1·41)	127	< 0·0001
Thickness	≤ 0·4 mm	108 (100)	0 (0)	108	< 0·0001
	> 0·4 mm	8 (42)	11 (58)	19	

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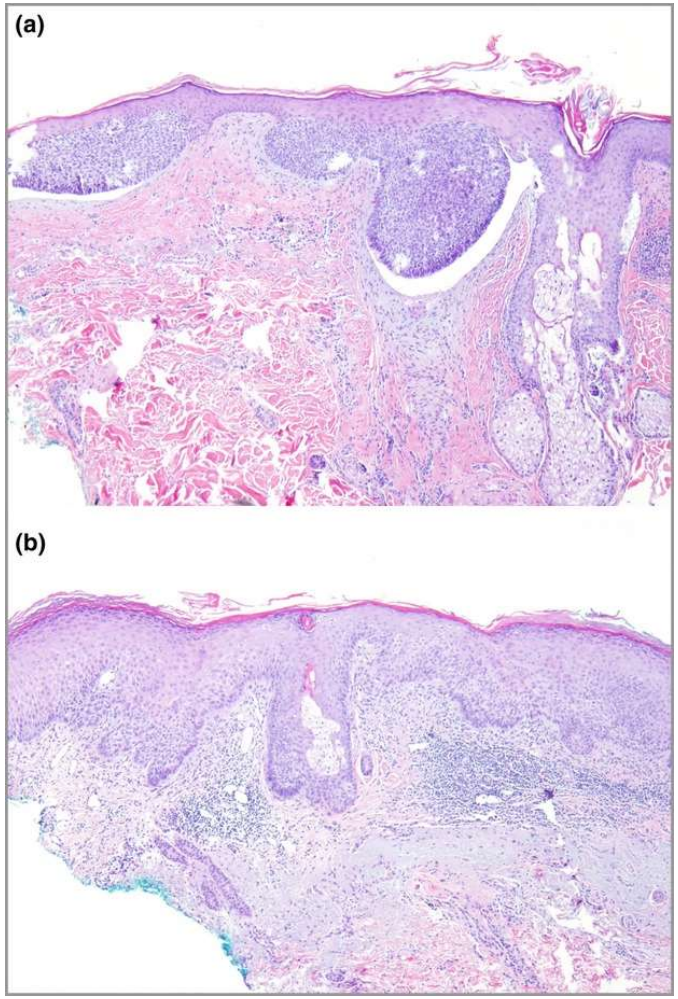
SUPERFICIEEL > 0.4 MM RECIDIEF



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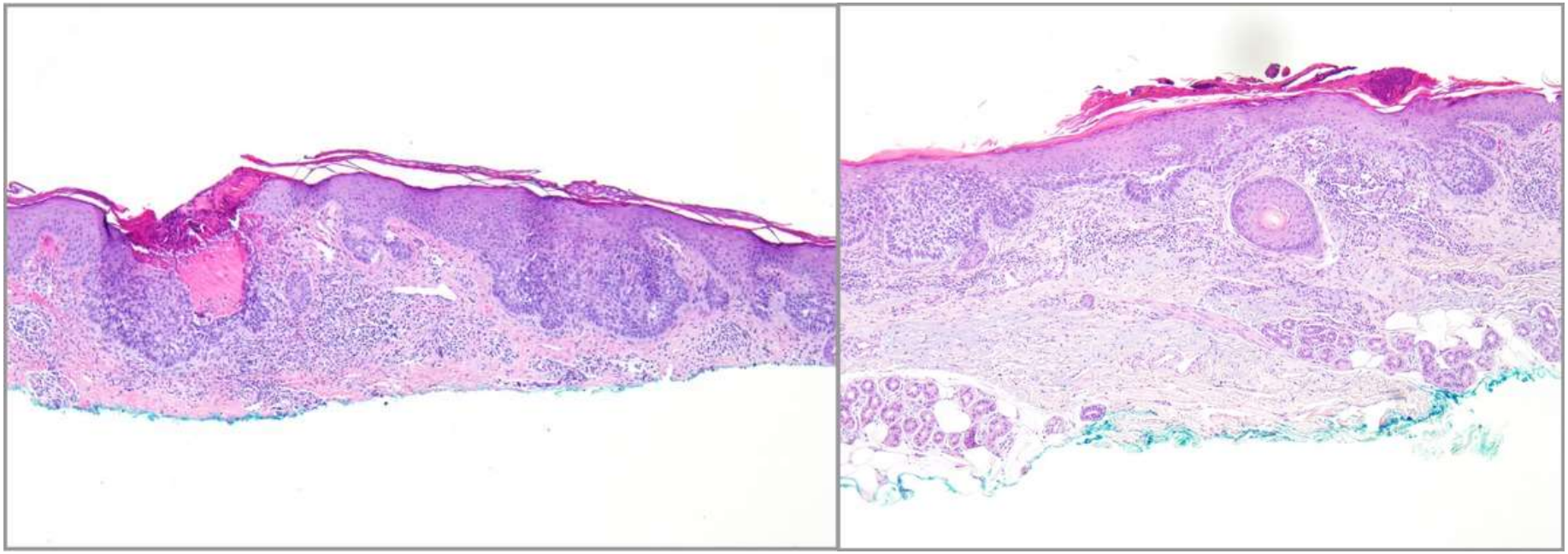
< 0.4 MM, GEEN RECIDIEF



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CONCLUSIE

- Invasiediepte voorspelt respons op imiquimod

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Tumor thickness and adnexal extension of superficial basal cell carcinoma (sBCC) as determinants of treatment failure for methylaminolevulinate (MAL)-photodynamic therapy (PDT), imiquimod, and 5-fluorouracil (FU)

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Table I. Patient and tumor characteristics for cases (treatment failure) and controls (treatment success)

Characteristics	Treatment failure (n = 112)	Treatment success (n = 224)	*P* value
Gender, n (%)			.64
Male	57 (51)	107 (48)	
Female	55 (49)	117 (52)	
Age, y			.21
Mean	60	62	
Median (range)	61 (36-88)	61 (26-87)	
Tumor location, n (%)			
Head/neck, reference	17 (15)	26 (12)	
Upper extremities	11 (10)	37 (16)	.09
Lower extremities	19 (17)	26 (12)	.80
Trunk	65 (58)	135 (60)	.38
Tumor surface area, mm^2			.08
Median	66	47	
Tumor thickness, mm			.90
Mean (range)	0.39 (0.20-0.85)	0.39 (0.20-1.00)	
Median	0.35	0.35	
≤0.4 mm, n (%)	61 (54)	115 (51)	.64
>0.4 mm, n (%)	51 (46)	109 (49)	
Adnexal extension, n (%)			.30
Absent	101 (90)	192 (86)	
Present	11 (10)	32 (14)	
Treatment, n (%)			
MAL-PDT, reference	49 (44)	72 (32)	
Imiquimod	29 (26)	76 (34)	.04
5-FU	34 (30)	76 (34)	.13

P values < .05 were considered to be statistically significant. *FU*, Fluorouracil; *MAL*, methylaminolevulinate; *PDT*, photodynamic therapy.

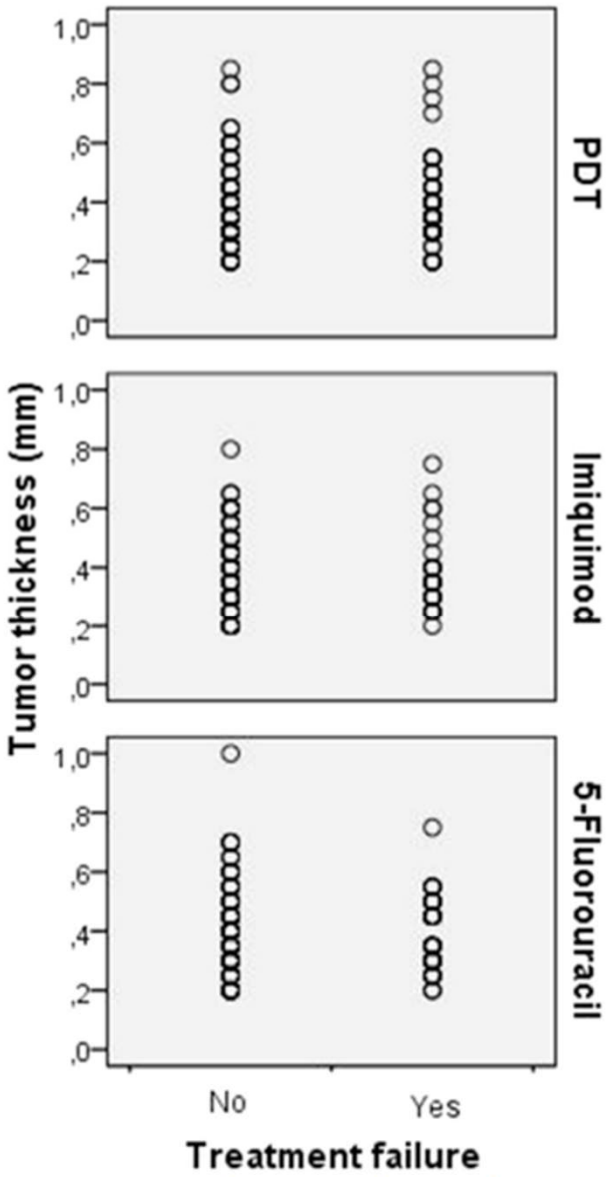

Fig 2. Scatter plot for tumor thickness and treatment failure per treatment. *PDT*, Photodynamic therapy.

CONCLUSIE

- In Nederlandse trial lijkt invasiediepte geen voorspeller voor behandeling effect

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RESEARCH ARTICLE

Superficial basal cell carcinoma, think deeper: Step sectioning of skin biopsy specimens yields 14% more aggressive subtypes

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Definitie superficieel BCC: =/< 0.4 mm of niet voorbij de oppervlakkige vasculaire plexus

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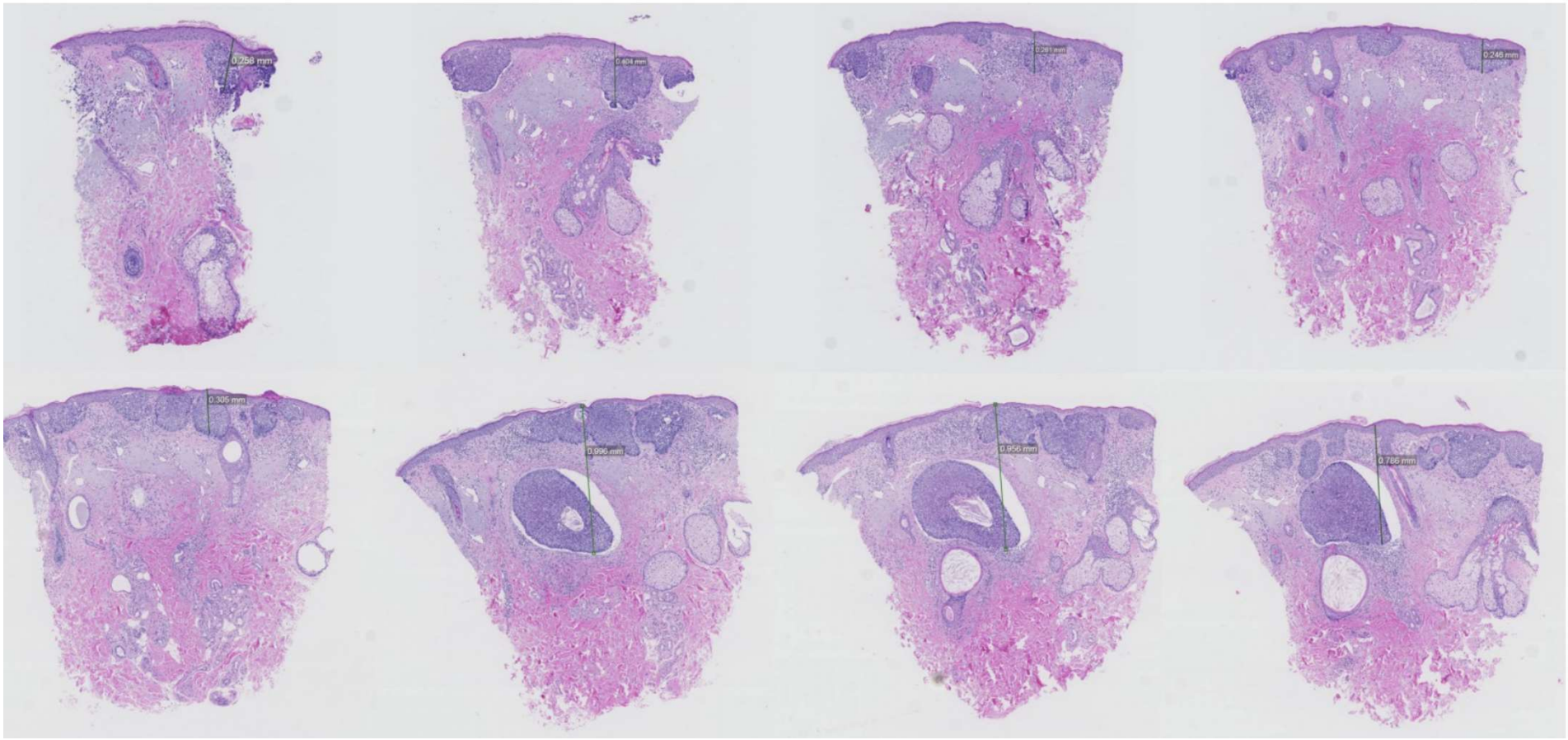

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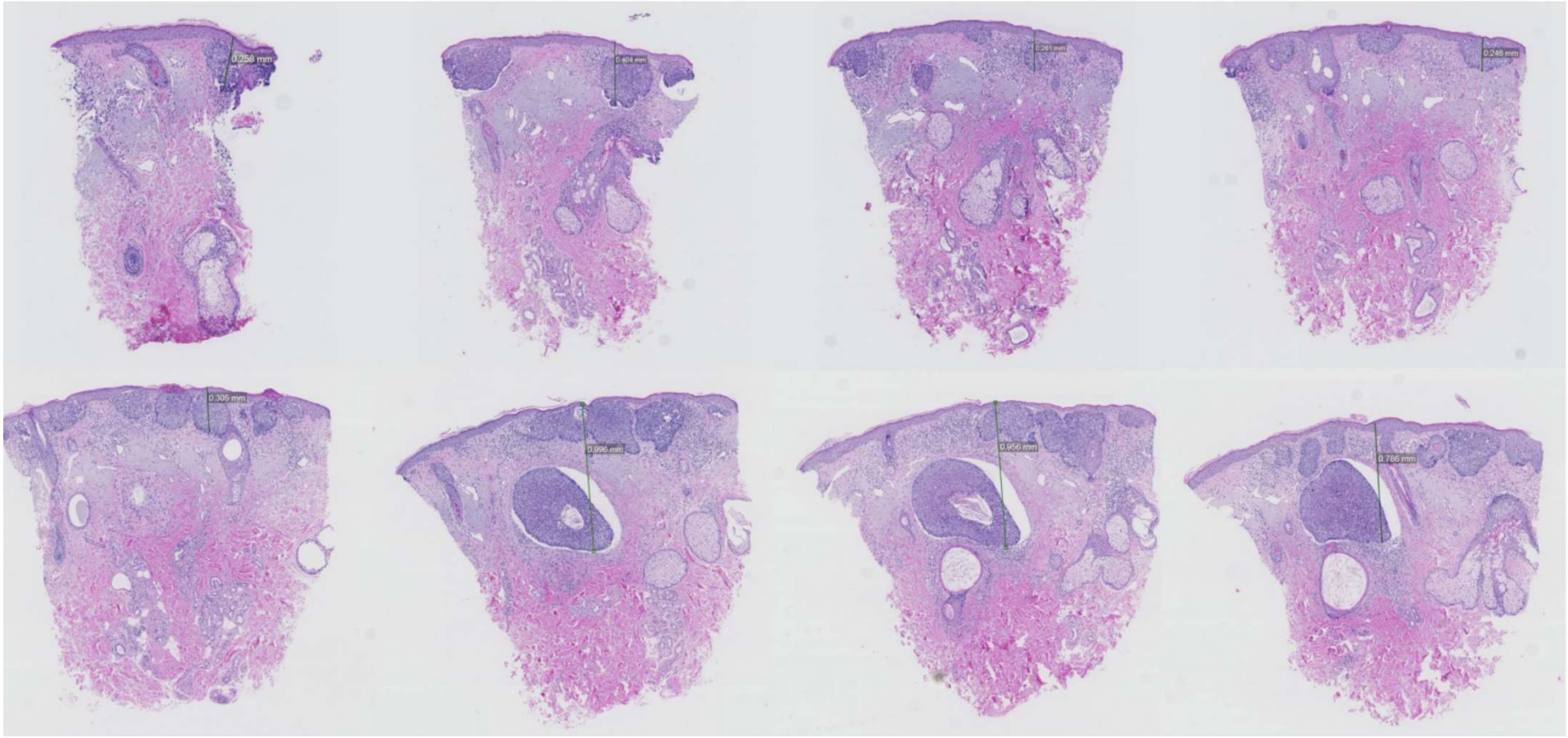
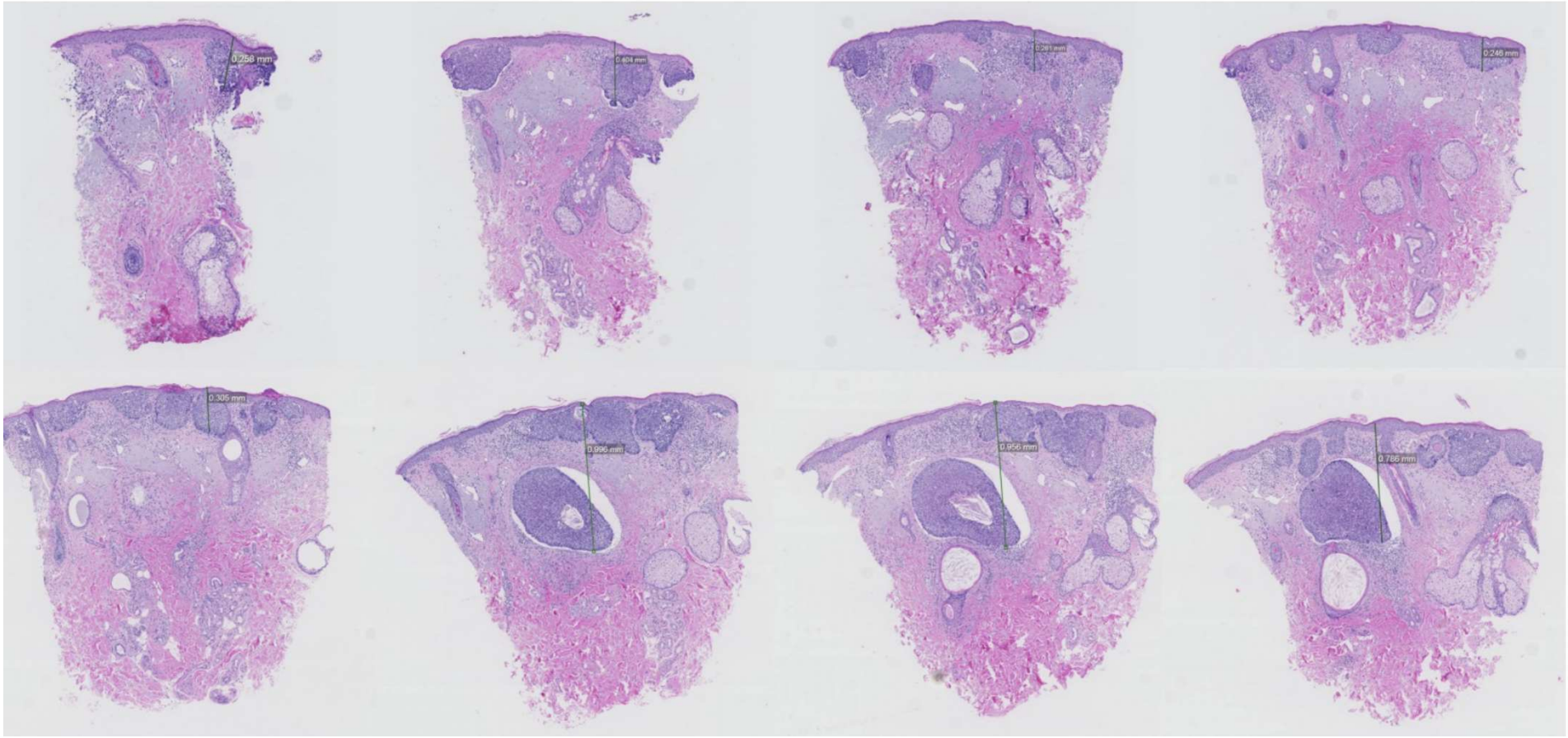
Hoogte 1 t/m 4



Hoogte 5 t/m 8

Hoogte 1 t/m 4



Hoogte 5 t/m 8

14 /100 =14%

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Table 3. Overview of HE levels of the 14 patients with a more aggressive BCC component in deeper HE slides (levels 5–8). All patients had a deeper, nodular component. sBCC = superficial basal cell carcinoma, nBCC = nodular basal cell carcinoma.

Patient nr	Level							
	Standard sectioning level				Additional, deeper sectioning levels			
	1	2	3	4	5	6	7	8
1	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC
2	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC
3	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	NA
4	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC	NA
5	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC
6	sBCC	sBCC	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC
7	sBCC	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC
8	sBCC	sBCC	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC
9	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC
10	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC	nBCC
11	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC	nBCC
12	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC
13*	sBCC	sBCC	sBCC	sBCC	nBCC	sBCC	sBCC	sBCC
14	sBCC	sBCC	sBCC	sBCC	sBCC	nBCC	nBCC	nBCC

CONCLUSIE

- Diepere doorsnijdingen– meer nodulair
- Met name bij hoofd/hals of thorax

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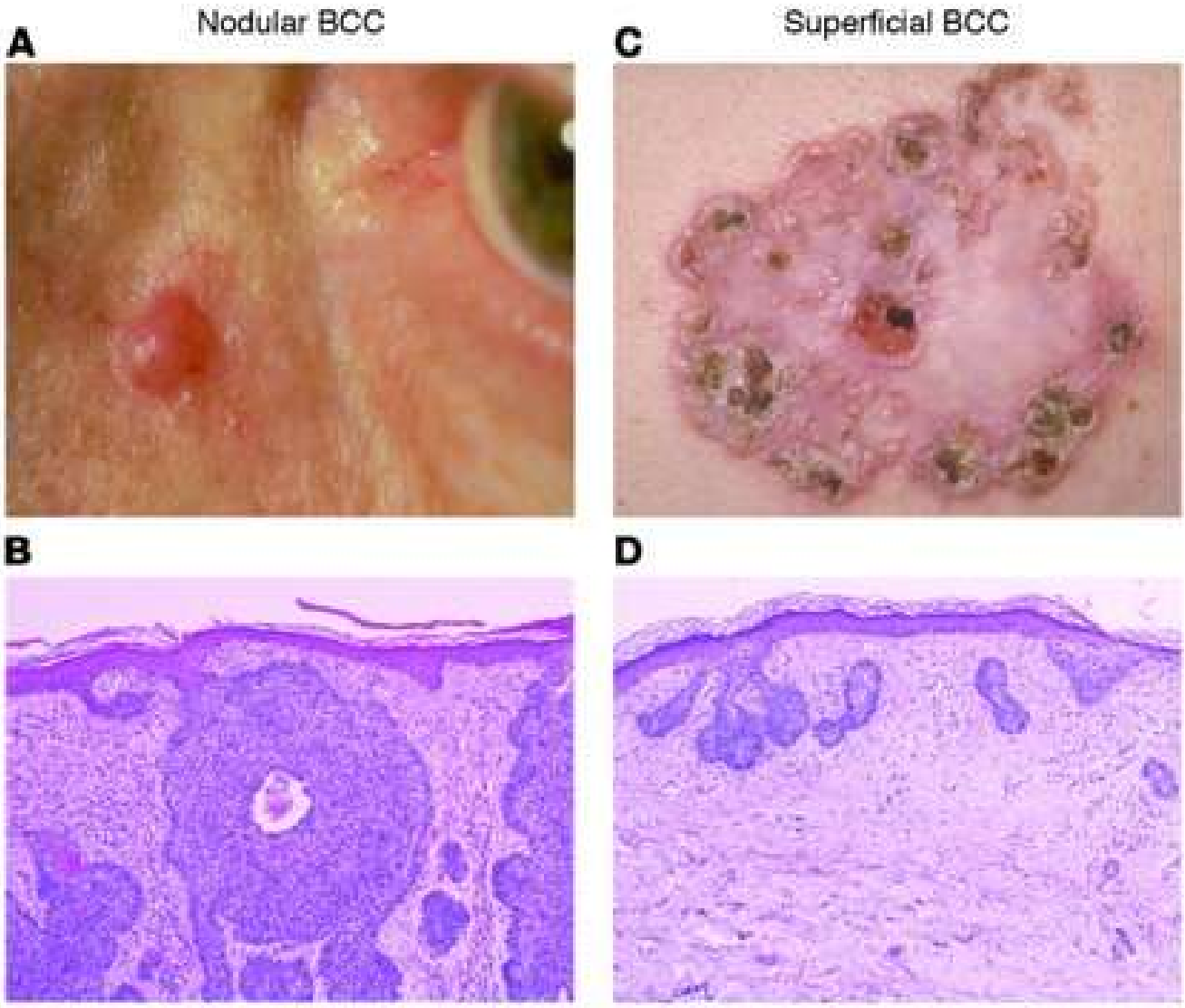

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CONCLUSIE

- Suboptimale definitie van subtype van het basaalcelcarcinoom

- Consequenties zijn er wel

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