TREATMENT OF T1 NONMELANOMA SKIN CANCER OF FACE WITH GRAFTS

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Background:

Though nonmelanoma skin cancer (NMSC) is frequently excluded from cancer registries, it is the most common cancer amongst Caucasians[1]. In USA its annual incidence is now estimated to equal all other cases of malignancies combined[2]. Basal cell carcinoma (BCC) accounts for almost 75% of all NMSC, whereas squamous cell carcinoma (SCC) accounts for the majority of the remaining 25%. Australia has the highest rate of BCC in the world with reported incidence of up to 2% per year in certain regions[3]. Face is by far the most common site of origin of both BCC and SCC[4]. The highest choice of cure is achieved either by radical excision or by destruction with radiotherapy. The final cosmetic result, regardless of the site of the tumor on the face, has been shown to be significantly better with surgery than with radiotherapy[5]. The major problem of skin cancer is the defect left behind after its excision. We aim at presenting our experience with closing such defects of the face with grafts.

Methods:

Traditionally there are three methods of repairing defects after excision of skin cancer: linear repair, local flaps and grafts. Linear repair is the first choice treatment. Local flaps have certain disadvantages: they violate basic principles of following relaxed skin tension lines, they often necessitate significant dissection, they are more time consuming. Consequently in cases of lack of skin or previous operations or to avoid the possibility of complications (for example, ectropion) we use full thickness skin grafts or composite grafts (for nasal ala).

Twelve patients (9 males and 3 females) with tumors of head and face are included in this paper. The age range of the patients is from 29 to 88 years. All of them were treated with full thickness excision of the tumor and cover of the defect with full-thickness skin grafts obtained from the supraclavicular or lower abdominal area, except for one involving the nasal alar margin, which was covered with composite graft (skin – cartilage – skin) obtained from the auricle. All operations were conducted in one step. Histology proved 9 BCC, 1 SCC and 2 benign tumors.

Results:

Our follow-up ranges from 6 months to 18 years. Neither a full rejection nor a local recurrence has been observed through these years. We did have partial rejections (in cases of diabetes mellitus – a factor which is described in literature as being aggravating for operations involving grafts, or chemotherapy for other reasons). Though we had no local recurrence, we have operated on a man with a recurrent BCC having already been operated elsewhere and on a man with a second and a third primary tumor. It's worth mentioning that we have used full-thickness skin graft on bone without periosteum. The final aesthetic result was acceptable by all patients.

Conclusion:

Grafting of defects of T1 nonmelanoma skin cancer of the face, if meticulously performed, is a very satisfactory treatment both from the curative and aesthetic point of view.

References:

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