Comments on the giant basal cell carcinoma*

Comentários sobre o carcinoma basocelular gigante

Rafael Denadai[1] Luís Ricardo Martinhão Souto[2]

To the Editor,

It was with great interest that we read about the recent case reported by Nasser *et al*.[1] The authors defined *giant basal cell carcinoma* (GBCC) as a lesion larger than 5 cm at its greatest diameter according to the American Joint Committee on Cancer (AJCC).[1] However, because the 7th edition of the AJCC Cancer Staging Manual was recently published with a modification of the TNM system for BCC staging,[2] some information should be reconsidered. The major change was that the 5-cm diameter cutoff was eliminated.[2] In the previous edition, a lesion > 5 cm was classified as T3. Now, bony invasion is determinant to characterize a tumor as T3.[2] Some studies[3-5] on BCC patients with a long-term follow-up have shown that size alone is not the main determinant of poor prognosis, which is consistent[5] with the modified staging system by AJCC.[2]

Radical surgical excision with microscopically tumor-free margins remains the treatment of choice for GBCC because it is associated with a satisfactory disease-free survival, as reported by Nasser et al.[3-5] Since these tumors can be destructive and infiltrative, they often create problems of oncologic radicality.[3-5] Therefore, wide surgical excision often results in large complex defects, which can pose a significant reconstructive challenge, particularly when lesions occur in aesthetically or functionally important areas.[3-5] Thus, doctors who deal with these patients should master reconstruction techniques so that optimal oncologic results can be achieved with maintenance of function and aesthetics.

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REPLY

Nilton Nasser [1]

Dear Sir, We would like to thank you for your great collaboration in order to clarify rare cases such as this one. The studies to which the author of the letter refers explain the success of surgical excision, with complete cure, despite the size of the lesion. These studies are a source of knowledge and instruction to everyone. Congratulations on the observations that cooperate with the educational and therapeutic aspect of the case.

Sincerely,
Nilton Nasser.

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Training young surgeons in sectioning scalp for hair transplantation; a simple method *

Treinamento de jovens cirurgiões na divisão do couro cabeludo para transplante capilar: um método simples

Harinatha Sreekar[1] Shashank Lamba[2] Ashish Kumar Gupta[3]

Dear Sir,

Surgical hair transplantation is now a commonly performed procedure. It is done by harvesting an elliptical strip of scalp which is then dissected into small slivers of 1 or 2 follicular unit width (1-2 mm) under a microscope or loupe. This is a crucial step, and meticulous microscopic dissection needs to be done to avoid transaction of hairs.[1,2] The slivers are then dissected into units of one, two, three or four hair units. It has been generally recognized that stereomicroscopic dissection is needed for proper identification and dissection in order to minimize transaction.[3] However, training in an equipped laboratory is necessary for performance of dissection.

Excised scalp skin can be used to train surgeons to perform microscopic dissection. Scalp excision is done for several reasons, including cases of swellings like sebaceous cysts and vascular lesions. These are generally excised as an ellipse. The area of uninvolved scalp around the swelling in the ellipse can be used for training purposes (Figure 1). Surgeons can then practice cutting slivers and harvesting follicular units under magnification. Hair dissection is a skilled job, and dissectors require proper training. This simple use of excised scalp skin can serve to train young surgeons.

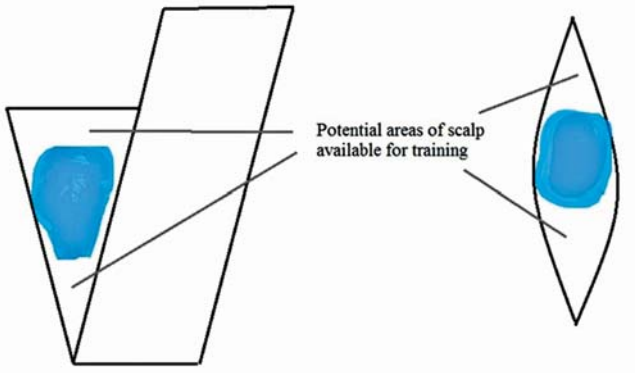

FIGURE 1: Potential areas of scalp available for training include the scalp skin adjacent to a lesion being excised in an ellipse and the scalp skin being sacrificed in triangulating a defect for transposition flap

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Consultation due to Pruritus: still a challenge*

Pruritus: ainda um desafio

Lei Chu[1] Min Zhang[2]

We have read the review paper by Prof. Cunha et al. about pruritus and have learned a lot from it. However, the comment "Tacrolimus has been found to have no effect beyond that of the vehicle control", has confused us. Our clinical practice, along with some other original articles, has confirmed the efficacy of topical tacrolimus as an antipruritus drug. Studies on animal models, clinical practice from several comparative studies, and the exploration of the possible mechanism of the disease have shown that tacrolimus can relieve itching. Therefore, we think that the comment could be more specific if reference to the treatment of hemodialysis-related pruritus was made. This would be more suitable and avoid misunderstanding.

We have learned a lot from the review entitled "Pruritus: still a challenge" by prof. Cunha PR. [1] The authors concluded "Tacrolimus has been found to have no effect beyond that of the vehicle control". This made us confused. Based on our clinical practice, tacrolimus can relieve itching. Therefore, we checked the references and realized that it is in reference to haemodialysis-related pruritus. [2]

Some articles have confirmed its potential antipruritus effect. In an animal model, Samukawa [3] et al. concluded that topical treatment with tacrolimus significantly inhibited scratching. As to clinical practice, Suys E [4] proposed topical tacrolimus as a possible treatment for resistant idiopathic pruritus ani.

Although skin burning and pruritus are common adverse events during the early stages of treatment, tacrolimus is still an effective and well-tolerated option for patients with atopic dermatitis (AD). AD is a common disease with a hereditary disposition to a lowered threshold for pruritus and manifested by lichenification, excoriation, and crusting. Kim KH [5] et al. confirmed that tacrolimus improved the life quality of AD patients in Asia and other areas. To investigate its possible mechanism, NI Chun-ya[6] et al. used immunohistochemistry to determine the expression of proteinase activated receptor 2 (PAR-2) in skin specimens. They concluded that the expression of PAR-2 is enhanced in the keratinocytes of lesions from AD patients, which is positively correlated with itching, and affirmed that tacrolimus may suppress its overexpression.

Therefore, topical tacrolimus sometimes can be effective against pruritus. We believe that the comment could be more specific to avoid misunderstanding.

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REPLY

Paulo R. Cunha, PhD[1]

Oswaldo Delfini Filho, MD[2]

We appreciate your interest and comments. You are right and we agree that Tacrolimus results refer to the findings of the authors about the treatment of haemodyalisis-related pruritus. Our experience using Tacrolimus to treat atopic dermatitis shows that some patients quit early and request another treatment option due to frequent adverse effects like burning and more severe pruritus, as you pointed out. We have no experience treating resistant idiopathic pruritus ani with Tacrolimus, but your comments make sense.

Sincerely,
Paulo R. Cunha, PhD
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