Results and recurrence after surgical treatment :-

Recurrence of basal cell carcinoma following surgical excision can be linked, statistically, with several factors. It is commoner in areas where surplus soft tissue is scarcest *(Koplin and Zarem, 1980)*, and in younger female patients *(Hauben et al.,1982)*; perhaps these two factors are linked by a reluctance to excise any more tissue than necessary under such circumstances. Recurrence is commoner when the tumour is of the morphoeic type *(Koplin and Zarem, 1980; Hauben et al., 1982)*.

It is more difficult to control recurrent disease than to control new tumours, and it is generally agreed that the margins of excision recommended for the latter are inadequate for the former *(Rank and Wakefield, 1958)*.

In order to allow for a 5 year minimum follow-up, the patients presenting for surgical treatment of basal cell carcinoma during the decade 1970 to 1979 were reviewed by Richmond and Davie (1987). During this period 676 patients had 950 basal cell carcinomas exscised; 65 % of these patients had not been previously treated, and 7% of these subsequently developed recurrent disease. The remaining 35% had recurrent disease at

the time of presentation and 15 % of these subsequently developed further recurrences.

A total of 67 patients were reported as having tumour cells present at the margins of excision.

Twenty-eight (41 %) of these patients had not been previously treated. Of the 39 (59 %) being treated for recurrent disease 20 had had radiotherapy, 12 previous surgery and radiotherapy, and 7 surgery alone.

Thirty-seven were reported as having been incompletely excised at a lateral margin, 25 at the deep margin, and 5 at both.

Twenty-nine patients had the surgical defect directly closed, 17 were resurfaced with full thickness skin grafts, 7 with split-skin grafts and the remaining 14 with local flaps.

Twelve of the 67 patients had morphoeic tumours : 6 of these were mew tumours and 6 had been previously treated *(Richmond and Davie., 1987)*.

The method of closure of the surgical defect did not seem to influence the rate of recurrence. The time taken for recurrence to become clinically detectable was longer when flaps were used or the

wound directly closed than when grafts were used. This would suggest that the opening of tissue planes associated with the fashioning of local flaps was more important than delay in diagnosis in those patients where recurrent disease proved difficult to control *(Richmond and Davie., 1987)*.