Summary and conclusion

Basal cell carcinoma (BCC) is a form of skin cancer and is one of the most common cancer found in humans and if left untreated or inadequately treated it can cause extensive destruction of tissue particularly on the face. More than 99% of individuals with BCC are white and 95% are between the ages of 40 and 79 years.

Most common risk factors for BCC are exposure to ultraviolet radiation, Skin type 1, red or blond hair, a positive family history of skin cancer, Patients on immunosuppressive treatment, albinism, xeroderma pigmentosa, Bazex's syndrome and the naevoid basal cell carcinoma syndrome.

There are several treatment modalities of facial basal cell carcinoma the most efficient one is the surgical excision with sufficient safety margin. The surgical margin size depend on many factors as tumour size, location, histopathological type, type of prior treatment and number of recurrences so for lesions that have a low risk of sub clinical extension a 0.4 cm will yield a 95% or greater cure rate, For tumors less than 1 cm, a 0.5 cm margin was required. This increased to 0.8 cm for tumours between 1 and 2 cm in diameter and to 1.2 cm for tumors greater than 2 cm in diameter. The average margin required to completely remove nodular BCC was 0.47 vs. 0.72 cm for infiltrative BCC. The number of surgical stages required for complete removal of tumor and the depth of the defect after resection were also greater with infiltrative BCC.

Improving surgical excision of facial BCCs with free safety margin can be achieved by the use of preoperative assessment and marking of the tumour extension with various procdures as the varioscope, dermatoscopy, Cutaneous Fluorescence Diagnosis, High-frequency sonography and Preopeartive curettage.

Mohs Micrographic Surgery and staged surgical therapy have the highest cure rate while standard surgical excision with a sufficient safety margin is the most applicable method.

Reconstruction of facial defects is a challenging endeavor. Successful reconstruction requires a thorough understanding of skin anatomy and physiology, careful analysis of the defect, thoughtful consideration of multiple options for donor tissue and skillful and meticulous soft tissue handling techniques.

Reconstructive surgeons use the concept of a "Reconstructive ladder" the more problematic the wound, the higher up the ladder the surgeon has to climb. Simple wounds may be closed by primary suturing sometimes in the primary care setting. But others may require complex reconstruction including free tissue transfer.

The decision as to which method to employ in any given case should arise from the general health of the patient, the characteristics of the defect and the patient's own expectations and desires. In other words, the repair should fit the patient and his or her defect.

We have to think in reconstruction in term of units, try to replace like with like, always have a pattern and a backup plan, use what the body has to reconstruct a deficit and Never Forget the Donor Area. We have to monitor flaps carefully make every effort to prevent its complications as infection, heamatoma, necrosis and trapdoor phenomena.

Finally if the surgeon work passed unnoticed with efficient function of the organ the plastic surgeon has to be congratulated.