Radiation Efficacy Requires Adequate Tumor Margins

BY BRUCE JANCIN
Denver Bureau

DENVER — A margin of 10 mm beyond the gross tumor border of a nonmelanoma skin cancer is required to achieve a 95% probability of obtaining clear resection margins, C. Richard Choo, M.D., said at the annual meeting of the American Society for Therapeutic Radiology and Oncology.

In contrast, a 5-mm margin will fully cover the microscopic tumor extent in only 62% of cases, added Dr. Choo, a radiation oncologist at the Mayo Clinic, Rochester, Minn.

This sort of information is critical to the success of radiation therapy, a modality that does not provide resection margins. The radiation therapy volume selected must be sufficient to cover the potential microscopic tumor extent beyond the clinical lesion while avoiding treatment of normal tissue, he explained.

Dr. Choo and his coworkers quantified microscopic tumor extension beyond the clinical gross tumor borders of 71 nonmelanoma skin cancers from 64 consecutive patients. Thirty-eight lesions were sclerosing basal cell carcinomas, 19 were other types of basal cell carcinoma, and 14 were squamous cell carcinomas. Thirty-one were previously treated recurrent malignancies. Sixty were located on the face. The mean tumor size was 2.1 cm.

Preoperatively, the visible border of each lesion was marked with a fine felt-tip pen, and marks were placed at 5-mm intervals in four directions from the outlined borders. A plastic surgeon then excised the gross tumor under local anesthesia, and a dermatopathologist examined frozen tissue sections. A positive resection margin led to further excision using thin slices until clear margins were achieved.

The mean distance of microscopic tumor extension beyond the clinically delineated border was 5.2 mm, with a maximum of 15 mm. The distance correlated positively with the size of the gross tumor, but not with histologic type, location, or history of prior treatment, perhaps due to the limited sample size. ■

iPLEDGE Implementation Delayed

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task," said a source at FDA. "We've all been having daily meetings on this for months."

By mid-October, about 15,000 of 55,000 retail pharmacies in the United States had registered with Covance Inc., the company running the iPLEDGE registration system, according to Douglas Hoey, R.Ph., a senior vice president with the National Community Pharmacists Association.

The association was one of several organizations, including the American Academy of Dermatology, that had begun lobbying the FDA for the delay, Mr. Hoey said.

"We wanted to make sure that as many pharmacists as possible were ready to serve patients," he said.

It is expected that most pharmacies will sign up and that physicians who prescribe isotretinoin will not have trouble finding a dispensing pharmacy in their area, Mr. Hoey said. The snafu was in the timing, getting the word out, and getting pharmacists informed and up to speed, he added.

The delay comes at a time, however, when dermatologists and other physicians are expressing increased irritation about the restrictions being placed on isotretinoin prescribing (Skin & Allergy News, November 2005, p. 1).

And, sources told this newspaper that physician registration to date in the iPLEDGE program has not been exceptionally brisk.

The number of isotretinoin prescriptions dropped significantly in the year after the implementation of the SMART program.

Alan Shalita, M.D., said he was somewhat relieved to learn of the program implementation delay, adding that he was not worried about being able to prescribe isotretinoin when the time came. He had registered with the iPLEDGE program soon after it came online and by November had still not received his patient materials from the program.

"I think it was an intelligent move to put implementation off," said Dr. Shalita, chair of dermatology at the State University of New York Downstate Medical Center in Brooklyn.

Dr. Shalita is a consultant for Ranbaxy Pharmaceuticals Inc., a company that manufactures an isotretinoin product. ■

Aggressive Scalp Tumors May Require Bone Resection

ORLANDO — Bone or perineural involvement portends a poorer prognosis when it comes to aggressive and extensive tumors of the scalp, according to a study presented at the annual meeting of the Florida Society of Dermatologic Surgeons.

In the study, 6 of 11 patients with aggressive squamous cell carcinoma of the scalp had bone involvement, said Pearon G. Lang Jr., M.D.

"We don't think of this—tumors in bony areas such as the scalp."

The nine men and two women who were diagnosed with aggressive squamous cell carcinoma over a 9-year period all had alopecia or thinning hair. "Their scalps were exposed to chronic actinic damage," explained Dr. Lang, professor of dermatology, pathology, otolaryngology, and communicative sciences at the Medical University of South Carolina, Charleston.

You have to strip off the periosteum when tumors go down to the bone. This may be the source of recurrence, and tumors may progress quickly.

"You have to strip off the periosteum when these tumors go down to the bone. This may be the source of recurrence, and tumors may progress rapidly," Dr. Lang said.

Consider a CT scan but be aware, however, that pitting of the bone is helpful as a sign but not always reliable. "To cure, you must resect the bone. Decortication is not recommended—I've seen cases over the years where the tumor goes deeper," he said.

All tumors were moderately or well differentiated. A total of 4 of the 11 patients had satellite lesions, including 1 patient with a satellite lesion at time of initial treatment. Six patients developed regional or systemic metastases; five of them died.

The study also included four patients with aggressive basal cell carcinoma of the scalp.

"These aggressive basal cell carcinomas all occurred in women with full hair," Dr. Lang said.

Tumors were 3 cm or bigger in size, up to the entire vertex of the scalp. One case of basal cell carcinoma mimicked recalcitrant seborrheic dermatitis. All of the patients had Mohs surgery along with extensive reconstruction. There were no recurrences or metastases among the patients.

"Remember that a recurrent tumor can look like granulation tissue," Dr. Lang said at the meeting.

Most squamous cell and basal cell tumors recur within 2-6 years (average, 3 years). "You can get near a 100% cure rate if there is only skin involvement," Dr. Lang said, but there is less than a 30% cure rate if there is perineural involvement.

Perineural tumors can be asymptomatic for years. Lesions are often small and benign in appearance.

MRI imaging is preferable to CT scans, Dr. Lang said, although only 50% of patients with such tumors will have positive findings.

—Damian McNamara