

# Letters

## COMMENT & RESPONSE

**In Reply** We thank Drs Montuno and Coldiron, Kantor, and MacFarlane and Perlis for their comments on our Viewpoint.<sup>1</sup> As our colleagues understand, the Mohs appropriate use criteria (MAUC) were created to limit use of Mohs surgery (MS) when simpler treatments would be more appropriate. Our Viewpoint was written with this in mind, reinforcing the importance of MS for more complex tumors, while emphasizing that primary superficial basal cell carcinoma (sBCC) can generally be treated more efficiently and less expensively with simple excision and curettage alone or combined with other modalities.<sup>1</sup>

Drs Kantor and MacFarlane and Perlis suggest that high reported cure rates with non-MS treatments are undermined by several studies showing that up to 50% of sBCCs contained foci of more aggressive, deeper BCC tumor subtypes.<sup>2</sup> We note this fact,<sup>1</sup> which would apply to any BCC study.<sup>3</sup> The very high cure rates we cite for alternative surgical treatments, despite the presence of other BCC subtypes, support our conclusion about MS for most sBCCs.

Drs Montuno and Coldiron comment about lower cure rates for sBCC using imiquimod. We agree, and have documented this, stating that imiquimod had “potentially acceptable cure rates, particularly in aged or infirm populations.”<sup>1(p756)</sup> While not approved by the US Food and Drug Administration for use in areas H (forehead, temples, central face, ears, postauricular, hands, feet, areola, and genitalia) and M (scalp, posterior aspect of the cheeks, neck, and anterior aspect of the legs), except the neck, many studies have evaluated off-label imiquimod use in these areas.

Dr Kantor incorrectly states that “sBCC has not specifically been studied for Mohs surgery.” We cited several studies demonstrating that MS for sBCC results in significantly larger surgical wounds, requires more stages to clear margins, and has higher recurrence rates than for all other subtypes.<sup>4,5</sup> Yet, MacFarlane and Perlis suggest that these findings are justification for MS use. We noted that cure rates for excision with 4-mm margins (96.8%), curettage plus cryotherapy (C&C) (98.1%),<sup>6</sup> and curettage and imiquimod (96%)<sup>7</sup> are equivalent to MS (97.4%).<sup>4</sup> Dr Kantor faults the study of C&C for excluding tumors in high-risk areas. The study referenced BCCs on the face and scalp, including tumors on the nose, ears, and eyelids.<sup>6</sup>

MacFarlane and Perlis suggest we “miss the point” that MAUC identify cases appropriate for, but not mandated for, MS, and that reclassification creates barriers to appropriate care. They cite the example of a younger healthy patient with an ill-defined, indurated nasal tip sBCC. In practice, none of us will rely only on a pathology report to determine optimal treatment; the clinical features, including location, appearance

(including induration), response to curettage, and other clues will guide appropriate treatment.

We cite data suggesting that MS for essentially all sBCCs does not merit a MAUC score of “appropriate,” and we note that this conclusion is supported by a majority of national comparative treatment guidelines. MAUC uses “uncertain” for scenarios where insufficient data are available for definitive categorization or there is varying agreement regarding MS appropriateness. Current data supporting MS for sBCC are at best uncertain.

The MAUC indicate that an appropriate treatment method is one in which the anticipated clinical advantage combined with clinical judgment outweighs the potential negative sequelae for a specific indication. Because MS for sBCC creates significantly larger defects, requires more stages than for other BCC subtypes, and offers cure rates no better than simple excision, C&C, and curettage and imiquimod, we maintain that the MAUC for sBCC merit reevaluation.

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