

Histologic Classification of Basal Cell Carcinoma

Dermatopathologists subclassify neoplasms. It is their calling. Some are "lumpers" and others are "splitters". None the less, they all do it. Classification of tumors may seem like birdwatching at times. To some, there are many kinds of shore-birds. To others, "they's all killdeers". How many kinds of basal cell carcinomas are there? Some say only two; completely excised and incompletely excised. Under the microscope however, we see a wide variety of patterns of growth that reflect the capacity of basaloid cells to differentiate and mimic the various normal structures of the skin (hair follicle, epidermis, eccrine duct, sebaceous gland). Reasons for subclassification of basal cell carcinomas include: correlation of histologic patterns with clinical appearance of the tumor, prediction biological behavior, prediction risk for local recurrence, and guidance for therapy. Several classification schemes have been offered (see Table 1). We use the classification according to Lever. In addition we make a diagnosis of "infiltrating type".

The different patterns of basal cell carcinoma can be grouped into categories with different relative risks for local recurrence (see Table 2). Morphea (sclerosing), infiltrating, metatypical and superficial (multifocal) types have higher risks for recurrence. This relates to difficulty in clinically determining the extent of tumor. Morphea, infiltrating and metatypical types of basal cell carcinoma may also be inherently more aggressive. Cystic and pigmented types are probably the least likely to recur. Other types are intermediate in risk.

It is common to see two or more patterns of growth in biopsies or excisions of basal cell carcinoma. We note the predominant pattern. If one of the types with more aggressive potential are identified, this type will also be noted in the diagnosis.

We do not routinely comment upon the margins of biopsies which contain basal cell carcinoma. We will if specifically requested. Margins are evaluated on excisions. "Positive margins" indicate that basal cell carcinoma cells are present at the edges of the specimen and that tumor has apparently been cut across. We often comment that tumor "appears close" to a margin. This is used when basal cell carcinoma cells are a fraction of a millimeter from a margin.

Table 1

HISTOLOGIC CLASSIFICATIONS OF BASAL CELL CARCINOMA			
<u>Lever</u>	<u>Weedon</u>		UTMCK (Googe & Fitzgibbon)
solid-primordial	solid	keratotic	solid
keratotic-pilar	micronodular	follicular	cystic
cystic	cystic	metatypical	adenoid
adenoid	adenoid	basosquamous	superficial
morphea-like fibrosing	sclerosing	mixtures	morphea
superficial	multifocal superficial		metatypical
fibroepithelioma (Pinkus)	fibroepithelioma		infiltrating
basal squamous metatypical	pigmented		pigmented
mixtures	infiltrating		fibroepithelioma

			mixtures

Table 2

BEHAVIOR OF SUBTYPES OF BASAL CELL CARCINOMA		
High risk	Intermediate risk	Low risk
morphea type	solid type	cystic type
infiltrating	adenoid	pigmented
superficial	fibroepithelioma	
metatypical		

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