Basal Cell Carcinoma: ethical and medico-legal issues

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Abstract: Skin cancer has the highest prevalence of all cancer, with basal cell carcinoma (BCC) as the most common form. Patients diagnosed with BCC may benefit from various treatments starting from the gold standard treatment (surgical excision) to non-invasive therapeutic approaches. The goal of the treatment is to remove entire tumor without affecting the physical appearance and with maximal preservation of the function. Given the possible medico-legal consequences due to local destructions and local disfigurement and last but not least, the ethical aspect regarding patient-doctor relationship, the treatment decision should be individualized according to the patient's preferences and the assessment of relative risk of recurrence. However, BCCs treatment may raise ethical concerns regarding patient's autonomy versus beneficence and the best interest of the patient.

Key Words: basal cell carcinoma, ethics, medico-legal.

Basal Cell Carcinoma, BCC, are uncontrolled cellular growths that arise in the skin's basal cells, the deepest layer of the epidermis. BCC is the most frequently occurring form of all cancers (2.8 millions/USA population, 4n) [1]. Squamous Cell Carcinoma, SCC, are the second most common form of skin cancer (700,000 / USA population) [1].

Both are mainly caused by UV exposure either occasional as in the BCC or cumulative over the course of a lifetime as in the SCC [2].

While BCC almost never metastasizes except for rare cases when it may become life-threatening [3], SCC has an estimated resulting in approximately 2,500 deaths over 700,000 cases [1].

An accurate evaluation of basal cell carcinoma (BCC) was not possible before the 2011 release of BCC-specific International Classification of Diseases, Ninth Revision, Clinical Modification codes [4] which is now widely used. Treatment is somehow personally subjected when patient manifest a preference [5] and this may be the case for a doctor-physician relationship issue based on patient autonomy.

In Elias University Hospital of Emergency in Bucharest we found over one year, 2014-2015, a number of 92 patients with BCC, most frequently disposed facial and on trunk skin (Fig. 1). Gender distribution shows a prevalence of females and age distribution, as expected, a high prevalence over 80 years old (Figs 2 and 3).

Basal cell carcinoma has several clinical and histological variants. Most cases are common basocellular carcinoma, with nodular subtype, superficial (Fig. 4), infiltrative and multifocal forms. Nodular basal cell carcinoma is the most prevalent type (over 60%), frequently found on the head skin (Fig. 5)[6].

Clinical aspects and dermoscopy can diagnose most cases of BCC, histological examination being useful to determine basal cell carcinoma subtype that may influence treatment [7].

Immunohistochemical markers as PCNA, Ki-67, BCL 2 or p53 protein shows an intensive positive

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expression in tumor cell nuclei both in common basal cell carcinoma and its subtypes (Fig. 6) and several studies proved that immunohistochemistry analysis can be a useful tool for diagnosis of differentiation between BCC and other type of skin cancer [8].

Electron microscopy of basal cell carcinoma (Fig. 7) is more of scientific interest with little or no clinical role in influencing diagnosis or treatment.

The treatment implies a surgical (radical) treatment (excision with predetermined, safety, margins of 4 mm, CO2 laser, electrodessication), a nonsurgical treatment based on local chemotherapy such as 5-fluorouracil, imiquimod, combined treatment or radiotherapy in outdated surgical cases, when surgery is no more an option or when it involve major postoperative deficit [9, 10].

BCC may rise legal problems such as prejudice evaluation [11], legal and malpractice issues [12, 13] and least but not last, ethical issues regarding doctor-patient relationship [5].

If someone is searching the literature review it appears that all these issues are rare while the malignancy is extremely common. This apparent disparity or low rate disclosure may have different explanations such as: minimal lethal risk, patient forgiveness, patient age, patient autonomy conducting to patient responsibility, well established professional protocols, an open and clear doctor-patient relationship based on the informative discourse, a doctor position in the relationship looked upon as a simple consultant, etc.

Even if the litigation cases are rare, ethical view on the relationship with a patient with basal cell carcinoma has basically unchanged reluctant issues to the all above three treatment options.

Patients often prefer non-invasive treatment over curative methods such as excision surgery mainly due cosmetic outcomes and the risk of permanent scars [5]. Topical therapies are proved to be superior to surgical approaches, in superficial BCC, but the recurrence rates are higher [9].
Hence, BCCs treatment may raise ethical concerns regarding patient's autonomy versus beneficence. Patient decision making capacity and their life expectancy are prone to determine non-surgical decisions. When the goal of the treatment is the quality of life usually surgery is not an option. However patient who may not have a full decision capacity imply that the process of informed consent involve relatives but choosing the less invasive method is not always in the best interest of the patient. On the other hand, excess of paternalism in patient-doctor relationship situates the doctor responsible for unfavourable outcomes.

If the doctor performs biopsy procedure and the result is negative for cancer it may be asked why he still performed the radical treatment without a certitude diagnostic. If however he does not perform biopsy and vaporize the lesion one cannot recover the biopsy state of the case. Therefore there is a permanent risk of litigation. Nevertheless in the most frequent cancer of all the rate of malpractice is extremely low.

Conflict of interest. The authors declare that they have no conflict of interest concerning this article.

References