Response to the Letter by Motley & Holt

Sir,

Motley & Holt say an assumption that BCCs are homogeneous "is fundamental to [my] misconception" about MCCS. What rubbish! I spent most of three paragraphs discussing different characteristics, concluding that "either recurrences are going to occur at random or because ...BCCs... are different from the beginning in ways that only further study may eventually define". They totally miss my point that inhomogeneity can be used to support MCSS only when we can predict which tumours will go to the bad; and, until that happy day, the >95% cure rate from simple excision means that even if there are aggressive sub-groups, their prevalence is too low to justify MCSS.

Motley & Holt next try the hoary old trick of logical creep. They present the sad outcome of "a minority of BCCs [with] fine cords of tumour infiltrating the dermis". But even if we accept the dubious possibility that these account for most of the recurrences they see, we cannot accept their use of a minority case to justify a wider practice.

They repeat the dogma that the aim of treatment is to remove every last strip and shred of BCC and refuse to answer my arguments, or face the evidence that their removal isn't necessary. Thus, when they say "these tumours grow eccentrically from their origin...", they ignore studies, including the painstaking modelling used by Madsen (1), that show rests of BCC occur without bridges of continuity, indicating multicentricity or, more likely, that the process of destruction is commonplace. Worse still, they completely misunderstand the significance of a 20% spread of tumour in routine histological ribbons of 3–5 sections taken from completely excised BCCs. It is because this high figure is found in just a very small random sample of the edge, that one can predict that most, if not all BCCs have already spread beyond the limits of conventionally "complete" excision. And that is also why the <5% recurrence rate means that those residual rests of tumour are irrelevant, and why Motley & Holt's "supremely logical approach" of the excision of all residual tumour is supremely irrelevant.

They have also misunderstood my scepticism. If the justification for MCSS is not clinical science, that only leaves non-scientific reasons; and since it doesn't take a genius or a libel lawyer to guess what they might be, Motley & Holt will eventually find them.

Motley & Holt's extraordinary justification of the increasing use of MCSS for smaller BCCs by the "global quality movement" is totally unacceptable – and I do not just mean the horrible jargon. They say MCCS is only to be expected as the choice of the informed patient; but who has informed the patient, and what have they been told? Have doctors the right to worry patients about tumour rests, when they know that this will excite more fear than understanding? Is it not kinder, as well as more honest, to give a rate of recurrence, explaining that most are easily dealt with? MCCS is too easily powered by fear and other dangerous motives. The most helpful "global quality movement" will come from studies defining which situations can be improved by MCCS, not by a blind consumerist rush to operate an unproven surgical procedure.

Motley & Holt's revealing abreaction ends with the extraordinary suggestion that you cannot contribute to a field without personal experience of working in it. How much hands-on work do they think Watson & Crick had done, outside the tennis court, before their sublime cracking of the genetic code; or that I had done, before my comparatively ridiculous cracking of the dandruff/seborrhoeic dermatitis code, using just a creative review of what had been published. A sharp pen exposes more than a bluntly driven scalpel; understanding comes in many different ways, and the brute force of routine labouring is much less important than the keen edge of reason coupled with the soft, comical amoeba of creativity.

Nothing in Motley & Holt's reply invalidates my conclusion that "search and remove", the underlying assumption of MCCS, is incorrect, and that in the absence of proof of efficacy, use of MCSS should stop outside the few centres in which the procedure is studied to establish what, if any, are its advantages.

REFERENCE

1. Madsen A. Studies on basal cell epithelioma of the skin. Acta Pathol Microbiol Scand 1965; Suppl 1777: 9–63.

Sam Shuster
Medical School, University of Newcastle Upon Tyne, UK.