UNG THƯ BIỂU MÔ TẾ BÀO ĐÁY (BASAL CELL CARCINOMA – BCC) CHẨN ĐOÁN VÀ ĐIỀU TRỊ

THS. BS. ĐẶNG HÙNG ANH
KHOA NGOẠI
BỆNH VIỆN DA LIỄU TP.HCM

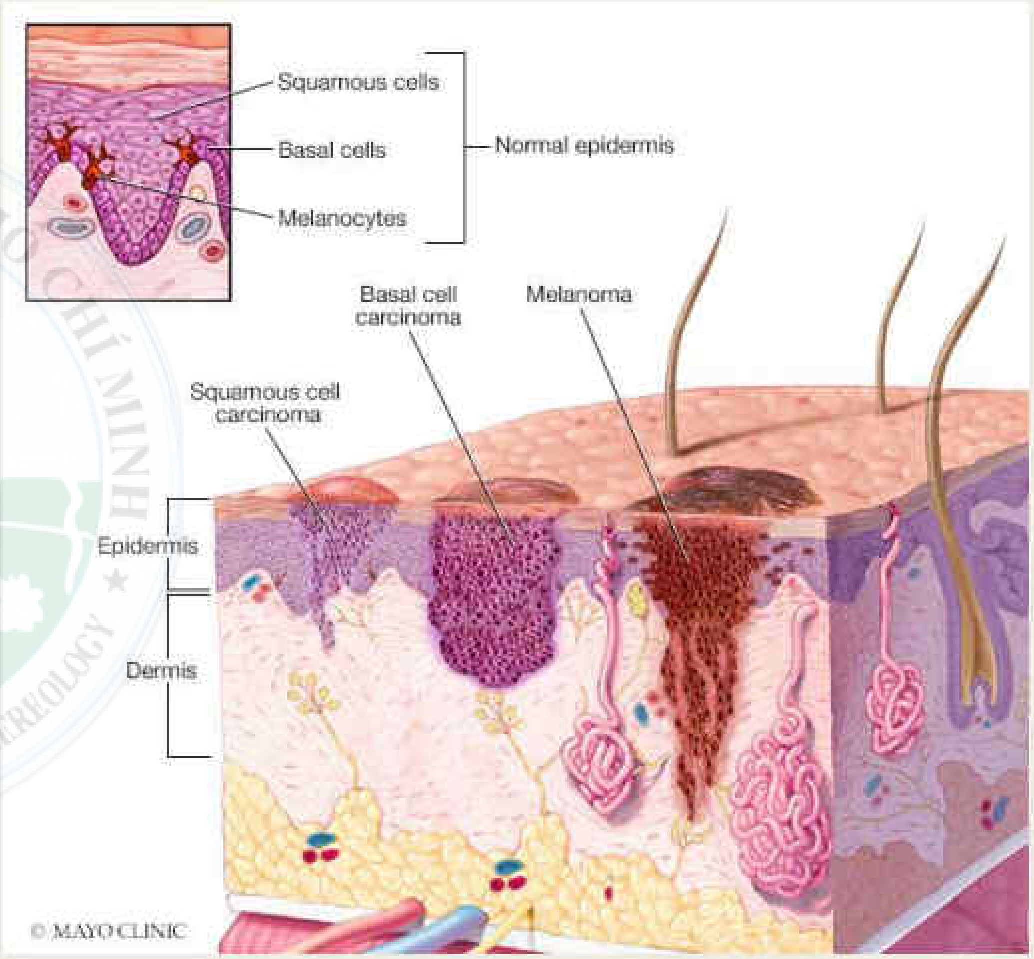
TP.HCM, ngày 24 tháng 10 năm 2025

NỘI DUNG

1. ĐẠI CƯƠNG
2. CƠ CHẾ BỆNH SINH
3. CÁC THỂ LÂM SÀNG
4. ĐIỀU TRỊ
5. KẾT LUẬN

1. ĐẠI CƯƠNG

- Ung thư không hắc tố thường gặp nhất.
- Hay gặp ở chủng tộc da trắng.
- Thường gặp ở người trên 50 tuổi.
- Liên quan với sự tiếp xúc thường xuyên với ánh nắng.



Urban K, Mehrmal S, Uppal P, Giesey RL, Delost GR. The global burden of skin cancer: A longitudinal analysis from the Global Burden of Disease Study, 1990-2017. JAAD Int. 2021 Jan 4;2:98-108. doi: 10.1016/j.jdin.2020.10.013. PMID: 34409358; PMCID: PMC8362234.

YẾU TỐ NGUY CƠ

Box 141.1 Risk factors for basal cell carcinomas

Fitzpatrick skin type I and II

- Solar UV radiation
- Human papillomavirus
- Iatrogenic immunosuppression
- Acquired immunodeficiency syndrome and non-Hodgkin lymphoma
- PUVA therapy
- Photosensitizing drugs
- UVB phototherapy
- Ionizing radiation
- Occupational factors
- Arsenic exposure
- Previous history of basal cell carcinomas

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2. CƠ CHẾ BỆNH SINH

Sonic Hedgehog (Shh) signaling pathway

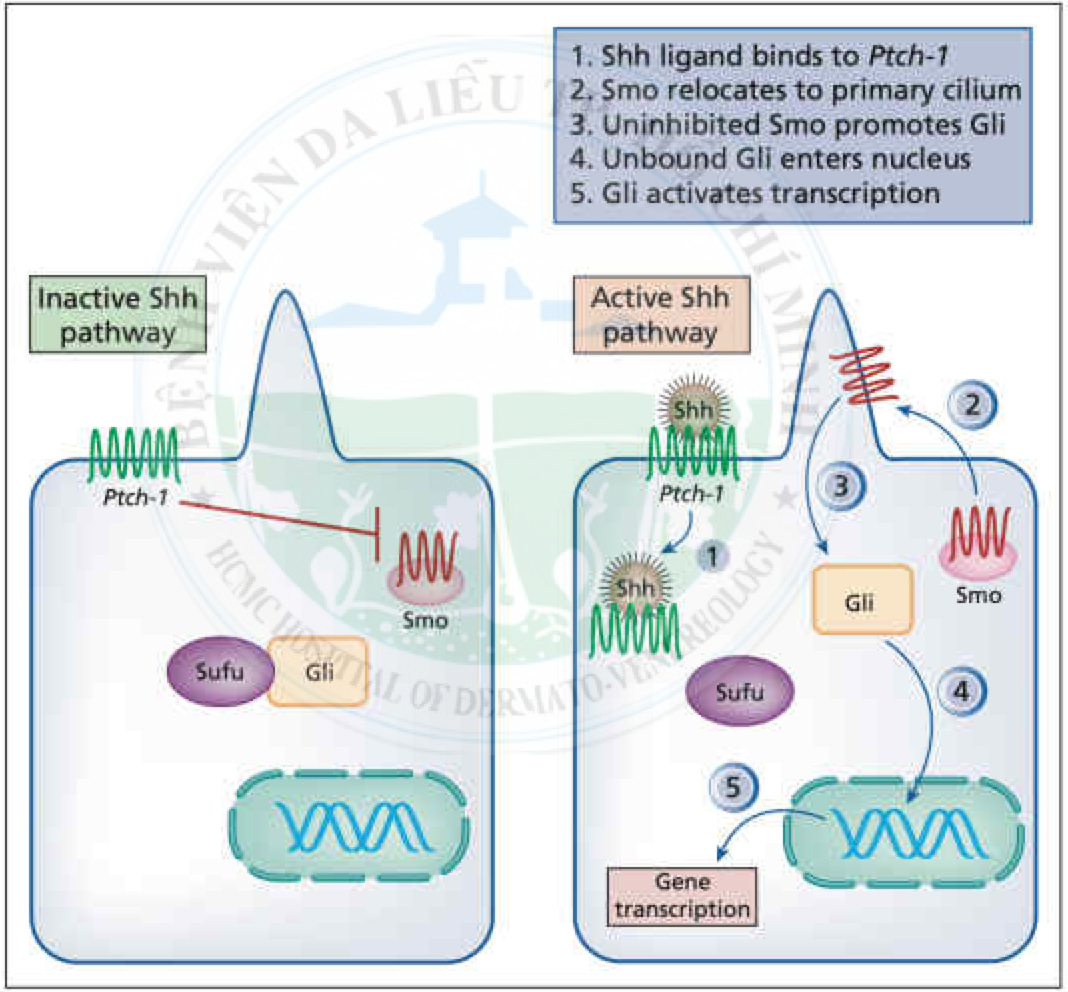

Figure 141.1 The sonic hedgehog (Shh) pathway in the pathogenesis of basal cell carcinoma.

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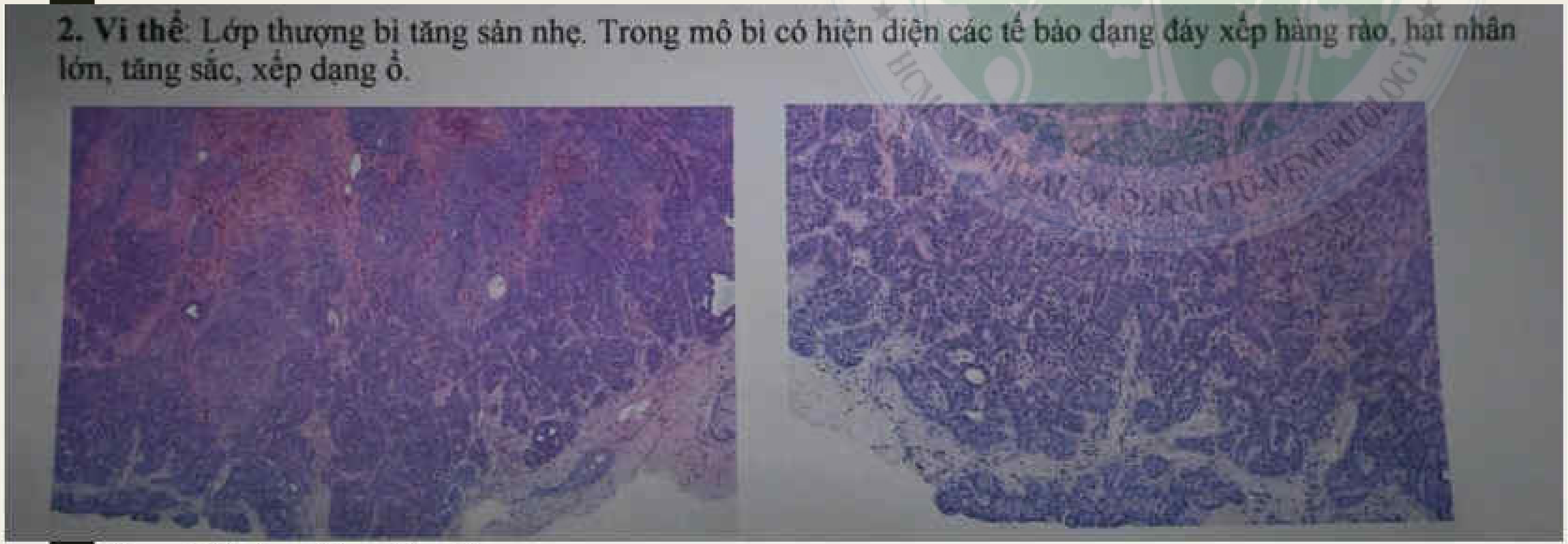
3. CÁC THỂ LÂM SÀNG

- Thể nốt
- Thể nông
- Thể thâm nhiễm
- Thể tăng sắc tố
- Thể xơ teo

Thể nốt (nodular BCC)

- Thường gặp ở vùng đầu, cổ và nửa trên thân mình.
- Khối u nhỏ, mật độ chắc.
- Bề mặt giãn mạch.
- Bờ có các sẩn bóng, chắc (hạt ngọc trai)
- Tiến triển chậm, tăng dần kích thước.
- Có thể loét, dễ chảy máu, đóng vảy tiết đen.



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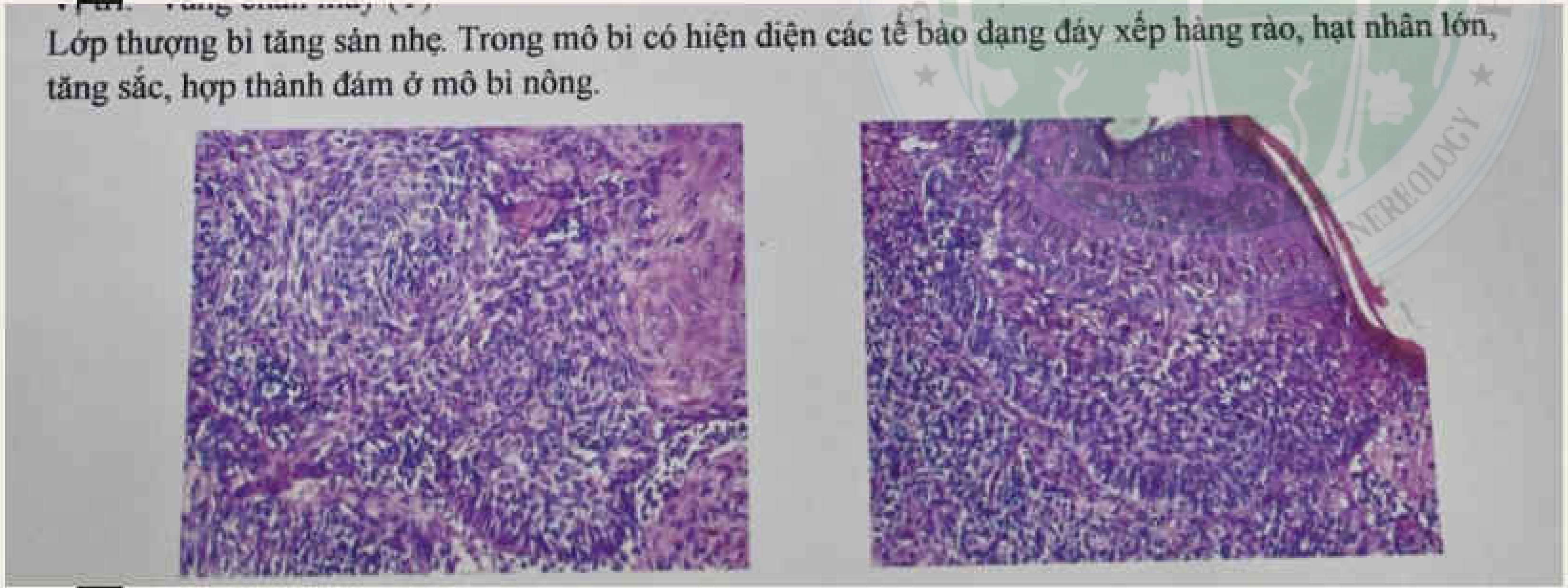
Thể nông (superficial BCC)

- Thường gặp ở vùng thân.
- Dát, mảng phẳng đỏ da, có vảy bao quanh.
- Trung tâm teo, giảm sắc tố.



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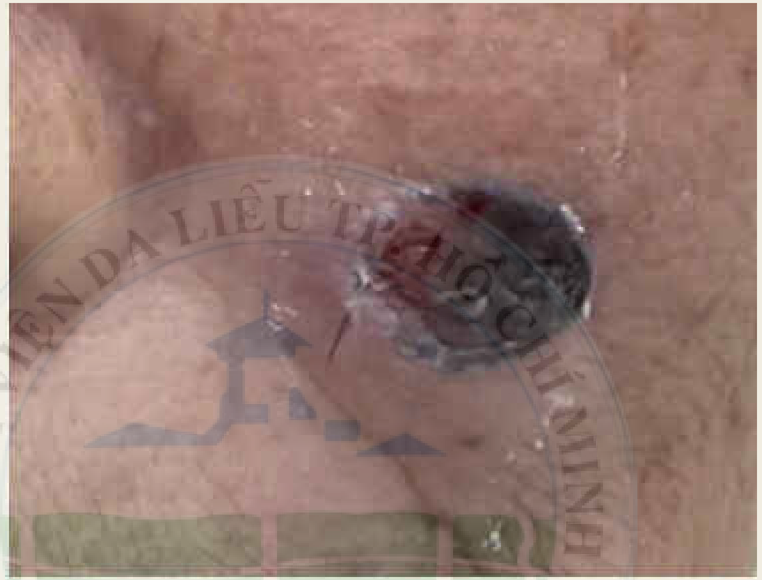
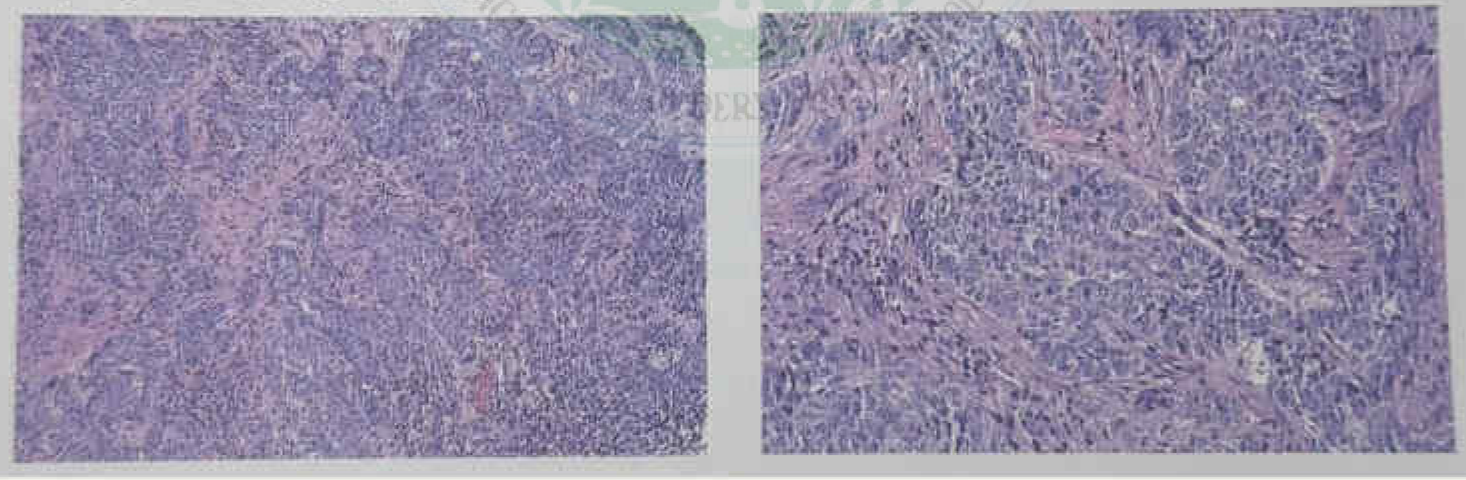
Thể thâm nhiễm (infiltrating BCC)

- Mảng dạng sẹo.
- Giới hạn không rõ.
- Bề mặt trợt, vảy tiết hoặc giãn mạch.





2. Vi thể: Lớp thượng bì tăng sản nhẹ. Trong mô bì có hiện diện các tế bào dạng đáy xếp hàng rào, hạt nhân lớn, tăng sắc, xếp dạng dây, dạng dải thâm nhiễm mô bì nông và bì sâu.

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Thể tăng sắc tố (pigmented BCC)

Màu đen đồng nhất xen kẽ với các vảy tiết màu đen hoặc các u nhỏ giống hạt ngọc trai.

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Thể xơ teo (morpheaform BCC)

- Thường gặp ở vùng mũi, trán.
- Tổn thương bằng phẳng với mặt da.
- Bề mặt có giãn mạch.
- Giới hạn không rõ với da lành.

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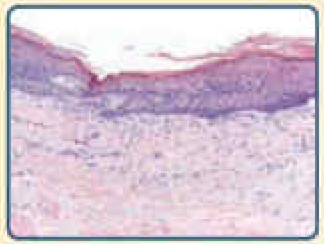
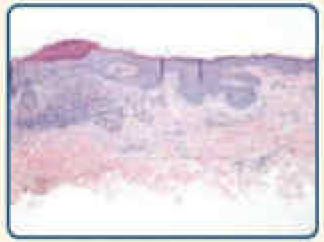
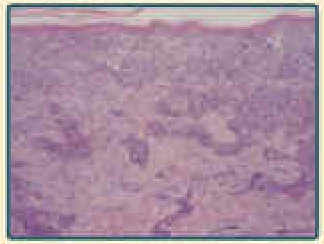
TABLE 111-2

Common Basal Cell Carcinoma Subtypes with Corresponding Kodachrome

TYPE OF BASAL CELL CARCINOMA (BCC)	CLINICAL DESCRIPTION	CLINICAL PHOTOGRAPHS	HISTOLOGIC DESCRIPTION	HISTOLOGY
Nodular BCC	Translucent papule or nodule, with telangiectasis and rolled border; may ulcerate		Nodules of basophilic nests with stromal retraction	
Pigmented BCC	Hyperpigmented translucent papule		Nodules of basophilic nests with melanocytes interspersed between tumor cells; melanophages within stroma	
Superficial BCC	Well-demarcated, erythematous patch		Buds of malignant cells extending into the dermis from the basal layer of the epidermis. Minimal dermal involvement.	
Morpheaform (sclerosing, infiltrative) BCC	Scarlike in appearance; ivory-white		Strands of tumor cells within a dense fibrous stroma	

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Dermoscopy

Multiple blue–grey dots and globules

Spoke-wheel pigmentation

Leaf-like areas

Blue–grey ovoid nests

Arborising vessels and erythema

Erosions and ulceration

Diagnostic Dermoscopy The Illustrated Guide by Jonathan Bowling

CHẨN ĐOÁN XÁC ĐỊNH

- Triệu chứng lâm sàng.
- Mô bệnh học: tiêu chuẩn vàng.
- Hoá mô miễn dịch: xác định nguồn gốc tế bào.

CHẨN ĐOÁN PHÂN BIỆT

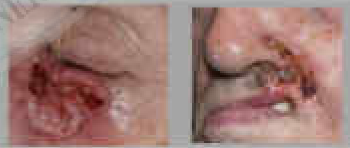
	Hình thái lâm sàng
BCC	Bờ có các sẩn bóng, chắc (hạt ngọc trai). Bề mặt giãn mạch. Dễ loét.
Dày sừng tiết bã	Mảng hoặc sẩn màu nâu – đen, giới hạn rõ, bề mặt sần sùi, không loét
Ung thư tế bào vảy	Sẩn, mảng dày sừng bong vảy. Loét, sùi, trợt, đóng vảy tiết.
Keratoacanthoma	U màu đỏ, nổi cao, trung tâm có tổ chức sừng như miệng núi lửa. Tiến triển nhanh.
Melanoma	Màu nâu đen không đồng nhất. Tiến triển nhanh.



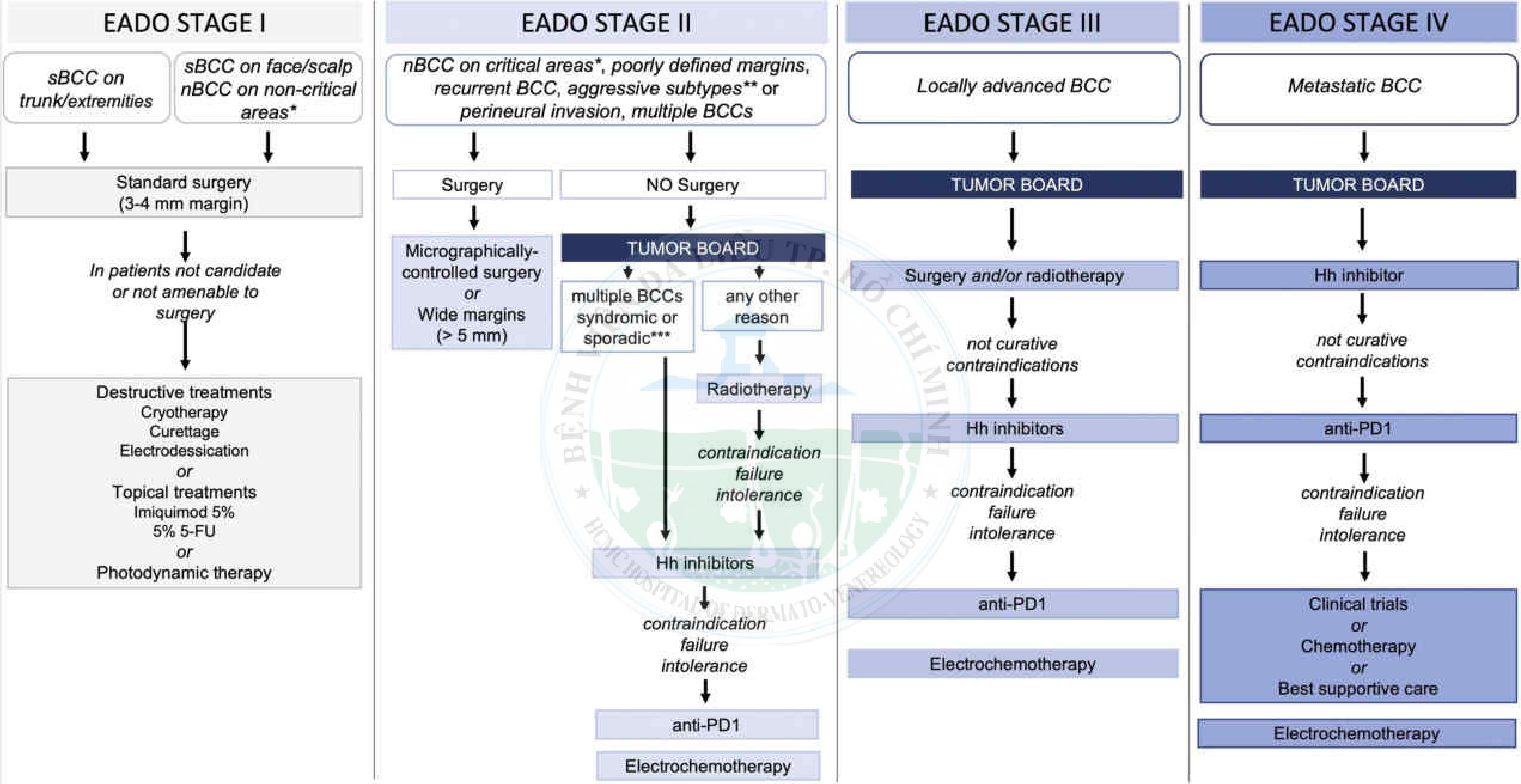


4. ĐIỀU TRỊ

PHÂN LOẠI GIAI ĐOẠN BCC THEO HIỆP HỘI UNG THƯ DA CHÂU ÂU (EADO) 2023

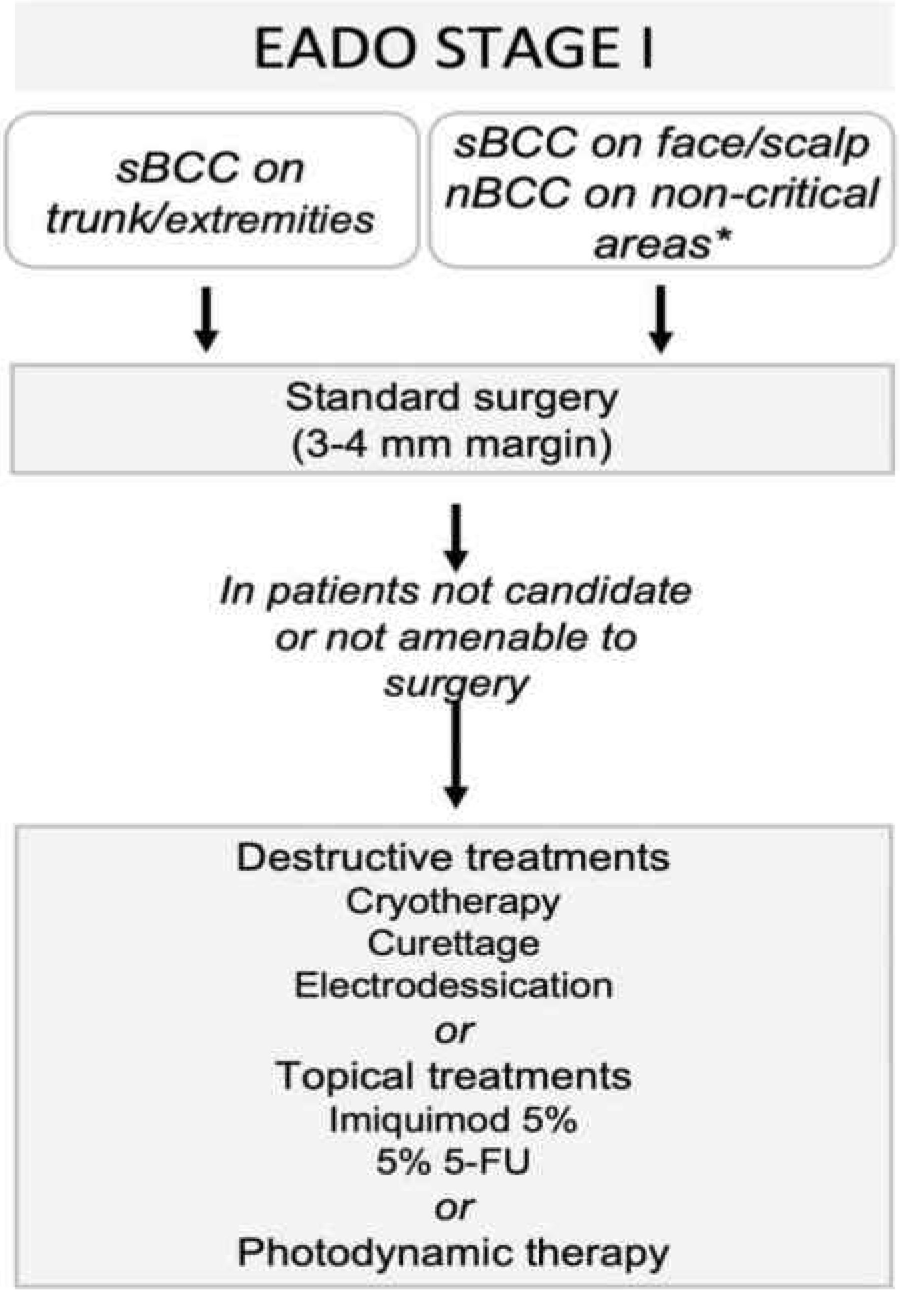
Risk	Stage			Characteristics	Illustrative pictures	DTT-BCC Group (part 1)
Easy To Treat and low risk of recurrence	Common BCC	I	Low-risk common BCC	**None of the other stages characteristics.** *Recurrences only come from blind treatments, or insufficient surgical margins.*		*Not included*
Increasingly Difficult To Treat and increasing risk of recurrence	Common BCC	IIA	Common BCC but somewhat DTT	Common BCC but management is more complex than usual for any reason linked to the tumor (location requiring technical skill, poorly defined tumor borders, prior recurrence) and/or to the patient (poor general status, comorbidities, or unwillingness to cooperate ...). *Good results and low rate of recurrence expected with surgery even if technically complicate, when the patient cooperates.*		*1*
Increasingly Difficult To Treat and increasing risk of recurrence	Common BCC	IIB	DTT-BCC mainly due to multiplicity of common BCC	Very high number of common BCC (>10) or multiple complex BCC (> 5) in the setting of apparently sporadic cases or in Gorlin syndrome*. *When at least 1 of the multiple BCC can be classified III or IV, the patient will be classified accordingly, and not IIB		*2*
Increasingly Difficult To Treat and increasing risk of recurrence	Advanced BCC	IIIA	Locally advanced DTT-BCC out of critical areas	Large and/or destructive tumors in non-critical or functionally significant areas. *Deemed curable without expected functional mutilations.*		*3*
Increasingly Difficult To Treat and increasing risk of recurrence	Advanced BCC	IIIB	Locally advanced DTT-BCC in critical areas	Large and/or or destructive tumors in critical or functionally important areas (periorificial, nose, ...). *Deemed curable by surgery, but functional impairment and/or mutilation are inevitable.*		*4*
Increasingly Difficult To Treat and increasing risk of recurrence	Advanced BCC	IIIC	Extremely advanced DTT- BCC	Giant and/or deeply invasive tumors involving extracutaneous tissue (bone, muscles, vital or sensorial structures) responsible for an extreme clinical situation. *Cure cannot be expected by surgery whatever its extent.*		*5*
Increasingly Difficult To Treat and increasing risk of recurrence	Metastatic BCC	IV		Distant metastases*. *Whatever the initial BCC staging, patient must be classified IV when metastatic.		*Not included*

https://doi.org/10.1016/j.ejca.2023.113254



*critical areas: central face, eyelids, eyebrows, nose, lips, chin, ear, periauricular; **aggressive subtypes: micronodular, morpheaform, infiltrative, metatypical (basosquamous carcinoma); ***in cases of multiple sporadic BCCs, radiotherapy might be used to treat one or few large tumors

https://doi.org/10.1016/j.ejca.2023.113254



Surgery	Evidence-based recommendation
Grade of recommendation A	Surgical excision followed by histopathological confirmation shall be offered as standard of care to treat BCC
Level of evidence 1	[82], [83], [84], [85]
	Strength of consensus: 100%

2D surgical margins—Low-risk BCC	Consensus-based statement
GCP	In low-risk BCCs, a safety margin of 3–4 mm is recommended for standard excision with 2D histology Strength of consensus: 100%

BCC, basal cell carcinoma; GCP, good clinical practice.

*critical areas: central face, eyelids, eyebrows, nose, lips, chin, ear, periauricular; **aggressive subtypes: micronodular, morpheaform, infiltrative, metatypical (basosquamous carcinoma); ***in cases of multiple sporadic BCCs, radiotherapy might be used to treat one or few large tumors

https://doi.org/10.1016/j.ejca.2023.113254

Topical or destructive treatments	Consensus-based statement
GCP	Topical or destructive (blind) treatments can be considered for low-risk superficial and nodular BCC in patients declining surgery or not amenable to surgery Strength of consensus: 100%

BCC, basal cell carcinoma; GCP, good clinical practice.

Tỷ lệ tái phát:

. Áp lạnh: sau 1 năm 6%, sau 2 năm 39%.

. Nạo ± đốt điện: sau 5 năm 3% - 20%.

https://doi.org/10.1016/j.ejca.2023.113254

Five-Year Results of a Randomized Controlled Trial Comparing Effectiveness of Photodynamic Therapy, Topical Imiquimod, and Topical 5-Fluorouracil in Patients with Superficial Basal Cell Carcinoma

Maud H.E. Jansen[1,2], Klara Mosterd[1,2], Aimee H.M.M. Arits[1,2,3], Marieke H. Roozeboom[1,2], Anja Sommer[4], Brigitte A.B. Essers[5], Han P.A. van Pelt[6], Patricia J.F. Quaedvlieg[7], Peter M. Steijlen[1,2,3], Patty J. Nelemans[8,9] and Nicole W.J. Kelleners-Smeets[1,2,9]

Table 1. Distribution of patient and tumor characteristics

Characteristic	MAL-PDT (n = 202)	Imiquimod cream (n = 198)	5-fluorouracil cream (n = 201)
Sex, n (%)			
Male	96 (48)	102 (52)	106 (53)
Female	106 (52)	96 (48)	95 (47)
Median age in years (range)	63 (26–87)	62 (30–91)	64 (35–86)
Median tumor size in mm^2 (range)	52 (5–1,382)	63 (5–1,413)	63 (9–5,472)
Tumor location, n (%)			
Head/neck (reference)	24 (12)	23 (12)	31 (15)
Trunk	119 (59)	121 (61)	120 (60)
Upper extremities	32 (16)	26 (13)	27 (13)
Lower extremities	27 (13)	28 (14)	23 (11)

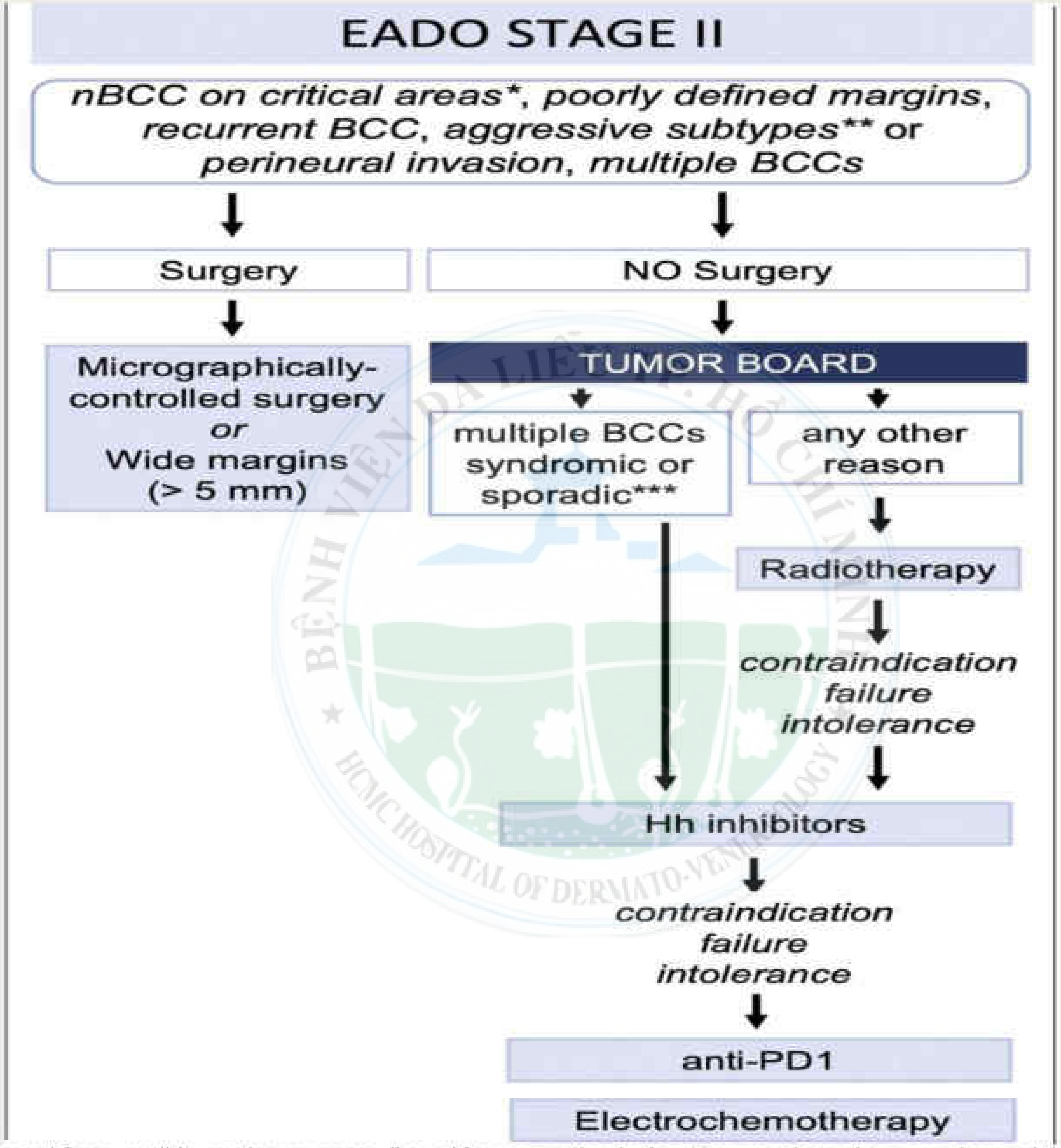
Abbreviations: MAL-PDT, methyl aminolevulinate photodynamic therapy.

Table 2. Cumulative probability of tumor-free survival 1, 3, and 5 years after treatment with MAL-PDT, imiquimod, or 5-fluorouracil for sBCC

	MAL-PDT		Imiquimod		5-Fluorouracil	
Time after Treatment	ITT, % (95% CI)	PP, % (95% CI)	ITT, % (95% CI)	PP, % (95% CI)	ITT, % (95% CI)	PP, % (95% CI)
1 year	73.0 (66.1–78.7)	73.4 (66.6–79.0)	83.5 (77.4–88.1)	83.5 (77.4–88.1)	80.1 (73.8–85.0)	79.8 (73.4–84.8)
3 year	65.3 (58.0–71.6)	65.3 (58.1–71.5)	81.8 (75.5–86.7)	81.8 (75.5–86.7)	74.2 (67.4–79.8)	74.4 (67.5–80.0)
5 year	62.7 (55.3–69.2)	62.7 (55.4–69.2)	80.5 (74.0–85.6)	80.5 (74.0–85.6)	70.0 (62.9–76.0)	70.1 (62.9–76.1)

Abbreviations: CI, confidence interval; ITT, intention to treat; MAL-PDT, methyl aminolevulinate photodynamic therapy; PP, per protocol; sBCC, superficial basal call carcinoma.

Five-Year Results of a Randomized Controlled Trial Comparing Effectiveness of Photodynamic Therapy, Topical Imiquimod, and Topical 5-Fluorouracil in Patients with Superficial Basal Cell Carcinoma
Jansen, Maud H.E. et al.
Journal of Investigative Dermatology, Volume 138, Issue 3, 527–533



*critical areas: central face, eyelids, eyebrows, nose, lips, chin, ear, periauricular; **aggressive subtypes: micronodular, morpheaform, infiltrative, metatypical (basosquamous carcinoma); ***in cases of multiple sporadic BCCs, radiotherapy might be used to treat one or few large tumors

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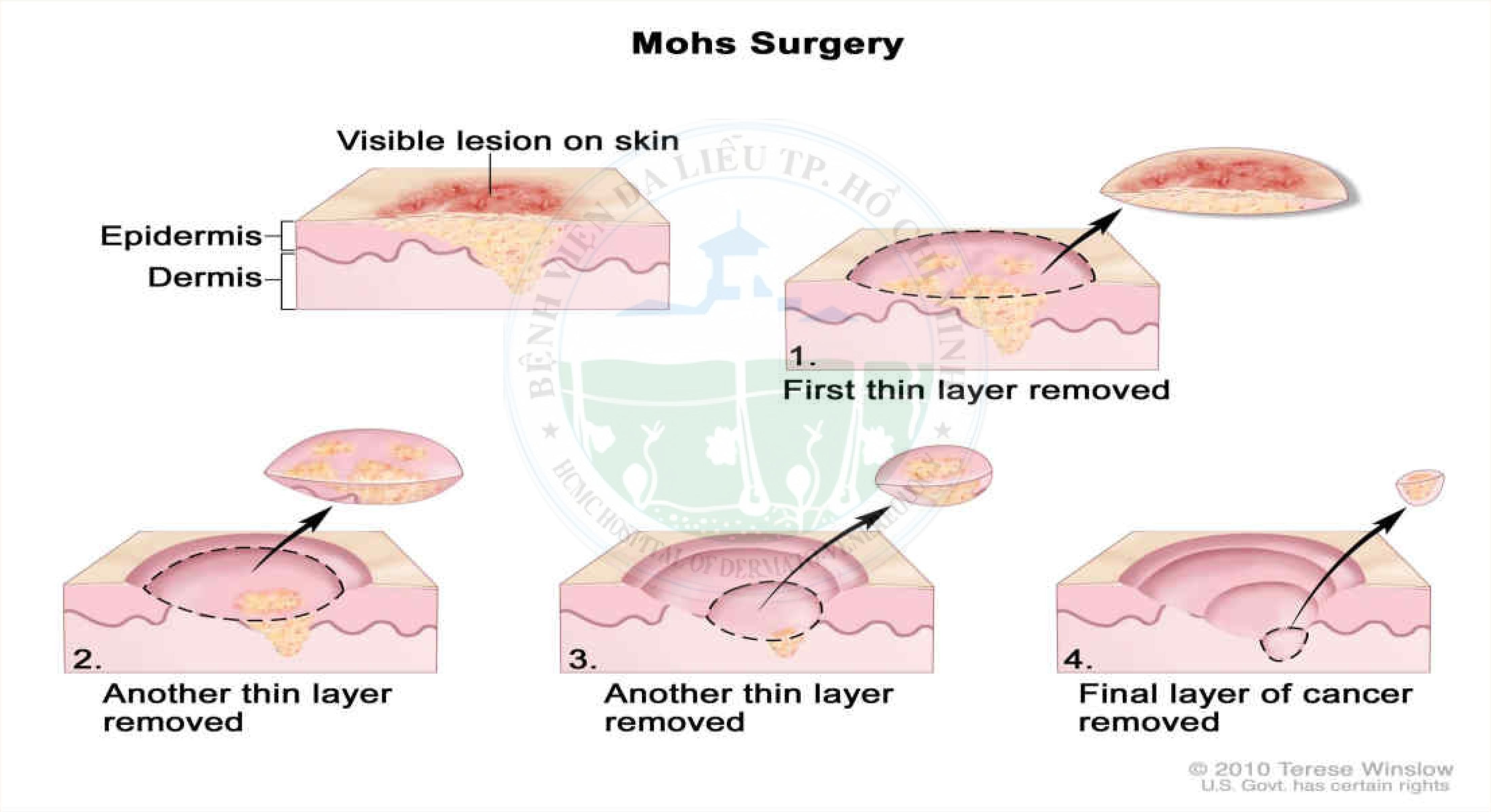
Phẫu thuật Mohs (Mohs micrographic surgery)



https://www.cancer.gov/publications/dictionaries/cancer-terms/def/mohs-micrographic-surgery

INDICATIONS FOR MOHS MICROGRAPHIC SURGERY FOR NON-MELANOMA SKIN CANCER
Tumor characteristics[10]
• Recurrent • High-risk* anatomic location (Area H): "Mask areas" of the face (central face, eyelids, eyebrows, nose, lips, chin, ear, and periauricular skin/sulci, temple), anogenital region, hands, feet, nail units, ankles, and nipples/areola (see Fig. 150.2) • Aggressive histologic subtype: - BCC: morpheaform (sclerosing), micronodular, basosquamous (metatypical), infiltrating - SCC: Breslow depth >2 mm/deeply penetrating, poorly differentiated or undifferentiated**, spindle cell, acantholytic, sclerosing, small cell, clear cell, lymphoepithelioma-like, sarcomatoid • Perineural invasion • Large size (>2 cm diameter) • Poorly defined clinical borders (lateral and/or deep) • Rapid growth • Positive margin on recent excision
Characteristics of background skin
• Prior exposure to ionizing radiation • Chronic scar (Marjolin ulcer)
Patient characteristics
• Immunocompromised: solid organ transplant recipient, chronic lymphocytic leukemia, HIV infection, pharmacologic immunosuppression • Underlying genetic syndrome, e.g. xeroderma pigmentosum, basal cell nevus syndrome, Bazex–Dupré–Christol syndrome • Patient known to have high-risk tumors without other known health risk factors
*High risk for recurrence. **High degree of nuclear polymorphism, high mitotic rate, or low degree of keratinization.

Table 150.1 Indications for Mohs micrographic surgery for non-melanoma skin cancer. BCC, basal cell carcinoma; SCC, squamous cell carcinoma.

Chỉ định Phẫu thuật Mohs

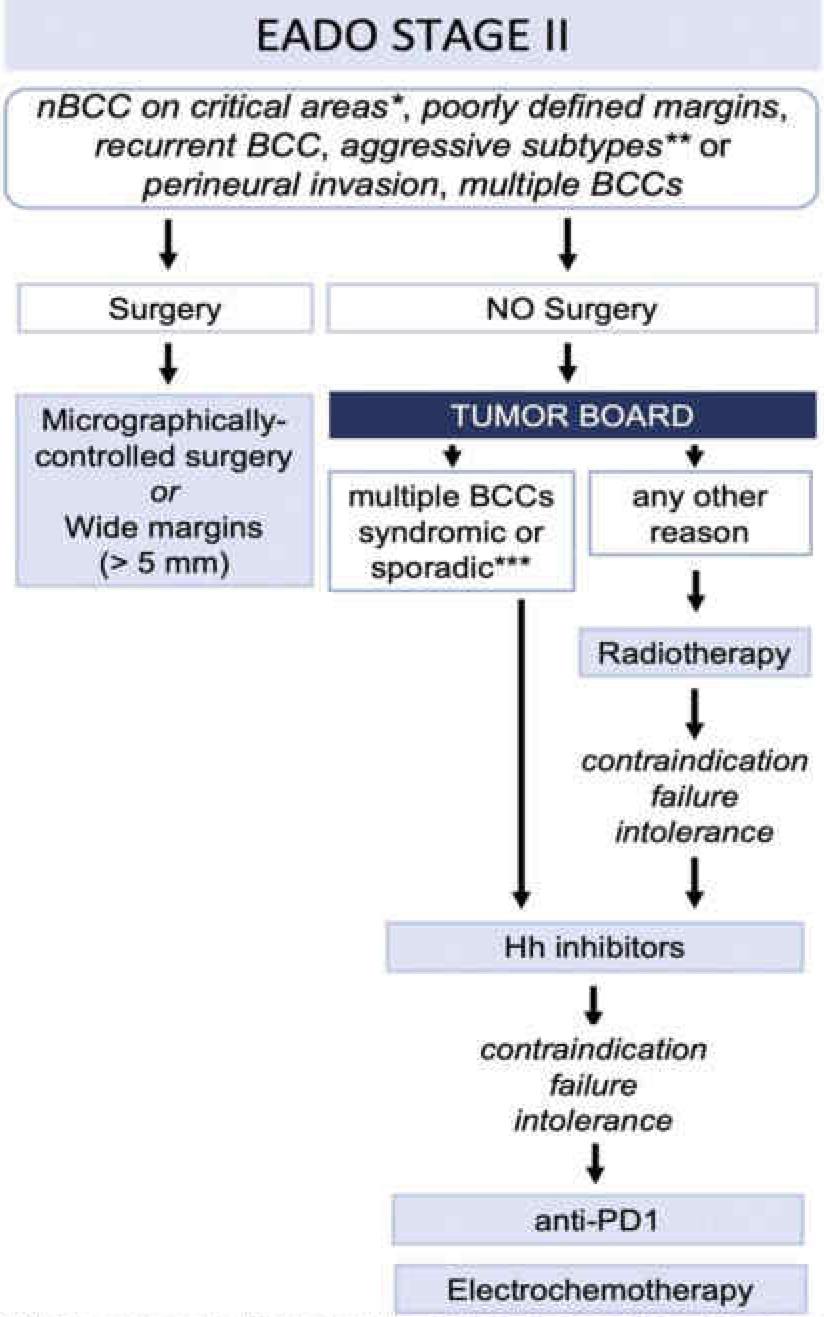
Dermatology Bolognia 4th edition

Tỷ lệ điều trị thành công trong 5 năm

FIVE-YEAR CURE RATES FOR PRIMARY BCC AND SCC		
	5-year cure rate	
Treatment modality	BCC (%)	SCC (%)
Surgical excision	90	92
Electrodesiccation & curettage	92	96
Radiation	91	90
Cryotherapy	93	N/A
All non-Mohs modalities	91	92
Mohs micrographic surgery	99	97

Table 150.3 Five-year cure rates for primary basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) by treatment modality. Based upon refs 1 and 4. There is some inherent bias in these data as the studies quoted in this table did not all use the same patient selection criteria. For example, techniques such as electrodesiccation and curettage appear to have higher cure rates for SCC than does excision to the adipose layer, but it is likely that patients who had curettage selected as a definitive treatment had superficial tumors. N/A, not available.

Dermatology Bolognia 4th edition



*critical areas: central face, eyelids, eyebrows, nose, lips, chin, ear, periauricular; **aggressive subtypes: micronodular, morpheaform, infiltrative, metatypical (basosquamous carcinoma); ***in cases of multiple sporadic BCCs, radiotherapy might be used to treat one or few large tumors

Radiotherapy	Consensus-based recommendation
Grade of recommendation A	Radiotherapy shall be used in patients who are not candidates for surgery or decline surgery
Level of evidence 1	[138], [163]
	Strength of consensus: 100%

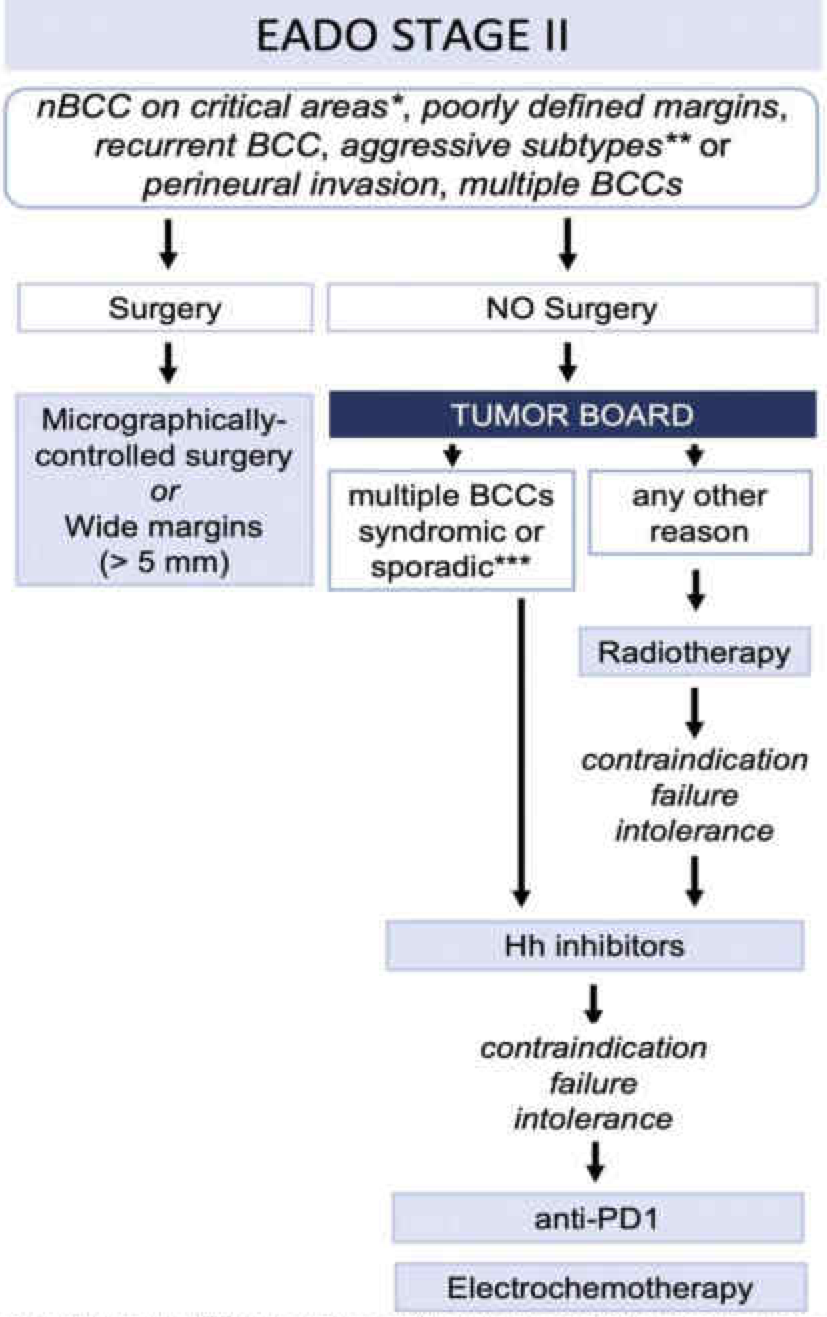
Xạ trị là một lựa chọn thay thế hợp lý cho phẫu thuật và có thể được xem xét như phương pháp điều trị chính cho những bệnh nhân không thể phẫu thuật:

- Bệnh tiến triển tại chỗ.
- Bệnh kèm theo.
- BN từ chối phẫu thuật
- Phẫu thuật gây biến dạng hoặc dẫn đến kết quả thẩm mỹ kém. (BCC nằm ở vùng mặt (như mí mắt, mũi, môi) hoặc các tổn thương lớn ở tai, trán hoặc da đầu.

https://doi.org/10.1016/j.ejca.2023.113254

Hedgehog inhibitors	Evidence-based recommendation
Grade of recommendation B	Hedgehog inhibitors should be offered to patients with locally advanced or metastatic BCC
Level of evidence 3	[182], [183], [185], [188]
	Strength of consensus: 100%

Chất ức chế con đường Hedgehog:
Vismodegib và sonidegib



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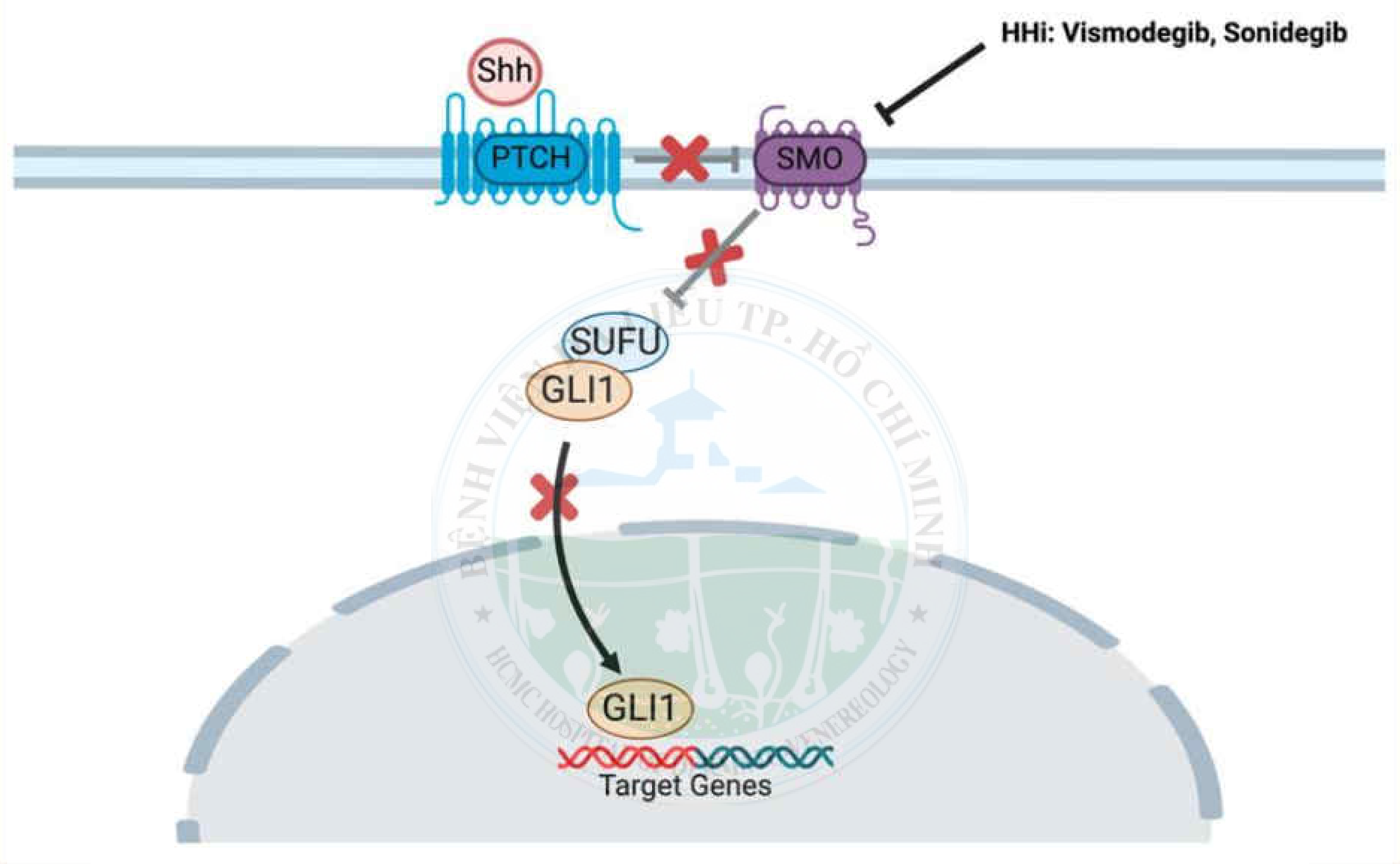
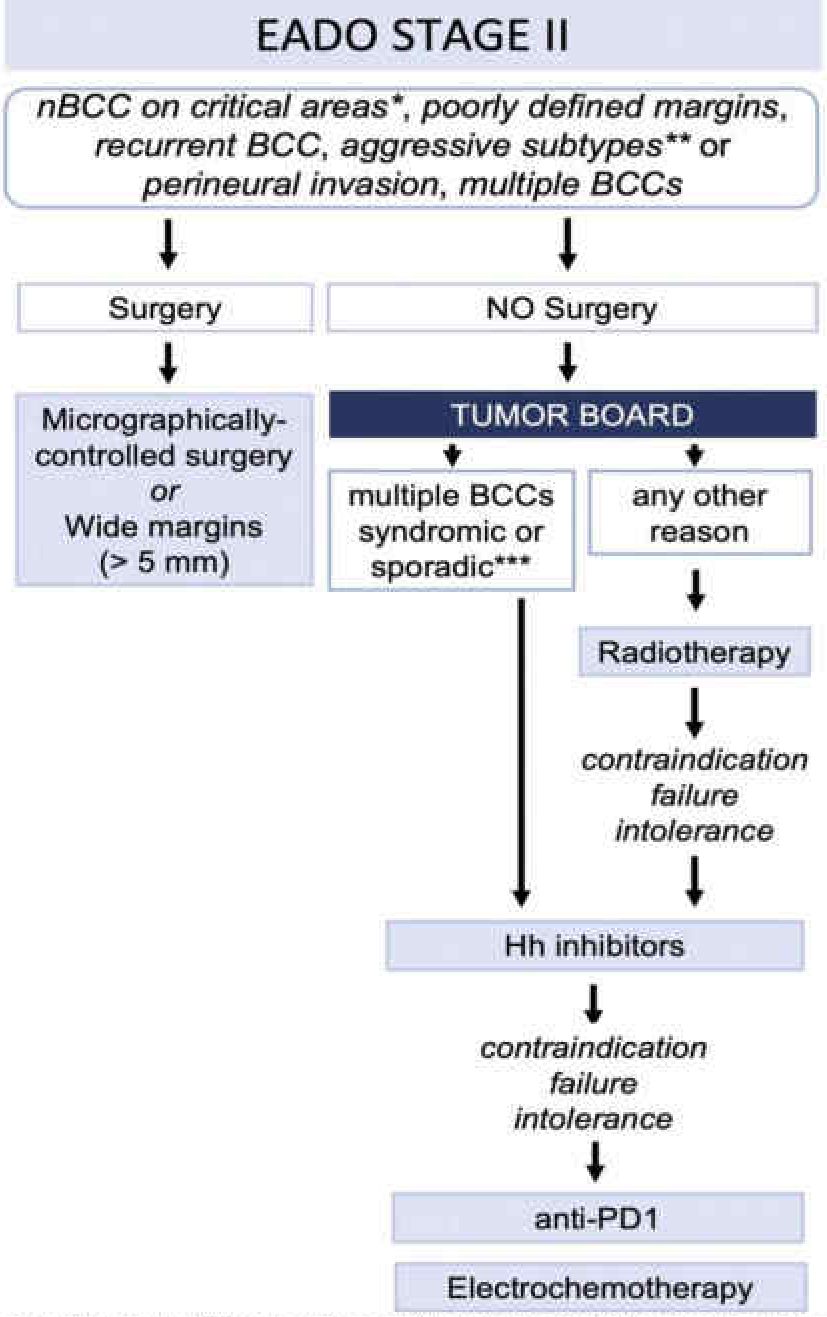


Mechanism of Action of Hedgehog Pathway Inhibitors. Hedgehog inhibitors bind to and inhibit SMO, allowing SUFU to bind to GLI1 which blocks its translocation to the nucleus. GLI: Glioma-associated oncogene, Shh: Hedgehog, HHI: Hedgehog Pathway Inhibitor, PTCH1: PATCHED1, SMO: Smoothened protein, SUFU: Suppressor of Fused. Adapted from (Hedgehog Signaling Pathway), by BioRender (2024).

Alkassis, Samer & Shatta, Maya & Wong, Deborah. (2024). Therapeutic Advances in Advanced Basal Cell Carcinoma. Cancers. 16. 3075. 10.3390/cancers16173075.

Immunotherapy	Evidence-based recommendation
Grade of recommendation B	Anti-PD1 immunotherapy should be offered as second-line treatment in patients who progress or have contraindications to hedgehog inhibitors
Level of evidence 3	[193]
	Strength of consensus: 100%



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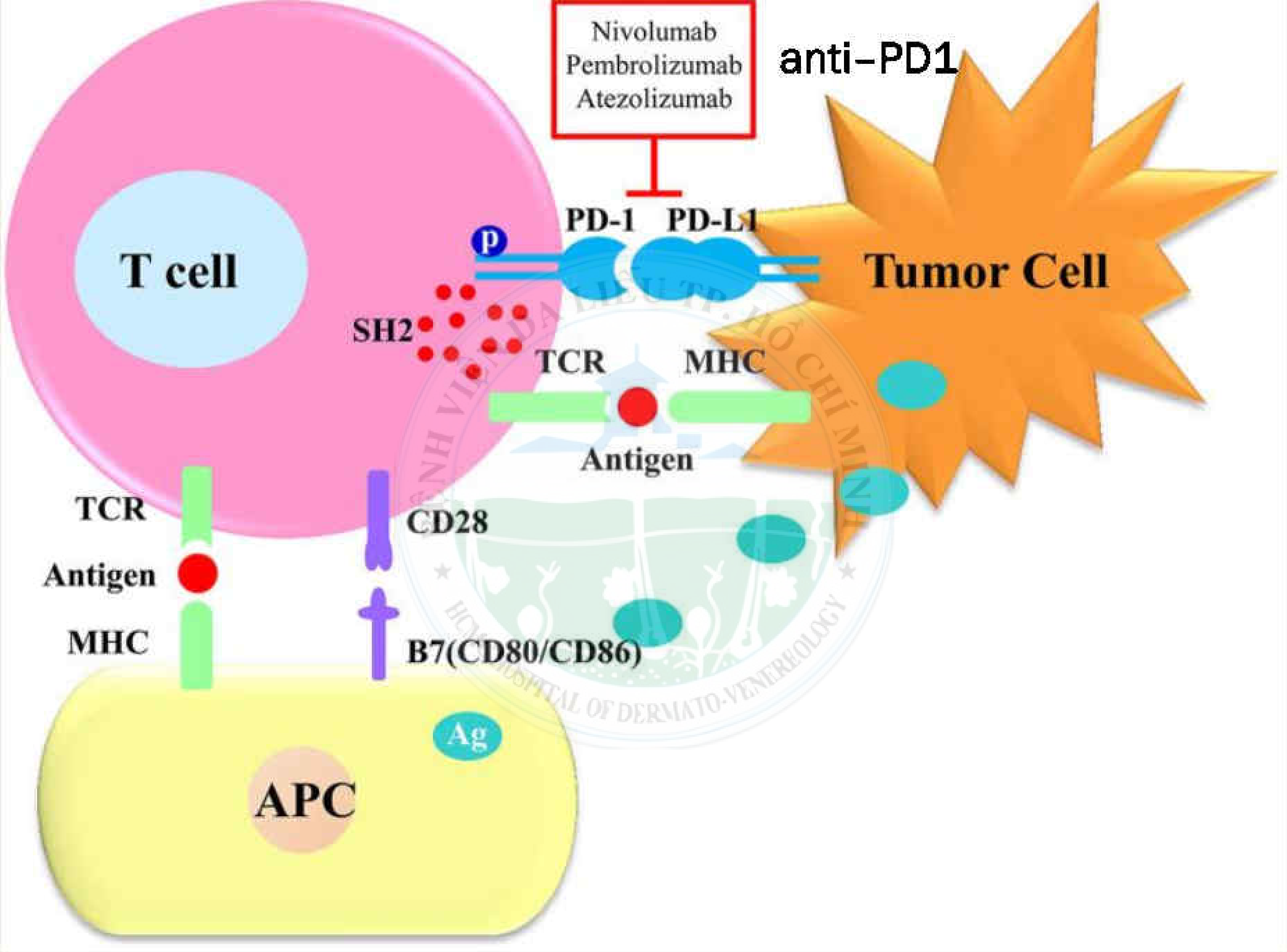


Zhang, Yu & Mou, Guang-Ze & Li, Tian-Zhu & Xu, Wan-Ting & Zhang, Tong & Xue, Hui & Zuo, Wen-Bo & Li, Yan-Nan & Luo, Ying-Hua & Jin, Cheng-Hao. (2021). PD-1 Immune Checkpoint Inhibitor Therapy Malignant Tumor Based on Monotherapy and Combined Treatment Research. Technology in Cancer Research & Treatment. 20. 153303382110049. 10.1177/15330338211004942.

EADO STAGE III

Locally advanced BCC

↓

TUMOR BOARD

↓

Surgery *and/or* radiotherapy

↓

not curative
contraindications

↓

Hh inhibitors

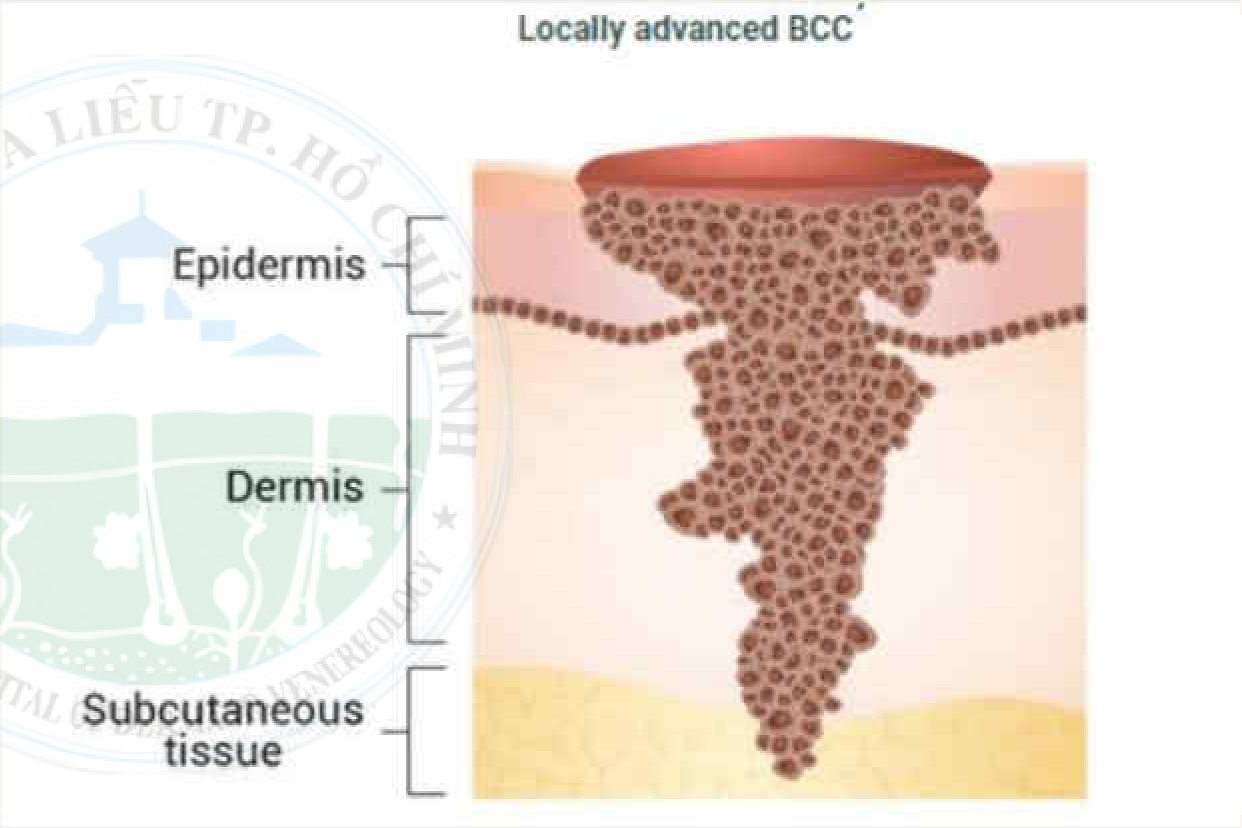
↓

contraindication
failure
intolerance

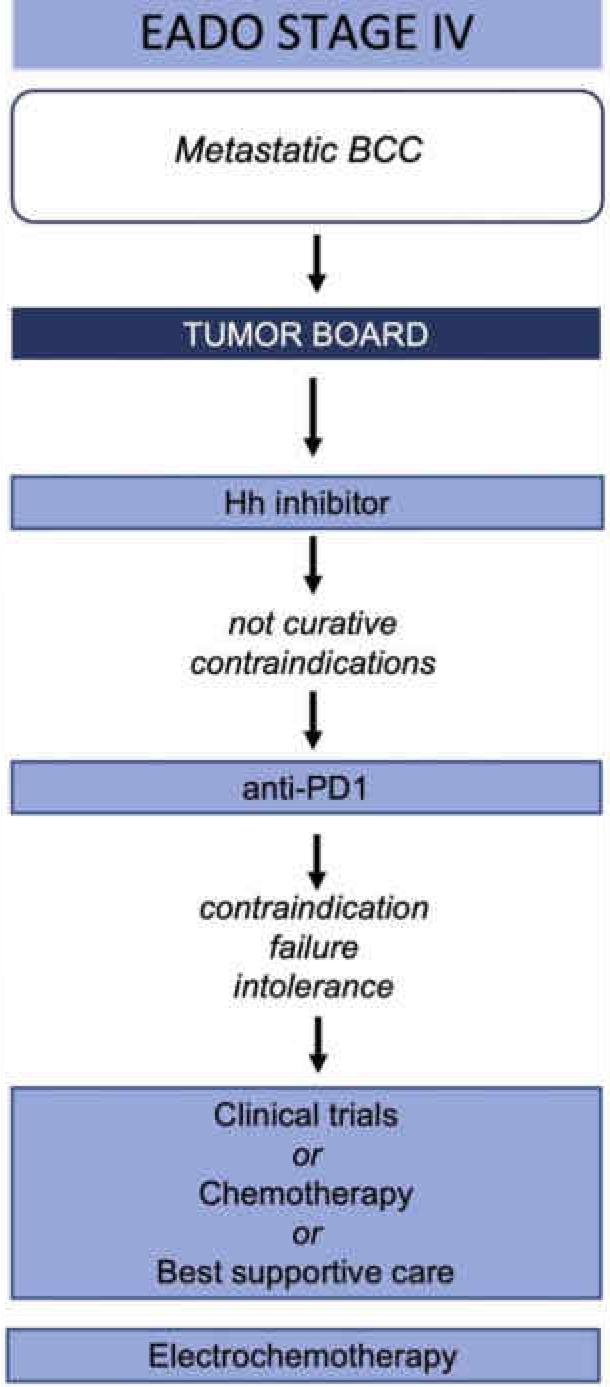
↓

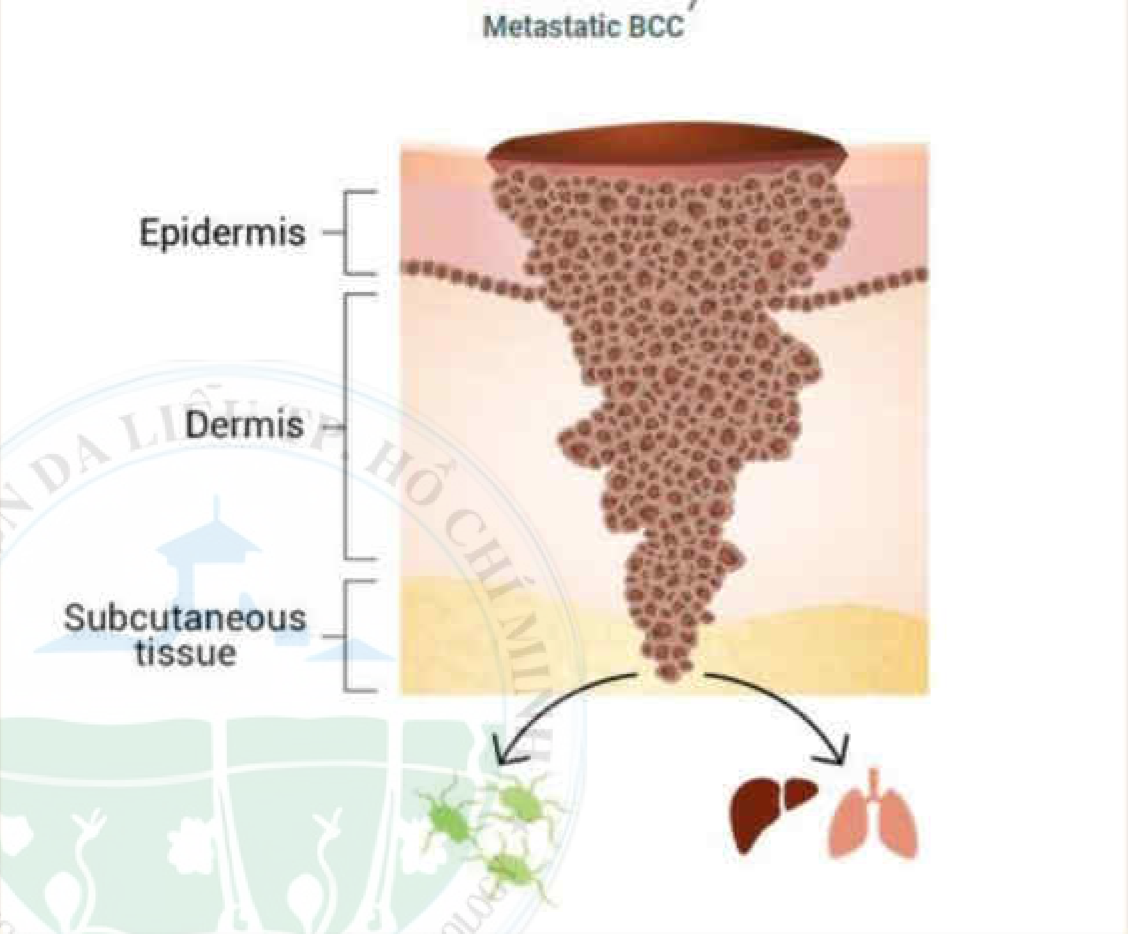
anti-PD1

Electrochemotherapy



https://doi.org/10.1016/j.ejca.2023.113254





Thử nghiệm lâm sàng:

- Chất ức chế con đường Hedgehog thế hệ 2: patidegib, saridegib (IPI-926), taladegib (LY2940680), and silmitasertib (CX4945).
- Virus diệt tế bào ung thư: TVEC, RP-1.
- Điều trị tân bổ trợ (neoadjuvant): sonidegib, pembrolizumab.

Hoá trị.

https://doi.org/10.1016/j.ejca.2023.113254

KẾT LUẬN

- Ung thư biểu mô tế bào đáy là loại ung thư da không hắc tố thường gặp nhất, chiếm khoảng 75% trong các loại ung thư da.
- Tia cực tím là nguyên nhân chủ yếu gây ung thư da, ngoài ra người có type da Fitzpatrick I và II, nhiễm HPV, thuốc ức chế miễn dịch, thuốc nhạy cảm ánh sáng, ... cũng là những yếu tố nguy cơ dẫn đến ung thư biểu mô tế bào đáy.
- Chẩn đoán xác định dựa vào: triệu chứng lâm sàng, xét nghiệm mô bệnh học và hóa mô miễn dịch (trong 1 số trường hợp để xác định nguồn gốc tế bào).
- Phương pháp điều trị ung thư biểu mô tế bào đáy phụ thuộc theo biểu hiện lâm sàng và phân loại mô bệnh học.

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XIN CẢM ƠN SỰ THEO DÕI CỦA QUÝ ĐỒNG NGHIỆP