Skin Cancer Basics

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No Conflicts of Interest

#TANDERMATOLOGIST

- Elephant in the room…I’m tan
  - Legit reason
  - I do wear sunscreen
  - Constant questions….

Objectives

- Identify clinical characteristics of precancerous lesions
- Identify and discuss common skin cancers
- Choose appropriate methods for treatment

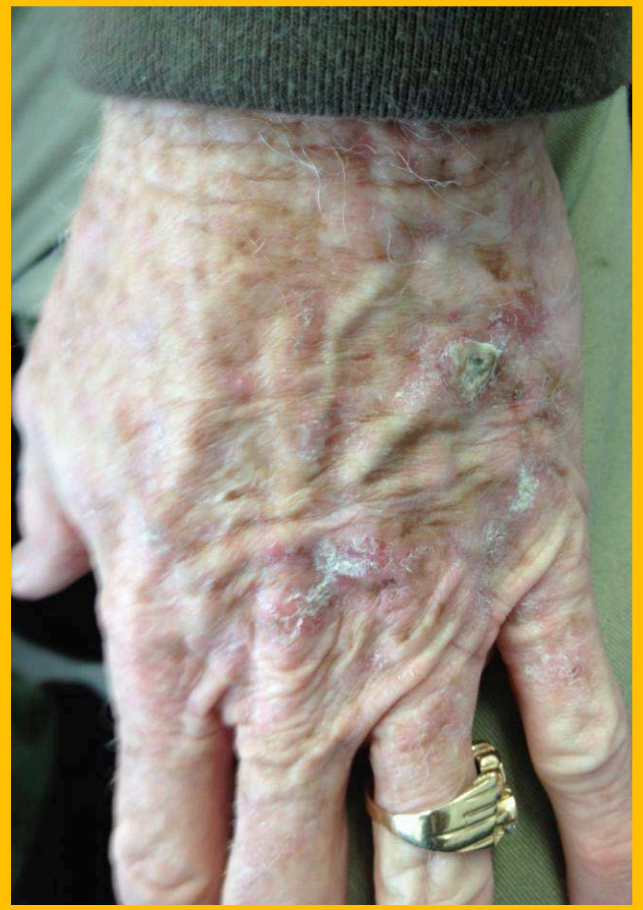
Precancerous lesions

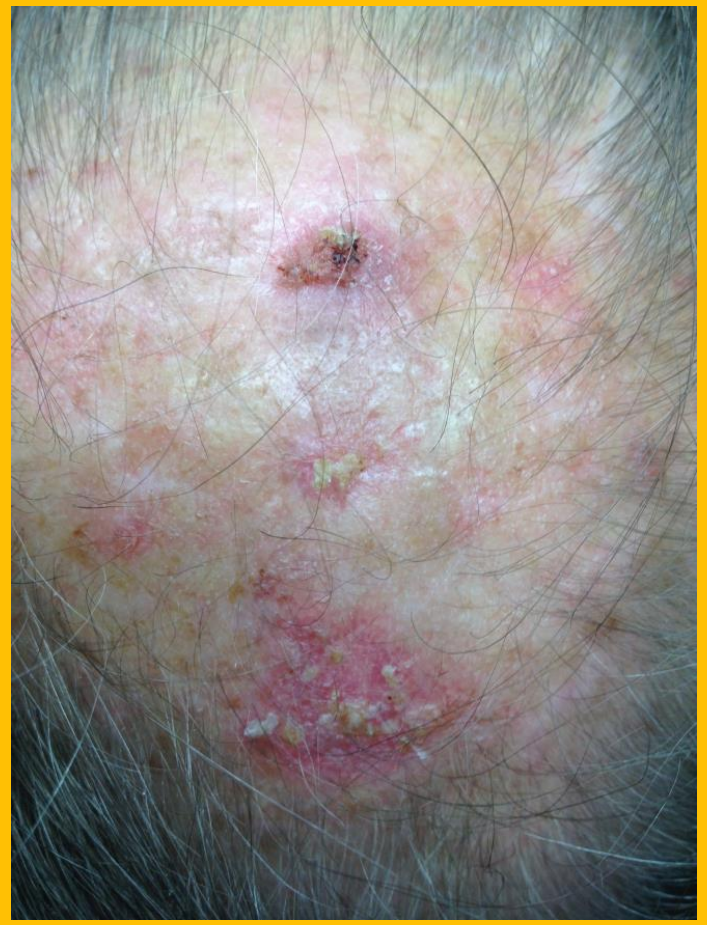
- Actinic Keratosis
- Dysplastic Nevi

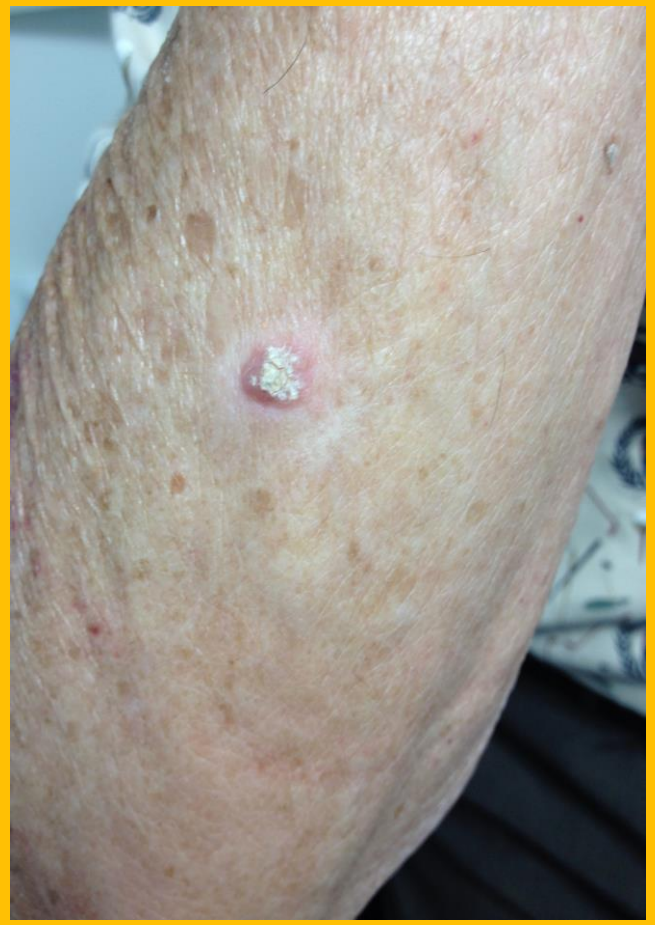
Actinic Keratosis

- **UV light–induced lesions of the skin that may progress to invasive squamous cell carcinoma**
- **Malignant transformation is 0.1-10%**

Actinic Keratosis



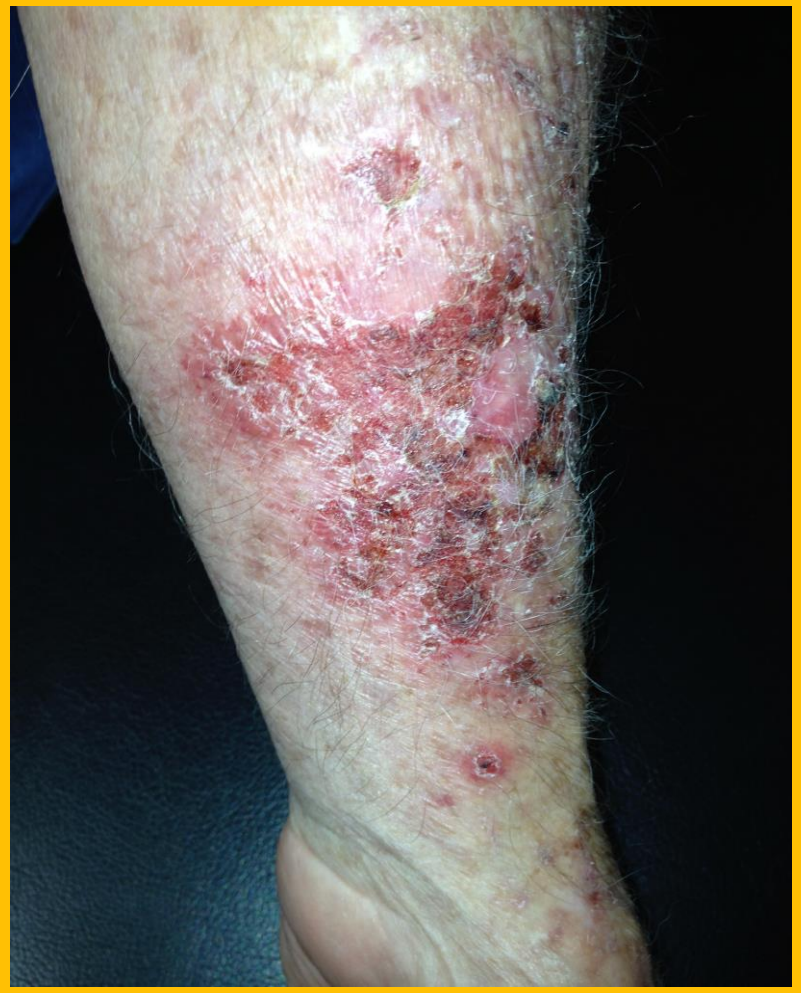




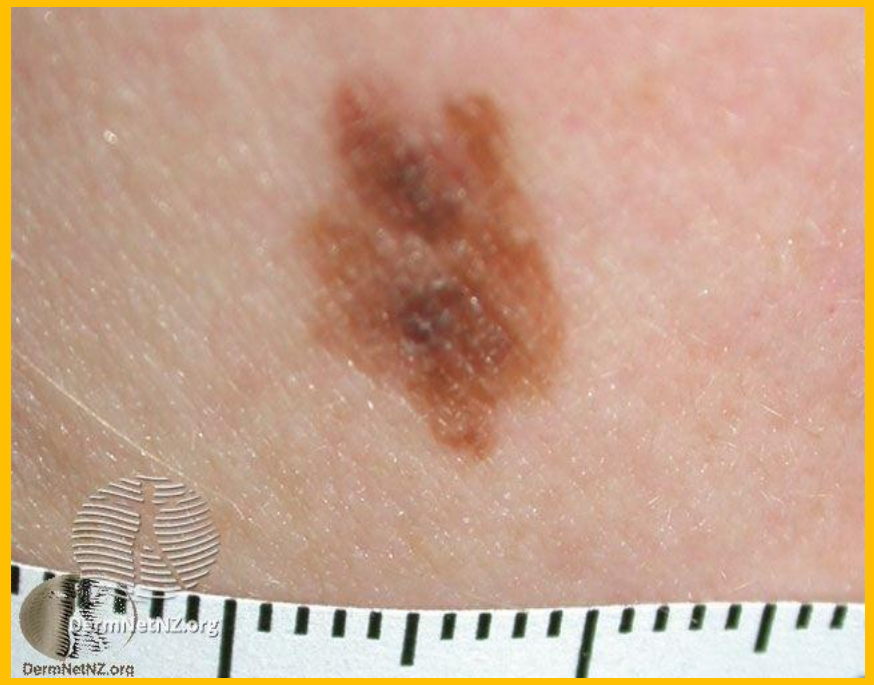
AK Treatment

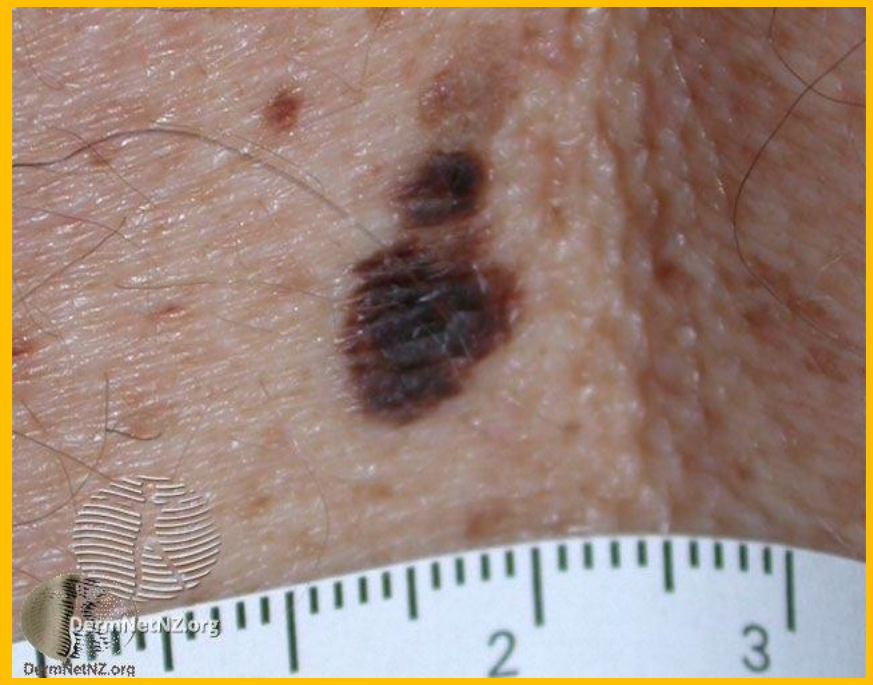
- **Liquid nitrogen cryotherapy- PIH**
- **Topical therapies**
- **5-FU (Efudex®) Imiquimod (Aldara®) Ingenol mebutate (Picato®)**
- **Curettage for hypertrophic lesions**

Topical TX: Imiquimod, etc…
Give FAIR WARNING!



Dysplastic nevi: 3 levels

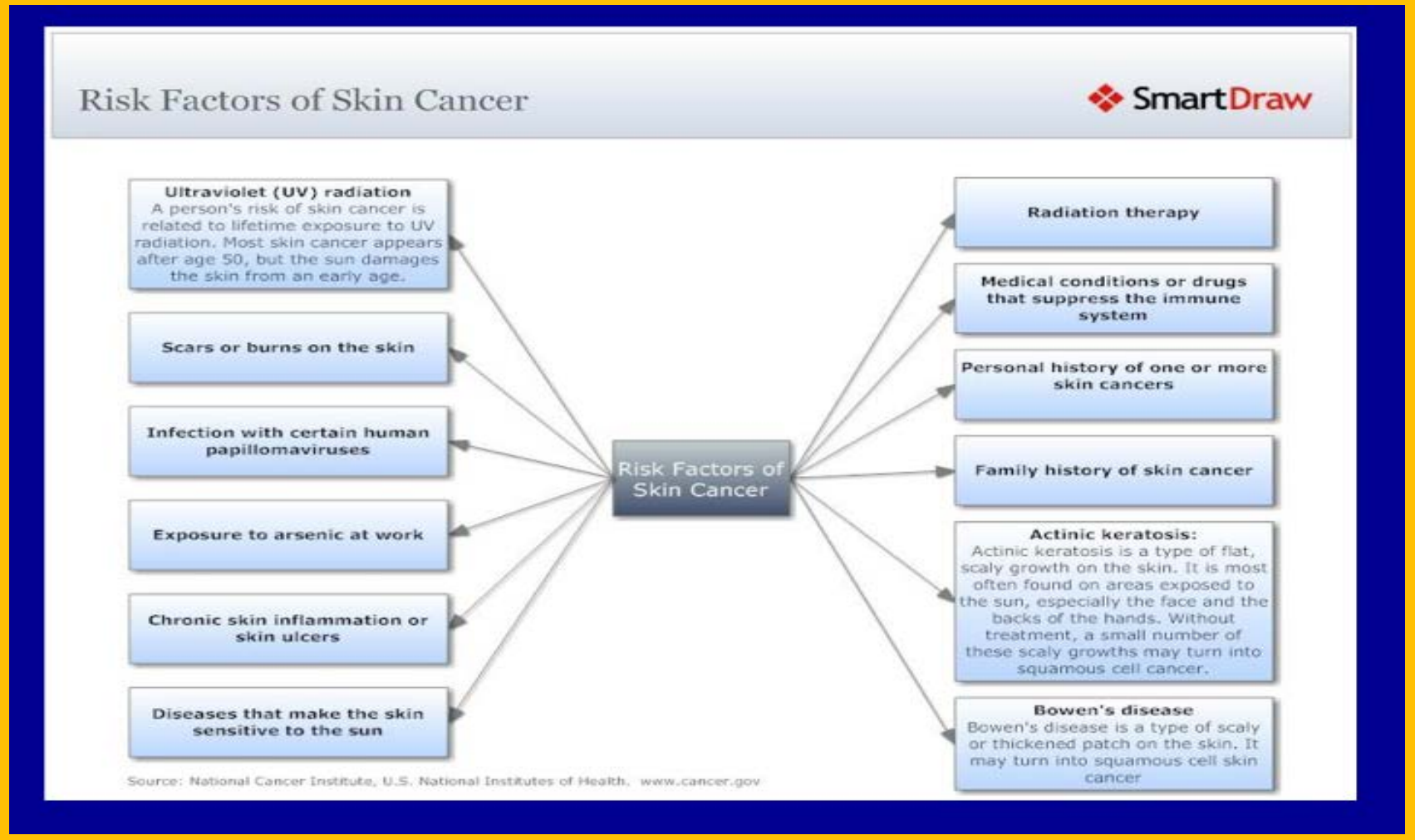




Non-Melanoma skin cancers

- Basal cell carcinoma
- Squamous cell carcinoma
- Merkel Cell, AFX, etc…

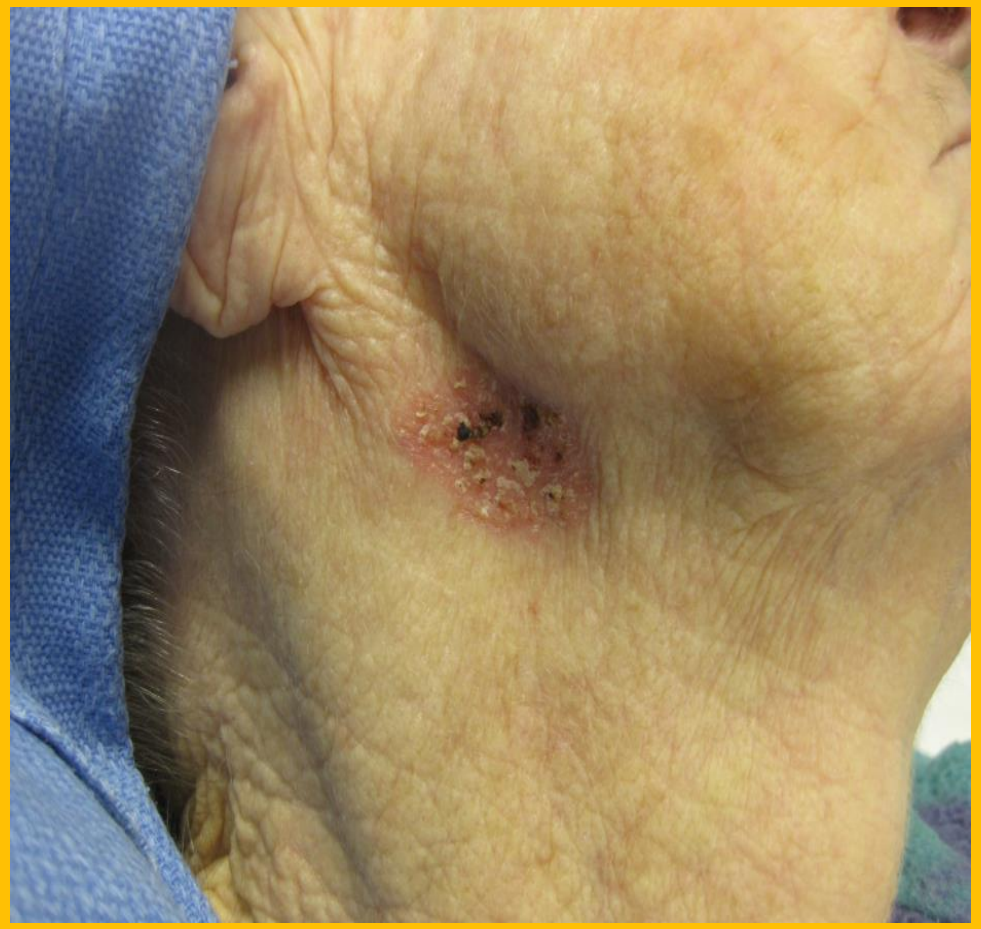
Risk factors for skin cancer

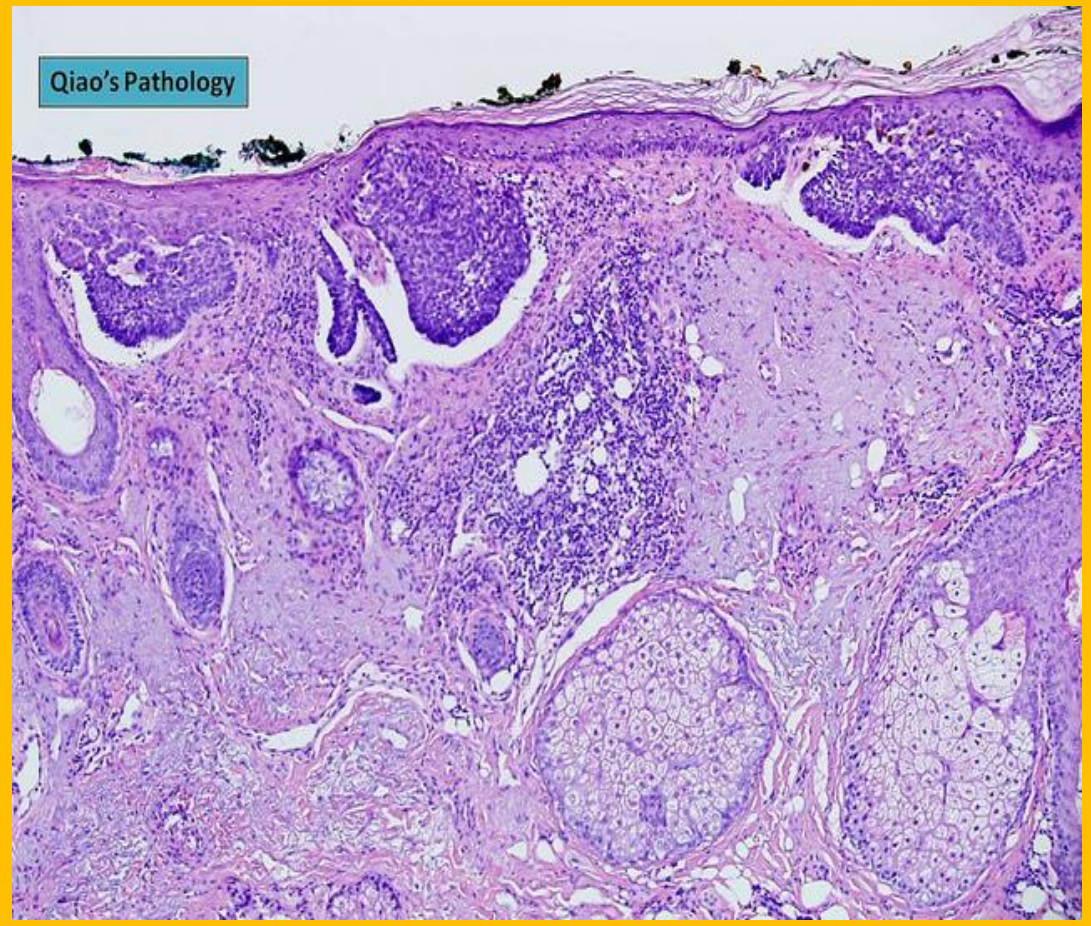


Basal cell

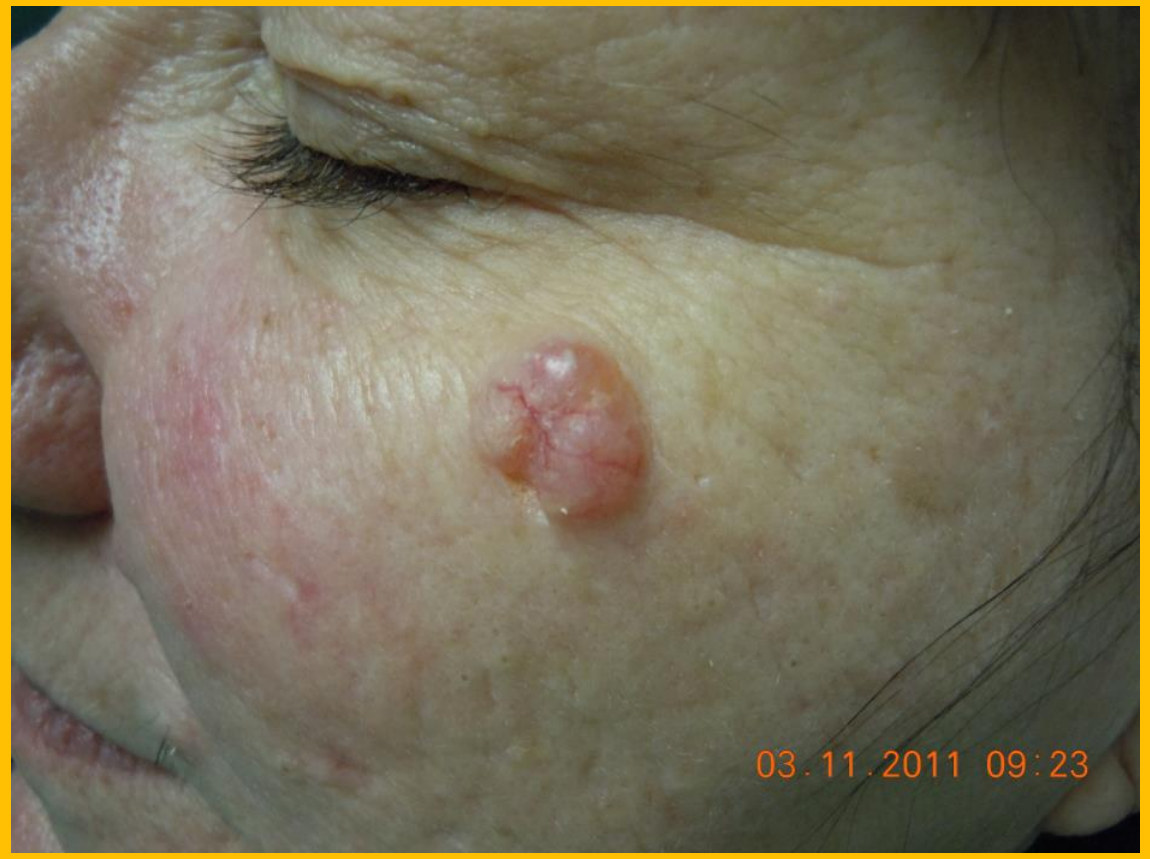
- **Most common skin cancer (80%)**
- **4x more frequent than SCC**
- **Metastases are rare (<1% of cases)**
- **Local destruction of tissue**

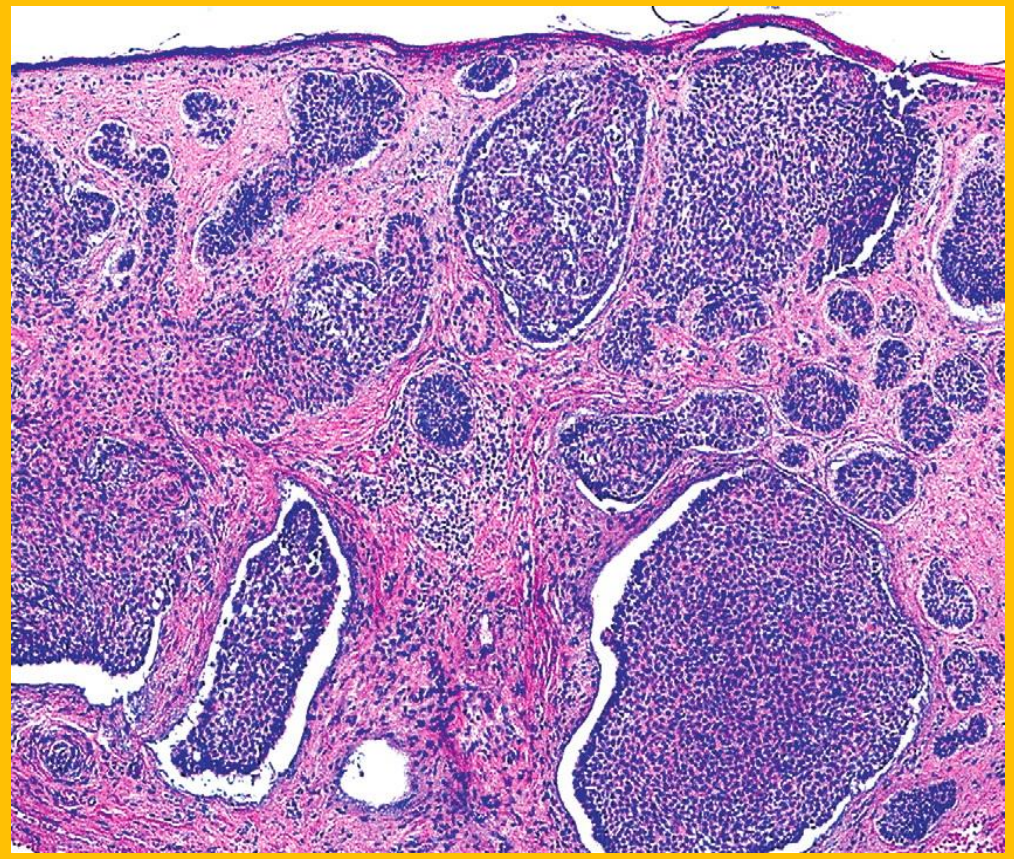
Superficial BCC: Pink, scaly plaque





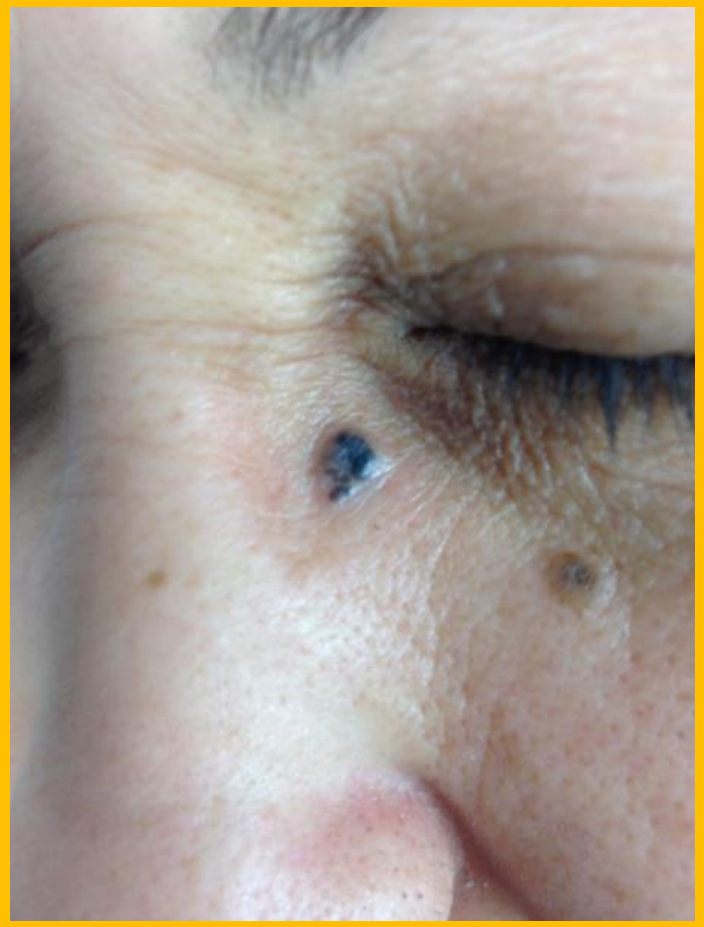
Nodular BCC

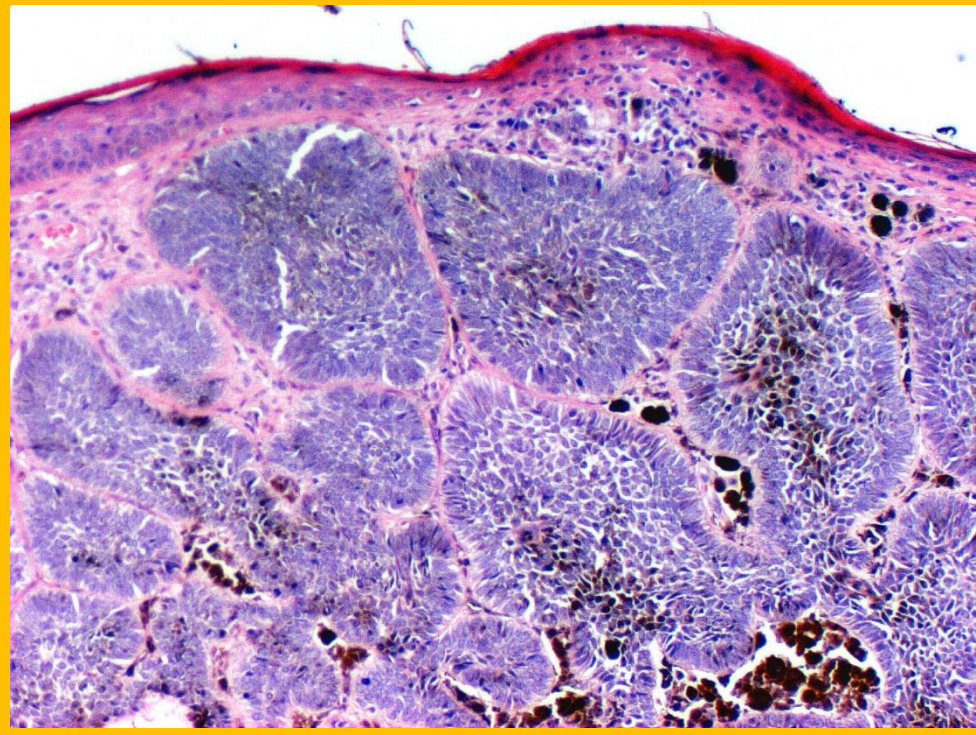




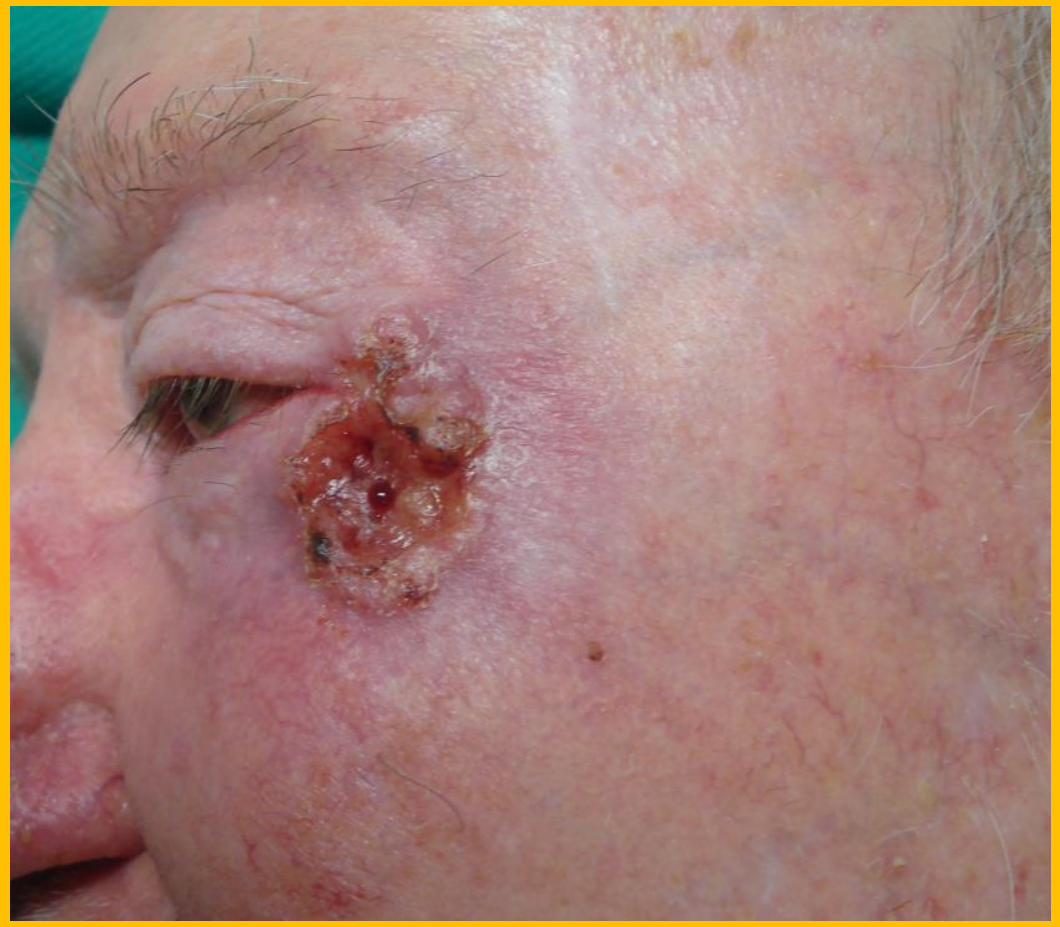
Pigmented BCC:

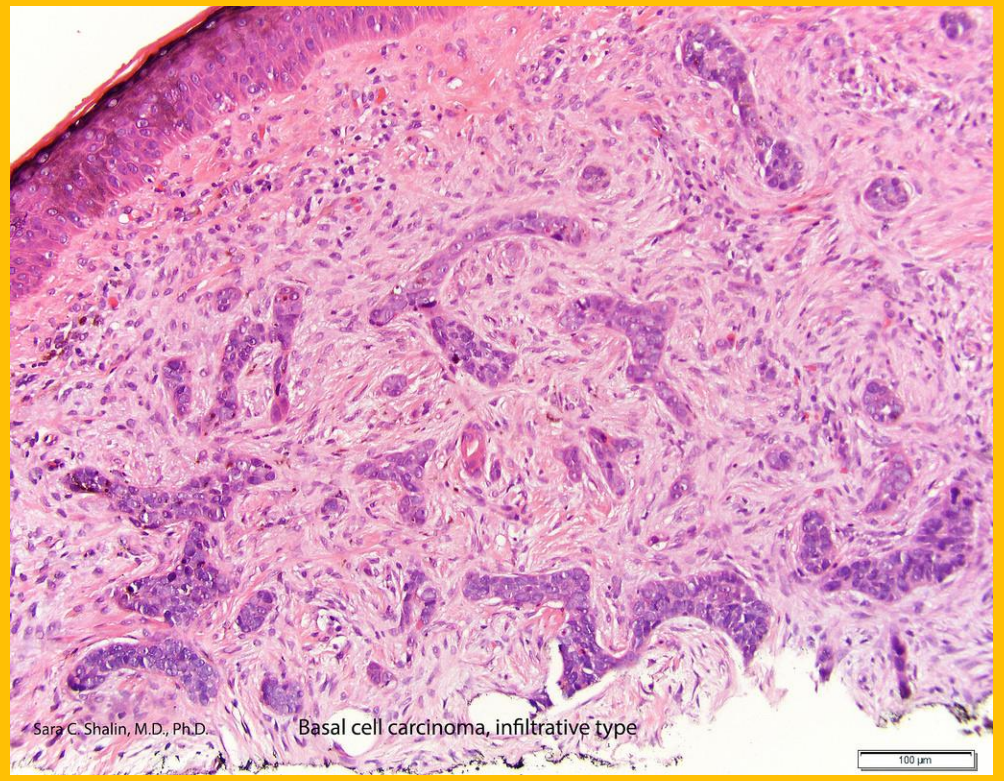
Melanin deposits
Pigmented races
Scary and east to confuse with MM



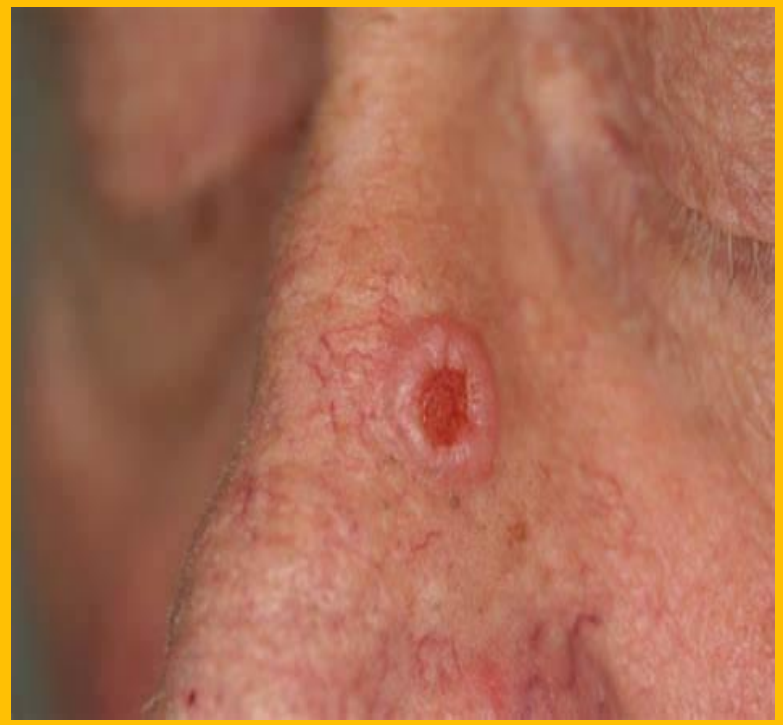


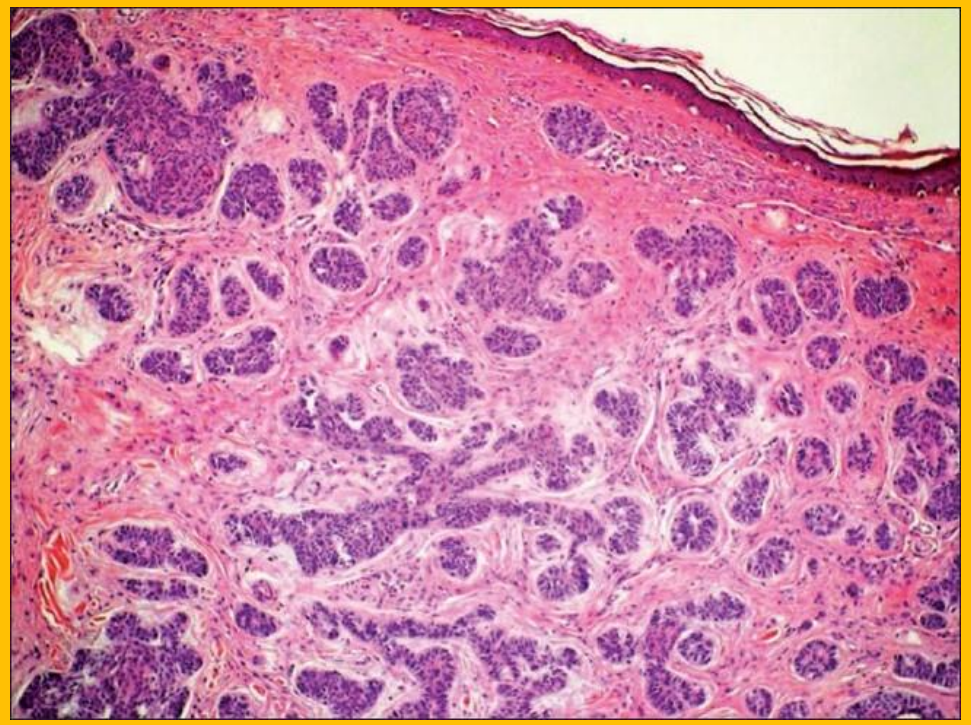
Infiltrative BCC



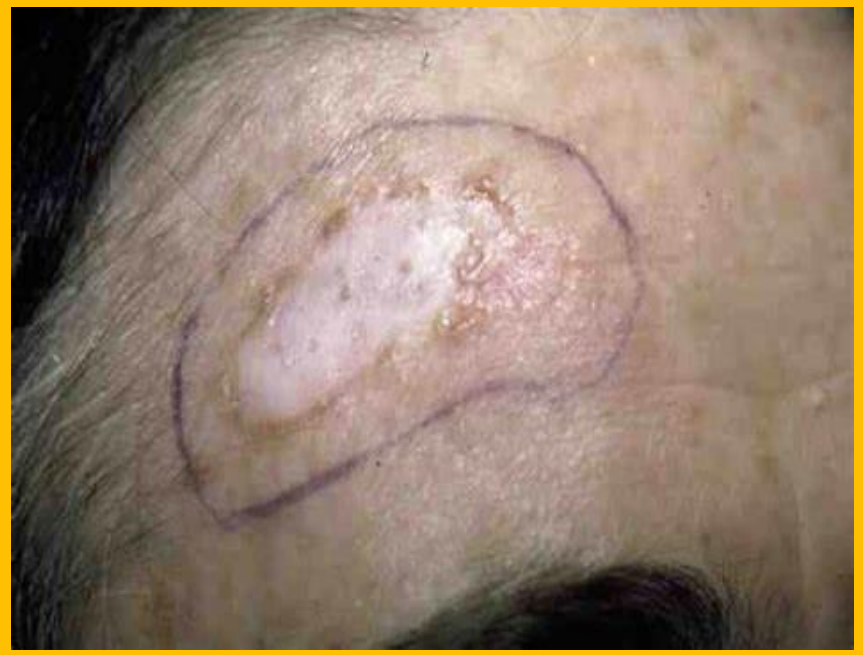


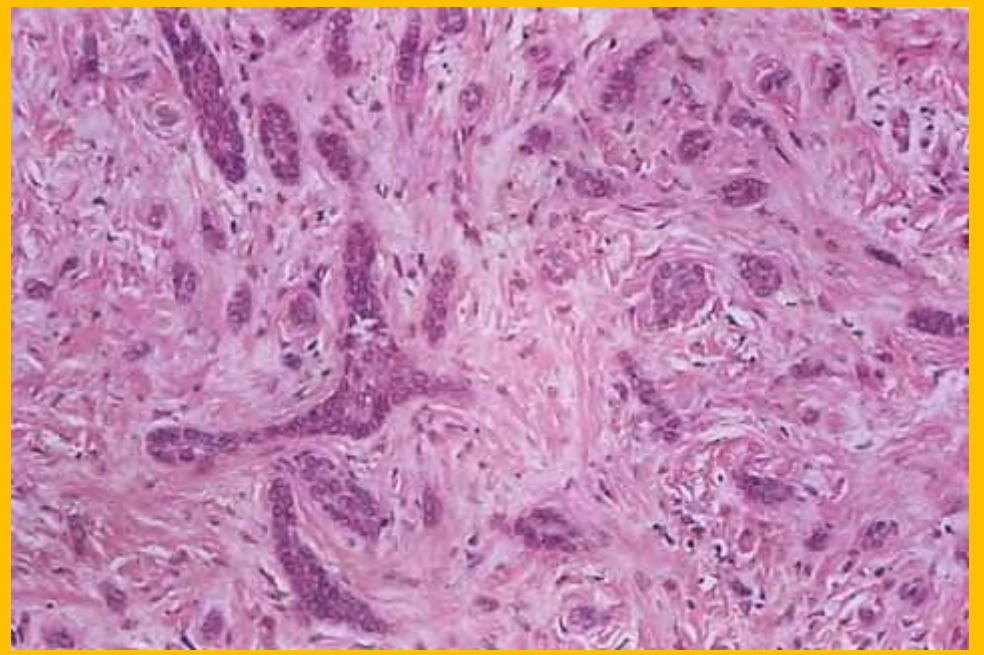
Micronodular BCC, subclinical extension common





Morpheaform BCC: Nasty



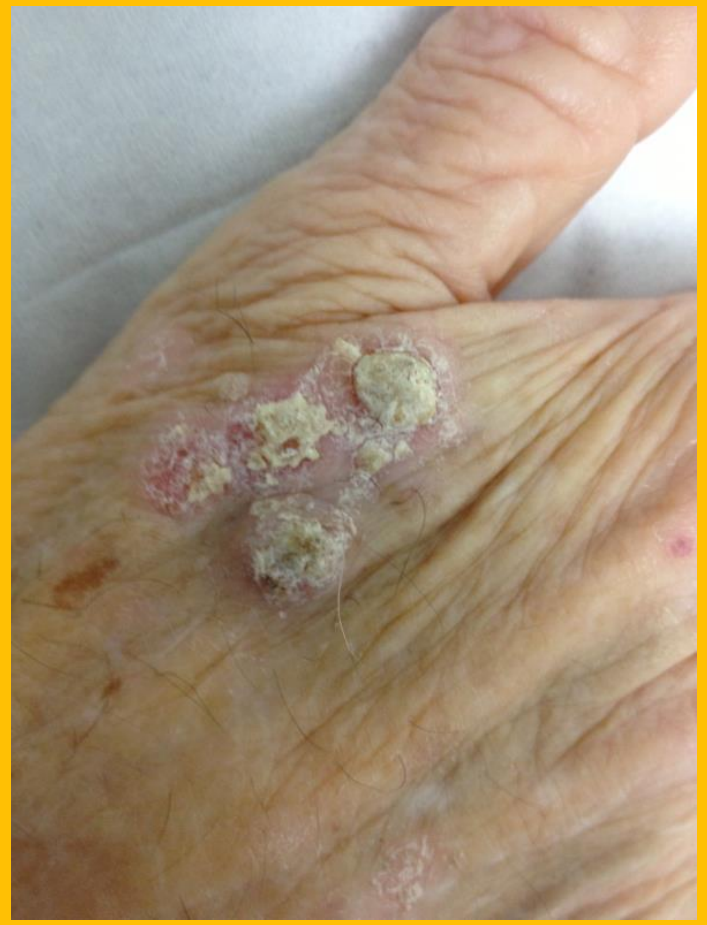


Squamous Cell Carcinoma

- More aggressive, will spread
- Subtypes:
  - SCC-IS
  - Keratoacanthoma
  - SCC invasive
    - Well diff
    - Mod diff
    - Poorly diff

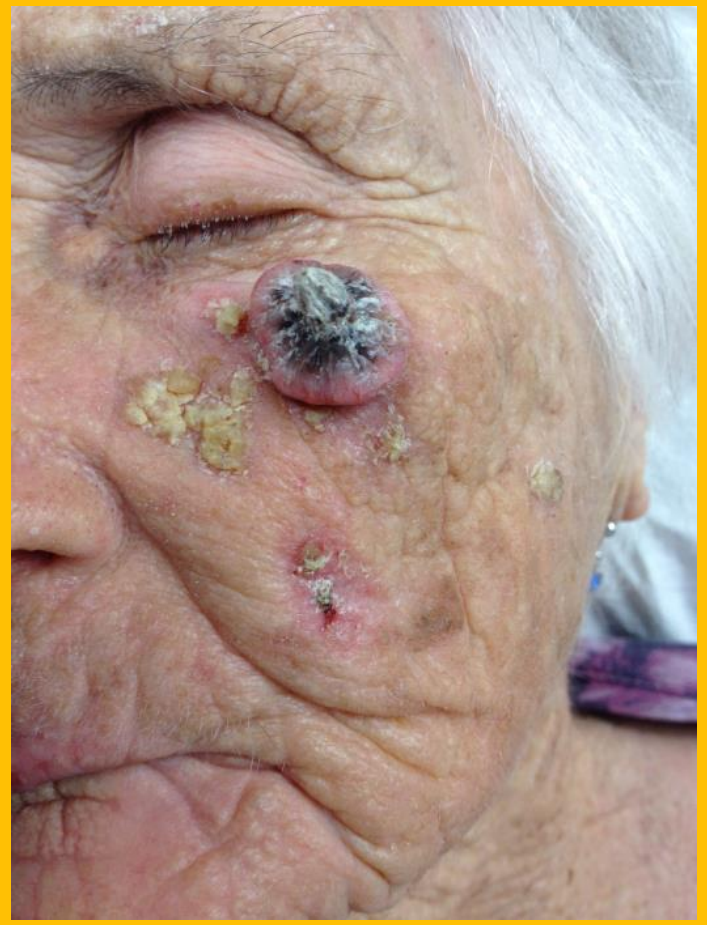
SCC-IS: Bowen's Disease

3% risk of developing invasion

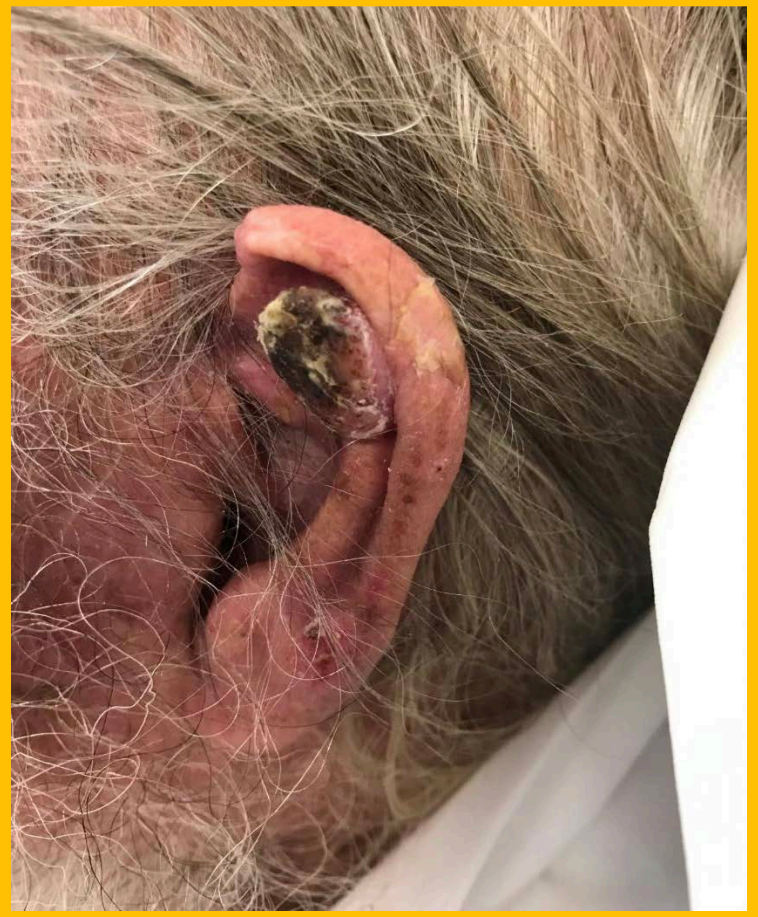


Keratoacanthoma

Low grade SCC
Rapid growth
”It popped up out of nowhere!”



Invasive SCC: Ear and lip are the WORST



SCC Risks

- **SCC is locally invasive and destructive**
- **Metastases in 1-3% of cases**
- **To lymph nodes 50-73% survival**
- **Distant sites (lungs) Incurable**

Treatment Of NMSC

- Divide into high risk vs low risk
- Low risk
  - Smaller than 1 cm on the body
  - Non-aggressive subtypes (superficial BCC, SCC-IS)

Treatment of low risk

- EDC
- Excision with 2-4mm margins
- Imiquimod
- Cryo (ouch)

Higher risk

- Subtypes
  - SCC, mod or poorly diff
  - BCC, micronodular, infiltrative, morpheaform
- Locations
  - Face, mask zone. Ears and lips especially
  - Scalp
  - Hands, feet, genitals, breasts, shin
- Other factors
  - Recurrence (even after LN)
  - Immune suppression (meds, illness, etc…)
  - Arising in a scar
  - Age <35

Treatment for higher risk

- Wider excision, 3-5mm.
  - Easy in low access areas like rural
- Mohs Micrographic surgery.
  - Gold standard
- Radiation, with our without surgery first
  - Post op radiation for nasty SCC and perineural invasion etc…

NMSC Protocol

- Be proficient at taking shave biopsies
- Be proficient at small excisions with layered closures
- Have a friendly Mohs surgeon on text speed dial


JOB
SECURITY