SKIN CANCERS AND AESTHETIC MEDICINE

DR PAUL CHARLSON PRESIDENT BCAM AND GPWER IN DERMATOLOGY

Skin lesions are a common concern amongst patients. Aesthetic clinics will see patients with a variety of skin lesions. Patients will ask them to be examined and removed. Sometimes they will not mention them as their agenda is with other signs of aging.

In my experience the more skin lesions you see the more you realise the difficulty of diagnosis without histology. However there are certain characteristics of lesions that you can observe and explore with the patient which might alert you to potential skin cancers.

Most skin cancers occur as a result of photo-damage and in fact skin aging occurs mainly as a result of photo-damage. There are three main forms of skin cancer, Basal cell carcinoma, Squamous cell carcinoma and Melanoma.

Basal cell carcinomas (BCC) are common particularity in Caucasians and the incidence is rising [i] . These lesions can be typical : A persistent slowly growing pearly lump but they can also be pinkish patches or appear in a variety of guises with pigmented lesions being quite frequent.

Two websites I find useful to illustrate skin cancers are the Primary Care Dermatology Society www.pcds.org and Dermnet NZ www.dermnetnz.org both have lots of diagnostic help and photographs.

BASAL CELL CARCINOMA

So how might you recognise a BCC? The key is to be alert to their existence. If a patient asks about a lump what should do?

TIP 1: Take a proper history – Ask about the lesion, how long have they had it? Has it got bigger? Any lesion that has not gone away in three months has to be regarded as at least suspicious. If a lesion is getting bigger then it is definitely of concern. Has the patient had a skin cancer before? If they have then this suggests photo-damage and a greater likelihood of skin cancer.

TIP 2 :What are the characteristics of the patient's skin? – Do they have fair skin? Type 1 or 2 Fitzpatrick scale is fair –The website below is helpful in deciding what type of skin your patient has.
www.arpansa.gov.au/sites/default/files/legacy/pubs/RadiationProtection/FitzpatrickSkinType.
Where is the lesion? Common sites are sun exposed[ii] face, neck, décolletage, ears, hands, forearms and lower legs in women. Look for signs of photo-aging. A fair skinned patient with a persistent lump which is slowly enlarging over several is likely to be a BCC. Whilst BCCs are commoner in older people they do occur in younger patients.

TIP 3 : Examine the patient. This means asking them to take some clothes off. A full examination of the skin means more than taking a cursory look at lesion and the surrounding area. You need to examine all of the skin. BCCs are often multiple. Pick the lesion up if it has substance and hard this may well indicate a BCC. Similarly if it is a flat plaque stretch it and look at edge to ascertain if it is raised ? This is called a whipcord edge and is characteristic of superficial BCC. Most BCCs are nodular and have a pearly edge with a sometimes ulcerated centre. If you use your phone camera to take a picture and enlarge it you can often see blood vessels running through the lesion like tree branches and this is characteristic of BCC. Sometimes BCC can arise in old scars so be aware of these too.

MALIGNANT MELANOMA

The most dangerous skin cancer is malignant melanoma. There are around 16000 new cases of melanoma every year in UK according to Cancer Research UK and

around 86% of these are preventable by effective use of sun block especially at a young age[iii]. Melanoma causes over 2000 deaths per year in UK and early diagnosis affects prognosis. 1 in 36 UK males will have a melanoma during their life so it is not rare.

Melanomas are related to sun damage and commoner in Caucasians. About a third occur in under 50s placing them in typical demographic of many aesthetic clinic clientele. These lesions are can be typically pigmented but vary considerably in their characteristics. A significant proportion are not pigmented often in the form of raised pink nodules.

Diagnosis even in expert hands can be difficult. Which is why the proliferation of clinics removing moles without histology is very dangerous.

TIP 4 : Take a good history . Most melanomas occur out of the blue but some are in existing moles. Ask about the “mole” , how long has it been there and has it changed? Generally melanomas grow over a few months but in my experience patients are frequently inaccurate about how long something has been there and whether it has grown.

TIP 5 : Use the ABCDEFG[iv] rule

A = Asymmetry. The two halves of the mole look different in shape and/or colour

B = Border. Look around the edge of the mole. Melanoma will often have an irregular, jagged, notched or blurred border

C = Colour. Several different colours or shades of colour, or a single colour that is different to other moles

D = Dimensions (changing size). Melanoma can spread outwards as a flat lesion, it can grow upwards as a hard lump and some do both

E = Elevation,

F = Firmness to touch

G = Growth. Persistent growth for over one month

Lesions are more likely to be benign if :

They are growing gradually and symmetrically through puberty

Brown moles that gradually become dome-shaped and soft/wobbly to palpate whilst maintaining a regular symmetrical edge

Colour

- Brown moles that are one colour
- Or two colours where the colours are similar (eg two shades of brown) AND where the pigment is arranged in a symmetrical fashion eg darker centre and lighter edge

Itchy moles that are not changing and otherwise appear normal

Moles that change rapidly (over a few days) becoming swollen, inflamed and crusty AND which then settle back down to their original appearance - these moles are likely to have been traumatised or become acutely infected.

Classical halo naevi in young patient

TIP 6 : Ignore TIP 5 Unless you are trained in dermatology and the use of dermatoscope do not manage the lesion yourself (even if you are a practised dermoscopist you have very low index of suspicion.) Refer the patient urgently to their GP and write to that GP immediately to inform them of your concerns.

TIP 7 : If you are tempted to remove, burn , freeze a “mole” ask yourself are you sure you know what the lesion is. There is no room for heroes here! In dermatology clinics if we are suspicious we remove the lesion for histology.

TIP 8 : Don’t forget the nails – any new dark line in a nail or nail destruction consider to be very suspicious.

TIP 9 : Beware of the UGLY DUCKLING – the mole that looks different from the other this could be a melanoma.

SQUAMOUS CELL CARCINOMA

Squamous Cell Carcinomas are the other main type of skin cancer. These are often keratotic warty looking lesions occurring on sun exposed sites and are more frequent in older people. They grow in a few weeks to months. They are often tender to touch with poorly demarcated induration which is a deep thickening of the skin. There is often inflammation which causes pain. If you examine an SCC it is firm. It can look like a nodule, a flat plaque, warty or ulcerated. Many look unpleasant and are painful and inflamed but sometimes they can be fairly non-descript.

TIP 10 : Any hard inflamed keratotic lesion that has grown over a few weeks or months especially in an older sun exposed individual needs urgent referral to a GP with a letter as this is likely to be an SCC.

This article is not intended to be exhaustive and designed to provide pointers to try to prevent clinicians missing skin cancers. Diagnosis is not easy and mistakes are made by everyone dealing with the skin. Patients surprisingly ignore potentially serious lesions. Aesthetic clinics are seeing patients for skin problems in particular the results of photo-damage so are going to see their share of skin cancers. If you spot one you may save a life or at least prevent unpleasant and potentially disfiguring surgery.

DR CHARLSON FRCGP DPD DRCOG DOccMed MBCAM is a RCGP accredited GPwER in Dermatology and has worked in secondary referral NHS dermatology clinics for 15 years in conjunction with Consultant colleagues. He has worked in the field of aesthetics since 2002. He has clinics in Yorkshire and London. He is a member of the PCDS and associate member of the BAD.

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[i] Lomas A, Leonardi-Bee J, Bath-Hextall F (2012) A systematic review of worldwide incidence of nonmelanoma skin cancer. *Br J Dermatol* **166** (5): 1069–1080.

[ii] Subramaniam P, Olsen CM, Thompson BS, Whiteman DC, Neale RE, for the QSkin Sun and Health Study Investigators. Anatomical Distributions of Basal Cell Carcinoma and Squamous Cell Carcinoma in a Population-Based Study in Queensland, Australia. *JAMA Dermatol.* 2017;153(2):175–182

[iii] www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/melanoma-skin-cancer

[iv] . http://www.pcds.org.uk/clinical-guidance/melanoma-an-overview1