SKIN CANCER (AK-->BOWENS-->SCC)

- All 3 can produce keratin horns.
- They require biopsy.
- Cutaneous horn can arise on various conditions.
- But if very sun damaged then think SCC, as it can arise on SCC, as the mallignant cells can cause the keratinisation.

All 3 can produce keratin horns. They require biopsy.

Disclaimer:
Read the disclaimer at medimaps.co.uk/disclaimer

References:
1. Dermatology lecture, GP Scholar, Oct 2016
2. Dermatology consultant Alliance Federation Feb 2018
3. OnMedica.com

Actinic keratosis (AK)

- Is epithelial dysplasia.
- Hence AK does not get infected.
- Compared to SCC which can.
- AK is considered to be pre-malignant.
- If isolated lesion risk = 0.05%
- But if widespread then up to 5% risk.

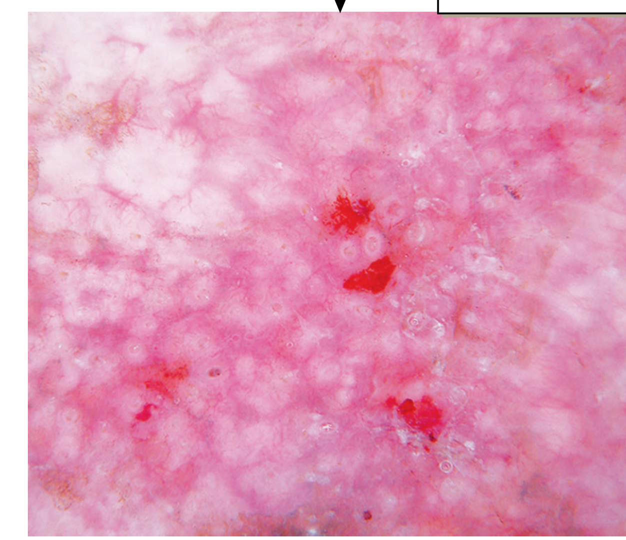
Red flags:
- If induration in AK then its a red flag as might be progressing to SCC.
- Be aware of tender AK.
- Lesions not responding well to treatment.
- Bleeding.
- In renal transplant pt, refer all AK.

- Routine referral to dermatology.
- Make sure you safety net if routine referral.

- Small plaque with white-yellowish surface scale on sun exposed areas.
- Rough surface (compared to lentigo maligna).
- Sharp scolloped borders.
- Strawberry pattern due to erythematous pseudonetwork on facial skin.
- Prominent hair follicles that are yellow (ovoid) and surrounded by a white coloured halo (can be target-like).
- Brown dots and globules may cause pigmentation.
- Annular-granular pattern, which consists of pigmentation and/or gray dots/granules surrounding adnexal openings.
- Angulated lines forming zig-zag lines and polygons. The most common polygons are rhomboidal structures.
- Blood vessels are curved.

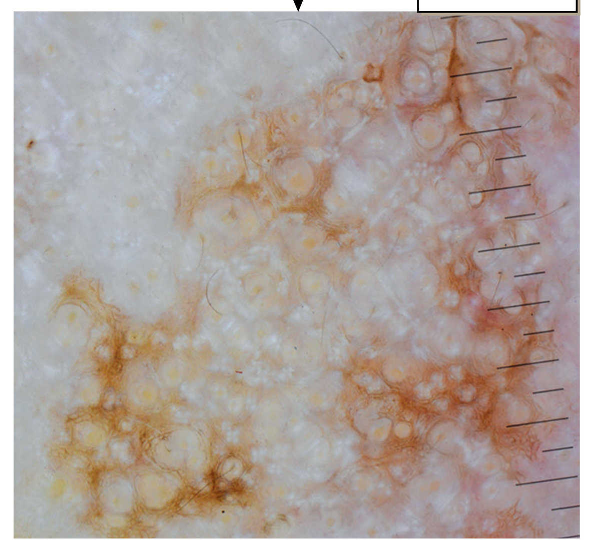
AK non-pigmented

Strawberry pattern



AK pigmented

- Rosettes
- Zigzag lines



Management

- Efudix suitable for most AK.
- Far superior clearance rate.
- Solaraze has a low clearance rate.

- Efudix OD for 4/52, and if needed use BD for a further 2/52.
- Efudix reactions are normal. Will make worse before better.
- Stay calm. If in doubt stop/interrupt.
- Dermol 500 can help.
- Hydrocortisone or eumovate if very severe.

- Solaraze BD for 60-90/7.

- Picato has high compliance as 3/7 treatment.
- Warn will get reaction 1/52 later.
- Use if Efudix fails or carer puts on.

- Can use cryotherapy, curretage.
- Cryotherapy = painful, risk of ulceration and carring, double freeze for 7-10 sec.
- Will leave flat white scar.
- Clearance rate 75%.

- If grade 3 use curretage by 2o care.

- Aktikeral removes crust if scally thick lesions.
- If redness remains but crust has gone, then you have succesfuly treated.

- Minimum sun exposure 11-3pm, shade, protective clothing, SPF 15-30.
- No sunbed. Avoid obtaining a tan.

Bowens disease (BD)

- Is SCC in situ.
- Full thickness epithelial dysplasia and increased atypia.

- Size 1-10cm.
- Crusty, scaly, pink patch on sun exposed sites.
- (See right SCC for schematic and photo's).

- Routine referral to dermatology.
- Make sure you safety net if routine referral.

- Can Bowens be managed in 1o care?
- Yes if you are confident.
- Effudix for 6/52. Can shave/curretage.
- However, dermatology tend to biopsy the lesion so they can detect the worst area and follow up in 6/52.

SCC

Invasion into dermis.

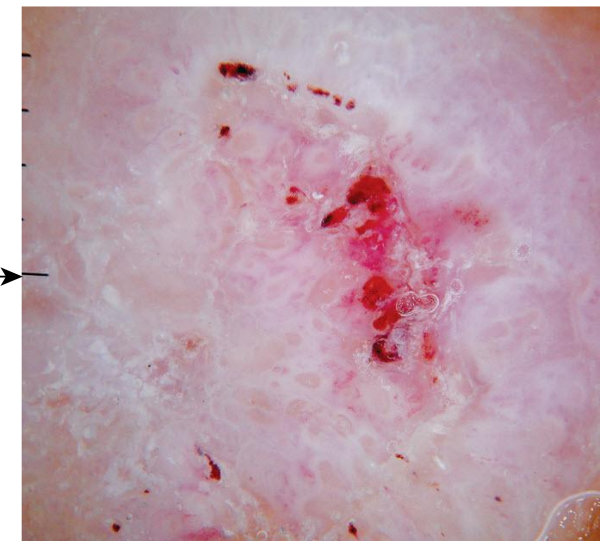
- Rapidly growing.
- Firm and fleshy base.
- Painful (almost every SCC is painful).
- Nodule.
- Hard crust.
- Ulcerated.
- Hairpin/looped, dotted, glomerular and/or serpentine vessels.
- Treatment refractory.

Keratoacanthoma

- Some consider it a well differentiated SCC.

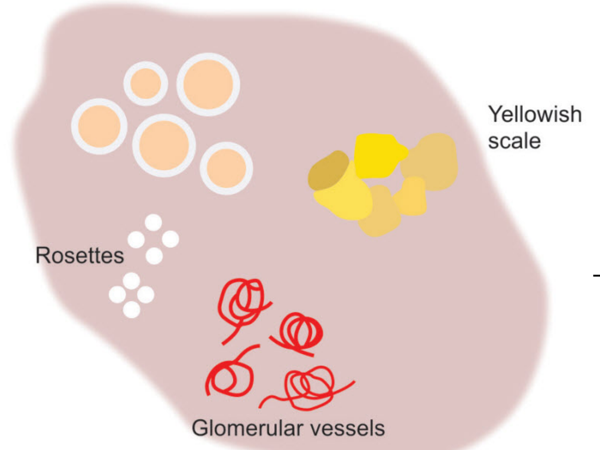
- Rapidly growing lesion.
- Dome-shaped papule or nodule with a central keratin filled crater.
- Impossible to differentiate from SCC clinically, so send on 2ww to get excised.

- Central brown-to-yellowish keratin scale-crust.
- Hairpin/looped vessels surrounded by white halo usually tend to surround the central keratin crust in a radial fashion.
- Serpentine, dotted and glomerular vessels, which also tend to be surrounded by a white halo.
- Ulceration.
- White circles (keratin pearls).

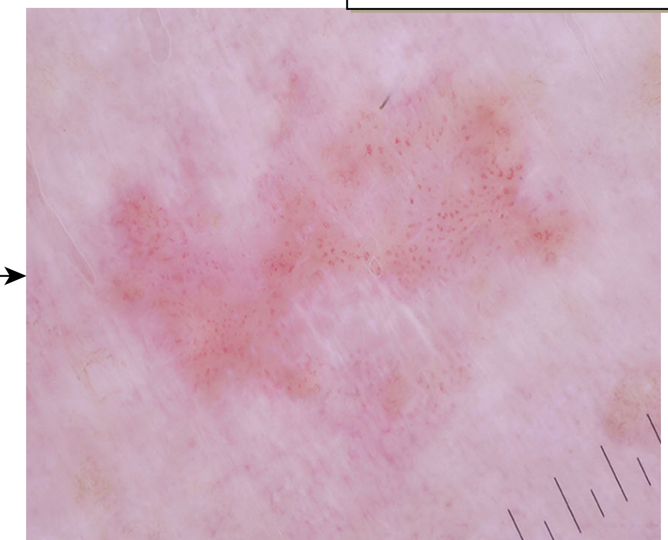


Non-pigmented SCC/BD

- Yellowish scale present focally or throughout the lesion.
- Dotted and/or glomerular vessels usually distributed focally at the periphery. However, glomerular vessels can also be present diffusely or aligned linearly within the lesion.
- White circles (keratinizing pearls).

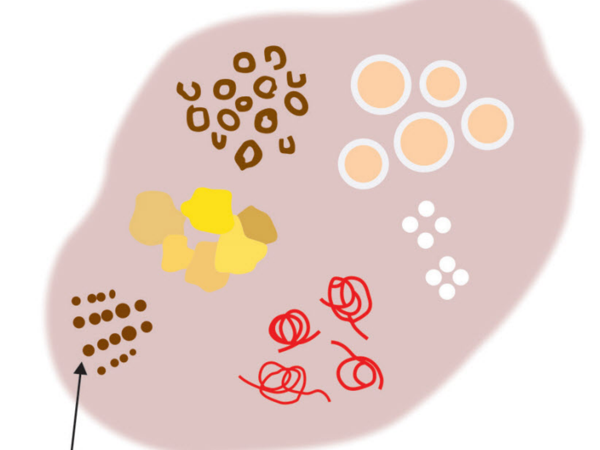


- Focal areas of glomerular and dotted vessels, scale and hyperkeratosis.



Pigmented SCC/BD

- Additional features:
- Brown dots or globules arranged in a linear configuration.
- Brown circles.



- Focal areas of dotted vessels (circle) and pigmented dots radially aligned (squares).