A SUMMARY OF MANAGEMENT IN CLINICAL PRACTICE

BASAL CELL AND SQUAMOUS CELL CARCINOMA


Non-melanoma skin cancers include squamous cell carcinoma, basal cell carcinoma and a third group of lesions comprising keratinocyte dysplasias. The latter include solar keratosis, Bowenoid keratosis and squamous cell carcinoma in-situ (Bowen’s disease) which are not invasive cancers but may require treatment.

Non-melanoma skin cancers are the most common cancers in Australia. At least 250,000 people require treatment for one of these tumours each year.

WHEN TO REFER

Referral to a specialist such as a dermatologist, plastic surgeon or radiation oncologist should be considered when there is:

- Uncertainty of diagnosis
- Any doubt about appropriate treatment
- A tumour larger than 1cm
- Frequent multiple tumours, for example, organ transplant patients, Gorlin’s syndrome
- Recurrent tumours, despite treatment
- Incompletely excised tumours, especially when complete excision may be difficult
- Recommended treatment beyond the skills of the practitioner
- Anticipation of difficulty with technique or anatomy
- Squamous cell carcinoma on the lip or ear
- Infiltrating or scar-like morphoeic basal cell carcinoma, particularly those on the nose or around the nasolabial fold – because there may be a problem in determining the tumour’s extent and depth
- Cosmetic concerns, such as lesions of the upper chest and upper arms where keloid scarring is a potential problem
- Areas where palpable regional lymph nodes are suggestive of metastatic spread of squamous cell carcinoma, especially head and neck, axilla and groin
- Organ transplant and other chronically immunosuppressed patients are best referred to organ transplant clinics

KEY POINTS

- GPs play a pivotal role in the early detection and management of non-melanoma skin cancer
- Uncomplicated small tumours are best removed by an elliptical excision with a 3mm margin for BCC and 4mm margin for SCC. These wounds are closed by primary suture
- The first opportunity for treatment is the best strategy to achieve cure
- Caution should be used in the management of tumours on the face including the ears, lip and around the eyes
- It is important to be aware of guidelines for referral
- It is best that specialists be given the opportunity to deal with a problematic lesion in its entirety
- Opportunistic screening with a total-body cutaneous examination on all patients should be practised

Please see over for a GP Guide to Treatment

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# A GP GUIDE TO TREATMENT

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Squamous cell carcinoma (SCC)</th>
<th>Basal cell carcinoma (BCC)</th>
<th>Keratinocyte dysplasias</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Treatment of choice for most tumours. Simple ellipse with primary closure in most cases under local anaesthetic with a margin of 4mm.</td>
<td>Primary treatment of a large proportion of tumours. Simple ellipse with primary closure in most cases under local anaesthetic with a margin of 3mm.</td>
<td>Solar keratosis Bowenoid keratosis SCC in-situ (Bowen’s disease)</td>
</tr>
<tr>
<td>Cryotherapy</td>
<td>Not a treatment of choice. Suitable for primary, well-defined, histologically confirmed, superficial tumours at sites away from head and neck. Contraindicated for morphoeic or ill-defined tumours. Long-term follow-up is essential.</td>
<td>Not a treatment of choice.</td>
<td>High cure rates for solar keratosis, particularly with a single freeze cycle of 5-10 seconds directly to the lesion. A 3mm margin and 30 second single freeze cycle for Bowenoid keratosis or SCC in-situ (Bowen’s)</td>
</tr>
<tr>
<td>Curettage</td>
<td>Not a treatment of choice. May be used for keratoacanthoma when the operator is skilled in both the technique and tumour selection. Suitable for primary, well-defined, superficial or nodular tumours. Not suitable for morphoeic or recurrent tumours. Requires supervised training in tumour selection and technique.</td>
<td>Suitable for biopsy-proven superficial BCC, but not on nose or around eyes. May be suitable for nodular BCC on occasion, but requires referral for specialist opinion. Treat Monday-Friday five times weekly for six weeks.</td>
<td>Not a treatment of choice. May be used occasionally in Bowenoid solar keratosis or SCC in situ (well-localised Bowen’s disease).</td>
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<tr>
<td>Imiquimod</td>
<td>Not a treatment of choice. Suitable for biopsy-proven superficial BCC, but not on nose or around eyes. May be suitable for nodular BCC on occasion, but requires referral for specialist opinion. Treat Monday-Friday five times weekly for six weeks.</td>
<td>Suitable for field change of multiple solar keratoses. Suitable for localised biopsy-proven Bowen’s disease. Treated three times a week for four weeks and then review prior to continuing therapy.</td>
<td></td>
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<tr>
<td>Superficial x-ray therapy</td>
<td>An optional treatment in biopsy-proven tumour when surgery is not feasible or will cause unacceptable morbidity.</td>
<td>May be an option for biopsy-proven tumours in older people where surgery is unacceptable to the patient.</td>
<td>Not a treatment of choice.</td>
</tr>
<tr>
<td>Diclofenac Gel</td>
<td>Not a recommended treatment.</td>
<td>Not a recommended treatment.</td>
<td>Suitable for field change of multiple keratoses. Treat twice daily for 90 days.</td>
</tr>
<tr>
<td>Photodynamic Therapy</td>
<td>Not a treatment of choice. Suitable for biopsy-proven superficial or small nodular BCC but not on nose or around eyes.</td>
<td>Suitable for field change of multiple solar keratoses. Suitable for localised biopsy-proven for Bowen’s disease.</td>
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</tbody>
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