



Medicine for Managers

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Basal Cell Carcinomas

There is high public awareness about melanoma but there are two principal types of skin cancer, melanomas and non-melanomas. There are two common types of non-melanoma skin cancers, the basal cell carcinoma (BCC), which accounts for about three-quarters of all skin cancers and the squamous cell carcinoma (SCC) which accounts for about one fifth of skin cancers.

The cause of basal cell carcinomas is not known but they are associated with the same factors that cause melanoma, namely over-exposure to ultraviolet light, sun-beds, pale skin which burns easily, and red hair.

There may also be an association with family history and, once a person has had a basal cell carcinoma, they may be up to eight times more likely to develop another one. Of course, skin lesions are extremely common but, as a rule of thumb, it is wise to seek the opinion of a GP if a localised skin change occurs and persists for longer than about three weeks.

A basal cell carcinoma develops as a painless flat or nodular red or pearly lesion which is discrete



and which may show minute blood vessels on the surface. It may develop a rolled everted edge

with a central crater which may contain some crusting. Indeed it is the cratered appearance which led to its alternative name of rodent ulcer. The crusting (scab) may be lost resulting in



some slight bleeding and the lesion itself does not completely heal.

It normally develops by slow direct extension into surrounding tissues.

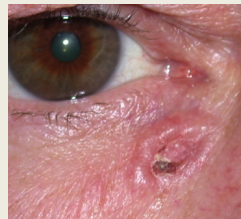
Estimates vary considerably but it is suggested that there are between 80-200,000 new cases annually.

Diagnosis is normally made by a GP by direct inspection. The shallow central crater with the pearly everted rim is characteristic. Sometimes, however, the appearance is not so clear cut and the GP may seek the opinion of a specialist. Alternatively the GP, depending on his level of surgical skill and experience, may remove part

(incision biopsy) or all (excision biopsy) of the lesion under local anaesthesia to send the specimen to the laboratory for histological assessment.

The histologist can make the diagnosis from the characteristic changes associated with the development of whorls of abnormal cells derived from the basal layer of skin.

Management of the basal cell carcinoma is effective and results in a cure virtually every time when done appropriately.



The standard methods of treatment are either excision, where the lesion is cut out with a margin of healthy skin under local anaesthesia, electrocautery, where the lesion is cauterised with an electric cautery and curetted under local anaesthesia, or cryotherapy where the lesion is destroyed by freezing using liquid nitrogen.

All methods are effective although an excision does have the advantage that diagnosis can be confirmed by histological review under the microscope.

On occasion the treatment may be more difficult if the lesion is large or located in an awkward place such as around the eye or on the nose. In such circumstances,

radiotherapy and occasionally a chemical therapy is the treatment of choice.

Seldom, if ever, does a basal cell carcinoma spread other than by direct enlargement.

Prevention of BCCs can be difficult but, as with other skin cancers, preventing overexposure to ultra-violet light, avoiding sun-beds and sunlamps and keeping an eye on the skin to identify any persisting skin lesions should ensure early diagnosis and effective treatment.

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