WPRS

Warrnambool Plastic & Reconstructive Surgery

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this issue

Let us answer some questions you may have

- **What are the non-surgical treatment for BCC's?**
- **Who needs skin checks and who should perform them?**

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What are the non-surgical treatment options for BCC's?

Treatment of Basal cell carcinoma is still predominantly surgical. There are however , other options for certain types of basal cell carcinoma. Here is a summary of the options:

1. **Radiotherapy:** Has clearance rates similar to surgery. Down side is that it requires 4-6 weeks of treatment, if tumor's reoccur following radiotherapy a larger excision is required and reconstruction in radiotherapy field is difficult. I use radiotherapy as adjuvant treatment for large BCC's or BCC's with narrow margin of excision.
2. **Aldara (5% Imquimod):** Indication for use is superficial BCC <2cm on the trunk or limbs. Not indicated for other subtypes of BCC or face/neck BCC Treatment regime is 5 times per weeks for 6 weeks. Clearance rates are 75%. I use it for superficial BCC on the lower limb that may avoid the patient needing a graft.
3. **Cryotherapy:** Indication of use is the same as Aldara. Requires 3 freeze-thaw cycles to adequately treat. Clearance rate 85%
4. **Curette and diathermy:** Indication for use again the same as Aldara. Curette must be combined with diathermy. Not safe for head and neck BCC. Clearance rates 85-90%.

Other options such **ablative laser** and **photodynamic therapy (PDT)** have extensively been researched and been shown to have very lower clear rates and are **not recommended by the NHRMC for treatment of BCC.**

The other important factor to remember with the non-surgical options is that there is no pathology to review. Hence, patients do not know if it is completely removed which can create dilemmas around possible recurrence in the future and surveillance.

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Skin checks... Who needs them and who should perform them?

Skin cancer is extremely common in Australia with the highest rate in the world. 1 in 3 Australian men will develop a BCC in there lifetime, the rate for melanoma is 1 in 13 and increasing. Hence, with these figures skin surveillance is obviously very important.

So who should perform skin checks? Data from the NHMRC estimates that 70-75% of skin cancers are identified by patients, 15 to 20% by their general practitioners, with the rest identified by other means e.g.: skin check clinics, specialists, mole map etc.
In my experience, lesions missed by patients and general practitioners are often small or difficult to pick and with observation would be identified.

I believe that patient education regarding the changes of skin cancer combined with regular assessment by their General practitioners identifies the vast majority of skin cancers. Referral to a specialists is only really required in high risk patient, if there is a lesion of causes concern or a second opinion is sort

I often get questions regarding Mole map (and associated surveillance programs). I am unaware of any evidence that it increases the pick up rate of skin cancer in the general population. It is certainly of use in high risk patients (i.e. immunosuppressed, previous melanoma, high family risk of melanoma) and with people who have a very large number of neavi (>100) that are difficult to observe.

So who needs skin checks?

1. Previous skin cancer: 1/3rd of people who had one BCC will have another within 3 years, 10% of people who have had one melanoma will get another. For non melanoma skin cancer I recommend 6 monthly reviews for 2 years, then yearly. For melanoma, I recommend 3 monthly reviews for 2 years then 6 monthly for 5 years.
2. High risk patients (e.g. Immunosuppressed patients, strong history of sun exposure, strong family history): yearly review.
3. Fitzpatrick skin types one and two patients (e.g. people that burn easily): yearly review.
4. Patients >60 years old with sun damaged skin (i.e. solar keratosis, solar lentigo): yearly review