WPRS
Warrnambool Plastic & Reconstructive Surgery

Removal of Skin Cancer

Skin cancers are named after the type of cell they develop from. The most common forms are basal cell cancer and squamous cell cancer – these are sometimes called non-melanoma skin cancer. The third type of skin cancer is melanoma.

Basal Cell Carcinomas appear like a small, slow growing shiny pink or red lump and if left, become crusty, ulcerate and bleed. They are commonly found on the face, scalp, ears, hands, shoulders and back.

Squamous Cell Carcinomas are commonly pink lumps and look like a red patch.

Melanoma begins in melanocytes, the skin cells producing the melanin pigment that produces moles, freckles and skin tan. Melanoma is the most aggressive form of skin cancer, and one of the most aggressive of all cancers. Melanoma may arise directly from a melanocyte or an irregular mole, which then becomes cancerous.

Alternative options to Removing Skin cancers

Topical prescription creams such as Aldara can be used to treat superficial BCCs.

Radiotherapy can be used to treat both BCC and SCC. It is generally more time consuming and does have associated side effect. However, overall it is a well-tolerated therapy, and is sometimes recommended in addition to surgery.

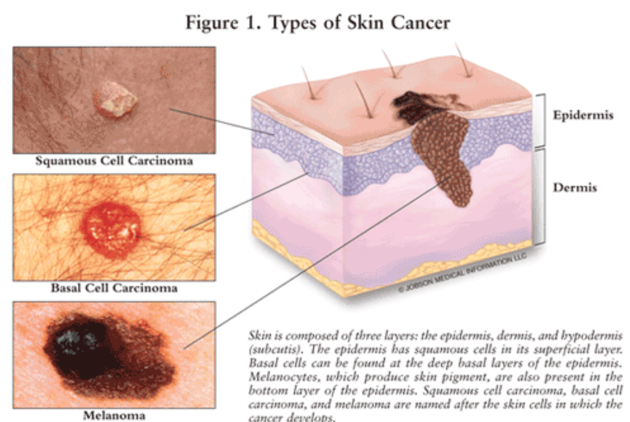
What does the operation involve?

The operation is usually a day procedure and can be performed under local and sedation or a general anaesthetic. The length of the operation usually takes around 30 minutes but is depend on both the size and site of the lesion.

An incision is made at the site of the lesion and the lesion is removed. The surgeon then uses stitches to close the cut. The stitches may be dissolvable. If not, they are usually left in for approximately one week depending on their location.

After removing some skin cancers it may not be possible to stretch the nearby skin enough to stitch the edges of the wound together. In these cases, healthy skin may be taken from another part of the body and grafted over the wound to help it heal and to restore the appearance of the affected area. Other reconstructive surgical procedures can also be helpful in some cases.

Figure 1. Types of Skin Cancer



Skin is composed of three layers: the epidermis, dermis, and hypodermis (subcutis). The epidermis has squamous cells in its superficial layer. Basal cells can be found at the deep basal layers of the epidermis. Melanocytes, which produce skin pigment, are also present in the bottom layer of the epidermis. Squamous cell carcinoma, basal cell carcinoma, and melanoma are named after the skin cells in which the cancer develops.

Source: National Cancer Institute. NCI Visuals Online. http://visualsonline.cancer.gov. Accessed October 9, 2012.

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Post-operative course

You will be able to go home on the same day of surgery in most instances following removal of a skin cancer.

Post operatively you will have a scar at the site of the previous lesion. The length of the scar will depend upon the size of the lesion and also the approach used to perform the procedure. On completion of the surgery a dressing will be placed over your wound.

You will be provided with post-operative instructions and pain relief medication and you should follow these as directed. You will be discharged home with an appointment card for a wound check and dressing change at WPRS. Contact phone numbers to call if you have any concerns once you have been discharged home will be available with your post-operative instructions.

You should rest following your operation and only perform light duties. You should avoid heavy lifting and strenuous activity for a few weeks, returning to normal activities by around four to six weeks. You may drive a car when you feel safe and comfortable to do so (check with your insurance company for any policy requirements). Most people can return to work at around one week post-operative (depending on the type of work).

Potential risks of surgery

Bleeding/haematoma: any bleeding after surgery is usually minor. However rarely you may bleed enough to require a return to theatre.

Infection: uncommon, however if it occurs you may be required to commence antibiotics. If the implant becomes infected it may require removal.

Numbness: damage to nerves that supply the skin may cause a nub patch at the site.

Wound separation/delayed healing: is uncommon in removing benign skin lesions.

Scar tenderness: is common for around 6 weeks and improves for most people, though is rarely permanent.

Scar widening/hypertrophy: this can occur with any scar. Your wound will be carefully closed however some people may develop widened or elevated scars. WPRS monitor for this and provide information to avoid this potential complication.

Risk of incomplete excision: 4% for primary lesion, however, for re current lesion maybe as high as 10%.

Flap/Graft Failure: ~5% of grafts/flaps may have healing problems, these are often managed conservatively.

Recurrence: <1% for completely excised BCC/SCC. Rate of recurrence for melanoma depends on depth of lesion.

Anaesthetic complications: sore throat, nausea/vomiting, other rare complications (i.e. allergic reaction to anaesthetic) can be discussed with your anaesthetist.

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