A SUMMARY OF MANAGEMENT IN CLINICAL PRACTICE

BASAL CELL AND SQUAMOUS CELL CARCINOMA

For further information please refer to "Basal cell carcinoma, squamous cell carcinoma (and related lesions) – a guide to clinical management in Australia". Australian Cancer Network / Cancer Council Australia 2008. website: www.cancer.org.au/skincancerguides

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

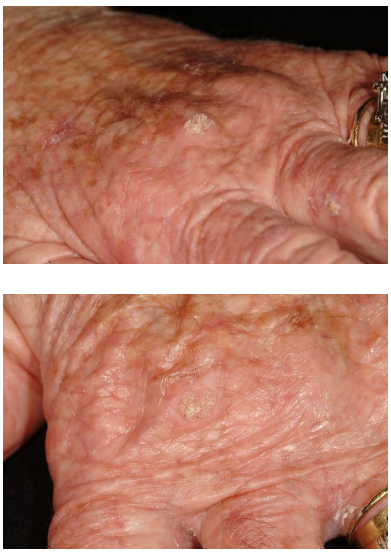
Please see over for a GP Guide to Treatment

This summary card was originally produced in conjunction with and distributed by, Australian Doctor.

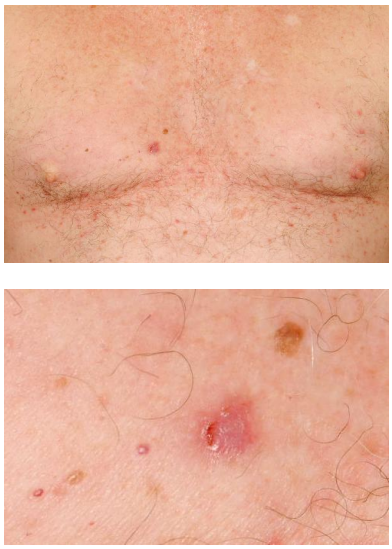
This summary card was developed with funding received from the Australian Government.

November 2008

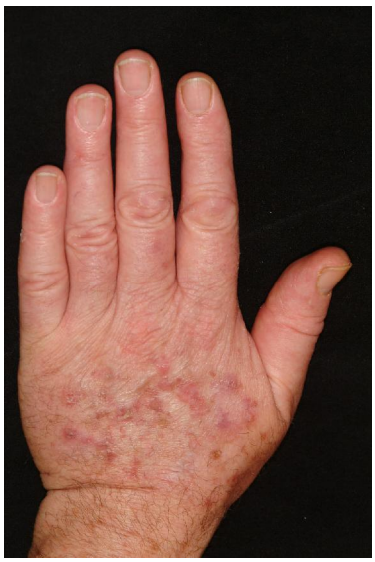
A GP GUIDE TO TREATMENT



Two views of an early squamous cell carcinoma on the back of the hand



A small nodular basal cell carcinoma on the chest, distant and close up



Solar keratoses on the dorsum of the hand

Treatment	**Squamous cell carcinoma (SCC)** (variant keratoacanthoma)	**Basal cell carcinoma (BCC)**	**Keratinocyte dysplasias** Solar keratosis Bowenoid keratosis SCC in-situ (Bowen's disease)
Surgery	Treatment of choice for most tumours. Simple ellipse with primary closure in most cases under local anaesthetic with a margin of 4mm.	Primary treatment of a large proportion of tumours. Simple ellipse with primary closure in most cases under local anaesthetic with a margin of 3mm.	Not a treatment of choice unless there is doubt about whether the lesion is invasive SCC.
Cryotherapy	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.	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)
Curettage	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.	Not a treatment of choice. May be used occasionally in Bowenoid solar keratosis or SCC in situ (well-localised Bowen's disease).
Imiquimod	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.	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.
Superficial x-ray therapy	An optional treatment in biopsy-proven tumour when surgery is not feasible or will cause unacceptable morbidity.	May be an option for biopsy-proven tumours in older people where surgery is unacceptable to the patient.	Not a treatment of choice.
5 Fluorouracil	Not a treatment of choice.	Not a treatment of choice.	Suitable for field changes of multiple solar keratoses and localised biopsy-proven Bowen's disease. Treat twice daily two-four weeks.
Diclofenac Gel	Not a recommended treatment.	Not a recommended treatment.	Suitable for field change of multiple keratoses. Treat twice daily for 90 days.
Photodynamic Therapy (requires specialist centre and equipment)	Not a treatment of choice.	Suitable for biopsy-proven superficial or small nodular BCC but not on nose or around eyes.	Suitable for field change of multiple solar keratoses. Suitable for localised biopsy-proven for Bowen's disease.