Dermoscopy Pictures

We now have state of the art photography equipment to monitor suspect moles. "Surveillance photography" can reduce the number of benign moles being removed.

PREVENTION OF SKIN CANCER

It is never too late to help your skin even if you already have a sun cancer or sun damaged skin. We recommend that everyone wears SPF30+ sun block when in the sun and wears a hat and skin protective clothing and sunglasses. We also recommend staying out of the sun between 10am and 2pm (11am and 3pm daylight saving time) when UV radiation is at its maximum.

SKIN CANCER CHECKS

Anyone who has had skin cancer or is worried that they may have a changing spot or mole should have their skin thoroughly examined. If there is a family history of skin cancers, your skin may be more at risk of sun damage and regular checks are important.

It is easy to cut corners but unwise to do so.

We often find when we examine a patient's skin all over for sun damage that we diagnose cancers, indeed melanomas, which were not the reason the patient wanted their skin examined. We therefore strongly recommend that if you've had skin cancer or are worried about it, that you have an annual complete skin check for which you will need a separate consultation. Alternatively make an appointment for a prolonged consultation for a complete check up including skin examination. **It is important not to wear makeup when you come for a skin check.**

OTHER COMMON SKIN SPOTS

SEBORRHEIC KERATOSES - These are warty spots which are extremely common and are often mistaken by patients (and sometimes by doctors) for skin cancers. These can vary in colour from normal skin colour to jet black. Usually they require no treatment but we may sometimes remove or biopsy them if there is any doubt as to whether or not they may be a skin cancer. They may also be removed if they cause friction or irritation such as can happen under a collar or bra strap.

CAMPBELL DE MORGAN SPOTS - These are extremely common small red spots which are of no clinical consequence but can be removed by laser treatment if they cause cosmetic disability.

WARTS - These are common in children, both on the feet (plantar warts) and elsewhere. Sometimes no treatment is required but they can be removed by creams, paints or cryotherapy.

SHOAL BAY & ANNA BAY MEDICAL CENTRES

SKIN CANCER SERVICES

Solar skin damage and skin cancer

We are committed to provide expert skin cancer care. All our regular doctors have trained with the melanoma unit in Newcastle and a number of us have undergone advanced skin cancer training including a Masters degree in skin cancer surgery.

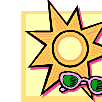
SUN DAMAGED SKIN AND SKIN CANCER

Everybody knows that skin cancer is a common problem in Australia and we spend a lot of time diagnosing and treating sun damaged skin. There about 140,000 new cases of skin cancer in Australia each year.

Over 1,000 people die in Australia each year from skin cancer. Most of these die from melanoma.

We see a number of different types of sun related clinical problems and these are outlined below:

1. SOLAR KERATOSES



These are often called sun spots and are not cancerous as such. They do however indicate sun damaged skin and can develop into skin cancer. They occur as single or multiple red scaly spots. They can be treated in the following ways:

a) Observation - minor keratoses may merely be observed over a period of time to ensure that they do not develop into more serious lesions.

b) Cryotherapy - solar keratoses may be frozen off using liquid nitrogen. This treatment is somewhat painful especially on the face and will result in blisters or scabs which may take time to heal. Cryotherapy sometimes can cause permanent depigmentation.

c) Efudix and other creams - these creams cause erosions of abnormal skin but spare normal skin. Efudix treatment will cause redness and can be irritating. It leaves patients sensitive to sun light during and for a period after treatment.

d) Biopsy or excision - if we are not sure that a solar keratosis is benign, we may recommend that a small amount of the spot is biopsied or the whole lesion excised and examined under the microscope. This gives a definite diagnosis ensuring best treatment.

2. BASAL CELL CARCINOMAS (BCC)

These are the most common of skin cancers. They generally grow fairly slowly and are easily treated. They do not spread internally but if left untreated can cause extensive tissue damage requiring major plastic surgery.

Treatment- if the BCC is not typical we may recommend biopsy to confirm the diagnosis. The most widely used treatment is excision where the cancer is cut out and the skin stitched. On the face a flap repair may be required to give the best cosmetic result. Occasionally for small BCCs curettage (scraping off the lesion under a local anaesthetic) may be appropriate.

BCCs around the nose and eyes can cause particular problems and different cancers of course require different treatment. We also refer some patients to Sydney for Mohs microsurgery - with this treatment small amounts of tissue are removed and examined there and then under the microscope to ensure that all the cancer has been excised - if it has not, more tissue is removed.

Aldara (Imiquimod) Cream
This is an alternative to excision for superficial BCC. Its advantages are that it spares patients the pain of excision and that it can give a very good cosmetic result.

It is often difficult to decide by looking where BCCs end and for this reason all excised specimens are examined under the microscope. If the cancer has not been completely removed we may have to recommend a wider excision. It is always our aim to leave **the least cosmetic disability** and expertise in treating skin cancers depends on getting the right balance between removing the cancer and leaving unsightly scars.

3. SQUAMOUS CELL CANCERS (SCC)

These are more dangerous than BCCs and can be lethal if left unattended for too long. They may present in a number of ways such as a sore that doesn't heal or a raised scaly lesion which seems to be growing.

We normally recommend excision for these cancers. Although potentially dangerous, with appropriate treatment, they should not present a problem. Experience tells us that we need to be particularly cautious with SCCs on the ears and lips and we may need to send these for specialist opinion and management. As with BCCs we may biopsy the skin spot, before excision, to be certain about the diagnosis.

Bowens Disease is a form of squamous cell cancer where the cancer is localised to the very superficial layer of the skin. This is not as dangerous as fully fledged squamous cancer although it may develop into squamous cell cancer if left unattended. Excision is not always necessary and other treatments such as Efudix can work well in clearing this condition.

Keratoanthoma (KA)
These are benign lesions which often look identical to SCCs. They can grow quite quickly over a few weeks. Because they look similar to SCCs and indeed it can be difficult to tell the difference under the microscope, we almost always treat them by excision.

4. MELANOMAS

These are the rarest of Australian skin cancers but are also the most dangerous as they can spread quickly to other body parts if neglected.

The main sign of melanoma are a freckle or mole which bleeds or is changing either in colour or size over a period of weeks or months. Melanomas **should always be cut out** (excised). We discuss/refer all melanomas with the Newcastle Melanoma Unit.

5. MOLES

We see an awful lot of moles which worry people. Moles which are changing and have specific features on examination should be treated as melanomas and removed so that histopathological examination of the specimen, under the microscope can confirm whether the lesion is a melanoma or benign mole. This means we cut out a number of 'normal moles' to ensure that we do not miss early melanomas. **Melanomas are curable if found early**.

However, cutting off moles can leave a scar. Melanomas are extremely rare in teenagers and it distresses us to see teenagers who have had multiple normal moles cut off with subsequent unsightly scars.

Dermatoscope. The dermatoscope is a special microscope which we use to aid diagnosis of moles and melanoma. The dermatoscope gives us a magnified picture of the structure of the lesion. Certain features suggest melanoma and other features benign moles. Thus we can limit the number of unnecessary excisions. We have state of the art dermatoscopes at both our medical centres and expertise and training in their use.

Sometimes observing moles closely over a period of time is a good alternative to excision. Some moles may be biopsied or shaved off with a scalpel blade and sent for pathological examination to make sure they are not melanomas.