

Surgical skin cancer treatment: non-melanoma skin cancer

The surgical management of skin cancer, particularly extensive lesions, may require a specialist surgeon with a reconstructive repertoire. The management of such lesions should be within the remit of a multidisciplinary team (MDT). Surgery should be carried out with good lighting and the perimeter of the lesion marked with ink followed by the surgical excision margin after measuring.

BCC

It is a good principle that a pathological diagnosis and subtype of the skin lesion is established with a punch biopsy. A small lesion may be removed in toto by a 5-7mm punch biopsy. Once the diagnosis is established a basal cell carcinoma (BCC) should be excised with a 3-4mm margin (giving 85-95% clearance) with direct closure achieved where possible. Larger lesions may require reconstructions including full thickness skin grafts or local flaps when the lesion is confidently excised.

For lesions which are large (>2cm) with ill defined margins, a staged excision can be undertaken, the wound dressed and the patient returns for further surgery dictated by the pathology (further excision or reconstruction). Mohs surgery can be used in these circumstances, however, the procedure is more time-consuming for the patient and is costly.

SCC

Squamous cell carcinoma (SCC) should have tissue diagnosis using an incision or punch biopsy and the regional lymph node basins must be examined. Excision is undertaken with 4mm margin for low risk and ≥6mm for high risk lesions. In the limbs this includes skin and subcutaneous tissue over fascia. In the scalp the galea (which provides a good oncological barrier) is excised with the lesion, preserving the loose areolar tissue over the periosteum. The wound is closed where possible and reconstruction undertaken where direct closure is not possible. Reconstructions include full thickness skin grafts, split thickness skin

grafts and local flaps. High risk lesions can be excised using Mohs, however, there is no randomised controlled study to show that this is superior to conventional surgery.

For all skin excised skin cancers a marker suture is placed at the periphery of the lesion and the position (e.g. superior) labelled to aid the histopathologist. Where the surgeon feels the deep margin is close it is good practice to take a separate deep margin specimen and send this to pathology in a separate pot. The orientation of this deep margin can also be marked, suturing its deep surface to a piece of card.

In regard to choice of reconstruction following skin cancer excision several issues should be considered including, colour, contour, aesthetic units, donor site and the patient's wishes. It is very important when using an 'expensive' reconstruction that the reconstructive surgeon be certain regarding the adequacy of excision. Where there is any doubt a temporary dressing, 'low cost' reconstruction or frozen section should be considered.

How would you do it?

Share your tips by emailing diana@pinpoint-scotland.com or on Twitter using hashtag #pmfaHDI

AUTHORS



Mr Sultan Hassan,

Consultant IN Plastic, Reconstructive, Breast and Aesthetic Surgery; GMC Specialist Register for Plastic Surgery; Medical Director, Elite Surgical Ltd; Director, Primary Care Training Academy.

Declaration of competing interests: None declared.

E: elitesurgical@gmail.com

Mr Justin S Chatterjee,

Plastic, Reconstructive & Hand Surgeon, Glasgow, UK.

SECTION EDITOR



Dalvi Humzah,

Aesthetics Sub-editor, Consultant Plastic Reconstructive & Aesthetic Surgeon, West Midlands / Worcestershire / Gloucestershire; Plastic Surgery Rep, MAC Nuffield Health Wolverhampton Hospital; Bupa Cosmetic Clinical Lead; UK Regional Advisor (West Midlands), RCPSCG.

Declaration of competing interests: None declared.