

Skin Cancer

When it comes to skin cancers, there are generally two types. You have melanoma and non-melanoma skin cancers. Non-melanoma skin cancers are comprised primarily of basal cell carcinomas (approximately 75%) and squamous cell carcinomas (25%). It also includes actinic keratosis (AK's), Merkel Cell carcinoma, keratoacanthomas and dermatofibrosarcoma protuberans. AK's are considered precursors to non-melanoma skin cancers.

Sun exposure is a major factor in developing skin cancers. Basal cell carcinomas are locally invasive and if treated in a timely manner, will not metastasize. If you have to have a cancer, this is the best one to have. Squamous cell carcinomas have more of a propensity for spreading if untreated. Melanomas can spread and lead to your demise that they should be treated aggressively.

Once a diagnosis has been established, with non-melanoma skin cancers, your options include continued observation if your skin has healed to where the scar or lesion is imperceptible (have to accept the risks of recurrence and progression), radiation therapy (appropriate under certain circumstances but with long term consequences), curettage and cauterization (done by dermatologist without pathology), or surgical excision, including Mohs surgery. If you have a melanoma, wide surgical excision is currently known to be the only real cure.

Melanomas can involve taking a lymph node (sentinel node) from the armpit, groin or neck that drains the area of involvement if your tumor is more than 1.0 mm deep and with special characteristics, 0.75mm or deeper. This provides a prognosis and helps guide treatment. If negative, we assume that your melanoma has not spread and your follow-up is straightforward. If positive, the melanoma has spread and this will necessitate a much more extensive work-up and node dissection as well as referral to an oncologist to consider what other therapies are out there to address metastatic melanoma. If you know you're not going to continue with aggressive treatment, then the sentinel node biopsy is no longer warranted.

The defects left from excisions can be closed in a variety of ways, much depending on the location and size of the post-excision defect.

The simplest is to leave the wound open to heal on its own, called secondary healing. Obviously, the resultant wound must be on the smaller side and this will leave a concave, hypo-pigmented scar.

The next closure is called a purse-string closure as it is similar to that of a drawstring, pulling in tissue from all directions but this leaves puckering that is anticipated to flatten with time. The suture is left in for 3 weeks as well. If the wound cannot be closed completely, secondary healing is utilized for full healing.

Complex closure was the traditional way of excising and closing wound in the past. It involves a longer fusiform excision that is closed by undermining the skin edges and re-approximating the skin in a linear manner. This leaves a scar that is approximately 2.5 times the width of the excision site.

Skin grafts can always be used to avoid extra scars but skin grafts have to be harvested from somewhere else on your body leaving a donor scar and the graft itself is rarely a good color match so it can leave a "patched" appearance similar to that of a quilt. If used on the scalp or back where the skin is thick, it can leave an indentation as well. It is good for large defects where one does not wish to have the scarring from long incisions.

Finally, flaps can be used to close the larger defects. This involves longer incisions made in the adjacent tissues to allow the adjacent tissue to be advanced, rotated or transposed into the resultant defect. The color match is excellent and the scars tend to heal well but from a lengthwise standpoint, the scars are much longer.