CUTANEOUS MALIGNANCIES

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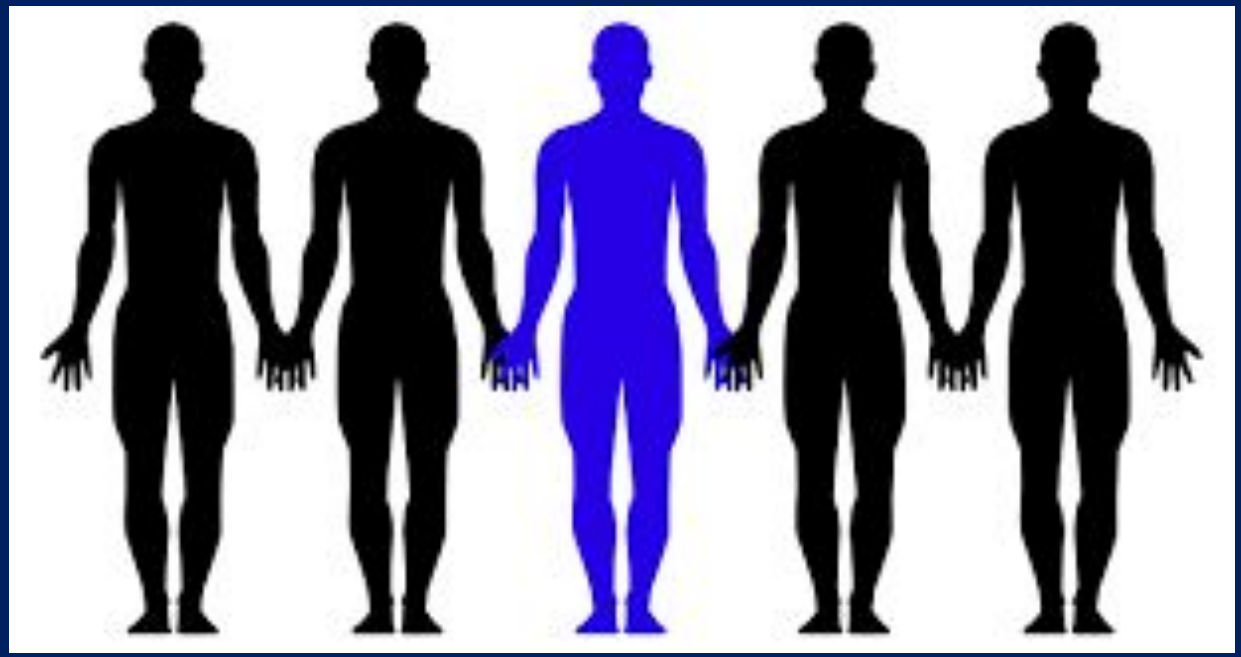
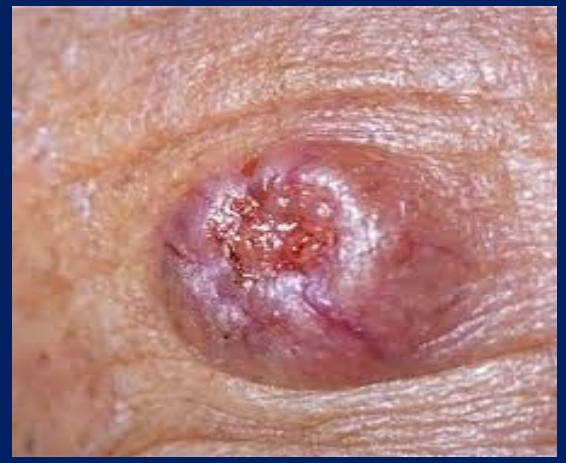
- one in five Americans will be diagnosed with skin cancer during their lifetime.

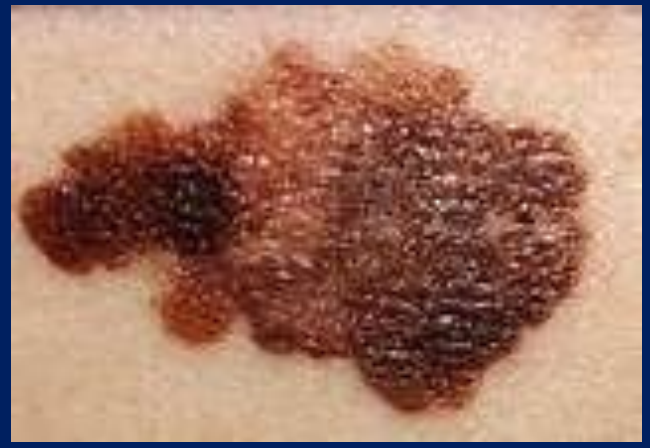


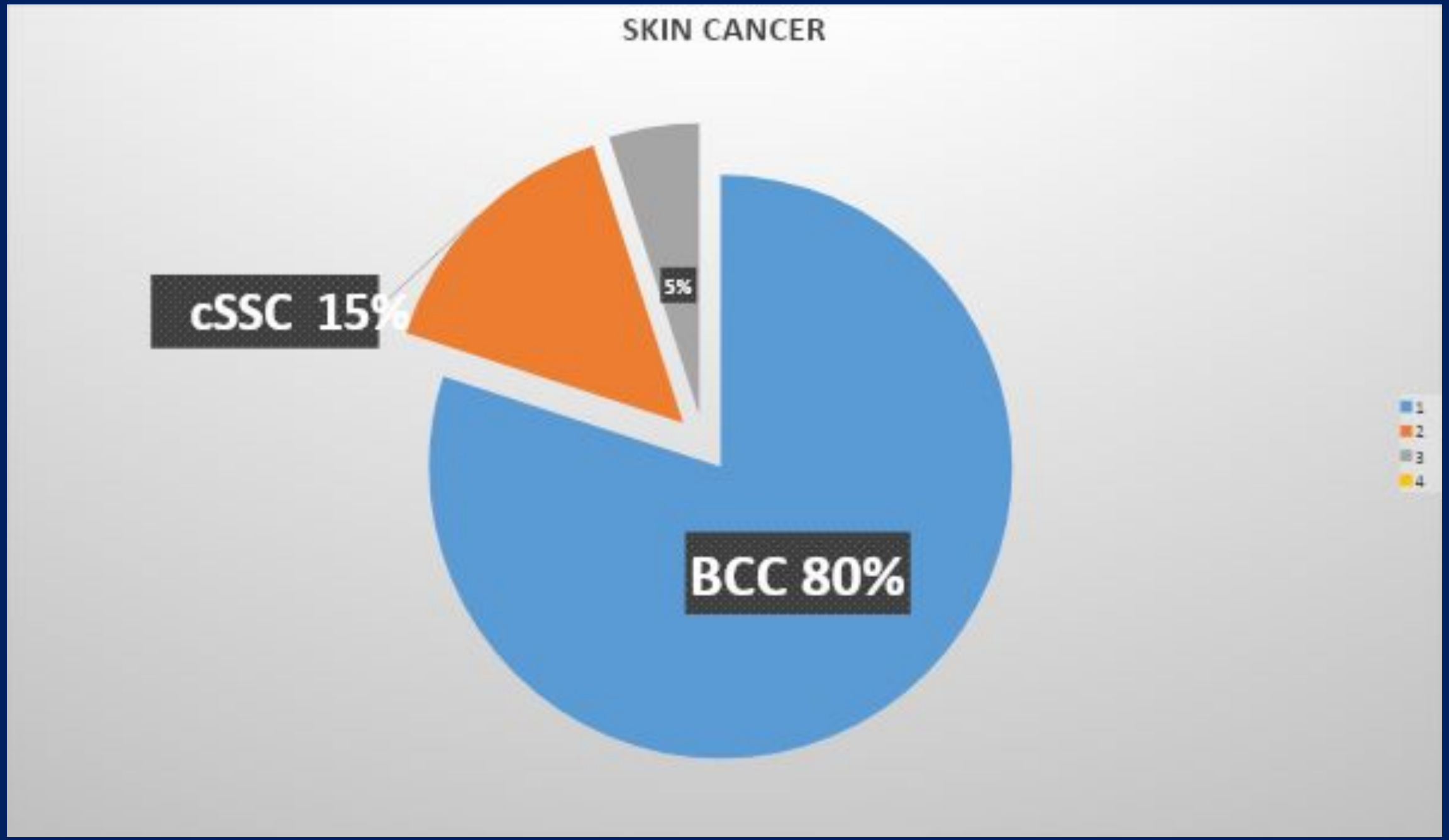
Types:

- Basal cell carcinoma (BCC)
- Cutaneous Squamous cell carcinoma (cSCC)
- Malignant melanoma (MM)

- BCC accounts for nearly 80% of all skin cancers
- (cSCC) accounting for 15% to 20% of all skin cancer.
- MM account for less than 5% of cutaneous malignancies






SKIN CANCER
cSSC 15%
5%
BCC 80%
1
2
3
4

Risk Factors:

Environmental factors:

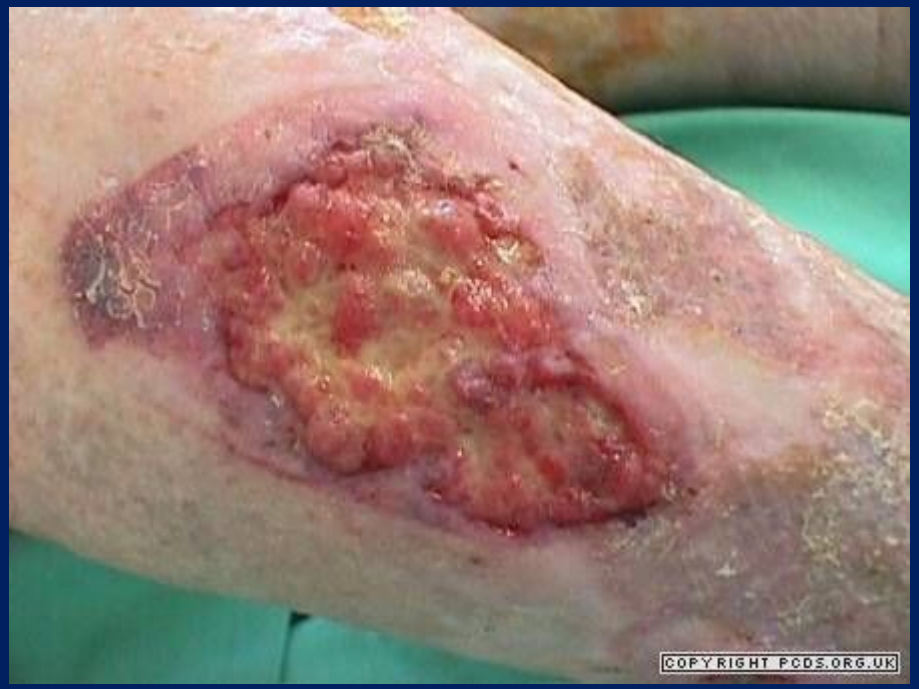
- Human papilloma virus HPP Sun light Smoking

- Radiation

immunosuppression

Arsenic and hydrocarbon

Chronic inflammation



Patient factors:

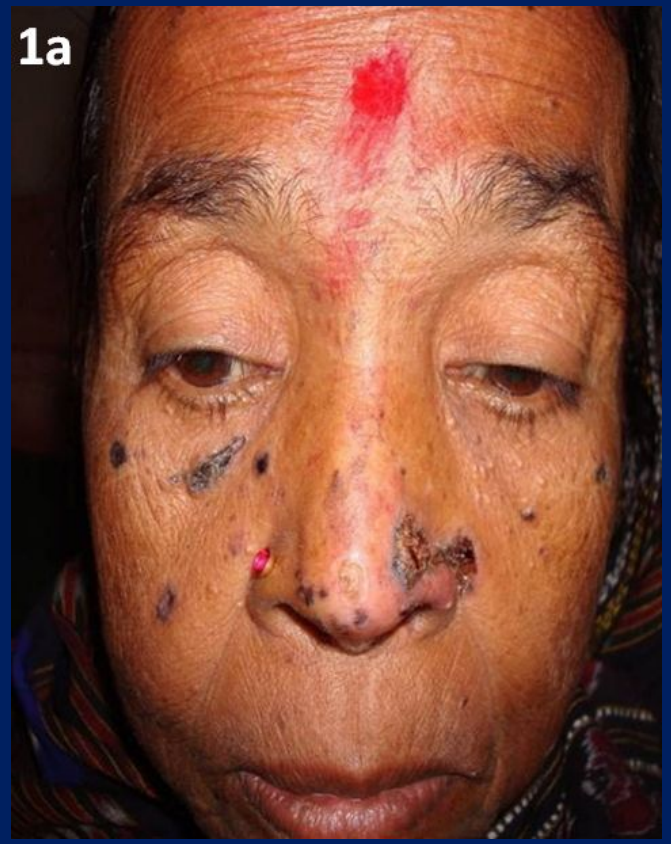
- Male patient

Increased age

Skin type I or II Fitzpatrick.

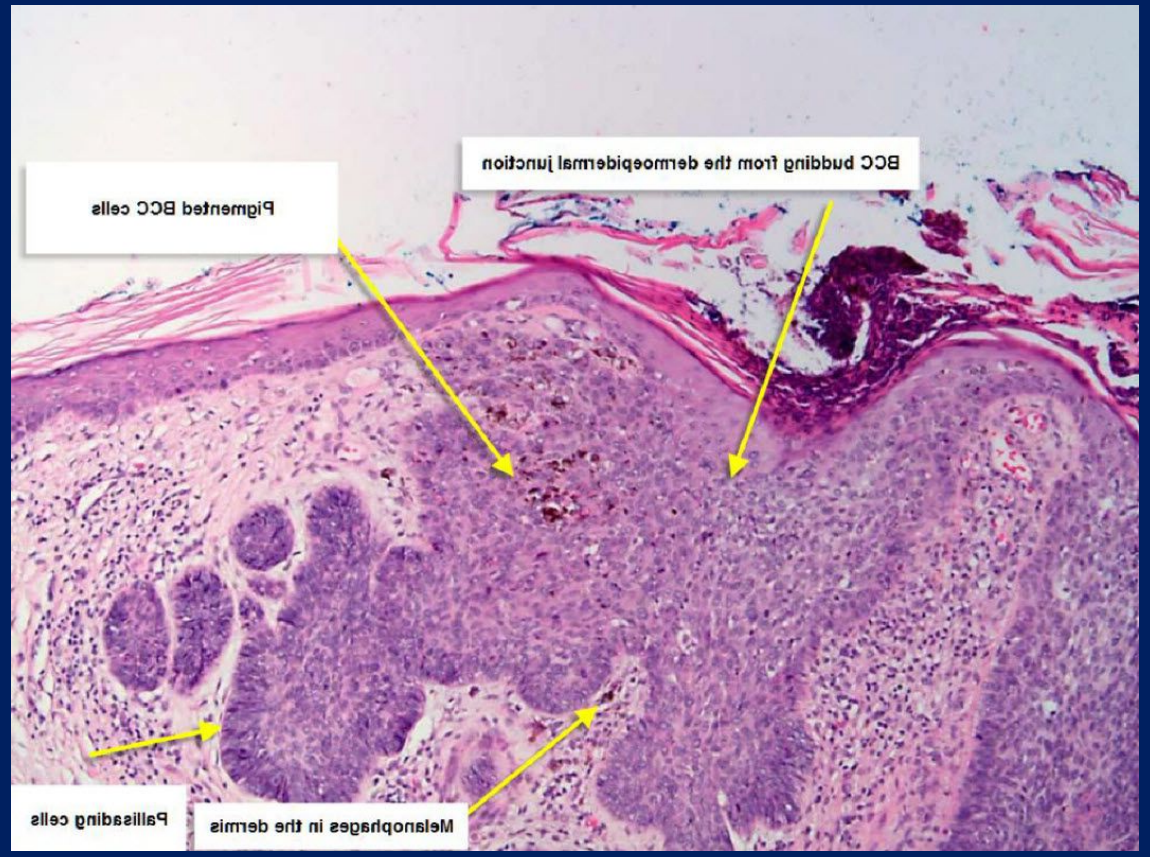
+ve family Hx.

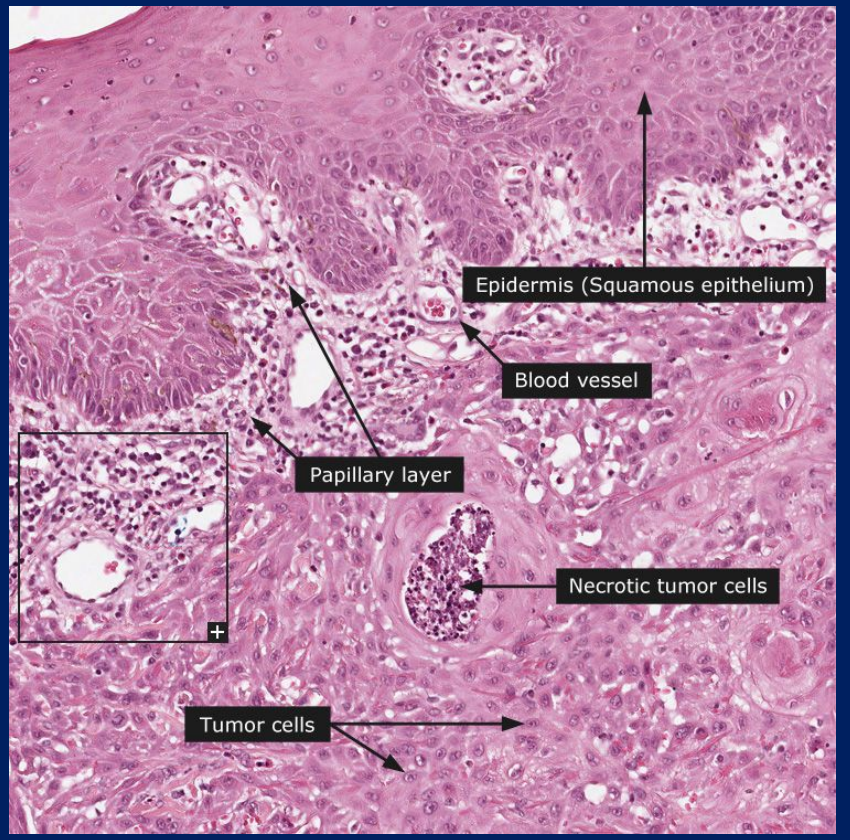
Part of syndrome e.g. gorline syn. (BCC)



Histopathology

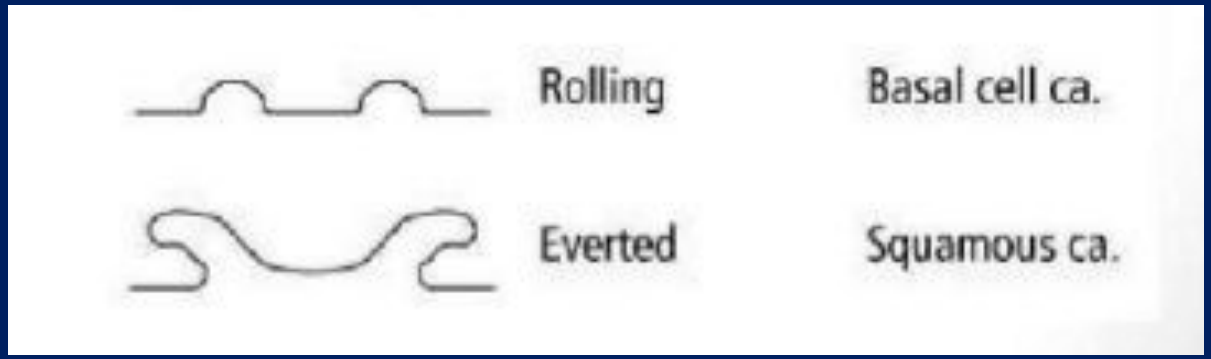
- Both arise from the basal layer of the epidermis

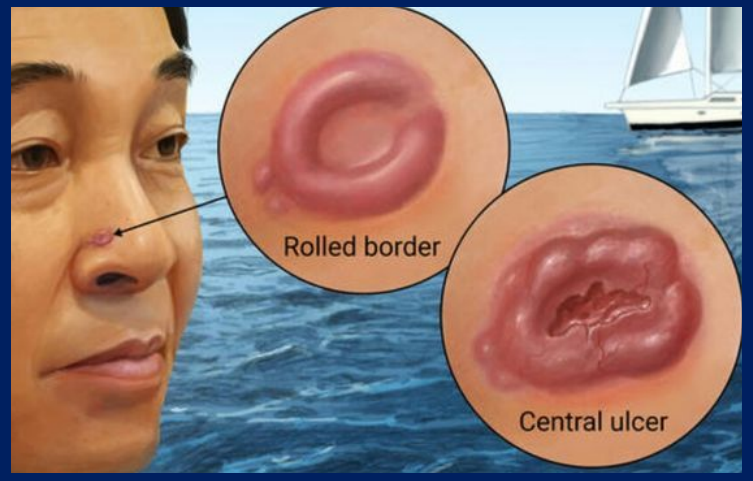


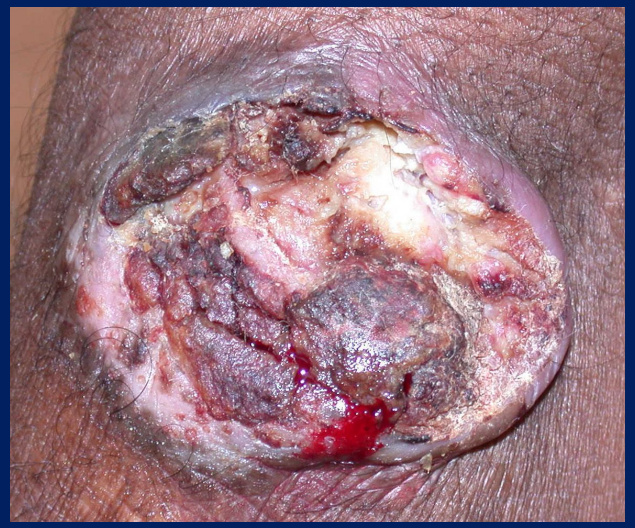


Edge type if ulcerated

Raised borders (rolled) edge in BCC everted (overhanging) edge cSCC





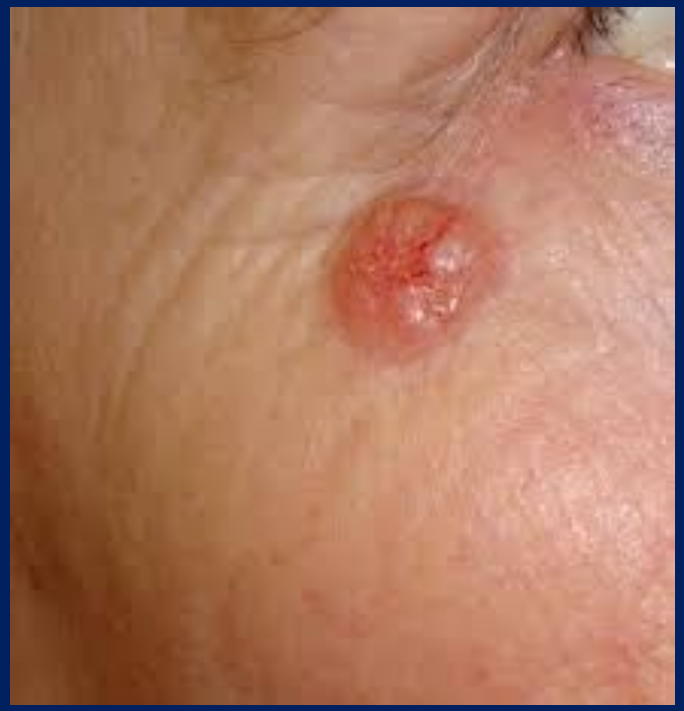


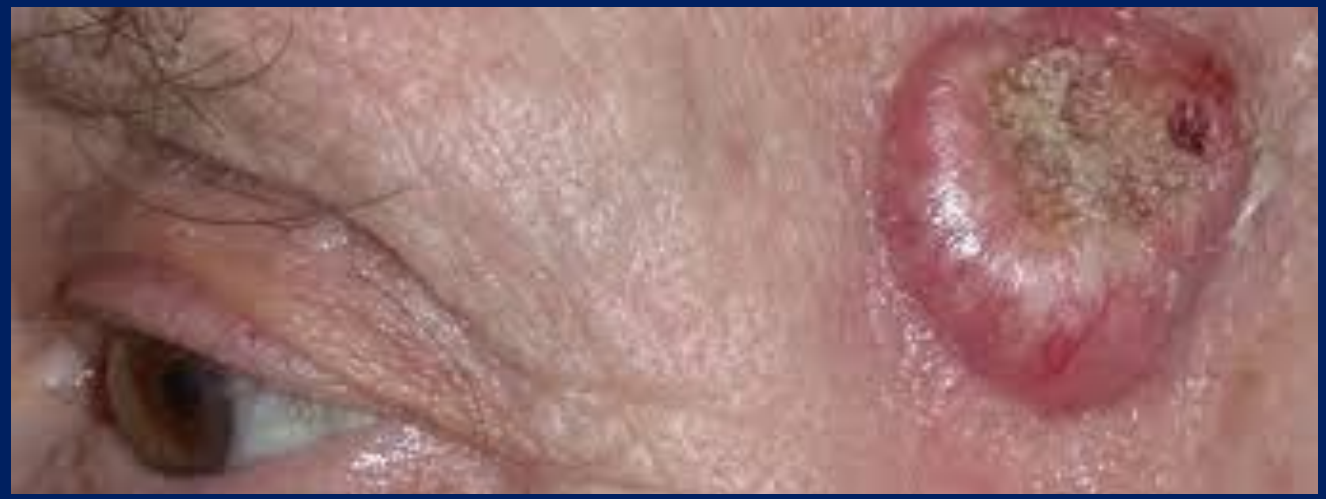
Metastasis rate

- **BCC <0.05%**
- **cSCC** As high as 14%.

BCC types:

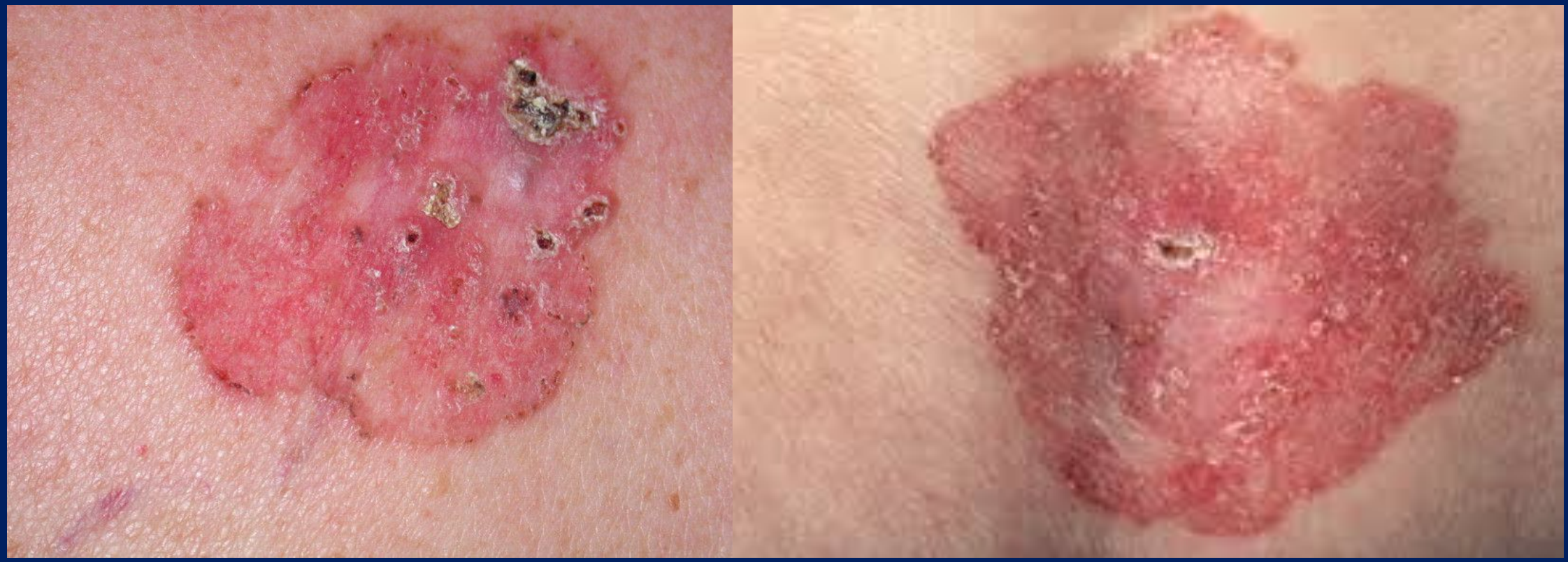
- **Nodular** BCC: dome-shaped nodular papule with a pearly surface, scattered telangiectasia, typically ulcerates centrally, giving it the classic **RODENT ULCER** appearance.





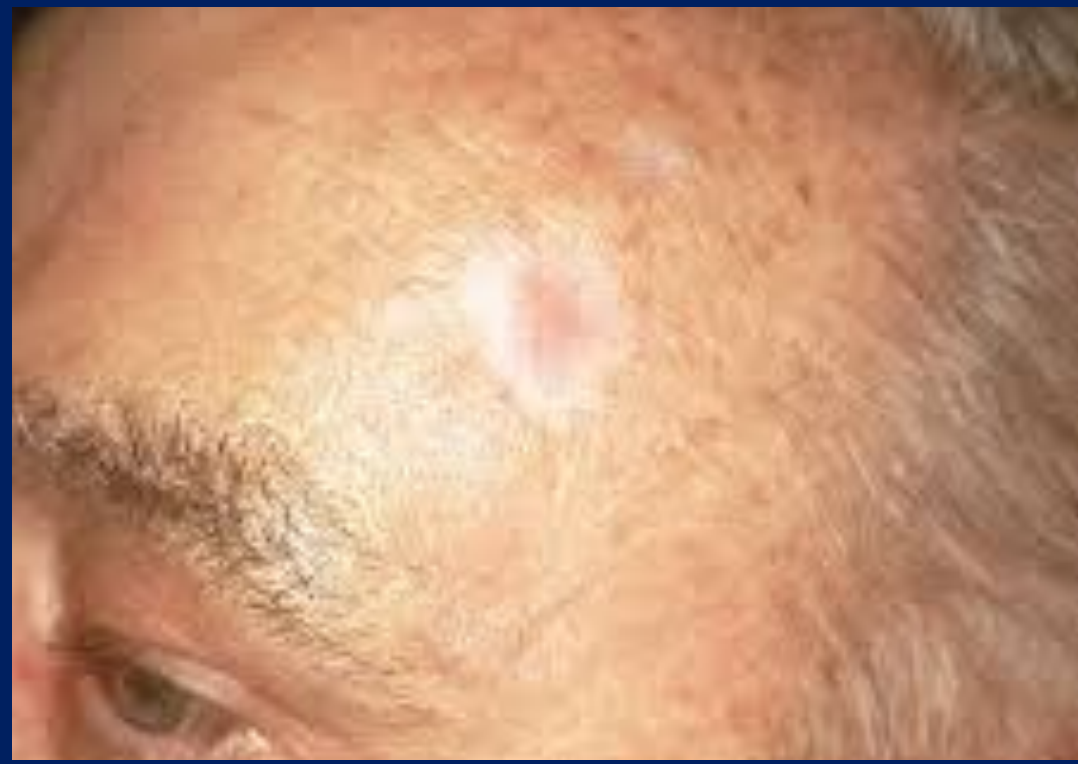
Superficial BCC:

multi-centric erythematous patch on the trunk and extremities

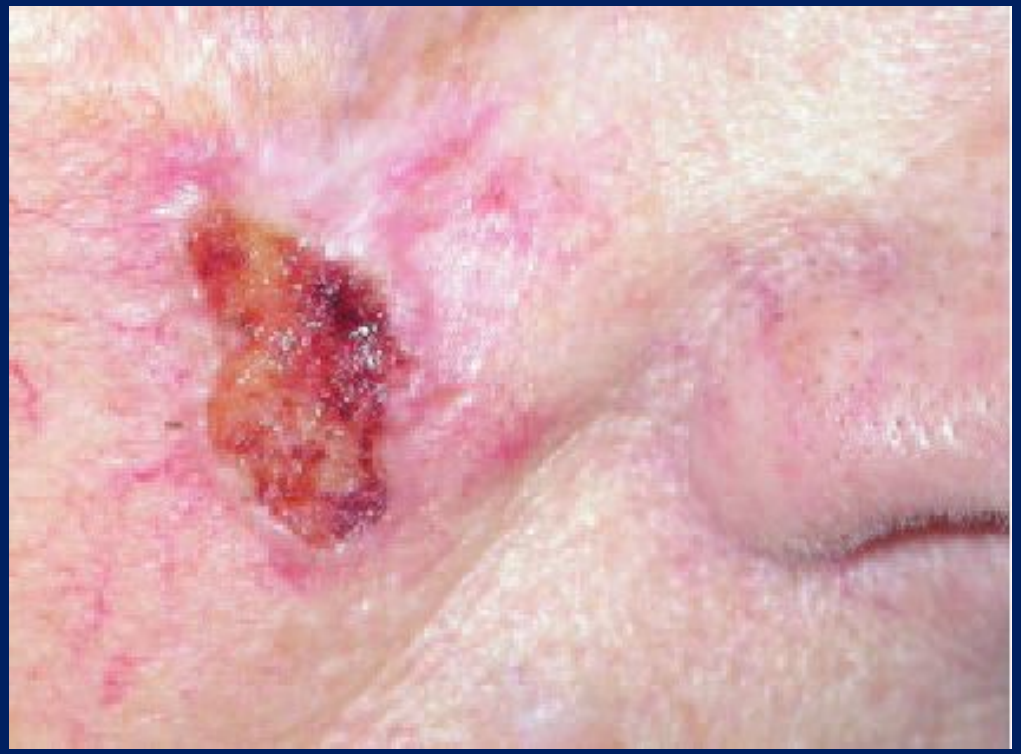


Morpheaform *or* sclerosing BCC

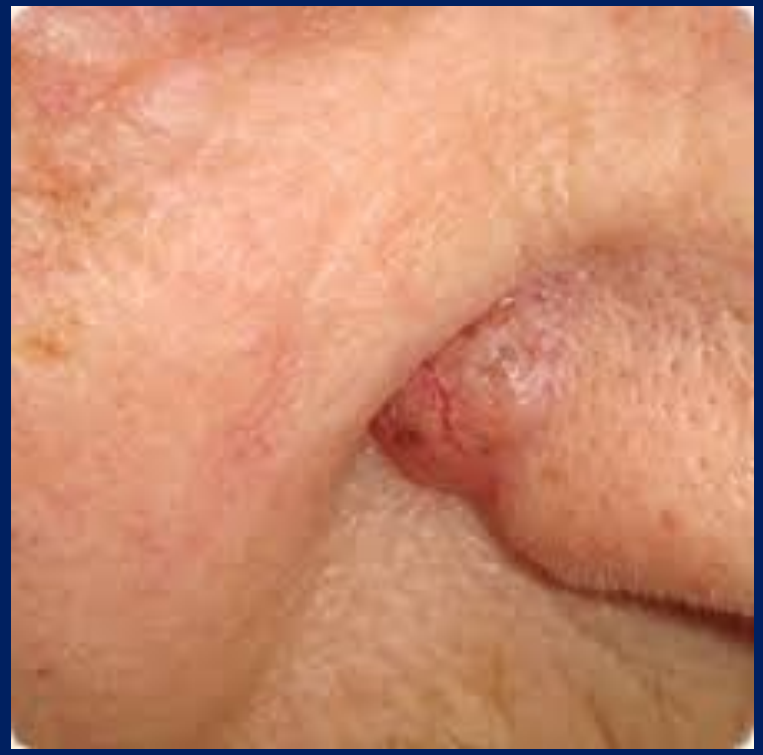
- is the most aggressive type.
- found in the head and neck.
- Indurated plaque that resembles a scar without a history of trauma.



Infiltrative



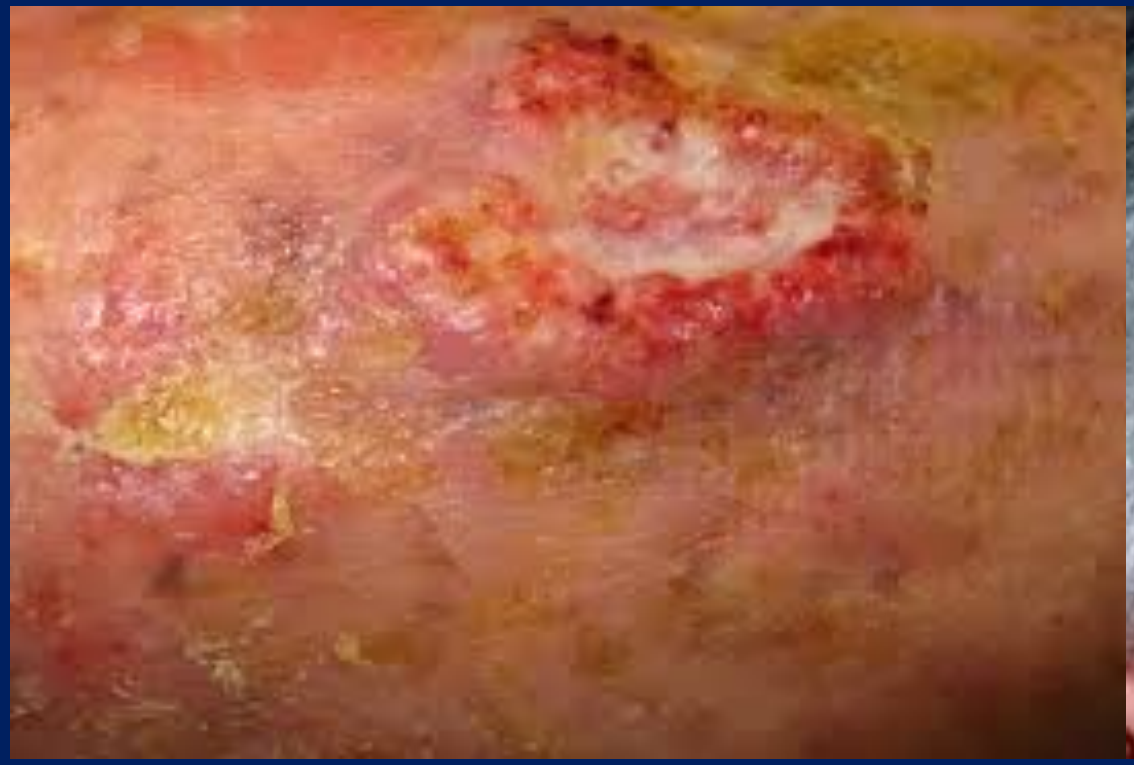
micro nodular

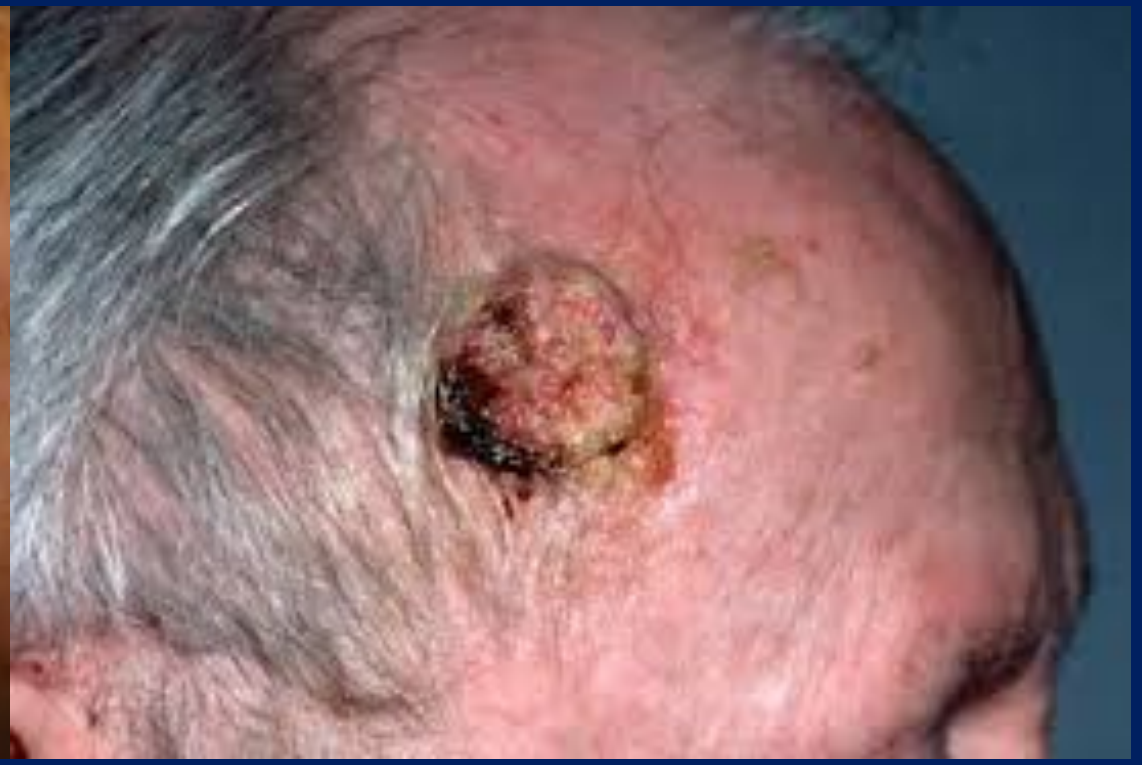


cSCC types:

- **Well-**differentiated tumor types: firm, Raised, pink- or .flesh-colored papules with frequent keratinization, scaling, ulceration, or crusting on the surface.

- **Poorly** differentiated type: soft, granulomatous nodules with areas of hemorrhage, necrosis, and ulceration and lacking in keratinization.





DIAGNOSIS:

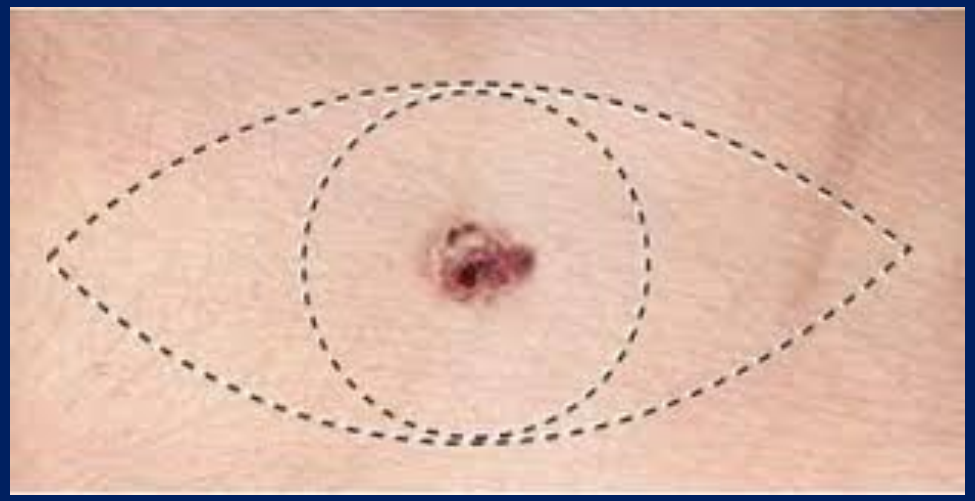
- Clinical examination: upper lip usually BCC , lower lip usually cSCC
- Tissue biopsy for histological examination.

TREATMENT

- **Destructive modalities**: for low risk basal cell tumors and selected low-risk cSCC cases by using a variety of methods including electrosurgery, cryosurgery, topical 5-fluorouracil, topical imiquimod, intralesional interferon, radiation, and photodynamic therapy.

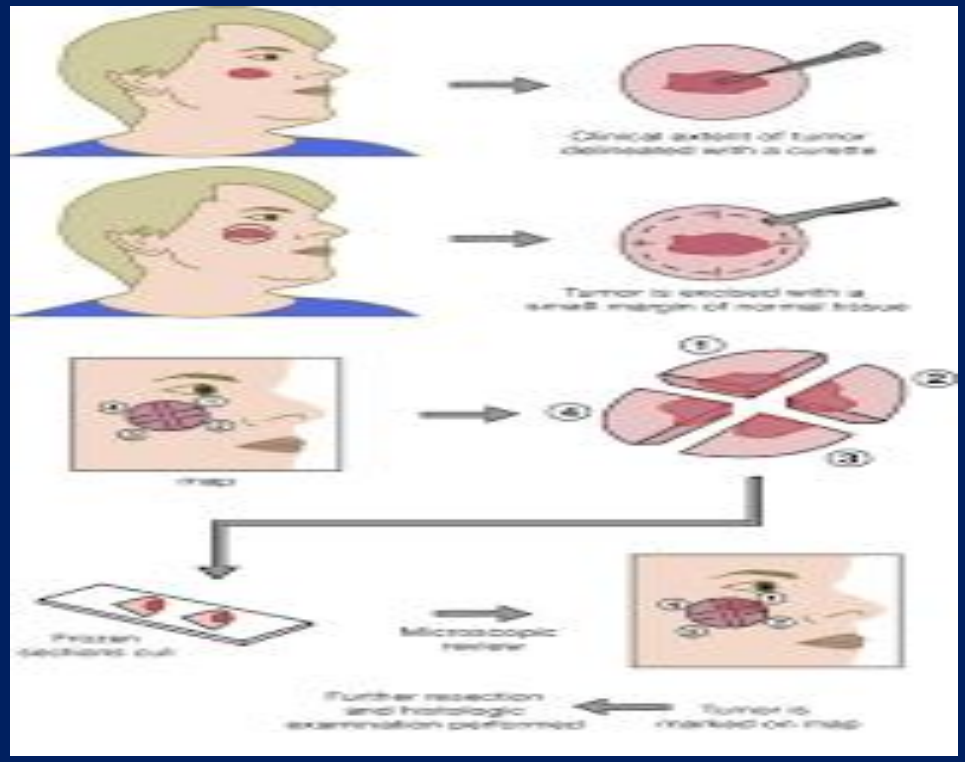
Surgical\ excisional modalities:

- **Direct excisional biopsy** with evaluation of the surgical margins to ensure that they are free of tumor.
- for tumors **<1 cm a clinical margin of *5* mm.**
- **tumors > 1 cm a clinical margin of 10 mm** is recommended.



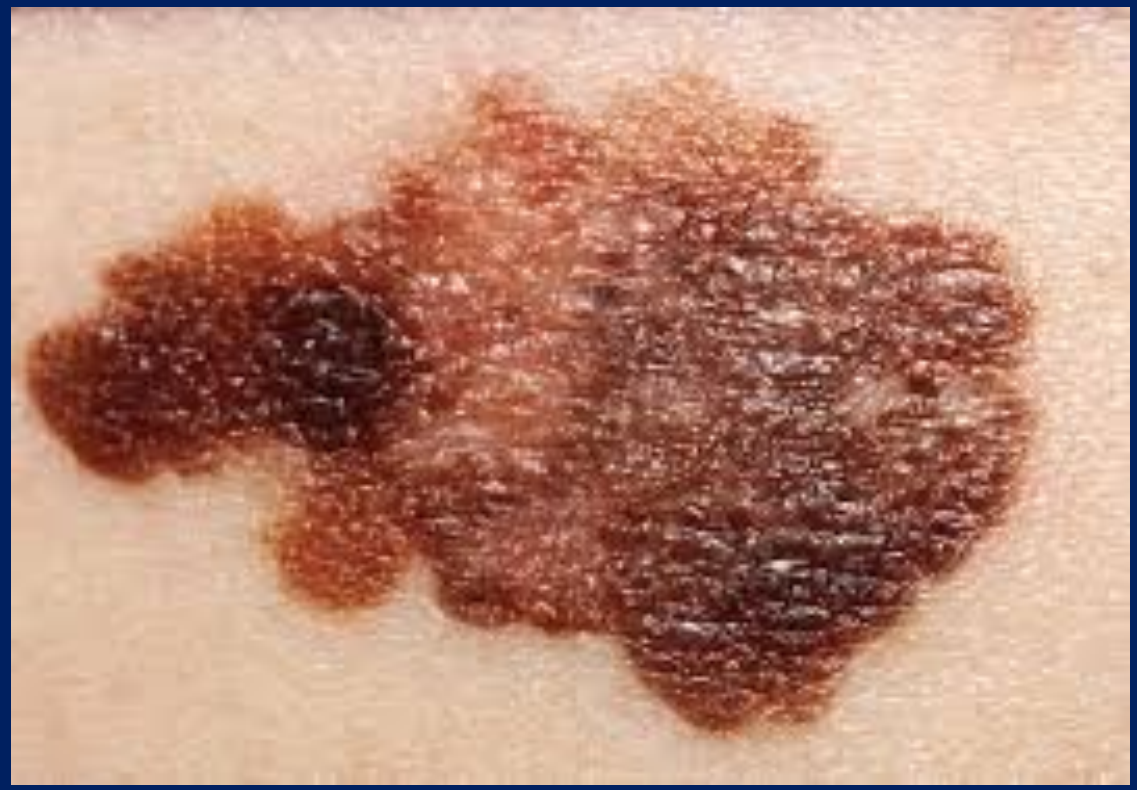
Mohs' micrographic surgery

- is the most definitive treatment of choice in high-risk BCC of anatomically complex areas on the face



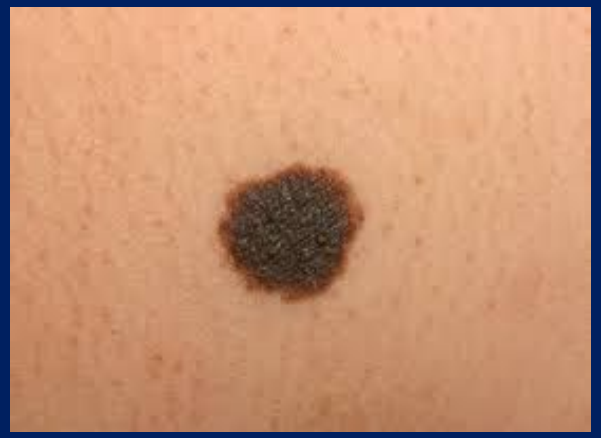
MALIGNANT MELANOMA

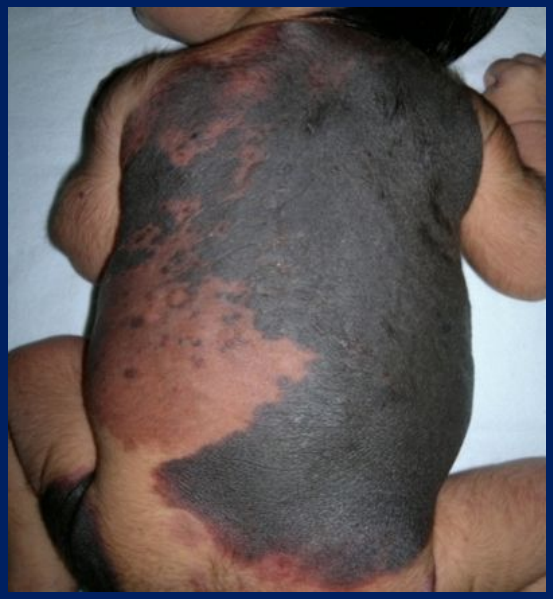
- arise from melanocytes.
- form >75% of skin cancer deaths



RISK FACTORS

- **Host factors:** Fitzpatrick I-ll skin types, and blue/ green eyes. Congenital nevi, atypical nevi, and giant nevi.

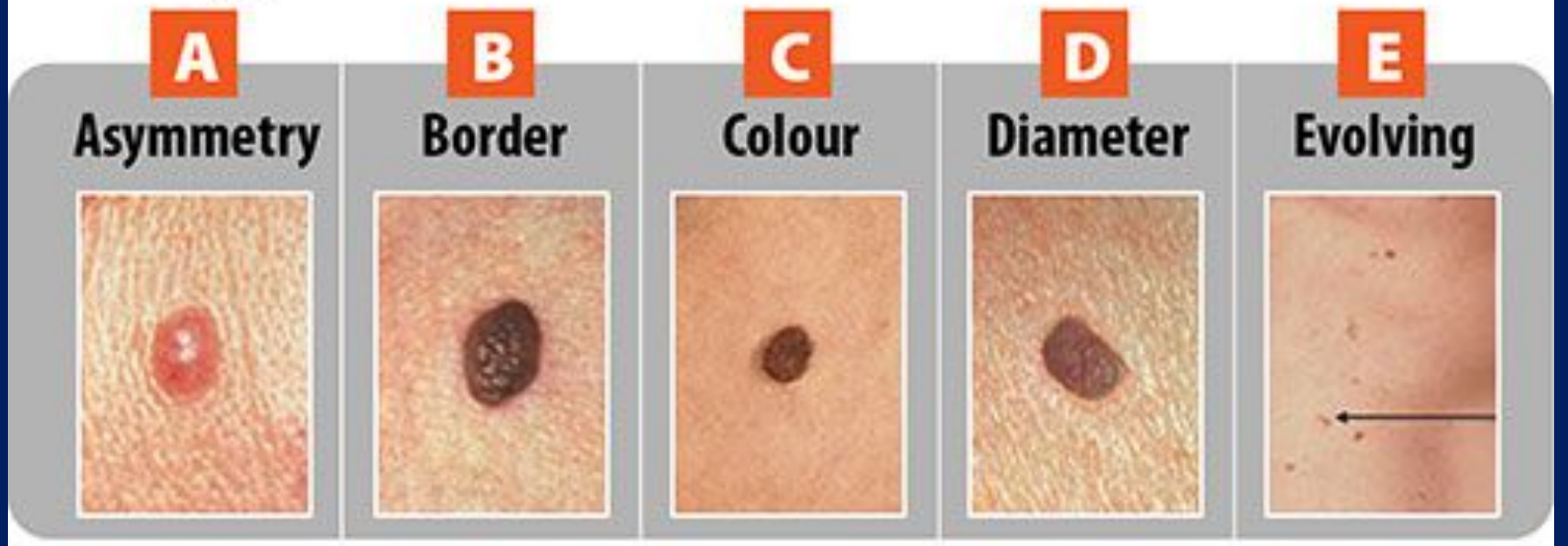




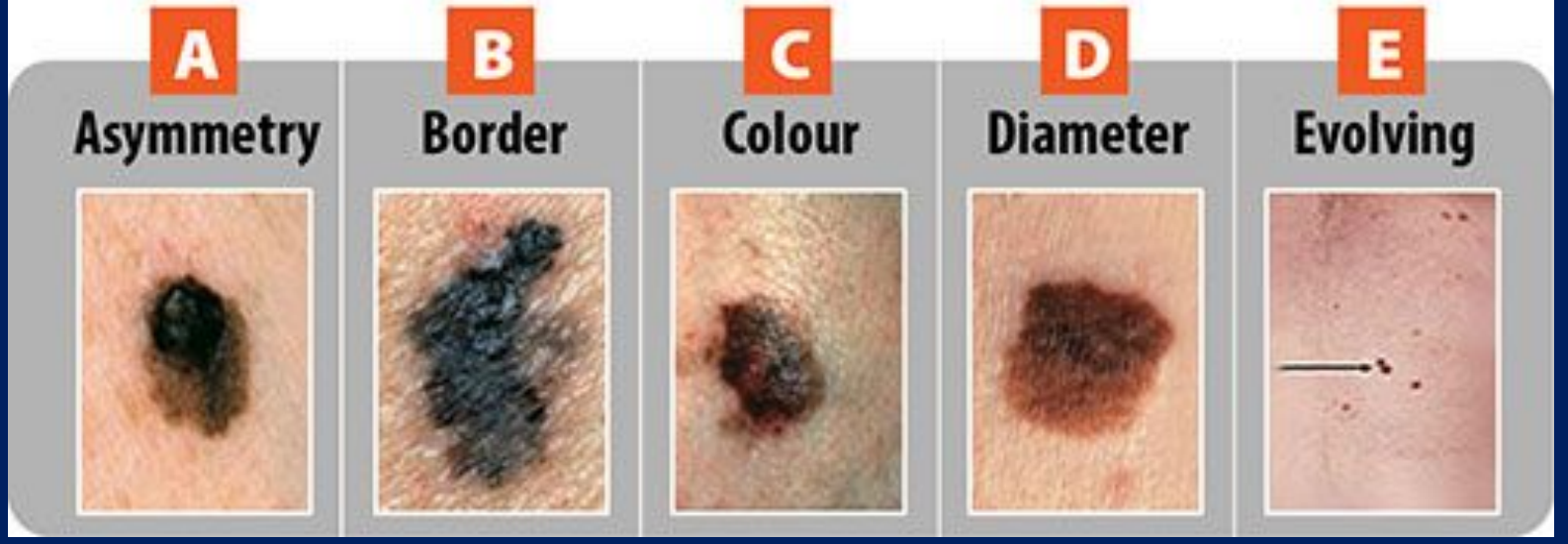
ABCDE diagnostic tool:

- The decision to biopsy a suspicious lesion utilizes five simple criteria for identifying pigmented lesions that are suspicious for melanoma:
- 1. Asymmetry
- 2. Border Irregularity
- 3. Color Variegation
- 4. Diameter> 6 mm
- 5. Evolution or change in the appearance of lesion over time.

Benign



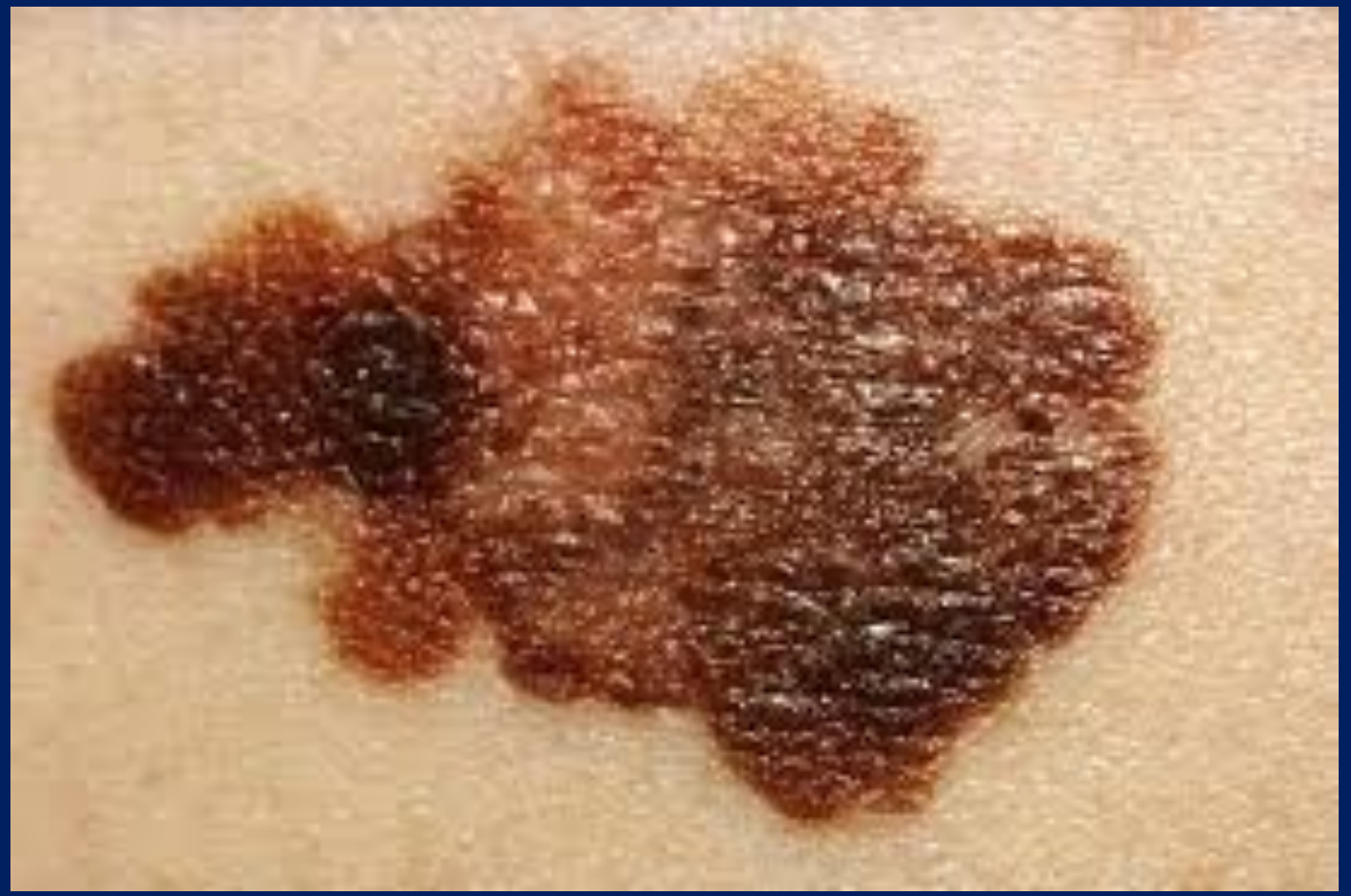
Melignant



Types:

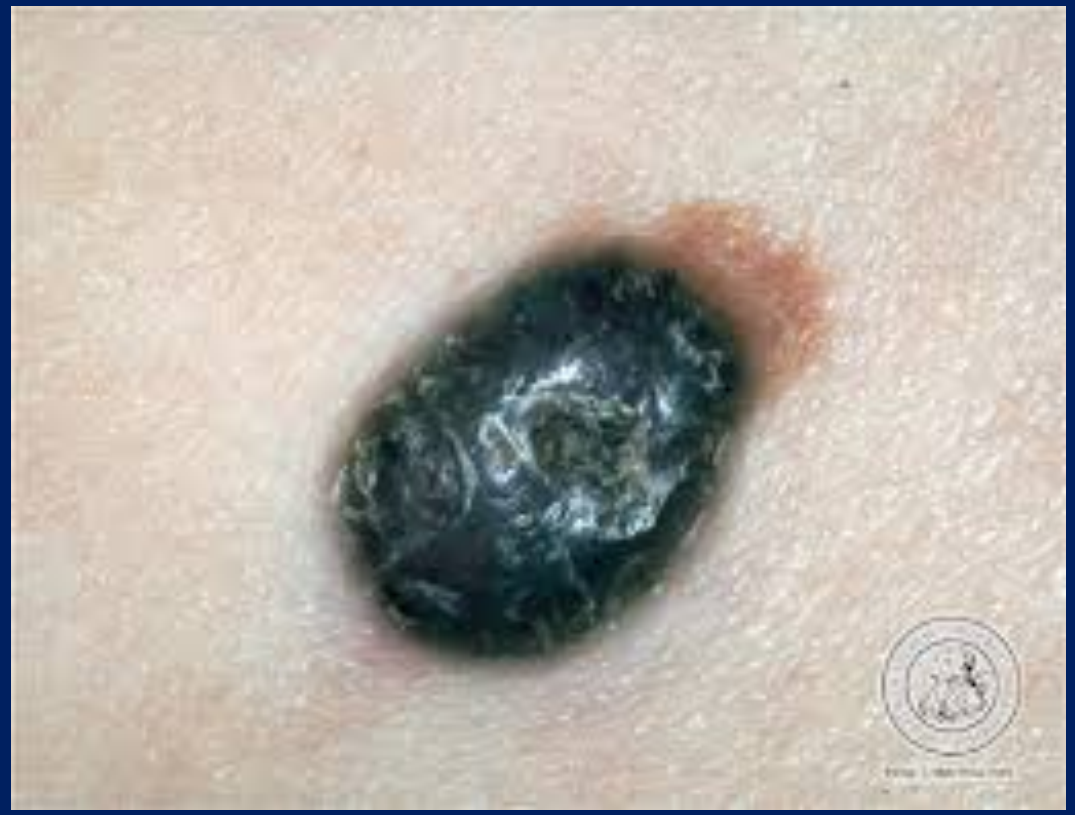
Superficial Spreading:

- trunk in men and the
- legs in women
- Age 30-50 years.
- flat or slightly elevated.



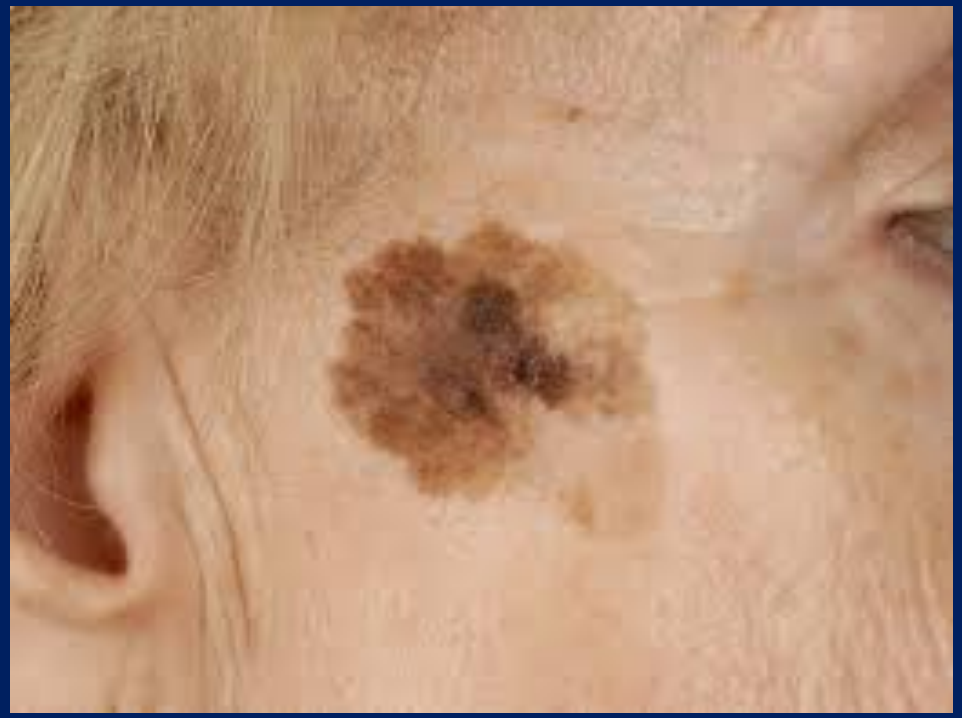
Nodular Melanoma

- Legs or trunk.
- elevated nodule or an ulcerated mass.
- **high** incidence of lymph node involvement



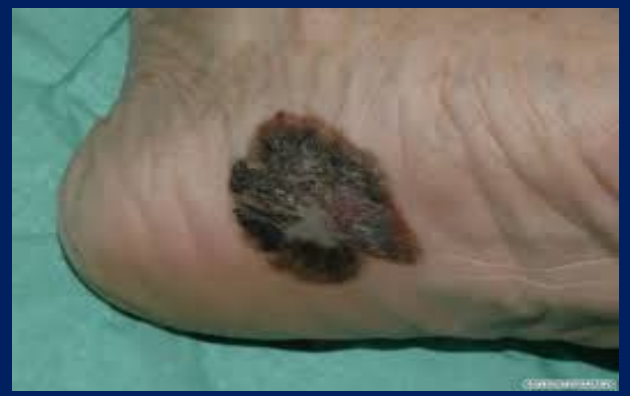
Lentigo maligna melanoma

- sun-damaged anatomic sites (head and arms).
- older patients average age at *65* years.



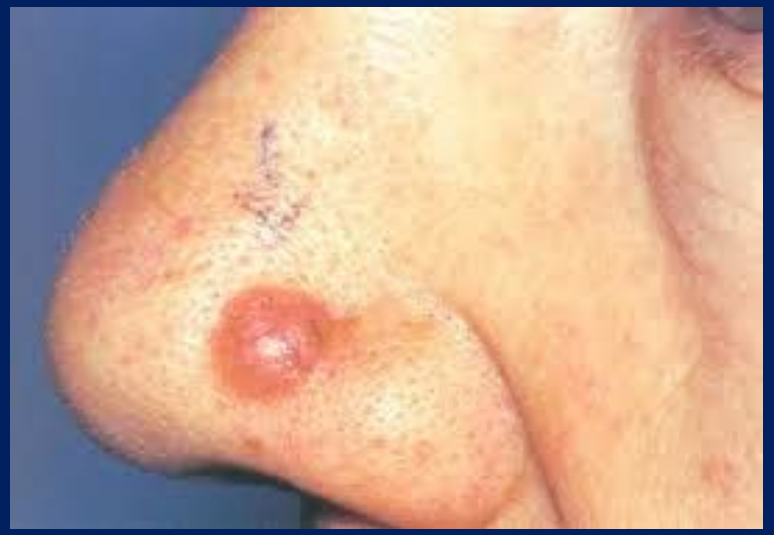
Acral lentiginous

- palms of the hand, sole of the feet, or beneath the nail plate (subungual).
- most common in African Americans.



Desmoplastic melanoma

- head and neck.
- Plaque or nodule
- **low** incidence of lymph node involvement.



DIAGNOSIS:

- **Full thickness** excisional or incisional biopsy to determine thickness of the tumor.
- Lymph node assessment.
- Screening for metastasis.

TREATMENT:

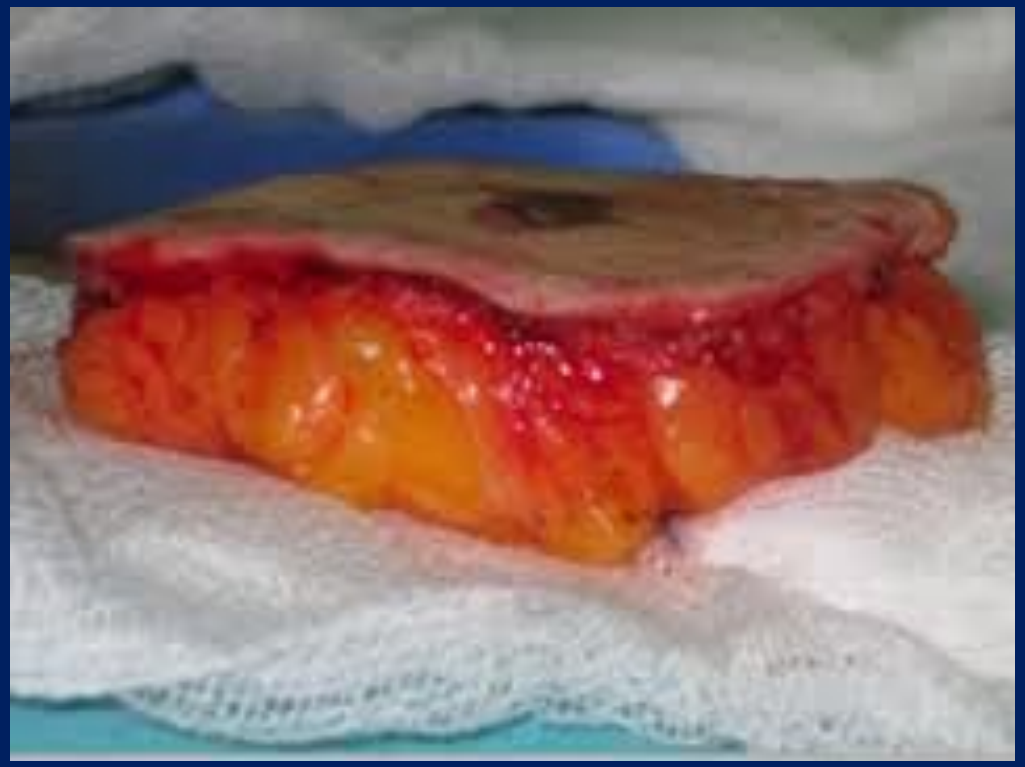
WIDE and **DEEP** Excision + regional **LYMPH NODE** treatment

Wide:

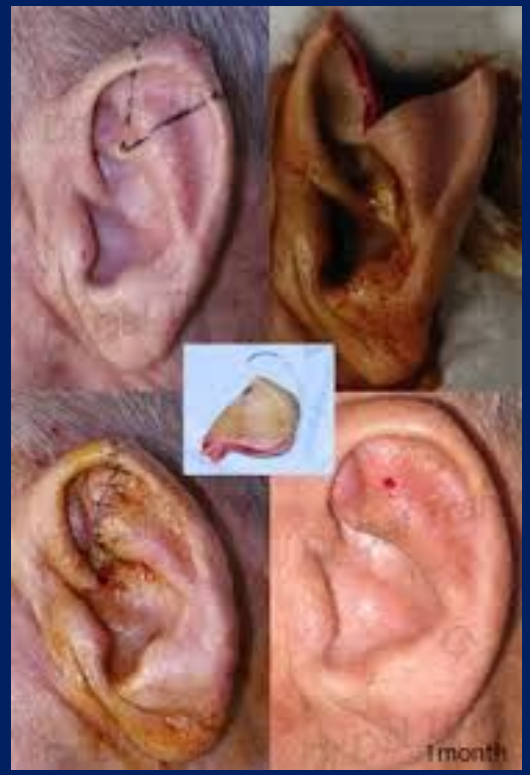
TUMOR THICKNESS	EXCISION MARGIN
In situ	0.5 cm
Less than 1.0 mm.	1 cm
1.0to4.0mm	2cm.
Greater than 4.0 mm	2 to3 cm

Deep Excision:

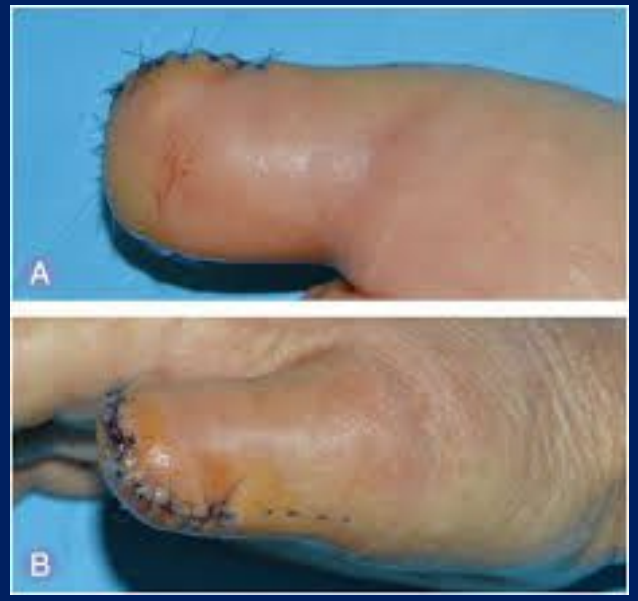
- A full thickness elliptical excision, down to the level of deep muscular fascia.

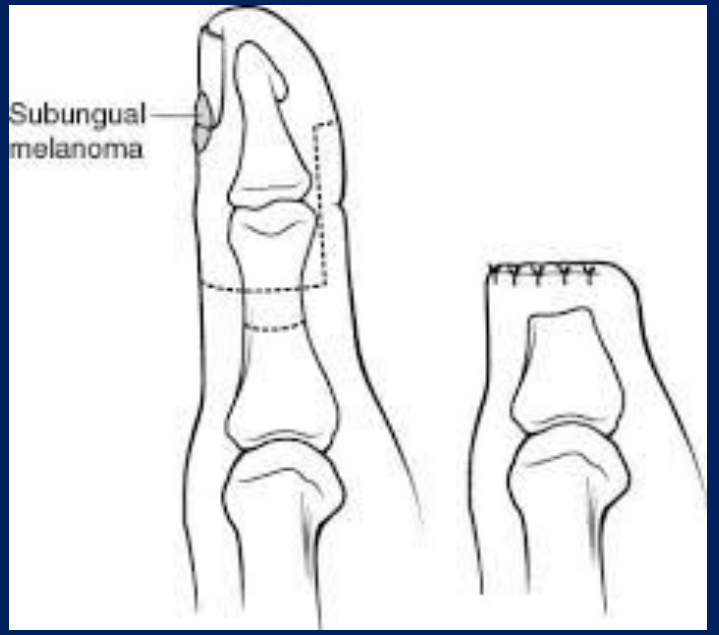


- Melanoma of the ear is generally treated by full thickness wedge excision and primary closure due to the proximity of the underlying cartilage to the thin overlying skin.



- subungual melanoma of the index, middle, ring, or little fingers, this requires amputation through the mid-portion of the middle phalanx; for the thumb, through the proximal phalanx.



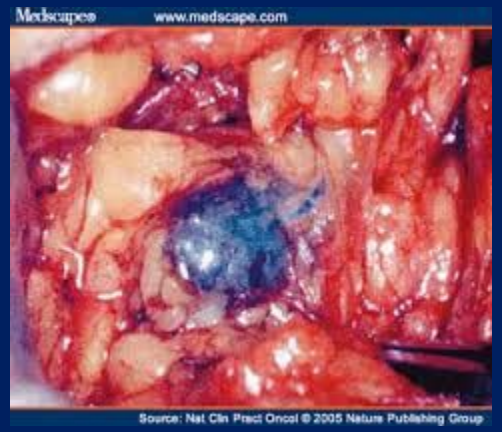


Regional Lymph Node Treatment:

Sentinel Lymph Node Biopsy: The sentinel lymph node is the first lymph node in the drainage basin to receive afferent lymphatic communication from the primary tumor site, indicated in clinically negative node involvement.

- **Lymphadenectomy:** Complete surgical lymphadenectomy is indicated in patients with clinically involved nodes diagnosed by examination, fine needle aspiration, and/or sentinel lymph node biopsy.

Sentinel Lymph Node Biopsy



Lymphadenectomy

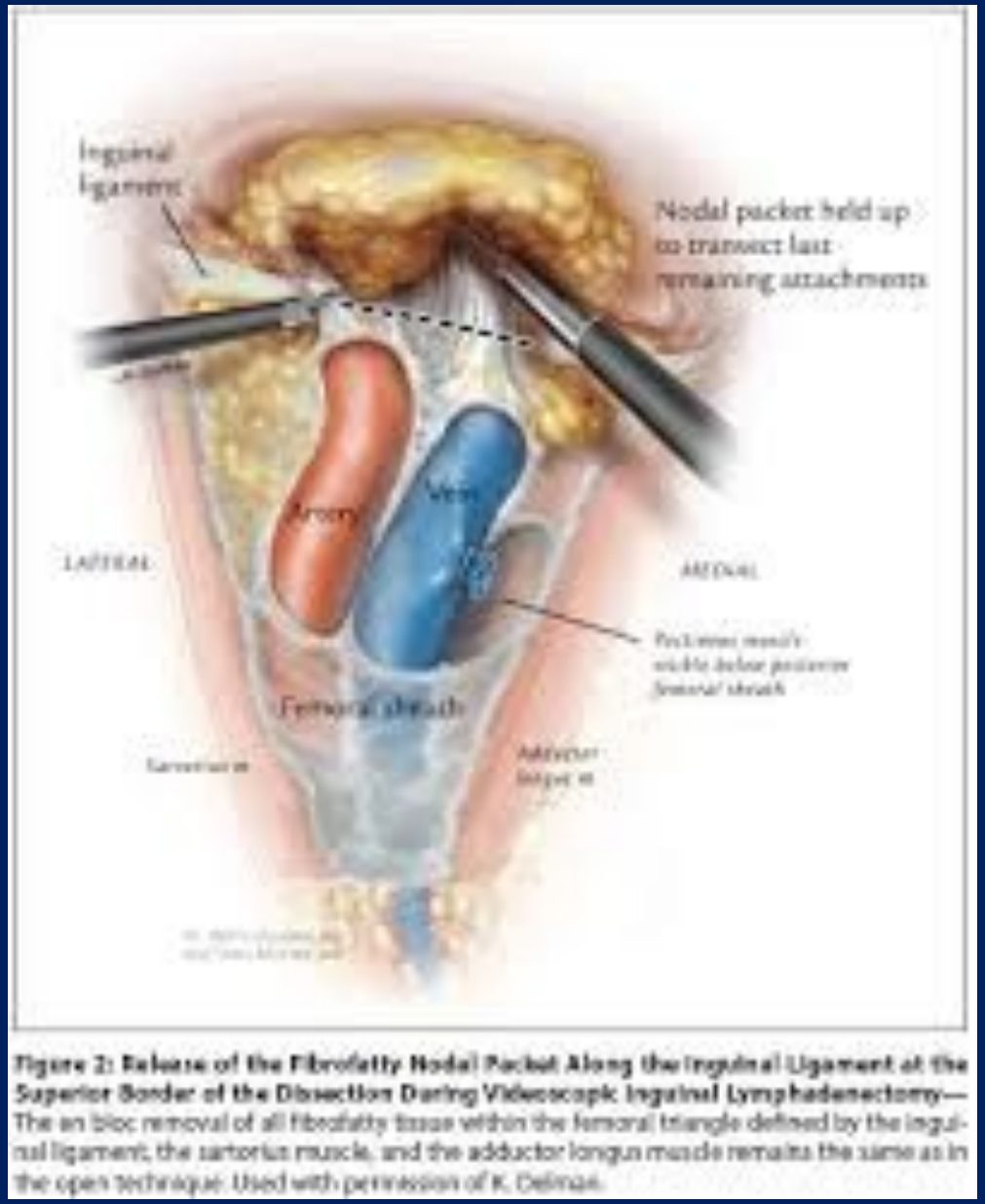


Figure 2: Release of the Fibrofatty Nodal Packet Along the Inguinal Ligament at the Superior Border of the Dissection During Videoscopic Inguinal Lymphadenectomy— The en bloc removal of all fibrofatty tissue within the femoral triangle defined by the inguinal ligament, the sartorius muscle, and the adductor longus muscle remains the same as in the open technique. Used with permission of K. Delman.

THANK YOU