

Skin Lesions

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Skin Lesions

- Increasing importance public awareness of skin lesions
- 70% of referrals to Glasgow Dermatology are lesions
- Many lesions referred are benign and require no treatment
- Unsustainable workload for Dermatology

Introduction - lesions

Benign

Pre-malignant

Malignant – non-melanoma and melanoma



Skin Tags

Very common and often multiple

- Overweight, diabetics
- Fibroepithelial polyp
- Treatment nil/ cryotherapy/ snip excision



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Dermatofibroma

- Common fibrohistiocytic tumour
- Most common in lower limbs
- Young females
- "insect bite"??
- Treatment –nil or excision





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Seborrheic Keratosis

- Basal cell papilloma
- Very common with increasing frequency after 30s
- Often multiple and occur on hair bearing skin
- Classically have a warty surface and "stuck on appearance"
- Look for keratin horn cysts

Seborrheic Keratosis

- May also be flat
- May have variable pigmentation and may be mistaken for melanoma/ lentigo maligna
- No treatment is required but cryotherapy of surgery may be used for troublesome lesions





Haemangiomas

- Benign lesions caused by vascular proliferation
- May bleed profusely with even minor trauma
- No treatment is required but can be excised



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Pyogenic Granuloma

- Rapidly growing papule or polyp
- Children and young adults
- Friable and bleeds profusely
- History of trauma in 30% of cases
- Proliferation of capillaries
- Removal by shave excision and cautery but can recur
- Differential diagnosis is amelanotic melanoma







AK Patient 1



Pre-Treatment



Week 2



Week 8

AK Patient 2



Week 2





Week 4



Week 8



Pre-Treatment



During



After

AK Patient 4



Pre-Treatment



During



After

Actinic Keratoses

- Erythematous patches with overlying keratosis
- Seen on sun exposed areas, i.e head and neck, arms, dorsum of hands
- Evidence of solar damage on surrounding skin
- Type 1 or 2 skin, sun exposure
- <1% risk of progression to SCC</p>

AK - Treatment

- GP treatment for uncomplicated cases?
- Cryotherapy
- Solaraze
- Efudix
- Surgery- currettage or excision
- Always review (3 monthly) and refer to dermatology if lesions not resolved



Bowen's Disease

- Intraepidermal squamous carcinoma in situ
- 2-3% risk of transformation to invasive SCC
- Typically presents as erythematous, scaly patch
- Most commonly seen in lower legs of elderly females but can occur on any sun exposed area

Bowen's - Management

- Cryotherapy
- Efudix
- Surgery- currette or excision
- Imiquimod
- Photodynamic therapy





Keratoacanthoma

- Rapidly growing nodule
- Classically has a central crater of keratosis
- Both clinically and histologically resembles an SCC
- However, natural history is regression with scarring
- Curettage/ Excision is advised





Basal Cell Carcinoma

- Most common skin malignancy
- Nodular
- Superficial
- Pigmented
- Morphoeic/ Infiltrating
- Classical history of slow increase in size
- Non healing with recurrent bleeding/crusting

Nodular BCC

- Most common form
- Usually arising on sun exposed areas
- Typical appearance is raised lesion with "pearly edge" and telangectasia
- Treatment is excision in almost all cases
- Radiotherapy may be used if surgery is not possible




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Superficial BCC

- Second most common group classically seen on the trunk
- Present as non healing slightly scaly or crusted plaques
- May have a slightly raised edge
- Several management options

sBCC - Management

- Cryotherapy
- Imiquimod

Photodynamic therapy

Surgery- curettage or excision

Morphoeic/Infiltrating

- Often poorly defined margins
- Morpheic form may have a scar like appearance
- These forms account for less than 10% of BCC
- Surgery is the treatment of choice



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Squamous Cell Carcinoma

- Malignant tumour arising from keratinocytes
- May arise from AK/ Bowen's disease but majority arise de novo
- May present as nodule, friable tumour or even ulcer
- Classified histologically by degree of differentiation which correlates to risk of recurrence/metastasis



SCC - Management

Surgical excision is treatment of choice

Curettage and cautery may be employed

Radiotherapy is also an option



Pigmented Lesions

Naevus

Lentigo

Lentigo maligna

Malignant melanoma

Naevi

- Most are acquired up until 3rd decade of life
- Approx 30% of melanomas arise from naevi
- Multiple naevi (>50) are associated with higher risk of melanoma



Blue Naevi

- Most commonly occur on scalp or dorsi of hands and feet
- Develop during childhood/adolescence
- Dark blue appearance due to dermal melanocytes and are well circumscribed
- Main differential diagnosis is melanoma especially in older adults





Intradermal naevi

 Present as papules which may not be pigmented

Most commonly seen on the face

May become more prominent in age



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Halo Naevi

 Naevus with a well defined depigmented halo (immunological phenomenon)

Naevus may regress completely



Atypical Melanocytic naevi

 These naevi are asymmetrical naevi which tend to have:

- More irregular shape with less clearly defined borders
- Variable surface and pigmentation

Management

- Consider excision if:
- Single lesion with recent history of change or family/personal history of melanoma

 Patients with multiple atypical naevi should have clinical photography and follow-up





Seen in 90% of patients over 60 (Caucasian)

Pigmented macules of varying size

No specific treatment needed



Lentigo maligna

Melanoma in situ

- Presents as irregularly pigmented macule.
- Risk of progression to lentigo maligna melanoma (becomes invasive)
- Usually treated with surgical excision but cryotherapy and imiquimod have been used where surgery not possible

Melanoma

 Increasing in incidence (3-7% in Caucasian population)

Majority arise de novo

 Early diagnosis important as depth <1mm has 90% cure rate

Melanoma

- Several types:
- Superficial spreading
- Nodular
- Lentigo maligna melanoma
- Acral (including subungal)
- Amelanotic

Table 114.1 Risk factors for the development of melanoma.

RISK FACTORS FOR THE DEVELOPMENT OF MELANOMA

- · Genetic markers (e.g. CDKN2A mutations)
- Family history of dysplastic nevi or melanoma
- Ultraviolet irradiation
- Sunburns during childhood
- Intermittent burning exposure in unacclimatized fair skin
- Number (>50) and size (>5 mm) of melanocytic nevi
- Congenital nevi
- Number of atypical nevi (>5)
- Atypical/dysplastic nevus syndrome
- Personal history of melanoma
- High socioeconomic status
- Skin type I, II
- Equatorial latitudes
- DNA repair defects (e.g. xeroderma pigmentosum)
- Immunosuppression

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Feature from History

- New pigmented lesion, especially in over 40s
- Rapidly growing lesion
- Change in colour, size, shape
- Atraumatic bleeding, crusting
- Itch

Features on examination

- Irregular shape or pigmentation
- Paler area suggesting regression
- Ulceration
- Inflammation

Management

 Excision as soon as possible (aim to do same day)

Regular follow-up for 3-5 yearsSun protection












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Conclusion

- Skin lesions are an increasing part of workload for both GPs and Dermatologists
- System cannot support hospital review of benign lesions unless there is diagnostic difficulty
- GP treatment of benign lesions and early premalignant lesions would be helpful