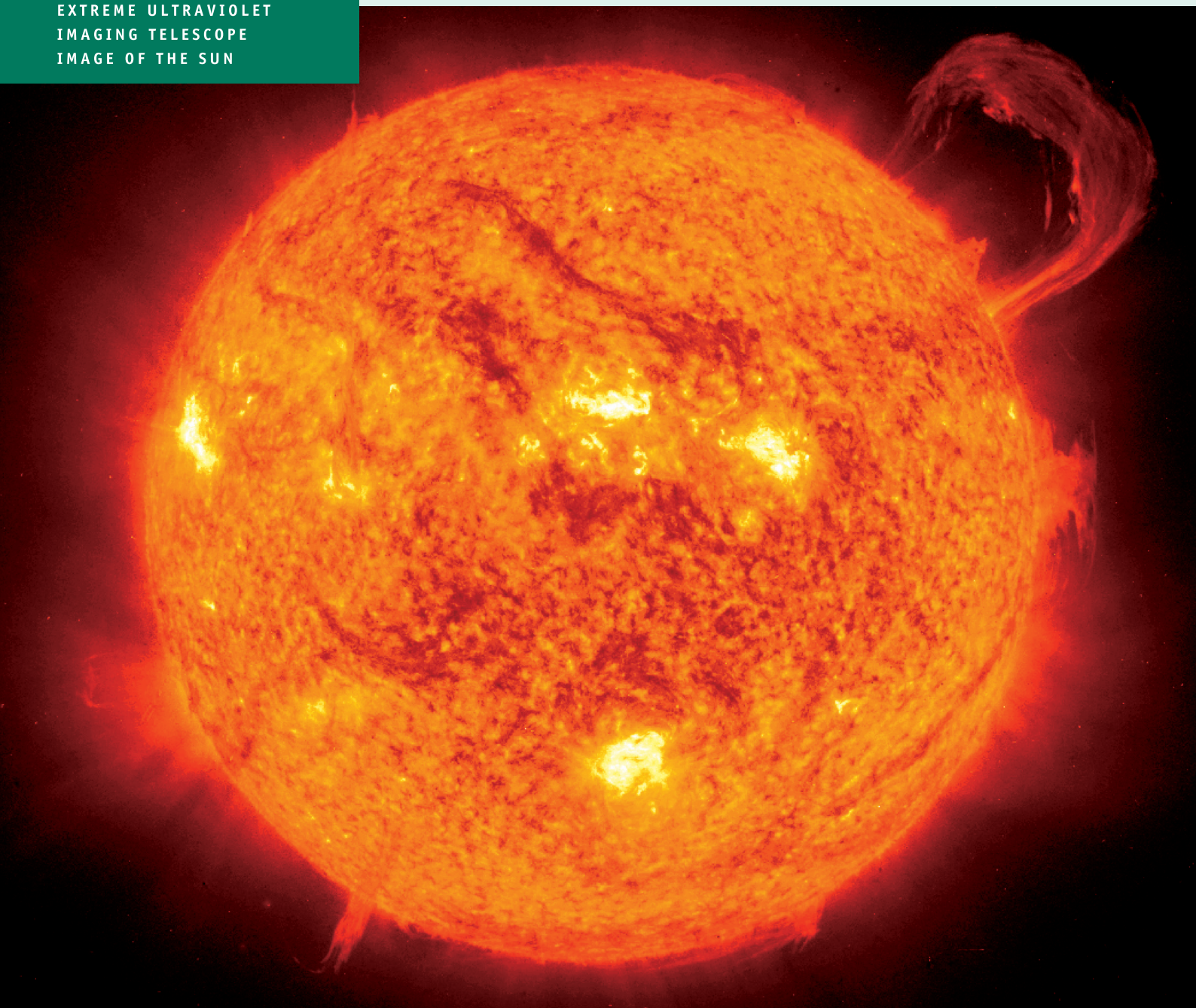


CORE TUTORIALS IN DERMATOLOGY FOR PRIMARY CARE

PDP SELF-TEST QUESTIONNAIRE

SKIN MALIGNANCY

EXTREME ULTRAVIOLET
IMAGING TELESCOPE
IMAGE OF THE SUN



UPDATED PDP SELF-TEST QUESTIONNAIRE
2022

‘Solar’ of the sun

CORE TUTORIALS IN DERMATOLOGY FOR PRIMARY CARE

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PDP SELF-TEST QUESTIONNAIRE

INTRODUCTION

This 'self-test questionnaire' has been written by Dr Brian Malcolm, based on the updated (2020) Chapter 4 "Skin Malignancy" of the Core Tutorials in Dermatology for Primary Care. This revised Chapter, can be ordered from Dermal at the address below. Alternatively, the Chapter is available to download from the Dermal website www.dermal.co.uk within the Healthcare Professionals Core Tutorials in Dermatology section.



DERMAL DERMATOLOGY RESOURCES

Dry, sensitive skin will benefit from the regular use of emollients and the avoidance of conventional detergent-based soaps or foaming shower or bath products.

PROFESSIONAL TRIAL PACKS – The Doublebase range of emollients moisturise and protect dry skin in patients of all ages. If skin is dry and inflamed Adex Gel is highly moisturising and helps reduce inflammation and redness as it contains an ancillary anti-inflammatory, nicotinamide.

Advanced emollient provides 24 hours' hydration – *Doublebase Once*
Long-lasting gel – at least 12 hours' protection – *Doublebase Dayleve Gel*
Original gel – *Doublebase Gel*
As a wash – *Doublebase Wash*
Under the shower – *Doublebase Shower*
In the bath water – *Doublebase Bath*
For dry and inflamed skin – *Adex Gel*



To assist with patient compliance, trial size packs are available to healthcare professionals.

PATIENT INFORMATION PADS – Dermal produce a set of Patient Information leaflets entitled 'Management of dry Skin Conditions – A guide for patients' and 'Managing dry and inflamed skin conditions – Tear-off guides for patients' which provides useful help and information for patients with dry skin conditions. These are available as pads of 20 tear-off sheets.

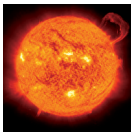


To request a supply of any of the above items, please contact Dermal at the address below. The patient information leaflets can also be downloaded from the Healthcare Professional Dermatology Resources section of the Dermal website www.dermal.co.uk.

QUESTIONS

1. What is the prevalence of actinic keratosis in the UK in the over 40's age group?

2. What cure rates can be achieved for selected BCCs with curettage and cautery?



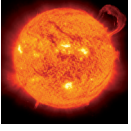
3. What is Bowen's Disease?

4. What is the estimated annual risk of an individual actinic keratosis progressing to a SCC?

5. How long do keratoacanthomas take on average to spontaneously regress after becoming fully developed?

11. What did I find useful about the learning module on 'Skin Malignancy'?

12. Having reflected on this module, how might my practice change in managing Skin Malignancy?



ANSWERS (PLEASE TURN UPSIDE DOWN)

QUESTION 10. Answer: 1. Men – the back: 2. Women – the legs
Ref page 9 “The majority of melanomas arise *de novo* and rather than superimposed on existing melanocytic lesions. The back is the highest risk area for men, accounting for a third of all melanomas, in contrast to women where 50% arise on the lower limbs. These sites clearly support the theory of sun exposure as a risk factor.”

QUESTION 9. Answer: No
Ref page 10 “**Halo naevus** (Sutton’s) – These lesions commonly occur in adolescents and cause undue concern because of their changing nature. However, the well circumscribed perilesional depigmentation gives the diagnosis. The development of halo naevi on older patients should be treated with more suspicion.”

QUESTION 8. Answer: 40
Ref page 8 “**MALIGNANT MELANOMA** – Never truer is the old adage ‘prevention better than cure’ than when applied to malignant melanoma.”
“A number of risk factors are well established.”
“Presence of large numbers of benign melanocytic naevi (the average person has approximately 40)”

QUESTION 7. Answer: 100 fold
Ref page 7 “**SQUAMOUS CELL CARCINOMA**”
“As previously discussed there are a number of pre-malignant conditions at risk of squamous metaplasia. Predetermined risk factors are chronic cumulative ultraviolet exposure, arsenicals, ionising radiation or impaired immune factors, for example secondary to transplantation and/or immunosuppressive medication. Indeed, transplantation poses particular risks with hundredfold increase in the incidence of SCC, and such tumours often behave more aggressively.”

QUESTION 6. Answer: Ear, lips, scalp, eyelids and nose
Ref page 7 “Clinically, the presentation is of an indurated, inflammatory or ulcerated nodule most commonly in the dorsum of the hands or the face. High risk sites for primary lesions most prone to metastases include the ear, lips, scalp, eyelids and nose.”

QUESTION 5. Answer: Approximately 3 months
Ref page 4 “**KERATOCANTHOMAS** – These are considered by some authorities a ‘form fruste’ of frank squamous cell carcinoma. These tumours characteristically arise *de novo* and erupt rather like a small volcano over a period of 6-12 weeks. They can grow at both an alarming rate and to quite a large size but on average plateau at between 10-20 mm diameter. The history then is of a spontaneous regression over the next 3 months.”

QUESTION 1. Answer: 6-15%

Ref page 1 "Prevalence in the UK is between 6-15% of the population aged over 40, rising to 23% over the age of 60. Males are most commonly affected. The presence of multiple AK's increases the risk of progression to SCC in an individual to 14% in 5 years. The clinical appearances are classically those of a textured, circumscribed, scaly, keratotic patch or plaque usually less than 1 cm in diameter. Colouration is varied from frankly erythematous through to yellow, pigmented or flesh-coloured. They always occur in sun exposed sites and particularly the scalp, ears, nose, dorsum of hands and forearms."

QUESTION 2. Answer: 80-90%

Ref page 6 "There are a number of 'high risk' sites where particular skill is needed to obtain adequate clearance and cosmetically acceptable results; these include tumour in the post-auricular or nasolabial folds, tumour near a free margin such as an eyelid or lip, or tumours closely approximate to vital structures such as the eye itself. My general preference is to excise surgically tumours on the head and neck, and also on the body of younger patients when possible, and to use other techniques, especially double curettage and cautery for truncal and more peripheral tumours. Excision gives a 95-99% 'cure' rate in competent hands. Curettage and cautery is reported as giving a 'cure' rate of 80-90%. In the latter, the option to excise recurrences usually remains. We increasingly see very elderly, frail patients with high tumour loads. Careful consideration on a case to case basis of such patients needs to be given to consider how "aggressively" they should be managed and a "watchful waiting" approach may well be in the patient's best interests in some instances."

QUESTION 3. Answer: Intraepithelial squamous cell carcinoma *in situ*

Ref page 3 "BOWEN'S DISEASE – (Intraepithelial carcinoma) – This common condition is *'in situ'* SCC. The potential for malignant changes is considerably higher than solar keratoses, estimated at 3-5% of untreated cases with a consequent metastatic potential of 13%. Clinically, it presents as an asymptomatic well defined erythematous, scaly plaque with a pattern of centrifugal spread. It can mimic an isolated patch of eczema or psoriasis. Sites of predilection include the face, lower limbs and fingers."

QUESTION 4. Answer: 1:1000

Ref page 1 "ACTINIC/SOLAR KERATOSES – These comprise by far the most common of conditions considered by some to be pre-malignant. Their presence acts more as a marker of significant cumulative exposure to ultraviolet radiation and thus a higher risk profile for the affected patient. The exact individual risk of progression from a solar keratosis to squamous cell carcinoma (SCC) is unknown but is considered to be in the 'ball park' of 1:1000² per annum and 1% in a lifetime."