## PRIMARY CARE MANAGEMENT GUIDELINES – Skin Lesions

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**NATIONAL GUIDELINE**

**DISTRICT HEALTH BOARD:** Canterbury

Skin lesions in this document refer to skin cancers, pigmented lesions, non-healing ulcers and other individual skin lesions.

### CLINICAL PROBLEM (Critical Determinants)

#### ACTIONS

#### LOCAL IMPLEMENTATION REQUIREMENTS

## PIGMENTED LESIONS

- **Clinically suspicious of malignancy**
- **Excision biopsy (not incision), full thickness, margins 2mm or greater**
  - Discuss with or refer to Specialist
  - Excise in 1° care if safe

- **Clinically not malignant**
- **Monitor in 1° care**
  - GP follow up

- **Seborrhoeic keratosis**
- **Cryotherapy (or excision) only if symptomatic**
  - GP Management

## NON-PIGMENTED LESIONS

- **Lesion < 5mm**
- **Excision biopsy**
  - Excise in 1° care if safe. Specialist assistance if beyond GP skill level

- **5mm or greater and clinically typical of Squamous Cell Carcinoma (SCC) or Basal Cell Carcinoma (BCC) or keratocanthoma**
- **Excision, full thickness, margins 2mm or greater with careful follow-up to confirm recurrence does not occur**
  - Excise in 1° care if safe. Specialist assistance if beyond GP skill level

- **Clinically suspicious of malignancy or Bowen’s disease**
- **Punch biopsy**
  - Biopsy in 1° care if safe. Specialist assistance if beyond GP skill level

- **Solar keratosis**
- **Monitor for development of SCC**
  - OR cryotherapy
  - OR 5-FU if numerous
  - GP follow up
  - Remove in 1° care
  - 5-FU requires “specialist recommendation”

## HISTOLOGY KNOWN

- **Melanoma**
- Discuss with or refer to Specialist

- **Squamous cell carcinoma excised with margin 2mm or greater**
- **Monitor in 1° care**
  - Review at 3 and 6 months then annually

- **Squamous cell carcinoma - excised incompletely or with margin < 2mm**
- **Complete adequate excision**
  - Excise in 1° care if safe. Specialist assistance if beyond GP skill level

- **Squamous cell carcinoma - with regional nodes**
- **Specialist assistance**
  - Specialist referral

- **Bowen’s Disease**
- **Complete excision or destruction (cautery, cryotherapy)**
  - OR 5-FU
  - Removal in 1° care if safe. Specialist assistance if beyond GP skill level.
  - 5-FU requires “specialist recommendation”

- **Basal Cell Carcinoma - completely excised**
- **Monitor in 1° care**
  - Look for other skin cancers

- **Basal Cell Carcinoma - incompletely excised**
- **Complete excision OR Destruction (curettage and cautery)**
  - Removal in 1° care if safe. Specialist assistance if beyond GP skill level.

- **Local recurrence**
- **Specialist assistance**
  - Specialist referral

- **Keratoacanthoma**
- **Complete excision or destruction**
  - Removal in 1° care if safe. Specialist assistance if beyond GP skill level.

## MISCELLANEOUS

- **Non-healing ulcers**
- If small, excision biopsy
- If large, full thickness biopsy of the margin
  - Biopsy in 1° care if safe. Specialist assistance if beyond GP skill level

- **Chondrodermatitis nodularis helicis ears**
- Treat conservatively if small OR Specialist assistance for excision

- **Pyogenic granuloma**
- Excision or biopsy then cautery with care to destroy feeding blood vessel
  - Excise or cautery in 1° care if safe. Specialist assistance if beyond GP skill level

- **Epidermoid cysts - sebaceous cysts - pilar (tricholemmal) cysts**
- Treat conservatively if asymptomatic OR excise completely
  - GP Management

- **Dermatofibroma**
- Treat conservatively
  - GP Management

- **Milia**
- Treat conservatively OR (rarely) incise and express intact
  - GP Management

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SEE NOTES ON REVERSE >>>
Skin Lesions

NOTES:
- Removal of lesions on the eyelids, nose, lips, and ears is often beyond the skill of the average GP
- All excisions, however benign on clinical examination, should be sent for histopathological assessment
- “Specialist assistance” in this document refers to the plastic surgery service (may include GPs with a special interest in this area). Dermatology service offers assessment/diagnosis and may offer surgery. Ophthalmology service may offer ocu-lo-plastic surgery. Radiotherapy may be used to treat SCC.
- Refer also to MOH National Dermatology Referral Guidelines - http://www.electiveservices.org.nz
- The Skin Lesions one-page guidelines can be found at the web address: http://www.electiveservices.org.nz

Malignant melanoma Most develop de novo, 25% arise in an existing mole. Have a high index of suspicion for any mole that has changed or any new pigmented lesion (that is not clinically a seborrhoeic keratosis).

Clinically suspicious features of malignancy in a pigmented lesion include:
- Asymmetry
- Border - irregularity or smudging of pigment over the border
- Colour variation - several different colours or increase depth of pigment within the lesion
- Diameter - any pigmented lesion with size > 1cm or any mole that is growing
- Increasing size
- Any bleeding or crusting (if not clinically a seborrhoeic keratosis)

Seborrhoeic keratosis Otherwise known as senile wart occurs anywhere on the body in people aged over 40 years. It starts as a pale yellow or brownish macule with a slightly greasy feel. With time it often becomes dark or even black, with a warty, sometimes dimpled surface (like a cauliflower). It appears to be stuck on the skin rather than arising in it. Occasionally they can be pedunculated. They never become malignant so they are removed only for cosmetic reasons or because they catch on clothing.

Squamous Cell Carcinoma (SCC) Early changes can show a flat scaly erythematous macule. This usually demonstrates reasonably rapid growth resulting in a nodule that may bleed earlier than a BCC. Often tender, this nodule usually has an eroded or heaped up cauliflower appearance. It can present as an ulcer with everted edges. Generally SCCs arise in sun exposed sites, common on the lip and back of the hand. SCC metastasise in 2-3% of patients, and this is more likely if on the lips or ears.

Solar Keratosis Solar, actinic or senile keratoses arise on skin exposed to sunshine. The lesions are superficial scaly roughenings of the skin, often more easily felt than seen. They are found mainly on the face, bald scalp and the back of the hands and wrists. A small percentage may progress to SCC.

Basal Cell Carcinoma (BCC) Early: Small smooth papule, which over months enlarges to a rounded lesion with pearly nodules in a rolled edge over which dilated blood vessels course. The pearly edge is best seen when the skin is stretched. Sometimes there will be an ulcer and the central scab/crust will need to be removed to reveal the characteristic pearly edge. Rarely tender. Generally slow growing and develop over months to years. BCC can be locally invasive but rarely metastasise

Kerato-acanthoma This lesion is on the borderline between hyperplasia and neoplasia. Considered to be a self-limiting form of SCC. Generally it shows rapid enlargement for about 2 months, often reaching 1-2 cm in diameter. It remains static for a further 2 months, then over a similar period involutes often leaving a somewhat unsightly pitted scar. At its maximum it is a dome-shaped yellowish nodule with a rounded edge across which blood vessels course and a central keratinous plug which can look like a crater. If this plug is removed it reveals more keratin; this helps to distinguish it from a BCC. The speed of growth is much more rapid than that of a SCC.

Clinical features of malignancy in non-pigmented lesions are any new lesion or a lesion increasing in size; a heaped up or rolled edge; a pearly appearance when stretched; dilated blood vessels on the surface of a nodule; ulceration in an existing lesion or chronic nonhealing ulcer with everted edges. SCC generally are more rapidly growing than BCC. Ulceration or bleeding may occur early in SCCs. SCC are often tender. BCC are rarely tender.

Bowen's Disease This is intra-epidermal carcinoma in-situ (SCC in-situ). Usually presents in those aged over 50 years, more commonly in women. It can occur anywhere on the body (not just on sun exposed skin). It is often itchy or erythematous plaques and may resemble solar/actinic keratosis or a patch of psoriasis or eczema that has been present for many years and may steadily enlarge. The edge is well defined and usually irregular.

Chondro-dermatitis Nodularis Helicis Also known as Winkler's disease, this is an inflammatory condition caused by degeneration of cartilage. It characteristically presents as an exquisitely tender nodule on the top of the pinna. It can often be painful to lie on and unless the patient can find another comfortable sleeping position may need excision. Can be confused with a SCC. While it can be treated conservatively by cortisone injection this generally only provides short-term relief.

Pyogenic Granuloma This is a misnomer as it is in fact a capillary haemangioimmunoma, which grows rapidly, distends and then usually ruptures the overlying skin. This leaves a naked mass of delicate blood vessels, which bleed copiously with minimal trauma.

Epidemoid Cysts Commonly known as sebaceous cyst and occurring anywhere on the body, it is a firm, slightly soft swelling with a central punctum. The cheesy material it contains is keratin not sebum. Similar to this, usually found on the scalp, is a pilar (or tricholemmal) cyst, which arises from the hair follicle but is without the central punctum.

Dermatofibroma Is most common on exposed parts of the limb in women but can occur anywhere on the body and in men. It is a fibrous nodule that looks and feels like a lentil in the skin. It can often be larger than 5mm.

Milia These are pinhead sized glistening white epidermoid cysts most commonly seen on the upper cheeks and around the eyes in young adults, especially females. They are best treated by using a sterile hypodermic needle to incise the overlying skin, and can usually be expressed intact.

REFERENCES:

This management guideline has been prepared to provide general guidance with respect to a specific clinical condition. It should be used only as an aid for clinical decision making and in conjunction with other information available. The material has been assembled by a group of primary care practitioners and specialists in the field. Where evidence based information is available, it has been utilised by the group. In the absence of evidence based information, the guideline consists of a consensus view of current, generally accepted clinical practice.