

**The American Academy of Otolaryngology—  
Head and Neck Surgery Foundation  
(AAO-HNSF) Presents. . .**



## **Chapter 16: Skin Cancer**

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## Chapter 16: Skin Cancer

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Dr. Gregory Staffel first authored this short introduction to otolaryngology for medical students at the University of Texas School for the Health Sciences in San Antonio in 1996. Written in conversational style, peppered with hints for learning (such as "read an hour a day"), and short enough to digest in one or two evenings, the book was a "hit" with medical students.

Dr. Staffel graciously donated his book to the American Academy of Otolaryngology—Head and Neck Surgery Foundation to be used as a basis for this primer. It has been revised, edited and is now in the second printing. This edition has undergone an extensive review, revision and updating. We believe that you, the reader, will find this book enjoyable and informative. We anticipate that it will whet your appetite for further learning in the discipline that we love and have found most intriguing. It should start your journey into otolaryngology, the field of Head and Neck Surgery.

Enjoy!

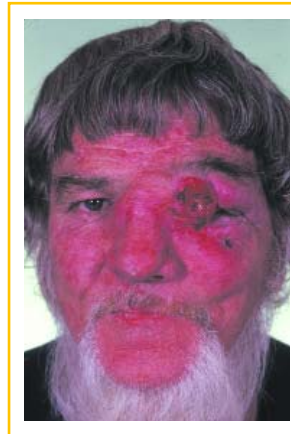
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## Chapter Number 16: Skin Cancer

The great majority of skin cancers arising on the skin of the face, scalp, and neck are **basal cell carcinoma**, followed by squamous cell carcinoma, then **malignant melanoma**. Basal cell carcinoma is very common and most often occurs on the face, so the otolaryngologist-facial plastic surgeon sees many cases.



**Figure 16.1.**

Very large basal cell carcinoma of the facial skin. Note the rolled edges with central ulceration, indicating subepithelial extension. Excision must ensure that the tumor is completely excised or recurrence is inevitable.

The typical basal cell carcinoma is a **nodular lesion with a raised, pearly-white border**. These are usually brought to the doctor's attention before they become very large. They don't metastasize and can be treated in a variety of ways. Dermatologists may freeze or curette them. Facial plastic surgeons tend to excise them with a small margin and do a meticulous closure of the defect. Occasionally, the defect will require the rotation of a small local flap.

Another way of addressing these cancers involves **Mohs' fresh tissue chemosurgery technique**, in which the tumor is removed in layers and completely examined under a microscope to ensure complete removal. This



## Chapter Number 16: Skin Cancer

takes significantly longer than any of the other methods, but the recurrence rate is lower when Mohs' technique is used. For this reason, certain tumors with a higher than usual chance of recurrence with conventional excisions may be better managed with Mohs' surgery. A basal cell carcinoma that **recurs** after primary treatment with either excision, electrodesiccation, curettage, or freezing is at higher risk for recurring after the 2nd course of treatment, so these patients will often undergo Mohs' surgery. Basal cell carcinomas that occur **near vital structures** such as the eyelids, nose, or ears are also often treated with Mohs' surgery in order to preserve as much normal tissue as possible. **Morpheaform basal cell carcinoma** is a kind of basal cell carcinoma that has very indistinct borders, more like a yellow plaque than a raised nodular lesion. It is very difficult to excise without the use of histology, so this type of basal cell carcinoma is best suited to Mohs' surgery. In addition, a basal cell carcinoma that is **very large** on initial presentation also has a higher incidence of recurrence and should be considered for Mohs' surgery. Unfortunately, Mohs' surgery is costly, so the merits of each case must be considered individually.

Squamous cell carcinoma is more aggressive and generally requires excision of a larger margin than basal cell carcinoma to assume complete removal. This tumor can



## Chapter Number 16: Skin Cancer

metastasize, although usually not early in its course. Evaluation of the neck nodes and careful follow up to detect early recurrence or metastasis is necessary. Larger tumors are usually treated with wide excision and neck dissection to remove any possible metastases.

### Malignant Melanoma:

Malignant melanoma is a capricious tumor that affects patients of all ages and has a high mortality rate. There is mounting evidence that sun exposure in childhood is a strong risk factor. It is very common in Australia, and public

education in that country has led to the widespread frequent wearing of broad-brimmed hats and use of sun-screen lotions among 50% of adults and children. If you're caucasian and have young children, be sure they're protected from the sun when outside in the summer and in warmer climates. Melanoma presents as a **pigmented**



**Figure 16.2.**

This large neglected squamous cell carcinoma of the face is present in this homeless individual.



## Chapter Number 16: Skin Cancer

**lesion (mole)** that changes by either growth, changes in color or margin, ulceration, or bleeding, or is deeply pigmented or raised.

**Melanoma begins in the epidermis and then invades the dermis.** The depth of invasion is strongly predictive of spread and, ultimately, patient survival. The classification system includes thin (less than 0.76 mm invasion), thick (greater than 4.0 mm), and intermediate (greater than 0.76 mm and less than 4.0 mm). The risk of metastatic disease is less than 10% with thin but greater than 90% with thick. It's important that every physician keep a close lookout for darkly pigmented moles and those that have changed, that bleed, are raised, or have irregular margins. Early detection and excision are lifesaving.

### Questions, Section #16

1. The most common types of skin cancer are \_\_\_\_\_,  
, \_\_\_\_\_  
and \_\_\_\_\_
2. Most basal cell carcinomas are nodular in appearance, with very distinct borders, and are easily treatable. There is, however, a certain type that has very indistinct borders. This is called a \_\_\_\_\_
3. Certain basal cell carcinomas have a higher incidence of recurrence than others. These include \_\_\_\_\_  
, \_\_\_\_\_  
and \_\_\_\_\_



**Chapter Number 16: Skin Cancer**

- 4. Some basal cell carcinomas may be very close to vital structures, such as the lower eyelid or the ala of the nose. In this case, maximum preservation of tissue is a consideration and these \_\_\_\_\_patients are candidates for surgery.
- 5. Squamous cell carcinoma of the face is aggressive and can metastasize to the \_\_\_\_\_
- 6. The metastatic potential of malignant melanoma depends on \_\_\_\_\_
- 7. Signs of malignant melanoma are a mole that \_\_\_\_\_  
, \_\_\_\_\_  
, \_\_\_\_\_  
, \_\_\_\_\_  
and \_\_\_\_\_

**Answers**

- 1. Basal cell, squamous cell, malignant melanoma
- 2. Morpheaform carcinoma
- 3. Recurrent, large (greater than 2 CM), and morpheaform
- 4. Mohs'
- 5. Cervical lymph nodes
- 6. Tumor thickness
- 7. Is darkly pigmented, raised, bleeding, changing, has irregular margins



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The American Academy of Otolaryngology—Head and Neck Surgery Foundation offers many programs designed to keep you up-to-date without leaving your practice. Most activities offer Category 1 AMA/PRA credits. The Academy/Foundation also serves as a primary resource for otolaryngology/head and neck surgery activities and events, and serves as an online clearinghouse for patient education and specialty information.

Visit the Academy's website, <http://www.entnet.org> to learn more about these programs.

