Dark Back Lesion

Benjamin Barankin, MD, FRCPC

Meet Danny...

- A large dark lesion on his back was noticed by his wife a few months ago, but he was too busy to go see his doctor
- He has no personal or family history of skin problems

Physical exam

- The lesion causes him no discomfort. It does not bleed and he is not sure how long it has been there, although he is certain it was not present at birth
- He does not take any medications, nor is he allergic to any medications

What's your diagnosis?

a) Pigmented basal cell carcinoma
b) Melanoma
c) Dysplastic nevus
d) Congenital melanocytic nevus
e) Blue nevus

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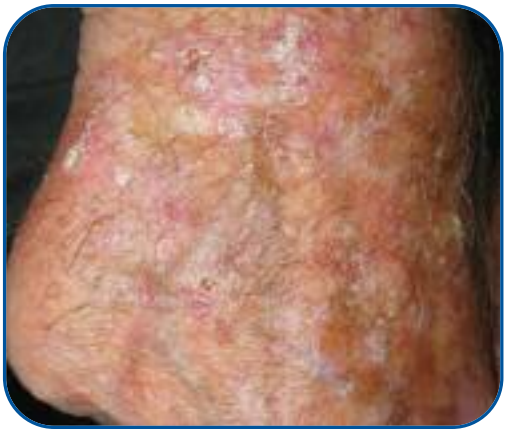
See page 2 for the answer to last month's case

Here is the answer to last month's case

Meet Sam...

- He is a 72-year-old Caucasian male with red and scaly papules scattered on his scalp and forearms
- He takes a few medications which he cannot recall for his high BP
- Sam has never had skin problems, nor skin cancer, though both his parents had various lesions on their faces burned or cut out



Physical exam

- The lesions are asymptomatic but appear to be increasing in number over time

What's your diagnosis?

a) Squamous cell carcinoma
b) Seborrheic keratoses
c) Bowen disease
d) Porokeratosis
e) Actinic keratoses

Answer: E

Actinic keratoses (AK) are the most common pre-cancer lesions in humans, most commonly found in individuals > 40-years-of-age and who are fair-skinned, tan poorly and burn easily and have had occupations or interests that resulted in significant sun exposure over many years. Patients will often also demonstrate a background of solar-damaged skin with telangiectasia, blotchy colour, elastosis and lentigines.

AK are most commonly found on sun-exposed areas of the face, ears, forearms and dorsum of the hands. They can, however, be found anywhere that chronic sun exposure took place. They appear usually as multiple, rough, scaly papules with an erythematous base and can often be felt easier than they can be seen. They range from 3 mm to 8 mm in diameter and can gradually enlarge and thicken. There is a small risk that over years, these lesions can develop into squamous cell carcinomas (SCC).

Diagnosis is clinical and involves a high-level of clinical suspicion (older age, excessive sun exposure, fair skin type). No blood work or imaging is required. A biopsy of lesions with pronounced erythema, hyperkeratosis and induration is warranted to rule out an AK that has progressed to a SCC. Lesions not responding to typical therapy or that are recurrent should also be sampled.

Treatment of AK depends on the number, location and thickness of lesions. A few AK can

often be treated with several seconds of liquid nitrogen cryotherapy (Q-tip or canister) and may need to be repeated. The AK are irritated, may erode or ulcerate and slough off in the days following treatment. Often, semiannual or annual monitoring and treatment are advised. Thicker lesions can be removed by curettage, although biopsy may be warranted.

Multiple lesions can be treated in several ways and depend on patient tolerance and acceptability and associated costs of several modalities. Both topical imiquimod and 5-fluorouracil can be used for covering an entire area since there is often "field damage." During the treatment phase, AK become increasingly erythematous and small subclinical lesions become highlighted. This treatment can be temporarily uncomfortable and unsightly, with erythematous ulcerations and crust formation. However, if treatment is completed, AK usually heal within two weeks of discontinuing treatment, the complexion becomes smooth and AK disappear. Treatment will often need to be repeated periodically in subsequent years. Lesions not resolving should be biopsied.

Other useful therapies for multiple AK include photodynamic therapy, chemical peels (glycolic, TCA), topical retinoids and topical diclofenac and less commonly, dermabrasion and laser resurfacing.

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Congratulations
to our winner for the month of March 2010!
Dr. Robert C. Dickson
from Hamilton, Ontario