



FIGURE 105-5 Cutaneous neoplasms. **A.** Non-Hodgkin's lymphoma involves the skin with typical violaceous, "plum-colored" nodules. **B.** Squamous cell carcinoma is seen here as a hyperkeratotic crusted and somewhat eroded plaque on the lower lip. Sun-exposed skin in areas such as the head, neck, hands, and arms represent other typical sites of involvement. **C.** Actinic keratoses consist of hyperkeratotic erythematous papules and patches on sun-exposed skin. They arise in middle-aged to older adults and have some potential for malignant transformation. **D.** Metastatic carcinoma to the skin is characterized by inflammatory, often ulcerated dermal nodules. **E.** Mycosis fungoides is a cutaneous T cell lymphoma, and plaque-stage lesions are seen in this patient. **F.** Keratoacanthoma is a low-grade squamous cell carcinoma that presents as an exophytic nodule with central keratinous debris. **G.** This basal cell carcinoma shows central ulceration and a pearly, rolled telangiectatic tumor border.

The margins of this tumor may be ill defined, and fixation to underlying structures may occur ("tethering").

A very rapidly growing but low-grade form of SCC, called keratoacanthoma (KA), typically appears as a large dome-shaped papule with a central keratotic crater. Some KAs regress spontaneously without therapy, but because progression to metastatic SCC has been documented, KAs should be treated in the same manner as other types of cutaneous SCC. KAs are also associated with medications that target *BRAF* mutations and occur in 15–25% of patients receiving these medications.

Actinic keratoses and *cheilitis* (actinic keratoses occurring on the lip), both premalignant forms of SCC, present as hyperkeratotic papules on sun-exposed areas. The potential for malignant degeneration in untreated lesions ranges from 0.25 to 20%. SCC in situ, also called *Bowen's disease*, is the intraepidermal form of SCC and usually presents as a scaling, erythematous plaque. As with invasive SCC, SCC in situ most commonly arises on sun-damaged skin, but can occur anywhere on the body. Bowen's disease forming secondary to infection with human papillomavirus (HPV) can arise on skin with minimal or no prior sun exposure, such as the buttock or posterior thigh. Treatment of premalignant and in situ lesions reduces the subsequent risk of invasive disease.

NATURAL HISTORY

Basal Cell Carcinoma The natural history of BCC is that of a slowly enlarging, locally invasive neoplasm. The degree of local destruction and risk of recurrence vary with the size, duration, location, and histologic subtype of the tumor. Location on the central face, ears, or scalp may portend a higher risk. Small nodular, pigmented, cystic, or superficial BCCs respond well to most treatments. Large lesions and micronodular, infiltrative, and morpheaform subtypes may be more aggressive. The metastatic potential of BCC is low (0.0028–0.1% in immunocompetent patients), but the risk of recurrence or a new primary NMSC is about 40% over 5 years.

Squamous Cell Carcinoma The natural history of SCC depends on tumor and host characteristics. Tumors arising on sun-damaged

skin have a lower metastatic potential than do those on non-sun-exposed areas. Cutaneous SCC metastasizes in 0.3–5.2% of individuals, most frequently to regional lymph nodes. Tumors occurring on the lower lip and ear develop regional metastases in 13 and 11% of patients, respectively, whereas the metastatic potential of SCC arising in scars, chronic ulcerations, and genital or mucosal surfaces is higher. Recurrent SCC has a much higher potential for metastatic disease, approaching 30%. Large, poorly differentiated, deep tumors with perineural or lymphatic invasion, multifocal tumors, and those arising in immunosuppressed patients often behave aggressively.

TREATMENT BASAL CELL CARCINOMA

Treatments used for BCC include electrodesiccation and curettage (ED&C), excision, cryosurgery, radiation therapy (RT), laser therapy, Mohs micrographic surgery (MMS), topical 5-fluorouracil, photodynamic therapy (PDT), and topical immunomodulators such as imiquimod. The therapy chosen depends on tumor characteristics including depth and location, patient age, medical status, and patient preference. ED&C remains the most commonly employed method for superficial, minimally invasive nodular BCCs and low-risk tumors (e.g., a small tumor of a less aggressive subtype in a favorable location). Wide local excision with standard margins is usually selected for invasive, ill-defined, and more aggressive subtypes of tumors, or for cosmetic reasons. MMS, a specialized type of surgical excision that provides the best method for tumor removal while preserving uninvolved tissue, is associated with cure rates >98%. It is the preferred modality for lesions that are recurrent, in high-risk or cosmetically sensitive locations (including recurrent tumors in these locations), and in which maximal tissue conservation is critical (e.g., the eyelids, lips, ears, nose, and digits). RT can cure patients not considered surgical candidates and can be used as a surgical adjunct in high-risk tumors. Younger patients may not be good candidates