BASAL CELL CARCINOMA

What are the aims of this leaflet?

This leaflet has been written to help you understand more about basal cell carcinomas. It tells you about what they are, what causes them, what can be done about them and where you can find out more about them.

What is a basal cell carcinoma?

A basal cell carcinoma (BCC) is a type of skin cancer. There are two main types of skin cancer: melanoma and non-melanoma skin cancer. BCC is a non-melanoma skin cancer, and is the most common type (greater than 80%) of all skin cancer (skin cancer incidence is less than 1%) in the UK. BCC are sometimes referred to as ‘rodent ulcers’.

What causes basal cell carcinoma?

The commonest cause is too much exposure to ultraviolet (UV) light from the sun or from sunbeds. BCC can occur anywhere on your body, but is most common on areas that are often exposed to the sun, i.e. your face, head, neck and ears. It is also possible for a BCC to develop where burns, scars or ulcers have damaged the skin. BCC is not infectious.

BCC mainly affects fair skinned adults, but other skin types are also at risk. Those with the highest risk of developing a basal cell carcinoma are:

- People with pale skin who burn easily and rarely tan (generally with light coloured or red hair, although some may have dark hair but still have fair skin).
- Those who have had a lot of exposure to the sun, such as people with outdoor hobbies or outdoor workers, and people who have lived in sunny climates.
- People who use sun beds or sunbathe.

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- People who have previously had a basal cell carcinoma.

Are basal cell carcinomas hereditary?

Apart from a rare familial condition called Gorlin's syndrome, BCCs are not hereditary. However some of the things that increase the risk of getting one (e.g. a fair skin, a tendency to burn rather than tan, and freckling) do run in families.

What does a basal cell carcinoma look like?

BCC can vary greatly in their appearance, but people often first become aware of them as a scab that bleeds occasionally and does not heal completely. Some BCC are very superficial and look like a scaly red flat mark; others have a pearl-like rim surrounding a central crater. If left for years the latter type can eventually erode the skin causing an ulcer; hence the name "rodent ulcer". Other BCC are quite lumpy, with one or more shiny nodules crossed by small but easily seen blood vessels. Most BCC are painless, although sometimes can be itchy or bleed if caught on clothes or picked up.

How will my basal cell carcinoma be diagnosed?

Sometimes the diagnosis is clear from its appearance. If further investigation is necessary to confirm the diagnosis then a small area of the abnormal skin (a biopsy) or the entire lesion (an excision biopsy) may be cut out and examined under the microscope. You will be given a local anaesthetic beforehand to numb the skin.

Can basal cell carcinomas be cured?

Yes, BCCs can be cured in almost every case, although treatment becomes complicated if they have been neglected for a very long time, or if they are in an awkward place, such as near the eye, nose or ear.

BCCs never spread to other parts of the body except very rarely (fewer than 1 in 20) if neglected for years, when it may spread to draining lymph nodes. Hence, although it is a type of skin cancer it never endangers life.

How can a basal cell carcinoma be treated?

The commonest treatment for BCC is surgery. Usually, this means cutting away the BCC, along with some clear skin around it, using local anaesthetic

to numb the skin. The skin can usually be closed with a few stitches, but sometimes a small skin graft is needed.

Other types of treatment include:

- *Difficult or neglected BCC* - Mohs micrographic surgery. This involves the excision of the affected skin that is then examined under the microscope straight away to see if all the BCC has been removed. If any residual BCC is left at the edge of the excision further skin is excised from that area and examined under the microscope and this process is continued until all the BCC is removed. The site is then usually covered with a skin graft. This is a time consuming process and only undertaken for certain BCC in difficult anatomical areas if simple surgery is not suitable.
- *Radiotherapy* - shining X-rays onto the area containing the BCC.
- *Very superficial BCC*:
    - *Curettage and cautery* - the skin is numbed with local anaesthetic and the BCC is scraped away (curettage) and then the skin surface is sealed by heat (cautery).
    - *Cryotherapy* - freezing the BCC with liquid nitrogen.
    - *Creams* - these can be applied to the skin. The two most commonly used are 5-fluorouracil (5-FU) and imiquimod.
    - *Photodynamic therapy* - a special cream is applied to the BCC which is taken up by the cells that are then destroyed by exposure to a specific wavelength of light. This treatment is only available in certain dermatology departments (see Patient Information Leaflet on Photodynamic Therapy).

Surgical excision is the preferred treatment, but the choice of other treatments depends on the site and size of the BCC, the condition of the surrounding skin and number of BCC to be treated (some people have multiple) as well as the overall state of health of each person to be treated.

Self care (What can I do?)

Treatment will be much easier if your BCC is detected early. BCC can vary in their appearance, but it is advisable to see your doctor if you have any marks or scabs on your skin which are:

- growing
- bleeding and never completely healing
- changing appearance in any way

Check your skin for changes once a month. A friend or family member can help you particularly with checking areas that you cannot easily inspect, such as your back.

You can also take some simple precautions to help prevent a BCC appearing:

Top sun safety tips:

- Protect your skin with clothing, and don't forget to wear a hat that protects your face, neck and ears, and a pair of UV protective sunglasses.
- Spend time in the shade between 11am and 3pm when it's sunny. Step out of the sun before your skin has a chance to redden or burn.
- When choosing a sunscreen look for a high protection SPF (SPF 30 or more) to protect against UVB, and the UVA circle logo and/or 4 or 5 UVA stars to protect against UVA. Apply plenty of sunscreen 15 to 30 minutes before going out in the sun, and reapply every two hours and straight after swimming and towel-drying.
- Keep babies and young children out of direct sunlight.
- The British Association of Dermatologists recommends that you tell your doctor about any changes to a mole or patch of skin. If your GP is concerned about your skin, make sure you see a Consultant Dermatologist – an expert in diagnosing skin cancer. Your doctor can refer you for free through the NHS.
- Sunscreens should not be used as an alternative to clothing and shade, rather they offer additional protection. No sunscreen will provide 100% protection.
- It may be worth taking Vitamin D supplement tablets (available from health food stores) as strictly avoiding sunlight can reduce Vitamin D levels.

Vitamin D advice

The evidence relating to the health effects of serum Vitamin D levels, sunlight exposure and Vitamin D intake remains inconclusive. Avoiding all sunlight exposure if you suffer from light sensitivity, or to reduce the risk of melanoma and other skin cancers, may be associated with Vitamin D deficiency.

Individuals avoiding all sun exposure should consider having their serum Vitamin D measured. If levels are reduced or deficient they may wish to consider taking supplementary vitamin D3, 10-25 micrograms per day, and increasing their intake of foods high in Vitamin D such as oily fish, eggs,

meat, fortified margarines and cereals. Vitamin D3 supplements are widely available from health food shops.

Where can I get more information?

Web links to detailed leaflets:

http://www.skincancer.org/basal-cell-carcinoma.html
http://www.intelihealth.com/IH/ihtIH/WSIHW000/9339/9528.html
http://emedicine.medscape.com/article/276624-overview
http://www.dermnetnz.org/lesions/basal-cell-carcinoma.html

For details of source materials used please contact the Clinical Standards Unit (clinicalstandards@bad.org.uk).

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: its contents, however, may occasionally differ from the advice given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

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