FRASER HEALTH LONG TERM CARE ROUNDS

MAY 2025

DISCLOSURES

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No sponsors or financial support to disclose

LEARNING OBJECTIVES

- Recognize the dermatologic presentation of skin cancer in LTC patients.
- Learn how to perform dermatologic procedures such as biopsies in the LTC setting.
- Understand the management and treatment options for skin cancer in LTC patients.

1. RECOGNIZE THE DERMATOLOGIC PRESENTATION OF SKIN CANCER IN LTC PATIENTS.

- Review the clinical features of skin cancer
- Discuss the special considerations for skin cancer diagnosis and management in LTC patients
- Understand bedside diagnostic tools that can be used in LTC patients

BASAL CELL CARCINOMA

- Head, neck, upper back, shoulders, chest
- Persistently growing
- Bleed spontaneously, non-healing
- Pruritic, painful, asymptomatic
- Ulcerated
- Scar-like area







ACTINIC KERATOSIS

- Indicator of increased sun damage
- Precancerous - ~1% malignant transformation over 10 years
- Rough, scaly
- Erythematous macule to thin papule
- No ulceration or erosion
- Usually painless





SQUAMOUS CELL CARCINOMA – IN SITU

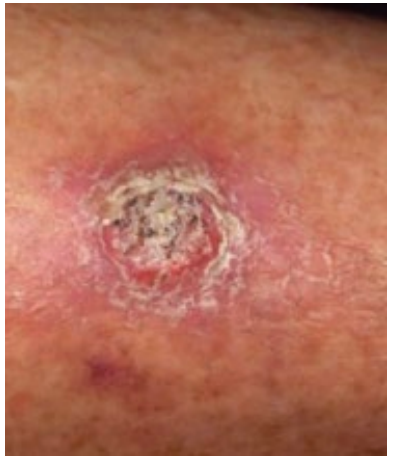
- 3-15% transform to SCC
- Erythematous scaly patch to thin plaque
- Crusted, scaly, eroded





INVASIVE SQUAMOUS CELL CARCINOMA

- Scaly, crusted
- Erythematous to skin-colored
- Erosion, ulceration
- Papulonodular, plaque-like
- Painful

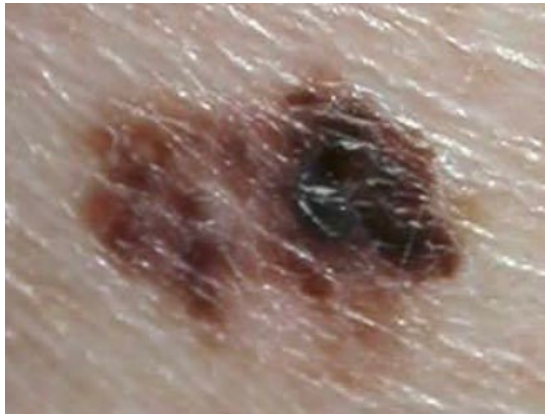






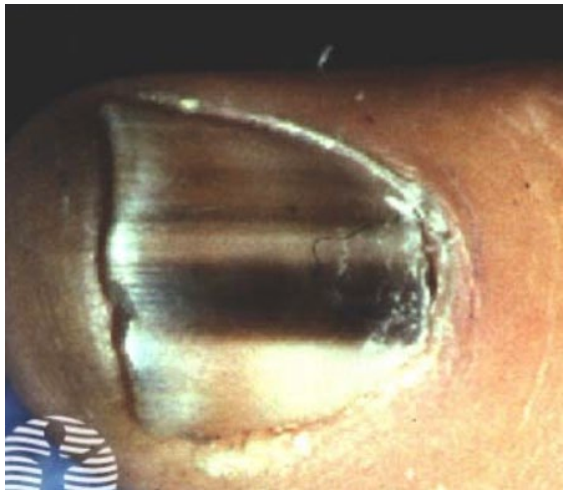
MELANOMA

- Irregular colors – black, blue, red, white
- Rapid growth
- Irregular border
- Asymmetric
- Ulceration, bleeding

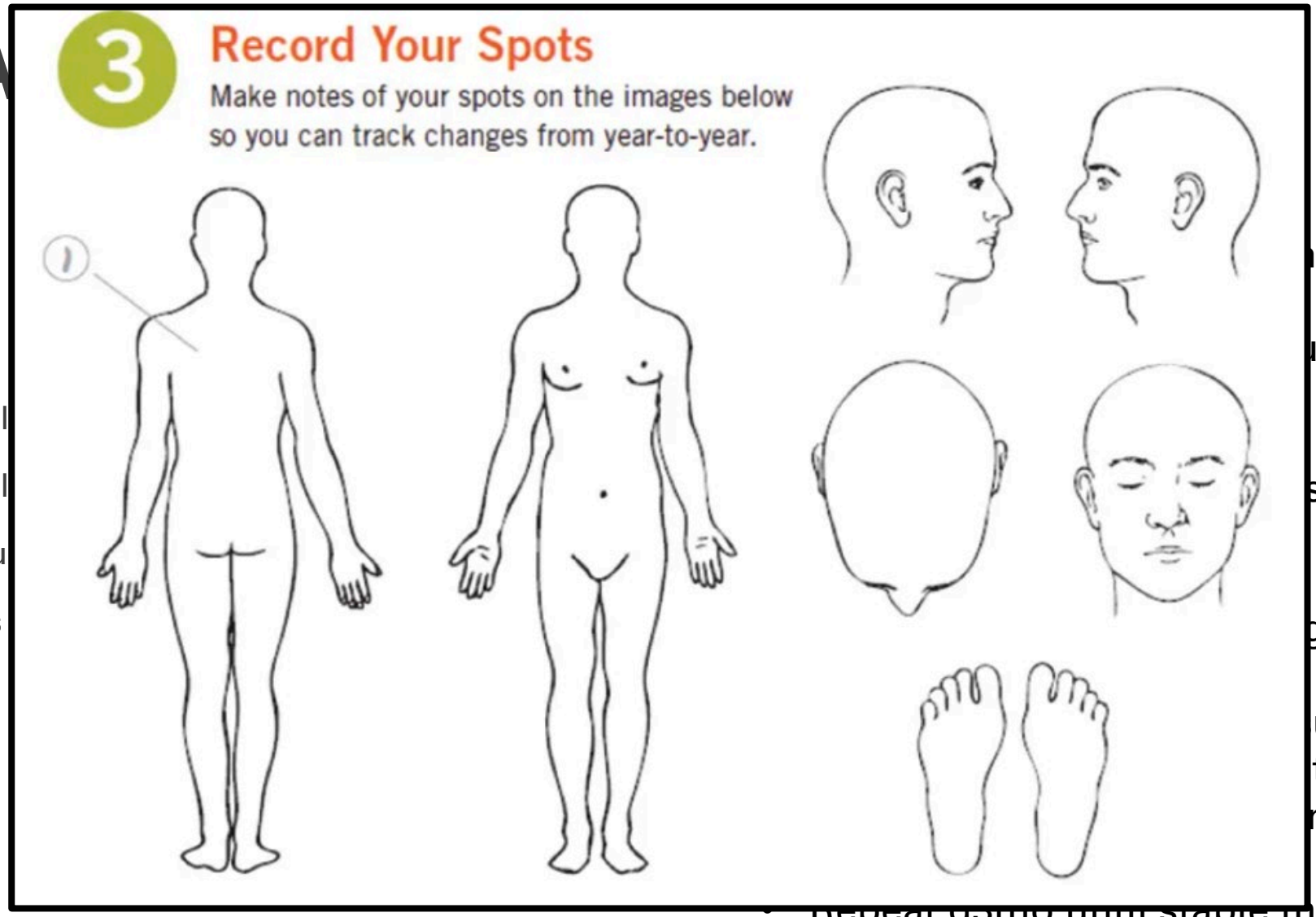








LTC PA



- Inability to sel
- Inability to sel
- Need for regu
- Bedside tools

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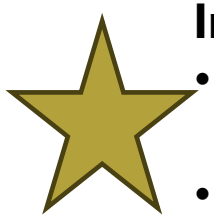
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take photos
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Repeat q3mo until stable then q6mo

INDICATIONS FOR A BIOPSY

- Patient/POA consent
- Persistently growing, bleeding, painful lesion
- Rapid evolution from previous – new colors, borders, asymmetry or ulceration
- New lesions that do not match others (the ugly duckling)



Informed Consent

- Benefits – determine a diagnosis, create a tailored management plan
- Risks - pain, bleeding, infection and scarring

2. LEARN HOW TO PERFORM DERMATOLOGIC PROCEDURES SUCH AS BIOPSIES IN THE LTC SETTING.

- Type of biopsy
- Equipment required
- Wound care

SHAVE VS PUNCH BIOPSY

Shave biopsy

- Pros
  - Quick
  - No stitches needed
  - Can be used to remove the whole visible lesion
- Cons
  - May be too superficial to get a confirmed diagnosis
  - Possible to sample incorrectly
  - May be difficult to stop bleeding or have persistent bleeding in thinner skin areas (ie forearms/shins)

Punch biopsy

- Pros
  - Quick
  - Deep tissue included – able to confirm diagnosis
  - Hemostasis achieved well
- Cons
  - Requires a suture
  - Possible to sample incorrectly
  - For larger lesions may not be able to get the whole lesion

EQUIPMENT NEEDED





- Non-sterile technique

1. Cleanse – alcohol wipe, stanhexidine
2. Anesthetize – lidocaine 2% with epinephrine (can be used for all sites)
   - 3cc syringe, 18g x 1.5” needle for drawing up and 30g x 0.5” needle for injecting
3. Biopsy
   - Shave – Personna double edge razor blade, scalpel blade #15 or Derma Blade
   - Punch biopsy – 3mm punch, iris scissors, needle driver, toothed forceps
4. Hemostasis
   - Post-shave – silver nitrate sticks, Extra Strength Drysol with cotton tip applicator
   - Post-punch – 4’0 Ethilon suture (remove in 7-10 days for head/neck and 10-14 days for body sites), 4’0 Vicryl Rapide suture (dissolvable)



WOUND CARE

- After procedure cover with Vaseline and a bandaid
- Leave dry x 24 hours
- After 24 hours the area can be cleansed with soap and water then reapply Vaseline and cover with a bandaid
- This can be done daily for 1-2 weeks until the skin has re-epithelized or the suture is removed
  - Suture removal in 5-7 days for face or 10-14d elsewhere
- Do NOT recommend Polysporin (if using an antibiotic ointment prefer fucidic acid or mupirocin)

3. UNDERSTAND THE MANAGEMENT AND TREATMENT OPTIONS FOR SKIN CANCER IN LTC PATIENTS.

- Review factors that play a role in picking a skin cancer management strategy.
- Discuss the options for therapy based on the type of skin cancer.
- Understand practical considerations for skin cancer treatment for LTC patients.

PICKING A MANAGEMENT STRATEGY

- Take into consideration: life expectancy, tumor characteristics, symptoms, quality of life
- Will the treatment help the patient during their expected lifetime
- Options for palliative or symptomatic treatment vs curative intent

FRAILTY SCORING

- Assess preoperative risk
- Predict complications and mortality from surgery
- Geriatric 8 – score =< 14 indicates frailty
  - On MDCalc

The G8 geriatric screening tool identifies elderly cancer patients who could benefit from comprehensive geriatric assessment (CGA).

Questions and possible answers (score)
Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
☐ 0: severe decrease in food intake ☐ 1: moderate decrease in food intake ☐ 2: no decrease in food intake
Weight loss during the last 3 months
☐ 0: weight loss > 3 kg ☐ 1: does not know ☐ 2: weight loss between 1 and 3 kgs ☐ 3: no weight loss
Mobility
☐ 0: bed or chair bound ☐ 1: able to get out of bed/chair but does not go out ☐ 2: goes out
Neuropsycholgical problems
☐ 0: severe dementia or depression ☐ 1: mild dementia or depression ☐ 2: no psychological problems
Body mass Index (BMI: weight in kg/height in m^2)
☐ 0: BMI < 19 ☐ 1: BMI = 19 to BMI < 21 ☐ 2: BMI = 21 to BMI < 23 ☐ 3: BMI = 23 and > 23
Takes more than three medications per day
☐ 0: yes ☐ 1: no
In comparison with other people of the same age, how does the patient consider his/her health status?
☐ 0: not as good ☐ 0.5: does not know ☐ 1: as good ☐ 2: better
Age
☐ 0: > 85 ☐ 1: 80-85 ☐ 2: < 80
Total score (0-17)

- The total G-8 score lies between 0 and 17. A higher score indicates a better health status.
- A threshold is suggested at 14 points, meaning that a patient with a score of 14 or lower should undergo full geriatric evaluation.
- The G-8 tool is not aimed at replacing geriatricians expertise in diagnosing frailty. Rather, it should be used as a screening tool to identify patients in need for a further assessment and appropriate care.

MORTALITY FROM SKIN CANCER

- Basal cell carcinoma
  - 5-year relative survival – 100%
  - Non-aggressive, metastatic rate < 0.1%
- Squamous cell carcinoma – depends on staging
  - 5-year relative survival in early stages – 95%
  - Increased incidence of poorer outcomes in older adults at later stages
  - Lymph node metastasis – 2-4%, higher if >2cm, immunosuppressed, lip/ear
- Melanoma – depends on staging
  - 5-year relative survival in early stages – >90%
  - Increased incidence of poorer outcomes at later stages

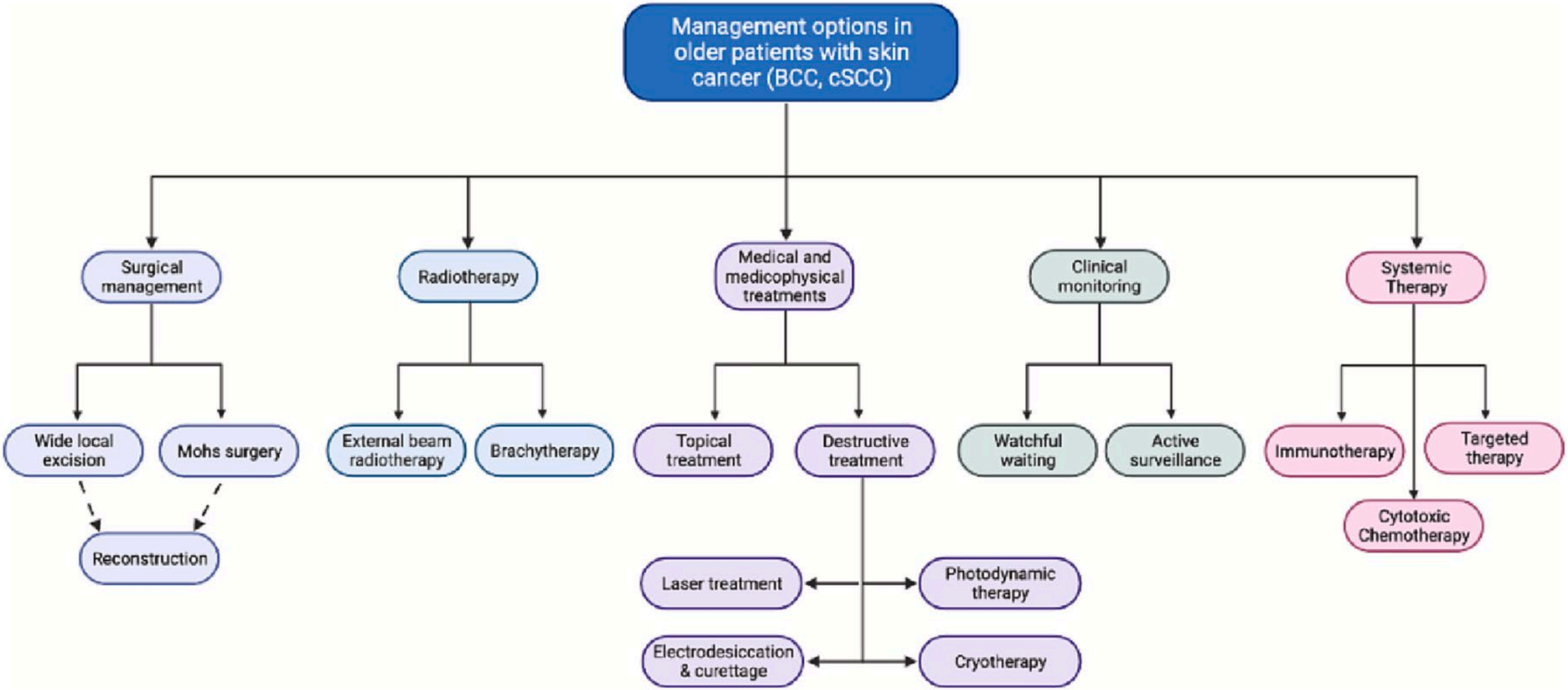


Fig. 2. Management options in older patients with basal cell carcinoma (BCC) and cutaneous squamous cell carcinoma (cSCC).

BASAL CELL CARCINOMA MANAGEMENT

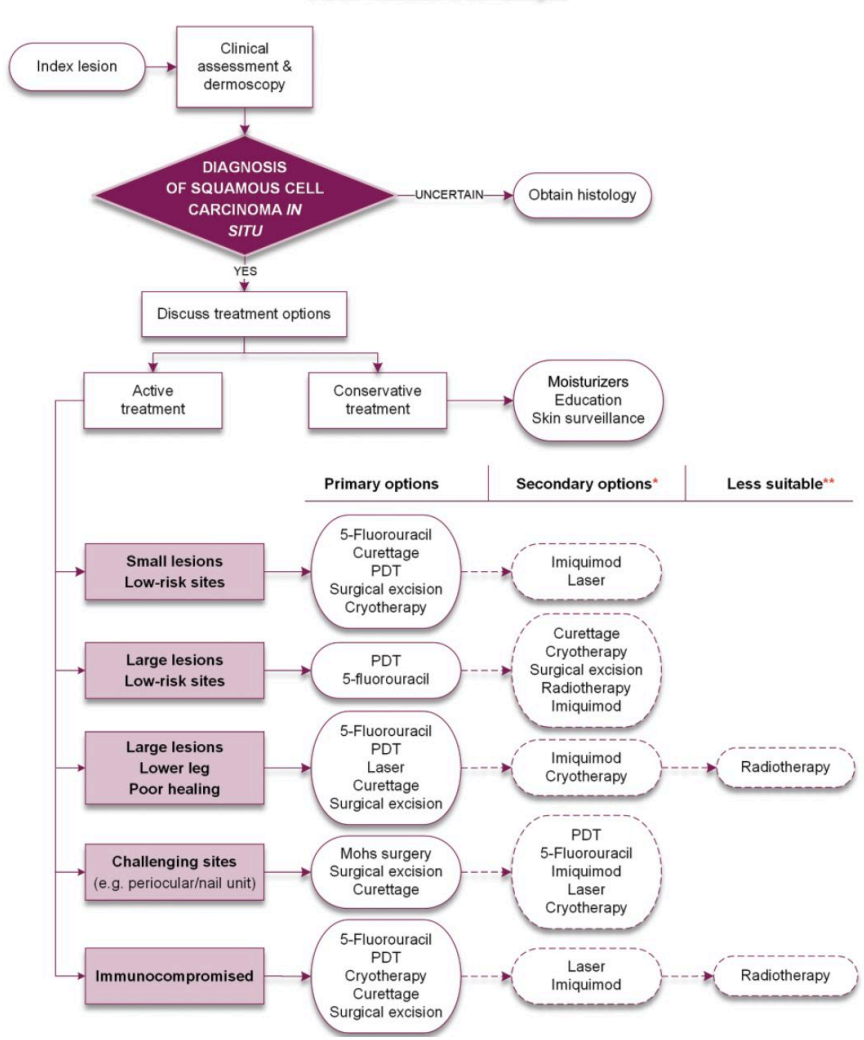
Treatment	5-year BCC cure rate
Surgical treatments	
Curettage and electrodessication	97%–98.8%[15–17]
Cryosurgery	99%[18,19]
Standard excision	98%[20]
Mohs	99%[20]
Nonsurgical treatments	
Radiotherapy	93%–96%[20]
Topical therapies	
Imiquimod	83%[20]
Fluorouracil	80%[20]
Targeting therapies	
Vismodegib	28%[21,†]
Sonidegib	21%[22,‡]

- Active surveillance
- ED&C, cryotherapy, wide local excision
  - Low-risk tumors – primary, well-defined, nodular or superficial subtype
  - Cryotherapy – ineffective for tumors that extend beyond the epidermis
- Mohs surgery
  - High-risk tumors – central face, large, recurrent, aggressive, functionally/cosmetically sensitive areas
- Topical - imiquimod, 5-FU
  - Low-risk superficial BCC
- Radiotherapy
  - Higher-risk tumors
- Intralesional therapy – MTX, 5-FU, bleomycin, interferon
  - Limited data

ACTINIC KERATOSIS MANAGEMENT

- Low risk of progression
- Active surveillance
- Can be treated if multiple lesions, thicker, bothersome
- Cryosurgery, curettage under anesthesia, topical therapy (5-fluorouracil)

SCC-IN SITU MANAGEMENT



*5-FU clearance rate 90-92%

SQUAMOUS CELL CARCINOMA MANAGEMENT

- Active surveillance with LN eval
- Surgical management
  - Electrodessication and curettage
  - Wide local excision
  - Mohs surgery
- Non-surgical management
  - Radiotherapy
  - Systemic therapy
  - Intralesional injections

Risk Group[a]	Low Risk	High Risk	Very High Risk
Treatment options	SCC-3	SCC-4	SCC-4 and SCC-5
H&P			
Location/diameter (cm)	Trunk, extremities ≤2 cm	Trunk, extremities >2 cm – ≤4 cm	>4 cm (any location)
		Head, neck, hands, feet, pretibia, and anogenital area (any size)[e]	
Clinical borders	Well-defined	Poorly-defined	
Primary vs. recurrent	Primary	Recurrent	
Immunosuppression	(-)	(+)	
Site of prior RT or chronic inflammation	(-)	(+)	
Rapidly growing tumor	(-)	(+)	
Neurologic symptoms	(-)	(+)	
Pathology (SCC-A)			
Degree of differentiation	Well or moderately differentiated		Poor differentiated
Histologic subtype[b]	(-)	(+)	(+)
Depth[c,d]: Thickness or level of invasion	<2 mm thick and no invasion beyond subcutaneous fat	2–6 mm depth and no invasion beyond subcutaneous fat	>6 mm or invasion beyond subcutaneous fat
Perineural involvement	(-)	(+)	Tumor cells within the nerve sheath of a nerve lying deeper than the dermis or measuring ≥0.1 mm
Lymphatic or vascular involvement	(-)	(-)	(+)

MELANOMA MANAGEMENT

- Lentigo maligna – ~80% clearance rate at 5 years with imiquimod
- Surgery - curative in Stage 1-2 localized melanoma
- Sentinel lymph node biopsy can be considered for Stage 1B or higher – prognostic tool
- Clinical outcomes are comparable to younger patients

PALLIATIVE TREATMENT

- Supportive care – wound care, pain medications
- Palliative treatment – cryotherapy, debulking (curettage, shave symptomatic areas, radiotherapy)
- Refer to Plastics directly for surgical debulking

PRACTICAL CONSIDERATIONS

- Asymptomatic, slow growing skin lesions - consider active surveillance with serial monitoring every 3 months
- Changing, symptomatic or functionally limiting skin lesions – consider biopsy
- Once the diagnosis is known can implement a management option that best aligns with the patient's goals, life expectancy and frailty score
  - Please send a referral and photo for a physician-physician phone call with us to discuss next steps to help guide discussion
- Consider less invasive options such as immunotherapy or cryotherapy
- Refer directly to Plastics for surgical management (curative or palliative) to avoid delays
- Refer biopsy-proven cancer to BCCA for patients who would like non-invasive curative treatment (radiotherapy)
- Refer to dermatology for management options such as ED&C
- Continue with ongoing skin/spot checks every 3-12 months depending on management plan chosen

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