PATIENT INFORMATION LEAFLET

BASAL CELL CARCINOMA

WHAT ARE THE AIMS OF THIS LEAFLET?

This leaflet has been written to help you learn more about basal cell carcinoma (BCC), a type of skin cancer. It will tell you what BCC is, what causes it and how it can be treated. It will also tell you where you can find out more information.

WHAT IS BASAL CELL CARCINOMA?

Basal cell carcinoma (BCC), also known as a 'rodent ulcer', is the most common type of skin cancer. It is also the most common cause of cancer worldwide. Currently, about 3 in 10 people with fair skin will develop a BCC in their lifetime and the number of people developing BCC is rising.

BCCs very rarely spread to other parts of the body and are almost never a danger to life.

WHAT CAUSES BASAL CELL CARCINOMA?

The most common cause is exposure to ultraviolet (UV) light. Those with the highest risk are:

- People with pale skin who burn easily and rarely tan; particularly those with naturally light or red hair. However, other skin types are also affected.
- People who have had a lot of sun exposure – for example, from outdoor hobbies or jobs, and those who have lived in sunny climates.
- People who use sun beds or sunbathe regularly
- People who have previously had a BCC.

BCCs can occur anywhere on the body. However, they most commonly appear on parts of the body that are exposed to the sun such as the face, head, neck, and ears.

BCCs are usually diagnosed in older adults. However, recent findings show that more young people are being diagnosed each year. This may be because people are spending more time in the sun.

Rarely, BCCs can develop in an old scar or an area of chronic inflammation. Other factors that can increase your risk of developing BCC are:

- having a weakened immune system (especially after an organ transplant),
- having had previous radiotherapy (particularly for childhood cancers),
- having had previous treatment with PUVA (a type of medical light treatment).

ARE BASAL CELL CARCINOMAS INHERITED?

BCCs themselves do not usually run in families, however factors which increase the risk of developing a BCC (for example, fair skin and freckles) do run in families.

In a very small number of cases, BCCs can be associated with inherited genetic conditions (such as Gorlin syndrome).

WHAT DOES A BASAL CELL CARCINOMA LOOK AND FEEL LIKE?

BCCs can vary in their appearance. People often first become aware of a scab that bleeds and does not heal completely, or a pink/red or pearly lump on the skin that does not go away. There may be tiny red blood vessels present across the surface.

Some BCCs may have a thickened rim around a central crater or crust and sometimes they can develop an ulcer.

Some BCCs are 'superficial' – this means they appear as a scaly pink/red flat mark on the surface of the skin.

BCCs can look different from one another because there are several different types. The specific type of BCC may determine which treatment options are offered. The exact type can usually be confirmed by a biopsy.

Most BCCs are painless, although sometimes they can be itchy or bleed.

HOW IS BASAL CELL CARCINOMA DIAGNOSED?

Sometimes the diagnosis of BCC is clear from the appearance, and you may progress straight to treatment.

Sometimes a small initial skin sample (biopsy) will be taken to confirm the diagnosis and type of BCC before definitive treatment is arranged. This involves a local anaesthetic injection into the affected skin area to make it numb, then a small piece of skin will be removed for testing. This is usually followed by a stitch or cautery to seal the skin.

CAN BASAL CELL CARCINOMAS BE CURED?

BCCs can almost always be cured. However, treatment can be more complicated if:

- the BCC has been left untreated for a long time
- the BCC is large at the time of diagnosis
- the BCC occurs in an awkward place to remove skin, such as close to the eye or on the nose or ear.

Larger BCCs may also result larger scars after surgery, which may cause concern, especially if they are on prominent areas such as the face.

HOW CAN A BASAL CELL CARCINOMA BE TREATED?

The most common treatment is surgery. This is usually performed under local anaesthetic. This means you will be awake for the procedure. However, there are also non-surgical options. The choice of treatment depends on many factors. These include:

- The features of the BCC such as size, type and location. These features can increase the risk of the BCC coming back after treatment.
- The number of BCCs to be treated (some people have more than one)
- Patient preferences and needs, age and overall health.

In some cases, it may be reasonable not to treat the BCC at all – for example, if the BCC is growing slowly on a non-critical area of the body or if the person would be unable to tolerate or recover from treatment due to other health issues.

Low risk BCCs – treatment options

'Low risk' BCCs are less likely to come back after treatment. These BCCs are generally small and have clearly visible edges. Low risk BCCs are 'nodular' or 'superficial' subtypes, which are classifications made from the biopsy. Surgical treatment options for low-risk BCCs include:

- *Surgery (excision)* – the BCC is cut out, along with a surrounding area (margin) of normal skin. The wound edges can usually be closed together with stitches, but sometimes a skin graft (skin taken from another part of the body to cover the wound) is needed. Alternatively, the wound may be left open to heal slowly. The edges (margins) of the piece of skin removed can be tested to indicate whether the BCC has been fully removed.
- *Surgery (curettage and cautery)* - the BCC is scraped off (a process known as

curettage) and then the skin surface is sealed using heat (cautery). Often the curettage and cautery are repeated a few times back-to-back to clear all the affected skin. Although it is usually not possible to test the edges of the sample to confirm that the BCC has been fully removed (such as with an excision), this procedure is generally considered effective for treating a low-risk BCC.

The following non-surgical treatments may be considered for low-risk BCCs if surgery is not appropriate or desired. They may not be quite as effective as surgical treatments and the BCC may be more likely to come back.

- *Cryotherapy* – 'superficial' type BCCs can be frozen with liquid nitrogen. This will generate a wound that will usually heal with a scar.
- *Creams* – these can be applied to the skin to destroy 'superficial' type BCCs. The two commonly used are imiquimod cream and 5-fluorouracil cream. Both creams can cause temporary skin reactions or discomfort in the treatment area.
- *Photodynamic therapy (PDT)* – a special cream is applied to the BCC. The skin is then exposed to a special light which causes destruction of the cancer cells. PDT is not commonly available and is mostly used for 'superficial' type BCCs.

High risk BCCs – treatment options

'High risk' BCCs are more likely to come back after treatment. They include BCCs that are large, have unclear edges, have grown back despite previous treatment, or are classified as 'infiltrative' or 'morphoeic' sub-type.

BCCs are also more likely to come back in people with weak immune systems. In these cases, it is important to make sure that the BCC has been completely removed.

For high risk BCCs, the following treatments are most likely to be offered:

- *Surgery (excision)* - the BCC is cut out with a surrounding area (margin) of normal skin, as described above. The margins of the skin sample can be tested to confirm whether the BCC has been fully removed.
- *Mohs micrographic surgery*. This procedure is used to treat more complex BCCs, especially those on more difficult sites such as the face. The surgeon removes the affected skin and examines it under a microscope straight away. If any cancer is seen at the edges of the sample, more skin is removed and examined again. This is repeated until all the edges are clear of cancer. The resulting wound may then be closed with stitches, sometimes with a skin graft, or sometimes just left to heal on its own. Mohs surgery is a specialist process and is not always available. It is undertaken when standard surgery may not be suitable.

Other treatments for BCCs that are less commonly used include:

- *Radiotherapy* – X-ray radiation is projected onto the BCC, and this treatment is repeated over a number of days/weeks. This treatment is usually delivered by the oncology team. Radiotherapy is not suitable for people with genetic skin cancer syndromes as it can increase the number of BCCs.
- *Vismodegib* – this is a type of chemotherapy medication that treats BCC by preventing cancer cells from growing and surviving. Although it is licensed for complex situations such as numerous BCCs, or when BCC has spread to other parts of the body (which is very rare), it is not currently routinely available on the NHS.

WILL I NEED DERMATOLOGY FOLLOW UP FOR MY BASAL CELL CARCINOMA?

Not everyone needs follow up after treatment. People are usually discharged if their BCC has been treated and the risk of it coming back is low, or if they are not

considered at high risk of future skin cancers. Follow up appointments may be considered for people who:

- have advanced BCC
- are at high risk of their BCC coming back
- are at high risk of developing multiple skin cancers (for example people with weakened immune systems or with genetic skin cancer syndromes)

SELF-CARE, PREVENTION AND EARLY IDENTIFICATION OF BCCS

Patients who have previously had a BCC have an increased risk of developing further skin cancers. Treatment of all skin cancers is more straightforward if they are detected early. Because of this, it is advisable to check your skin for changes once a month. A friend or family member could help with areas that you cannot easily see, such as your back.

You should see your GP if you notice any moles, marks, or scabs that are growing, changing, bleeding or not healing. You should also see your GP if you're concerned about changes where a BCC was previously treated. If your GP is concerned, you should be referred to see a dermatologist through the NHS.

You can also help to reduce the risk of a BCC (and other types of skin cancer), by limiting your sun exposure. Further advice sheets on this are suggested below, however key tips include:

- Protect your skin with clothing. Ensure that you wear a hat that protects your face, neck and ears, and a pair of UV protective sunglasses.
- Make use of shade, particularly between 11 am and 3 pm when it's most sunny.
- It is important to avoid sunburn, however, even a tan is a sign of skin damage and should be avoided. Sunburn and sun tanning increases your risk of developing a skin cancer in the future.
- Sunscreen should protect against both UVA and UVB. Use a 'high protection' sunscreen with high UVB protection (SPF of at least 30) and high UVA protection (5 stars). This information can be found on the bottle of sunscreen. Apply sunscreen generously 15 to 30 minutes before going out in the sun and reapply frequently when in the sun.
- Avoid sun-bathing
- Avoid artificial sunlight (sunbeds / tanning machines)

Vitamin D advice

People who avoid sun exposure may be at risk of vitamin D deficiency and should have their vitamin D levels checked. If the levels are low, they may consider:

- Vitamin D supplements (dosing advice can be obtained from the GP)
- Increasing intake of food rich in vitamin D such as oily fish, eggs, meat and cereals

WHERE CAN I GET MORE INFORMATION?

Web links to other relevant sources:

Early detection and prevention of skin cancer
www.skinhealthinfo.org.uk/symptoms-treatments/skin-cancer/

Sun safety
www.skinhealthinfo.org.uk/sun-awareness/the-sunscreen-fact-sheet/

www.skinhealthinfo.org.uk/sun-awareness/sun-advice-for-skin-of-colour/

www.skinhealthinfo.org.uk/sun-awareness/sun-protection-advice-for-children-and-babies/

Vitamin D
www.skinhealthinfo.org.uk/sun-awareness/vitamin-d-inform

Additional sources

www.skincancer.org/basal-cell-carcinoma.html

www.gorlinsyndrome.org/about-gorlin-syndromewww.dermnetnz.org/lesions/basal-cell-carcinoma.html

Jargon Buster:
www.skinhealthinfo.org.uk/support-resources/jargon-buster/

British Association of Dermatologists guidelines for the management of adults with basal cell carcinoma 2021:
www.onlinelibrary.wiley.com/doi/10.1111/bjd.20524

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: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

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

BRITISH ASSOCIATION OF DERMATOLOGISTS

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