ELECTIVE (SSC5a) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective/SSC supervisor will assess this.

During my 6-week elective period at Whipps Cross Hospital, I came across a wide range of dermatological conditions, ranging from simple naevas to squamous cell carcinoma and malignant malinomas. By attending various multi-disciplinary team (MDT) and regional meetings I managed to observe small team of dermatologist using their diagnostic skills to solve complex skin conditions.

An important learning point, with regard to any skin condition, is that the physical symptoms, especially the cosmetic appearance, can have a profound effect on the mental wellbeing of individuals. Patients can form stigma of their physical appearance as they may feel that others are being judgmental to their look. They may feel uncomfortable attending social gatherings, enjoying outdoor activities such as swimming, and even going to workplace. It reminds me of a famous quote I came across "When you rot from the outside people stare", from the video 'The Skin I'm in" (Baker., 2016).

There is no doubt that we often make our first impression on people by looking at their skin, therefore any skin changes can trigger psychological stress and lower self-confidence of an individual. It's one of the reasons that prompts these patients to seek treatment. This could explain an increased number of patients seeking treatment for conditions such as acne vulgaris and eczema. Nevertheless, there have been reports of patients with self-harm, depression and even suicide attempts because of their appearance (Picardi et al., 2013).

During the first ever clinic with Dr. Rajpopat, I recall a young gentlemen in his 30's, presenting with some of the key features of psoriasis. Upon examination, we noticed an irregular silvery-white scale on the extensor region of the elbows, measuring 2-3cm on both sides. The other signs included small erythematous patches on the penile glans; nail pitting and dry eyelids.

I realised that it is very important to know patient's understanding of their illness before further investigations are carried out. Surprisingly, this patient had an explanation for each of the signs he presented with. For instance, he associated the patches on his penile glans due to a recent circumcision; dry eyelids and silver-scale lesions on the elbows due to a flare up of his chronic eczema.

I think we are in an era where patients are overloading themselves with irrelevant information from various sources i.e. Internet sites, and doing a lot of detective work on their symptoms. As a doctor, our role is not just treating those symptoms, but to educate the patient and put their focus onto the right aspect of their condition.

During the 4th week of my elective, I was given an opportunity to take histories on my own and examine the patients under the guidance of a registrar. One of the thought-provoking patients I came across was a referral from the GP, who presented with non-healing purulent ulcer with well-defined borders and a granulating base. The lesion was located on the medial malleolar area of the right ankle. It was painful on standing and better on walking and had not been responding to two courses of fluoxacillin prescribed by the GP. Interestingly, the patient had been suffering from chronic ulcerative colitis; therefore pyoderma gangrenosum was the prime differential here. However, I

noticed that it was difficult to differentiate it from venous ulcer. With the guidance of consultant, the patient was referred for a biopsy. I learnt that missing key information on the past medical history could change the diagnosis completely. Had I not known about his ulcerative colitis, I could have simply gone for venous ulcer.

An increased incidence of skin cancers has been a huge topic of concern in the UK. Skin cancers are divided into melanoma and non-melanoma, with the former being the 5th most common in the UK and accounting for 4% of the cancer diagnosis in the year 2015. Surprisingly, there have been an over two-fold increase in the incidence of melanoma since 1990 and almost 2.5 fold increase in non-melanoma (Cancer Research UK., 2018). Skin cancer in general, have a lower incidence in the most deprived areas of England and this goes in line with the statistics for Waltham forest, making it in 20% of deprived areas in the England (Public Health England., 2016).

Melanoma of the skin or cutaneous melanoma is the most aggressive form and occurs when melanocytes undergo an uncontrolled growth and become malignant (Schofield., 2009). Melanoma can be cured via surgery if diagnosed and treated at an early stage, however, once the cancer metastasises, prognosis become poor with high mortality. Nevertheless, there has been a significant progress in the understanding of molecular mechanisms involved in the progression, which has led to the development of BRAF inhibitors in the immunotherapy, improving the prognosis (Mackiewicz et al., 2018).

Non-melanoma is divided into two main types as basal cell carcinoma (BCC) and squamous cell carcinoma (SCC). BCC affects the basal cells of the epidermis and is the most common type of skin cancer in the UK, representing 3/4th of the non-melanomas (CRUK., 2017). It almost never causes mortality but can metastasise to local anatomical areas. On the other hand SCC accounts for almost 1/5th of the non-melanomas. It has an ability to metastasise and cause mortality. One of the important causes of SCC is excess exposure to ultraviolet light, resulting in transformation of keratinocytes cells in the epidermis of the skin. Excessive ultraviolet light can also result in scaly areas of pre-cancerous patches or crusty lesions known as Actinic Keratosis (AK) or Bowen's disease that can change into SCC overtime, if untreated.

During my elective period, I came across many patients who were referred from the primary care for suspected skin cancers and required biopsy to be taken.

Before starting this elective, my understanding of biopsy was that it required a small sample of tissue to be obtained from the skin and the specimen was then examined under the microscope; checking for any histological changes. However, during my time in biopsy clinics, I came across different types of biopsies, such as shave, punch and excisional and their role in obtaining skin samples as well as removing lesions. Some of the conditions I came across for which biopsy was indicated included acitinic keratosis (AK), skin cancers (BCC, SCC and melanomas), skin tags, psoriasis, and suspicious moles.

I recognised the role of a dermatologist in taking full consent from a patient. I recall an 18-year-old male who presented with widespread rash over his hands that could not be well explained by his history and a punch biopsy was indicated. The patient was needle phobic and was anxious about the whole procedure. Could his anxiety be due to a lack of understanding? Well, I saw how the registrar took her time to explain the procedure thoroughly, including potential risk/complications and answering many questions that the patient had. I could see a sense of confidence on patients face prior to taking biopsy and he seemed more comfortable throughout the procedure.

In another occasion, I saw a 37-year-old female who was worried about having a scar, as one of the complications of punch biopsy. I think, when it comes to biopsies, no matter how experienced the dermatologist is, the likelihood of a scar in inevitable and must be well explained before the biopsy is carried out so that the patient is informed well of the consequences. It reminded me of an ethical lecturer in my early clinical years by Dr. Epstein, which explained that for consent to be valid, the patient must have sufficient information to make a choice.

Reference:

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