ONCOLOGY

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Elective Report 2012

I chose to undertake my elective in Harlow studying the diagnosis and treatment of facial skin cancer. I have previous experience seeing a few patients in clinics and taking punch biopsies but had few opportunities to observe their removal or reconstruction. The oral and maxillofacial department in Harlow was ideal for my choice of subject as it has a joint dermatology and maxillofacial clinic run every week, an MDT once a week and plenty of operating sessions. I already had close links with the department and know my supervisor from ongoing on call commitments. Although UK based and close to home, I aimed to improve my understanding and exposure to this increasingly common condition in order to aid in future career.

Being based at home I commuted to Harlow on a daily basis and observed and assisted in the clinics and operating lists not just for the skin cancer patients but more general oral and maxillofacial patients as well. The operating lists I observed were mainly those removing and reconstructing facial tumours under local anaesthetic. This technique provides a rapid turnaround of patients and the possibility of operating on all age groups and medically compromised patients. As one of the key risk factors for this disease is age, this ability to operate without general anaesthetic enables almost all of these cancers to have surgical treatment. Other operations being undertaken were salivary gland, dento-alveolar and trauma. It was clear to me the resection of most facial skin cancers is usually relatively straightforward to the experienced surgeon. The more difficult aspect is aesthetic reconstruction. Operating on the face, the planning of the incisions requires not just experience and knowledge of the skin structure but also the patient's wishes. Some elderly patients are more willing to accept reconstruction with skin grafts that may not be accepted in younger patients. The tension the skin can be placed under alters with age and subsequent revisions may be required to achieve the best possible result.

A large majority of the cases seen in the department were basal cell carcinomas but there was also SCC and melanoma. The link between facial skin cancer and sun exposure is widely documented. The other main risk factor is age. The cumulative impact of UV exposure especially in the younger years of life leads to a large increase in rick of SCC and BCC. Currently the number of new cases is increasing possibly due to increasing intensity of radiation form the sun and an increase in foreign travel, especially holidays. Traditionally BCCs were considered to be a disease of the elderly but I observed many younger patients attending the clinic, some in their 30's.

The typical referral pattern of skin cancer patients in the UK follows attendance to the GP referral to a dermatology clinic, biopsy, review, referral to surgeon then excision. The initial referral is usually under a 2 week wait but then there is a delay following the initial assessment and being seen by the surgeons. Most of this delay is logistical in nature, waiting for letters to be dictated and posted and processed. At Princess Alexandra Hospital there is a joint dermatology and oral and maxillofacial clinic. This eliminates the

delay enabling a smoother patient experience. It also enables there to be a discussion surrounding different treatment modalities resulting in optimal patient care. The once weekly MDT with histopathologists, dermatologists, oncologists and surgeons enables in depth discussion for each skin cancer patient coming through the trust. These links between specialities, although difficult to set up initially, provides a much faster and more efficient service and is a good model for many departments nationwide. The ability to discuss diagnosis and treatment at one visit eliminated a lot of worry from the patient and I observed them relaxing with this extra information, without a worrying delay.

The surgical treatment of facial skin cancer is performed by many different surgeons with an interest in the field from oral and maxillofacial specialists to general surgeons to plastic surgeons to dermatologists. Each NHS trsut utlilises its own preference which is usually historical in origin. The Oral and Maxillofacial Surgeons are becoming increasingly involved in ths area not only due to their extensive work on the face and knowledge of aesthetics but also as trained dentists they have extensive experience of treatment under local anaesthetic. However the training pathway in Oral and Maxillofacial Surgery does not encompass aesthetic reconstruction and trainees usually have to seek out opportunities for practice.

My time spent in Harlow has vastly increased my knowledge of patient presentations and the demographics of the disease. I also found out about alternative techniques, such as photodynamic therapy, with which I was unfamiliar. The flap design for aesthetic reconstruction remains an area I would aim to work on more throughout my training process for which I would like to maintain the contacts forged during the elective.