key points

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Basal cell carcinomas (BCCs) and squamous cell carcinomas (SCCs) are clinically and pathologically distinct and both are locally invasive. However, while BCCs rarely metastasise, SCCs have the potential to do so especially when they arise on the ears or lips. UV radiation is the most important risk factor for non-melanoma skin cancer (NMSC). The tumours most commonly arise in fair-skinned individuals on sun-damaged skin, especially the face. Incidence rises with age. Patients with one NMSC have a higher risk of developing another NMSC and of malignant melanoma.

SCCs are frequently more difficult to diagnose than BCCs. The clinical features depend on the degree of differentiation. Well differentiated lesions have a pronounced keratotic element, while poorly differentiated SCCs tend to be pink or red papules or nodules, lacking keratin, which may ulcerate. Tenderness can be a strong indicator of malignancy.

Around 5% of SCCs metastasise. High-risk SCCs include those: on the ear, lip, or sites unexposed to the sun and in chronic ulcers, scars or Bowen's disease. SCCs > 20 mm in diameter or > 4 mm in depth are high risk. Patients who are immunosuppressed, have poorly differentiated tumours or recurrent disease are also at increased risk.

Patients with a slowly evolving or persistent skin lesion where cancer is a possibility should be referred to a dermatologist. Lesions suspected of being BCC should be referred routinely. Urgent referral should be reserved for cases where there is concern that a delay may have a significant impact because of the size or site of the lesion. Any non-healing lesions > 1 cm with marked induration on palpation, showing significant expansion over eight weeks, should be referred urgently as they may be SCCs.

Treatment options for BCCs can be divided into non-surgical and surgical techniques, with the surgical options further divided into excision or destruction. Surgical excision is the treatment of choice for cutaneous SCCs. The goal is complete removal (or destruction) of the primary tumour and any local metastases.

Generally, patients treated for a single primary BCC are at low risk of recurrence. They should be given sun protection advice and warned of the risk of developing a second primary (almost 40% in five years), and are suitable for self-monitoring or follow-up in primary care. There is a strong case for following up patients with recurrent or multiple BCCs in primary or secondary care.

In SCC, early detection and treatment improves outcomes for patients with recurrent disease. Patients should be told to self-monitor their scar site, and local skin and to look for regional lymphadenopathy. Most relapses occur in the first five years after diagnosis and therefore patients with high-risk SCCs are often followed up for at least two, and up to five, years in secondary care.