

皮膚癌須知

簡介

皮膚癌是指一些不正常的皮膚細胞不受控地生長。原因大多是皮膚被紫外線過度照射，如太陽或人工太陽燈。那些不被配對的去氧核糖核酸(DNA)損害了正常的皮膚細胞，導致基因突變或缺陷，它們不斷繁衍，造成惡性腫瘤。皮膚癌大致有三十多種，其中百分之九十九可歸立為基底細胞癌、鱗狀細胞癌和黑色素瘤。前兩者是最常見的皮膚癌，而黑色素瘤卻是最致命的。

基底細胞癌

- ◆ 這是最常見的皮膚癌，但罕有會擴散到其他組織
- ◆ 這是位於皮膚表皮層最底的基底細胞不正常地生長
- ◆ 徵狀如潰瘍、紅斑、粉紅色腫起的皮膚增生或疤痕
- ◆ 久不癒合的傷口是早期徵狀



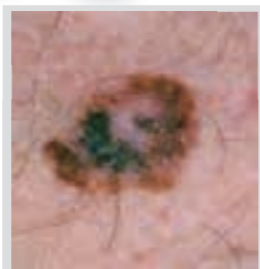
鱗狀細胞癌

- ◆ 這是第二常見的皮膚癌
- ◆ 源於表皮層最上層的鱗狀細胞不正常地生長
- ◆ 徵狀如疤痕狀的斑，厚且粗糙，輕擦也會流血，它有時會看似疣或邊緣腫起的潰瘍
- ◆ 大概百分之五的鱗狀細胞癌會演變成腫瘤轉移



黑色素瘤

- ◆ 這是最罕見但最危險的皮膚癌
- ◆ 黑色素瘤的腫瘤細胞源於皮膚表皮底層的黑素細胞，原用作製成色素
- ◆ 它的顏色可深如黑褐，也可淺如粉紅、紅或紫色；它會於短時間內迅速變大；其形狀、顏色和邊緣變化都是複雜和多元化的
- ◆ 它是容易流血和變成潰瘍
- ◆ 亦會通過淋巴系統擴散到身體的其他部位



診斷方法

- ◆ 要確診皮膚癌，抽取組織化驗是最準確有效的方法
- ◆ 電腦掃描、磁力共振掃描和正電子發射斷層掃描等放射檢查也能協助診斷繼發性腫瘤

治療

要妥善處理皮膚癌，醫生需要考慮其位置、大小和會否擴散至身體其他地方。治療惡性皮膚腫瘤需要跨學科的醫療團隊的共同參與、合作，如皮膚科專家、骨科醫生、整形外科醫生、腫瘤科專家、放射治療專家及病理學家，他們會提供相關專業知識和服務，令病人得到最適切的治療。

簡單的治療程序，如局部切除術、冷凍治療和外用藥物咪喹莫特，都可由皮膚科專家在診所完成。但如果皮損的範圍太大，腫瘤切除和軟組織瓣重建等大型的手術便更有效。

當癌細胞已擴散到淋巴系統，淋巴結切除術也可以幫助控制病情。

倘若腫瘤因某些原因不能切除但產生併發症，截肢手術便可能是最後的選擇。

手術前的準備

大型手術如淋巴結切除術、重建手術和截肢手術，有以下的準備：

- ◆ 健康評估及檢查
 - 血液檢驗
 - 心電圖
 - 尿液分析
 - 根據需要作掃描檢查
- ◆ 會見麻醉科醫生及骨科醫生
- ◆ 簽署手術同意書
- ◆ 病人需戒煙，並學習深呼吸運動，以減低手術後肺部感染
- ◆ 病人教育，包括術前術後的護理

手術後的護理

- ◆ 傷口及引流處理
 - 應保持傷口敷料清潔及完整
 - 術後的引流可幫助傷口排出瘀血以防止血清腫形成，待瘀血量減至最少引流便可拆除
 - 臉、頸的傷口縫線，大多於術後七天可考慮拆掉；而四肢的縫線則需要十四天
 - 醫護人員會密切監察皮瓣的情況，如皮瓣溫度和靜脈堵塞



◆ 止痛方法

- 麻醉科醫生會為你選擇最適的止痛方法，包括：
- 口服或注射止痛藥

- 持續性阻斷神經的止痛輸液
- 自控止痛機 (PCA)



◆ 患肢的護理

- 用枕頭墊高患肢以助消腫。
- 一般情況下，術後患肢可能需休息一段時間。
- 截肢手術後，病人應配帶彈性繃帶或夾板來減少殘端腫脹和預防攣縮。
- 病人可由護士或物理治療師協助下床坐椅或使用助行器步行。



併發症

1. 傷口感染: 傷口紅腫、痛楚或有不正常滲液從傷口流出
2. 皮瓣壞死
3. 下肢深層靜脈栓塞
4. 殘端攣縮

出院後護理

- ◆ 傷口敷料必須保持清潔及完整，如有紅腫、疼痛、滲液等發炎徵狀，應立即求診。
- ◆ 必須按時覆診。
- ◆ 回家後要按照物理治療師和職業治療師的訓練繼續做運動練習，以促進復康療程。


如有任何查詢，請聯絡閣下的主診醫生

以上資料由瑪麗醫院矯形及創傷外科提供



瑪麗醫院
Queen Mary Hospital

皮膚癌須知
SKIN CANCER

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SKIN CANCER

Introduction

Skin cancer is the uncontrolled growth of abnormal skin cells. It is largely caused by over-exposure to ultraviolet radiation from sunlight or tanning beds. Unrepaired DNA damage to the skin cells result in mutation or genetic defects that cause the cells to multiply and form a malignant tumour.

There are approximately 30 different types of skin cancer. About 99% of these can be grouped as Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC) and Melanoma. BCC & SCC are the two commonest types while melanoma is the deadliest form of skin cancer.

Basal Cell Carcinoma

- ◆ It is the commonest form of skin cancer, but rarely do they metastasize
- ◆ An abnormal growth of basal cells which line the deepest layer of epidermis
- ◆ It looks like open sores, red patches, pink swollen growths, or scars
- ◆ A non-healing lesion can be an early sign of BCC



Squamous Cell Carcinoma

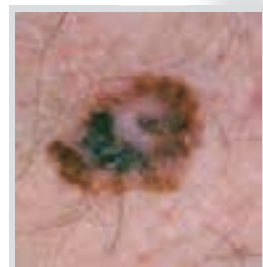
- ◆ The second most common form of skin cancer
- ◆ An abnormal growth of squamous cells which line the epidermis

- ◆ It appears as a thick, rough, scaly patch that can bleed if scratched. It often looks like warts or, appears as open sores with a raised border
- ◆ About 5% of primary SCC develop metastasis



Melanoma

- ◆ It is the least common but most dangerous form of skin cancer
- ◆ The malignant tumour cells originate from the pigment-producing melanocytes in the basal layer of epidermis
- ◆ They are black or brown but can also be pink, red or purple. The size can increase over a short duration. The shape, colour and the edge of the lesion are heterogeneous
- ◆ It can bleed and ulcerate
- ◆ It may metastasize via the lymphatics



Diagnostic Tests

- ◆ Biopsy is the gold standard for confirmation of skin cancer
- ◆ Imaging like CT, MRI and PET scan may be used to help detect metastasis

Treatment

In order to treat skin cancer, surgeons would consider its location, size and whether it would spread to other regions of the body. A multi-disciplinary team approach would be employed; Dermatologist, Orthopaedic surgeons,

Plastic surgeons, Oncologists, Radiologists, and Pathologists would work together to provide the most appropriate treatment and care for the patient.

Resection, cryotherapy, imiquimod application are common procedures carried out in the clinic by Dermatologists. More extensive resection and reconstructive procedures in the operating theatre may also be required for larger lesions. Lymphadenectomy may be helpful in cases with lymphatic involvement by the cancer.

In extreme cases where the cancer is unresectable but causes debilitating symptoms, limb amputation may be the last resort.

Pre-operative Preparation

For major operations like lymphadenectomy, reconstructive surgery and amputation:

- ◆ Investigation
 - Blood tests
 - Electrocardiogram
 - Urinalysis
 - Imaging if necessary
- ◆ Assessment by Anesthetist and Surgeon
- ◆ A written consent is required
- ◆ Quit smoking and practice deep breathing exercise to prevent postoperative chest infection
- ◆ Patient education on pre- and post-operative care

Postoperative care

- ◆ **Management of wound and drain(s)**
 - Dressing must be kept dry and intact
 - Wound drainage is inserted when necessary for removing exudate from wound to prevent seroma formation. It will be removed when the output is minimal

- Sutures on face/neck and limbs will be generally taken off on day 7 and 14 after surgery respectively
- Close monitoring on flap condition, e.g. local temperature and venous congestion



Pain relief measures

The Anesthetist will select the most appropriate pain relief measure. These may include:

- Oral analgesics or injection
- Continuous nerve block infusion
- Patient Controlled Analgesia (PCA)



Care of Operated Limb

- Elevation of the operated limb can reduce swelling
- Operated limb may be kept immobilized for a period of time
- If amputation is performed, dressing and splintage may be employed to reduce oedema and prevent contracture
- The patient can sit out of bed and practice walking exercise with assistance by nurses or physiotherapists if allowed



Complication

1. Wound infection: redness, swelling, pain or abnormal discharge from wound
2. Flap necrosis
3. Deep Vein Thrombosis
4. Stump contracture

Advice on Discharge

- ◆ If the wound becomes red, swollen, painful or wet, it may be infected. Seek medical advice immediately
- ◆ Attend follow up as scheduled
- ◆ Perform limb exercise and training as suggested by Physiotherapist and Occupational therapist to facilitate rehabilitation

Should you have any queries, please consult your doctor-in-charge

Information provided by Department of Orthopaedics & Traumatology, Queen Mary Hospital