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Dermatology

with Olivia Stevenson

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TRANSCRIPT

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Steven:

I'm joined by Dr. Olivia Stevenson, who is a consultant dermatologist lead clinician at Kettering General Hospital and who's appeared on the show once before was very, very helpful and informative about things we should be looking for when we're pouring all over our patients. Olivia, it's great to have you join us again. Thank you so much.

Olivia Stevenson :

No problem. Nice to be here. Thank you very much.

Steven:

Generally these days, for obvious reasons, I start by asking people how Covid 19 is affecting their practice. I mean, does it have any particular implications with dermatology?

Olivia Stevenson :

Well, I mean it's huge. It's a visual specialty and most of our patients don't have that easy access to video camera. So yeah, it's been quite a challenge. We have seen virtually no new routine patients at all for a couple of months. We're still seeing skin cancers and we're still following up the patients that we know by telephone because we've already made a diagnosis, but trying to do any routine checks is really pretty hard at the minute.

Steven:

So skin cancer is your biggest issue at the moment then? Is it?

Olivia Stevenson :

We're doing the two week waits. So I don't know how many of you familiar with that, depends mostly if you've had access to it yourself. But the two week wait means that if your GP is worried about cancer, you will be referred to two wait. So we're still seeing all of our rates except for patients who prefer, maybe because they're shielding to send us a photograph. But most of them are coming in. And of course most of them don't have skin cancer. The trouble is because the GPs know that actually the two week wait is the only way to be seen at the moment. They're referring maybe a little bit more inappropriately than you should.

Steven:

Well tell me about the two week wait. That is, they have to be seen within two weeks of being referred.

Olivia Stevenson :

So every cancer across the board. So it's not just skin. So if your GP thinks you might have a cancer of any type, you get referred in on what's called a two week wait. It's a special tracking which been going on for maybe 10, 12 years at least. So that you will be seen or at least offered an appointment to be seen, whether you can make it within two weeks.

Steven:

I was under the impression that, not necessarily for skin problems, but that we weren't hitting that target particularly well over recent years.

OIivia Stevenson:

No. I think the target is quite high, 98% or something, I think we normally hit it and almost all, almost all of the misses are patients just not being around. They've left. They've gone on holiday or something like that. So no that two week wait target, we're pretty good at. It's the 18 week, that's the issue, which is we don't get them treated within 18 weeks of being seen.

Steven:

Okay. I see. So I mean, I suppose that we, osteopaths, chiropractors, physiotherapists, we find ourselves to a certain extent in the same position as GPs in that we may be the first people to spot something like this in a patient. Given that probably there are bits of their skin that they don't see themselves very often. Where would you like to start us on what we should be looking for?

Olivia Stevenson :

Yeah, I think that's a good idea. I mean it's a nice sort of example. I had a patient come in the other day who was booked for a little skin cancer here. And he said, but, you know, can you have a quick look? One of my moles on my back is itching. UI said, have you got nobody at home, he said, only my four legged friend, he's not very useful. And when he took his shirt off he had a very large melanoma on his back. You know, if he didn't live alone, I'm sure he would've come sooner, but, you know, so there are certainly opportunities to, uh, t k up cancers that patients are unaware of.

Steven:

How long had he been worried about that particular skin problem?

Olivia Stevenson :

It had been itching for several months. But he'd sort of kind of contorted and tried to see and realize that it looks a little bit different from his other moles, but unfortunately he hadn't mentioned it to anybody, but, you know, patients often don't, they, they don't know what to look out for themselves. Sorry, I thought I'd start with what, what sort of things you might look out for in moles. Um so let me try and share my screen here for a moment.

Olivia Stevenson :

So melanoma, actually I'm going to get back a bit. Melanoma is actually the fifth commonest cancer in the UK. So I think a few years ago it was, felt the melanoma was really quite a rare cancer and it is it is still unusual compared to the big four your breast, prostate, bowel and lung really. But it is becoming more and more common and unfortunately it's not a cancer of the elderly. So, I think, it's something that we really need to be aware of. We have about 21 new cases per a hundred thousand population in the UK. And although the instance does increase with age, we see melanoma in youngsters. So that's really an important thing to be aware of.

Steven:

I guess that the increasing incidents with age is just a statistical thing, isn't it? You've had more chances to get it as you get older,

Olivia Stevenson :

You know, the older you are, the older you get, virtually every cancer increases. But, compared with other cancers, it's not a cancer of the elderly, it is a cancer of sun damage. And so the older you are, the more sun you've had. So that's kind of inevitable. Right. But, what's interesting for you lot is that positioning because it's, it's quite, understandable because there'll be obviously skin cancer. One of the biggest things that causes skin cancer is direct sun exposure. So we know that probably nearly 90% of all skin cancer is caused by sun damage. And we know that actually for melanoma, the majority of sun damage occurs in youngsters. And the biggest risk is sunburned under the age of five. So it's important that we're all educating our clients and patients that, you know, some protection is vital, especially in the youngsters.

Olivia Stevenson :

The youngest melanoma I've had is 12 you know, we do see them younger than that. We have to assume that there is a genetic susceptibility and a genetic risk with melanomas of that age because they're not necessarily a sunburnt or skin type one. So there's something else going on. I think for the majority of melanomas that are occurring at typical sites with sun exposure, you know, excessive sun exposure, you're talking, you know, mid-twenties onwards, really. So where we burn is where we get skin cancer. And so for the men it's on the trunk and the back, especially because young men have a habit of taking their shirt off as soon as the sun shines. And for ladies it's the legs because of course we tend to wear shorts and short skirts and obviously looking historically over the seventies and eighties, the fashion school uniform is tiny little ankle socks and a skirt above the knee or shorts for the boys. So they're getting plenty of sun. And so I think it's really vital because a lot of people don't really pay any attention to moles, especially on their back. So that's quite a useful thing that especially in men, it is the majority site for melanoma.

Olivia Stevenson :

I don't know how many of you are familiar with the ABCDE. Patients get taught it if they're worried about moles. And we use it to try and identify whether or not you would be worried about a mole. And the simplest thing is this ABCDE. So it's asymmetrical. Its borders are irregular. Its got more than three colours of brown. It tends to be large and obviously it's evolving. It's changing. Its growing in some way. No, itching is not a reliable sign, so we get referred an awful lot of itchy moles and itchy moles are normally actually because they got caught or that they got inflamed or they've rubbed on a bra strap or something like that. Not usually because they're worrying, unless you've got something else of those going on. This chap that I had talked with you about a moment ago. Yes, his mole was itchy, but it was also six centimetres asymmetrical, you know, black and red and growing. So, you know, it ticks every other box as well. So things like itching don't tend to be an early sign. I don't tend to be a reliable sign unless you've got other things going on.

Olivia Stevenson :

And here's a picture of a relatively bog standard melanoma just before I'm about to give it a two millimetre surgical margin. So I mean, I think the first thing is, we've got quite a large mole here sort

of larger than the normal three or four millimetre moles. So we've got something that's a bigger than a centimetre in size and we've got dark brown, we've got light brown, we've got pink, and we've got no colour at all. So we've automatically got at least four shades of colour in that mole as well as the fact that every little bit of it is irregular. Now when you look at moles, they're not perfect. They're not perfect round things that have, that are, that have the identical features all throughout. But what I like to try and think of is that actually every bit of it is different from every other bit of it.

Olivia Stevenson :

So if you were to look at that bit there, that looks different from that bit there you know, or, or that bit there. Do you know what I mean? So that's what we mean by asymmetry rather than irregular because it can be tricky. Well, one of the other things which is really, really helpful in melanoma is that in general moles fade out. So if you were to look at this mole or this bit, it would be really hard for you to identify exactly where that Brown stops. Do you see what I mean? Yes, it fades out. Whereas right here you've got this very sharp black line and these sites should be fading out towards the periphery of a mole. And so it can be very difficult to identify exactly where it stops. Whereas when you've got growth at the edge of a mole, you've got that pushing margin of colour. And you can see that here. That's a real push of pigment pushing growth. So that can be very suspicious.

Steven:

Can I ask a slightly off target question here? What's the purpose of the purple ink?

Olivia Stevenson :

Oh, that's just me drawing around it before I cut it out.

Steven:

But why, why the angles? I mean, it's been drawn like an eyeball there, hasn't it?

Olivia Stevenson :

Well, that's what we call a surgical ellipse. So if I was to cut this out, so the standard for a mole is to remove it with a two millimetre margin. So we've got two millimetres round it. That's the blue circle. If I take something out as a circle, when I close it, we will end up with pocket edges at the top and the bottom. So we turn it into an eye shape, so it close easily.

Steven:

Don't try this at home. Anybody.

Olivia Stevenson :

So this one says, you know, I said more than three colours and of course you've only got two there, but you've definitely got this asymmetry. You've got a pinkie Brown mole with a black edge, with a black lump in it. So you know, it, you have to appreciate that none of these sort of tick boxes can be used without common sense as well. And black is rarely any good at all. So dark skin people will produce very dark moles, but anyone fair skinned will produce pinkie Brown moles. And so anything black is, is, tends to be quite suspicious.

Steven:

So presumably on black skin it must be very difficult to determine what is a nasty mole as opposed to an innocuous one.

Olivia Stevenson :

It can be very difficult except to say, and one of the things I'll talk about is, is first of all, black skin is very unlikely to get melanoma. Having said that I think Bob Marley died of melanoma, so there are exceptions, but in general, melanoma in dark skinned people doesn't tend to be sun triggered, so they behave very differently anyway. They tend to be a non-sun exposed sites. And also they still have lots of other normal moles. So it would be looking at the difference of that mole compared to their others. But it is very, very rare.

Steven:

I'll ask you before you move on. We had a question that came in a little while ago and I thought I might put it to you now. Ray has said that dermatological changes can be difficult to categorize. What are the subtle differences in spotting a cellulitis rather than a normal discoloration of the skin.

Olivia Stevenson :

Okay. Do we want to take away completely from moles or answer that later? I'm happy to.

Steven:

Very happy to come back to that one later. I mean I have to sort of try and juggle between trying to read the questions and keeping up with you and if you want to come back to that one later, that'd be great. Topic of cancer for now. That was fantastic.

Olivia Stevenson :

Okay. Thank you very much. Right. I have to wait. Sorry Ray, I'll get back to you on that one. So this one again, this is under a breast, so very unusual site and, and I was, you know, we have changes here but moles under breast often get traumatized by bras straps. So I was thinking maybe this is going to be nothing, but the thing is that edge here, again, it's very sharp pigment coming out here whereas it's fading away at this edge. So that was another melanoma. So asymmetry and irregularity are the big things with the changes in colour. And I, I tend to produce a bit of a top tips of your hints that that change is usually obvious. So if patients can see the mole, which clearly if they're on the back they can't, always, if they can see it, they've usually noticed change.

Olivia Stevenson :

So it's not typical that patients say I'm pretty sure it hasn't changed. It would normally be a change that is occurring month by month that they are aware of. So it's grown or it has become dark or it has changed shape. So if it's an easily visible area and there are adamant it hasn't changed unless it looks hideous. You're probably fine. As I said, black or almost black is rarely any good. We don't like black moles and look for that irregular margin, that irregular colour. And as I said earlier, itching and bleeding tend to be fairly late signs. Right. I don't know. Yes. So some people get confused between irregular versus asymmetrical. So this mole is not perfect. It's got a dark patch and a light patch. So the pigment is irregular, but this is symmetrical. If we cut it in half here or in half here, the top looks like the bottom, the left looks like the right, etc. Whereas this mole we've got, if we take a

little section of this bit, it looks different to this bit, which looks different to this bit, you know what I mean? So even though then you can probably only find maybe two or three shades of Brown, you've still got that real asymmetry and we've got these little dots of colour coming right up to the edge again. So that can be quite helpful.

Olivia Stevenson :

And again, we've got a pinkish mole with a black lump growing in it. So often melanoma can be fairly typical, but it's much more likely if it's a high risk site that changes constantly. That's another thing which I, we find patients say, well it scabs than it heals. And if it's going back to how the mole is used to look, then it's just getting knocked or traumatized or it's not a mole at all. So that change is constant week by week, month by month. It's getting darker, not waxing and waning. And that's kind of, yeah, where we are with melanoma.

Steven:

When you said that you've got that month on month change, which kind of answers one of the questions here from Tammy, which is what time scale do you mean of the things evolving with the ones that you showed us there if they were left untreated, how long before they became serious or irreparable?

Olivia Stevenson :

It's very difficult, very different for different melanomas. Some melanomas will grow very slowly. So if we go back to something like that, that could might be changed over six months to six years. Gradually changing from an insight to melanoma to a cancerous mole, which then becomes thicker and deeper. So, but we're normally talking months, we're not talking weeks except for nodular melanoma. And I'll mention that briefly in a minute and then put a pin in that in the moment. Normally with your flattish moles, they're changing steadily over weeks and months. And so patients will say, this time last year, it didn't look like this rather than this time last month. Nodular melanoma grows very rapidly and it produces a rapidly changing lump. But nobody ignores those because they, they act, you know, in such a horrific way. They develop as a big bleeding nodule. So you think you've been caught or you think you've got an infection or you know, something quite obvious. So even if you don't think it's cancer, you still tend to present because they grow very rapidly as that sort of bleeding nodule. So that's a slightly different thing.

Steven:

You say the word cancer to people and quite understandably, they go into a flat spin with melanomas, how, where would you place them on a spectrum of dangerous cancers? How readily do they metastasize and how quickly?

Olivia Stevenson :

Majority of the cancers that we see, we diagnose early and when we diagnose them early, so when they are generally flat. So looking at ones that maybe look a bit more like this I haven't got any other pictures. Let me, sorry, I'm flicking through. When you have flattish moles, we rely largely on something called the Breslow thickness, which is the thickness of the melanoma or the thickness of the cancerous cells. And we know that in very flat melanomas the chances of metastasizing are probably only about 5%. Whereas when...

Olivia Stevenson :

When you have something that looks more like this we've obviously got a very big mole. And it's got a lump within it. I mean that chat was dead in 18 months. So we have a significant risk associated with delayed diagnosis and patients with thicker melanomas probably have about a 40% five year death rate, so 60% five year survival. So it is an important cause of cancer related deaths. But in general, we can you know, more often than not, we can treat them well early.

Steven:

Carol has asked if a mole is black but he doesn't fit any of your other criteria, is it still something to worry about? Is it fairly common for moles to be fairly black?

Olivia Stevenson :

No. So okay, so that's quite black. As you can see, it's got spiky edges as well. But apart from that, that it doesn't really have a lot of the other changes. It's looking out for the ugly duckling. So even if this was only a few millimetres. This chaps are tea coloured. These are his normal moles. And so if you have a black mole in the presence of coffee coloured and tea coloured moles, then it is abnormal. If you have lots of black moles, that's because you produce black moles. But in general, black moles, no, they're not normal.

Steven:

Caterina has asked is giant congenital melanocytic condition. Moles all over the body is, are they more susceptible to melanomas?

Olivia Stevenson :

Okay. so there's two things you asked there actually. So giant congenital nevus is where someone produces a very large birthmark type mole. And over the years, the advice from that has changed greatly. It is now felt that all congenital nevi, so whatever the size, so all birth mark moles do pose an increased risk of developing a skin cancer. Giant congenital nevi, which means something that takes up more than 10% of the body surface area or is at least, more than 10 centimetres in size. They have a significantly increased risk of melanoma. And in fact, right now I'm dealing with two very poor prognosis melanomas in congenital nevi, both, moles have been there for many years, both of them about this sort of size. So, you know, not huge, the size of the Palm of a hand. And both of them have developed melanoma and both of them are doing poorly.

Olivia Stevenson :

So because they tend to present quite late, because you've had a birthmark there for many years, you tend to ignore that can be an issue. People with hundreds of moles are also increased risk of developing melanoma. So there are people who just have hundreds of tiny little normal looking moles and there are people who have hundreds of rather irregular, most all look different from each other. Both groups of patients are at increased risk of developing melanoma. So yeah, it's, it can be a real tricky thing if you do have a lot of moles.

Steven:

Before you move off that picture Allison's asked a question which occurred to me as well. In the absence of that very large mole in the centre, would the mole on the right be of concern?

Olivia Stevenson :

Yes. Well done. So that was the second one I removed. So it's also the ugly duckling, isn't it? It's also different from his other moles. It's slightly irregular in colour and in fact that was removed and that was a dysplastic nevi. So that's a mole that's behaving in an inappropriate but not cancerous way. But yes, exactly right. And you can also see if we get a bit closer. Probably that little edge here is a little bit black towards the edge whereas that one's fading out a bit. But yes, that would also be a cause for concern.

Steven:

Simon wants to know how you differentiate between melanoma and basal and squamous cell carcinomas

Olivia Stevenson :

Quite easily. We can move on to that. Once everyone's finished their melanoma questions.

Steven:

Okay, well the last, another one from your Caterina. How do you identify, how do you differentiate a wart from mole?

Olivia Stevenson :

Okay. Yeah. Okay. So the, the warts and we're not talking about your viral warts on your feet. You've verruca's. I'm sure everyone knows about those. Especially you've got podiatrist in the room as well, but your seborrheic warts which are your senile warts, age warts, whatever we're going to call them today. These are the things that look a little bit like a mole or a warty mole. Sometimes they just look like a freckle cause they can be very flat when they are very flat. It can be difficult to differentiate. And let me see. I'm bound to have some pictures. So seborrheic warts have this

Olivia Stevenson :

Warty greasy surface. And sometimes it can be quite obvious, but sometimes it can be difficult to distinguish. So here we are going to try and screen share. So seborrheic warts have this warty crusty surface and that can be a real off an easy thing to identify and sometimes it can be a lot harder. But one of the things, so this is a seborrheic wart and you might think that's an irregular mole because you've got Brown and black and white and yellow. But what we have with the seborrheic wart is a very stuck on appearance. And I sometimes, you can almost get your nail and pick it off almost. So that can be quite, if they're raised can be quite helpful.

Steven:

You're not recommending that I don't think you,

Olivia Stevenson :

No, no, no, no. But you know, bits of it will crumble away and a melanoma doesn't crumble off quite so easily. So it's also got these little cystic openings. So you can see here these comedo like openings, like blackheads, and he's got these yellow cystic pores as well. So those two three together stuck on appearance and these cystic the keratin cyst and comdeo openings are quite typical for

seborrheic wart. When they are completely flat, it can be difficult to distinguish. Now this is easy because it doesn't matter if it's a mole or a seborrheic wart because it's even in colour, it's bland colour. It's not worrying. But what can be quite helpful is that the surface markings within it tend to be more obvious. So can you kind of get the impression that the fingerprint here is more obvious then the surrounding skin? And I sometimes equate it when you've got a seborrheic wart,, if you dip your finger in the candle wax at Christmas, you get that tiny little coating over the skin. And that's what a seborrheic wart is like, it's just very much on the surface there. When they are very irregular, it can be really difficult and we do see an awful lot of them. But if you've got lots and lots of crusted warty moles then again, it's unlikely that you've got lots and lots of skin cancers.

Steven:

Do you differentiate between freckles and moles?

Olivia Stevenson :

So freckles are completely different from moles. Freckles don't turn into cancers or moles or melanoma at all. So freckles are just an increase in melanin. So we can all get freckles when the sun shines. Melanin is stimulated and that's what produces a tan. And in certain people it produces freckles. A mole is a, is an increased number of melanocytes. So cells that actually produce the melanin. So, clinically there can be some difficulty in differentiating without my special dermatoscope, my little tool that I use to magnify, but in general freckles look like freckles. They look more like this, this flat Brown sort of T stains on the skin.

Steven:

Yeah. I was just thinking back to the chat with the big black wart that you showed. There were lots of little blemishes which we might've thought of as freckles all around that. And you pointed to them and said, look, he's got lots and lots of these.

Olivia Stevenson :

Yeah, no, they're definitely nevi moles. Yeah. Quite tricky. So okay, so does that answer the seborrheic warts question?

Steven:

I think it does. Yeah. Caroline wants to drag you back to melanomas and she's asked, is it possible to explain how melanoma can begin in the brain or the eyes and not necessarily show on the skin?

Olivia Stevenson :

Yup. Okay. so melanoma is a malignant tumour of melanocytes. So everywhere that has melanocytes can produce melanoma. And unfortunately, although the biggest area to have melanocytes is the skin, it's not the only place you have melanocytes in your bowel, in the back of your eye and in your meninges. So a few other places, but those are the commonist. So those melanocytes in your, I protect your the back of your eye from being damaged by sunlight. In the meninges. I don't know what they're doing there, but they are there and that is the lining of the brain. So it's not in the brain, it's in the, in the lining of the brain and they're also in the bowel. And so you can have a primary melanoma. Mmm. In those sites. It's also, which is also probably what she's asking.

Olivia Stevenson :

It's also possible to present with metastatic melanoma and no melanoma. So they present with brain mets or with melanoma already in the liver or wherever with no obvious melanoma. And what's happened there is that the body has produced one of two things. Either you've got a primary bowel melanoma, ocular melanoma, etc, hidden melanoma or else you have had a melanoma, which has been fairly subtle, which has grown, like the one of the first one we show. So nothing really gross, which has grown in the body's immune system just as it should do for cancer cells, which is doing all the time. It has mopped up that melanoma but not before it spread. So the melanoma has been eaten away by the body's immune system and disappeared. But in the meantime, the melanoma has already spread.

Steven:

So will the first symptom then be of those hidden melanomas, would it, would it be the metastasis?

Olivia Stevenson :

Yes, absolutely. So they present just like any what we call metastisis of unknown primary. So we have patients who present with, with weight loss or with jaundice or with a collapse because of headaches or a space occupying lesion in the brain. So yeah, these are patients who present with, with no obvious cause and it's picked up on a CT scan.

Steven:

A couple of people have asked why peripheral melanomas are more dangerous.

Olivia Stevenson :

Okay. So we used to believe that melanomas on the palms and soles were more common. We know that that's no longer the case. They are however more aggressive that is true and that is just down to the type of melanoma. So as we've all probably more personally come across family, friends, relatives with breast cancer, you can have good breast cancer and you can have bad breast cancer. And with lung cancer it's the same and it's the same with skin cancer. So the commonest of melanoma that we see is something called a superficial spreading malignant melanoma, which is that the melanomas I've shown you the second commonist and I'm sorry, I'm going to, you can all close your eyes if you don't want to be dazzled. The second commonest and we can look at all of these lovely pictures that you're passing by in a minute if you like.

Olivia Stevenson :

The second commonest is your nodular melanoma, which I mentioned to you and that presents like that. So this is what I said, it's not subtle. Nobody's going to ignore that. So she's got a bleeding red lump on her back. She's very young. So that's the second commonist. You then have acral lentiginous melanoma and both nodular melanoma and acral lentiginous melanoma, which is your palms and soles are just a poorer prognosis melanoma. They grow more rapidly, they spread more rapidly, they metastasize more rapidly.

Steven:

Can I, can I get onto some melanoma related questions

Olivia Stevenson :

Okay. Do some other questions.

Steven:

We had the one about cellulitis and normal discoloration of the skin earlier on.

Olivia Stevenson :

Okay. So, I mean this one is a real pain and I used to do a little five minute presentation to the whole hospital because I get very frustrated that no one seems to be able to do this. So it's not just you. So cellulitis is an infection in the skin at any site. Commonly, we see it in the legs. Cellulitis is a quite nasty infection. And so if your patient bounces in quite well and hops up on the couch, they don't have cellulitis. And that's almost as simple as it gets. It causes fever in the older population. It can cause confusion. They feel really fluey and the skin is very, very tender. So with the normal skin changes that you can see the changes in colour, especially with lymphedema, sort of swelling in the lower legs, the skin doesn't tend to be particularly tender. Cellulitis, the skin is hot and tender with just normal sort of congestion of the skin. It just tends to be a bit dry and a bit woody feeling. Did Ray particularly talk about legs? He was talking about legs, wasn't he?

Steven:

I think he said yeah, he just said cellulitis.

Olivia Stevenson :

So, yeah. So so those are the big things. It's hot, it's painful, they are unwell, rather than the skin just being pink

Steven:

A paramedic said to me once that it was the worst smell he had every encountered in a casualty.

Olivia Stevenson :

Okay, let me get back. It's unilateral. So my bugbear is the bilateral cellulitis. I've seen twice in 15 years. You don't suddenly get an infection in both legs. So if you have bilateral red legs, it's because you've, you've got swollen legs or you've got eczema or you've got congestion, you know, just sort of venous congestion. No, the smell is if they've got ulcers. Cellulitis doesn't smell. Leg ulcers, oh my god, they smell.

Steven:

Elsbeth, she says, have you heard about covid toes, which she seen only on an American forum.

Olivia Stevenson :

So one of the strange associations, so there's two, there's two possibilities. Patients very sick with covid can get disseminated intravascular coagulation called the IC, very sick, very septic, ill patients almost always in hospital and they get black toes or almost like gangrene. It's slightly different issue because they are ill, everyone knows they are ill. However, as a quiet side of covid is this strange dusky blueness of fingers and toes which seems to be associated with a fairly mild disease. And it's

just, it doesn't need to be dealt with. It's a bit like a sort of temporary raynauds. You can reassure the patient, they're not going to, toes aren't going to drop off, just keep them warm. Use anti-inflammatories and isolate because you have covid, but

Steven:

Given that you were advising them that they might have covid 19

Olivia Stevenson :

If you have suddenly developed blue toes, you probably have covid.

Steven:

So would you then say, well you need to go see somebody about the covid, so rather than just self isolate or is it something self isolation is fine?

Olivia Stevenson :

Well now that government's changed, you should be trying to get a test. So it changes every day. I think in the moment if you think you have covid you are supposed to try a get a test, so you phone 111 and find out where to go to get tested. That's the advice if you have blue toes.

Steven:

Okay. Kathy's asked about the incidents of familial tendency to melanoma.

Olivia Stevenson :

Very rare. I mean, so we do have a small number of patients who are familial melanomas. There's two common genes and I can't remember the one, but the other one is a BRACA. So the same as the breast cancer gene, they can have a melanoma gene. And there was another relatively common, but actually, you know, more than 90% of my melanoma patients just had too much sun.

Steven:

Okay. And Claire actually said, is sunscreen the best protection?

Olivia Stevenson :

No. there's an issue with sunscreen and in fact there's a lot of debate up and down with sunscreen. I think certainly it cannot be used as your only method of protection. There are some studies that, that it increased the risk of skin cancer because, and I think that's because it lulls you into a false sense of security. SPF is very misleading. The fact that anything of an SPF less than 15 exists is should be illegal because it's against the the trade descriptions act because we have proven that anything less than SPF is giving you no extra benefit than, you know, the E45. So you should be using at least SPF 15. And what people don't understand is that that number relates to how much longer you should be able to be in the sun compared to if you weren't wearing anything. Now, everyone can probably imagine that if I can normally manage an hour without burning, if I put factor 30 on once, I'm not going to manage 30 hours. And that's because the lab studies are based at inappropriate in usable quantities.

Steven:

Yeah. Well also halfway through it would be dark.

Olivia Stevenson :

Okay. No need to be facetious, but it needs to be reapplied. If it's on your face, you wipe it off within moments. If you get wet, you know, it just rubs away. So sun cream is useful. I'd certainly advocate using a factor 50 on my face throughout the summer so that I don't get skin cancer and I don't get prematurely aged. But when it is very bright for fair skin people, you need to wear a hat and you need to avoid those sunny hours. And you don't want to get vitamin D deficiency so you still need to be out and about. It's that balance isn't it?

Steven:

Yeah, it is very difficult balance. Jonathan asked about large but regular, very raised moles.

Olivia Stevenson :

We see lots of large, regular, very raised moles. If they've always been large and raised then it's not a problem. If they are newly raised, suddenly it's probably because they got caught and inflamed. But if they have become, they've always been large and they've become raised over a period of weeks, months, I would be cautious even if they're regular. Change. You know, if a mole has not been changing for years and now it's changing, why is it changing?

Steven:

This is a peculiar one from Ruth. She says every time her son showers, he suffers from ridiculously itching legs. To the point that he takes an antihistamine one hour beforehand and wraps his legs in clingfilm afterwards as the only relief from the discomfort. No one has been of any help or any ideas other than he's a fit healthy 21 year old and has no allergies and no medication. What'd you think?

Olivia Stevenson :

Yes. Aquagenic urticaria. It's very hard to treat. He's allergic to water. So sometimes there are two types. It can be one is just cold water and one is water of any kind. Now obviously he's not just cold cause he doesn't share in the cold. A lot of, a lot of people will notice it to a lesser extent. I'm sure if you, if you've been out running in the cold and then you get in the shower, often you come out and you're really itchy, things like that. You know, people notice that change in temperature hitch. Some people are just very much more susceptible. You're getting mast cells. So histamine cells breaking down. When they touch water, it's kind of bad luck. He may find that it happens for a few years and then just stops happening. There's not a lot you can do.

Steven:

Yeah. Poor guy. Sally has asked about psoriatic arthritis and what you think is the connection between the skin reaction and the joints.

Olivia Stevenson :

That's really interesting actually. And if you want to invite me back, we could do psoriasis and psoriatic arthritis

Steven:

Glad you said that Olivia, because I was going to, we've had loads and loads and loads of questions and we can't ask them all, so say we'll have to get you back if you're prepared to come.

Olivia Stevenson :

Yeah, yeah, definitely. We'll do the other cancers one time and then we'll do some psoriasis. I think that would be useful because obviously you are seeing arthritis patients. So it's really important. Psoriasis is actually a multisystem disease. Psoriasis is not a skin disease. It is a complex immune phenomenon which is occurring in the joints and in the arteries. So it is very much a total body disease. There is no direct correlation with the amount of psoriasis you have on your skin with your risk or activity level of psoriatic arthritis. So you can have virtually no psoriasis and have awful psoriatic arthritis. And vice versa. However, any significant inflammation in either of those, the skin or the joints does convey some significant arterial inflammation. So it's really important. Patients are aware that actually this is an arterial cardiac risk factor, so they need to be addressing weight, smoking et cetera. The only thing that is a little bit better of a link is that severe nail disease and inflammation of their fingertips joints is much more associated with psoriatic arthritis, but otherwise they can have awful psoriasis and their joints can be fine.

Steven:

We're really pretty close to being out of time here, Olivia, but there've been several requests on this one about lichen planus. They'd love to know what the triggers are or any advice for managing it. It's for a long suffering family member who's had flare ups every 12 years.

Olivia Stevenson :

Okay. So we don't know the cause for lichen planus at all. Some people will pose a viral trigger, about 10% of people will get it more than once. So that's why she's getting it again. It treatments, there are three main treatments for lichen planus. So one is very strong steroids, which I'm sure is what she gets a strong steroid creams applied to the, to the rash when they're itchy. The second is being on drugs that can control it internally and the commonist would be a retinoid. So people have probably of Roacutane for acne. It's similar to that. It's called acitretin. We use it for psoriasis and it's also helpful for like complainants. And the third, which can be very helpful is light treatment. And if she's getting flares every 12 years or so, probably light treatment is going to be the way to go because you can try and nip it in the bud and you're not going to be worried about having light treatment every other year because if we can suppress it quickly, we might be able to get you into a remission for another decade.

Olivia Stevenson :

For light treatment, we use UVB phototherapy, which should we use a narrow band of UVB light, which has the highest penetration into the skin with the least amount of unnecessary toxic UV to cause skin cancers. Do you think we've got time to go back to differentiating between melanoma and basal and squamous cell carcinomas? Yeah. Okay. That's the last one. There'll be no more questions. Okay. So in general melanoma, we're looking at a mole that has changed. Okay. I'm going to have to go back to screen-sharing badly just to make you all dizzy. So let's share that and then I'll try and have a play around before you invite me back, see if I can work it out. Is that sharing? So melanomas, melanomas, melanomas, melanomas, melanomas, melanomas, quite obvious.

Melanoma. That one. Hopefully no one's gonna miss that one. So squamous cell carcinoma is a fleshy lump, so we don't have any different, any, any worry about differentiating. And they're rapidly growing fleshy, warty lumps. So they're, they're totally unsubtle lumps.

Olivia Stevenson :

So sometimes they get misdiagnosed as melanoma only because somebody says, well, we've got a black crust on it. It's the crust. It's a scab. It's not the melanin. So in general, the only difference is that it's difficult to differentiate an amelanotic melanoma, that big red lump on the back we saw a little while ago, but there's so much rarer than an squamous cell carcinoma that you know, if you've got a rapidly growing fleshy lump, it's probably a squamous cell carcinoma. The other thing that's really important to know is it squamous cell carcinoma, you have to have an awful lot of sun. So we don't tend to see them under the age of 50. And most of my patients are over 70. Basal cell carcinoma very slowly changing. We'll have to go back to all these lovely pictures won't we. Basal cell carcinomas are shiny, slowly growing. Mmm. Pearly lumps, which scab and heal, scab, heal, scab and heal. They can be pigmented, but they're rarely, but there's this very, very common story of it almost healed up and then it scabs and weaps and bleeds, and then it heals and that it scabs, weaps and bleeds. And so you tend to get a lot of it from the history, but again, not normally pigmented. I hope that answers that.