# Basal Cell Carcinoma in an Elderly Patient

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DR. GEORGE H. THOMSON *(Assistant to the Director, Office for Family Practice):* I would like to introduce this discussion of the complexities of a simple problem by reading a note from a daughter of one of our patients. "Thank you for seeing that our mother was treated for the cancer of her face. We saw her this past week and the spot has healed beautifully." Their mother, Maude, is an elderly woman who was hospitalized for care of a basal cell carcinoma of her face. Now, Dr. Gould, you were the admitting resident, will you present your findings on Maude's admission to the hospital.

DR. JOSEPH E. ROSS *(Assistant Director, Office for Family Practice):* Dr. Thomson, before we proceed, you have introduced today's patient by her first name. We are reminded frequently that we should not address our patients in such familiar terms as a first name. Would you care to comment?

DR. THOMSON: The subject has received much recent coverage in medical literature and even more in Ann Landers' columns. How you should respond will depend on the style you and your patients adopt. In our village we get to know everyone and his pet dog by first name or nickname. The informality spreads to everyone calling me "Doc," but that has been true since I was five years old and made calls with my father. I would feel uncomfortable addressing most of my patients by their surnames.

How you address your patients should be based on whatever system ensures the most effective communication. As we go on, you will see presented a serious problem of communication with this patient because of her dementia. She spends most of her days in a commons room with about 20 others who have a greater or lesser degree of mental senility. Classically, these patients develop a retrograde memory loss. Each patient in such a condition responds best to his or her childhood given name or nickname, possibly for the same reason I respond more readily among friends to Doc than to George. Further, in the patient's environment, addressing each person with "Mister," "Miss," or "Missus" would produce a constant sibilant dissonance. You should develop your own style based on what your patients teach you, not what I might tell you. In our village, however, if you were always to use surnames, you would be ostracized as too aloof.

Now, Dr. Gould, you may present the problems of the patient.

DR. SUSAN GOULD *(Third-Year Resident in Family Practice):* Because we had discussed the problems before admission, I was only partly surprised when I first saw Maude. I knew that she was 90 years old, would not be oriented, and might be belligerent. However, she was totally uncooperative, combative, and incoherent. She was lying in a fetal position with the covers over her head. This mental status had been present for at least five years. She had moderate kyphosis, which was especially noticeable when she was sitting in a wheelchair. Although she was thin, her color and strength showed her to be in an excellent nutritional state.

Over the next four days I was able to do a complete physical examination, piecemeal though it was. I could not find any evidence of serious systemic disease.

Her skin presented two problems. She had multiple senile keratoses over her face, neck, and upper half of her body, which she constantly rubbed and picked, keeping many of them inflamed. They were all benign in appearance, but on the left side of her nose there was a 1.5-cm ulcerated lesion with a heaped-up border surrounding a nonhealing crater. The lesion had been present for one year. The appearance was that of the textbook lesion of a basal cell carcinoma. The depth was still shallow, and it did not involve the underlying bone or nasal mucosa.

The plan was to sedate her sufficiently so she could receive radiotherapy to the nose lesion.

DR. THOMSON: In the older British literature you

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will find that basal cell carcinomas were called rodent ulcers. A graduate of 50 years ago was asked about these lesions on an oral examination, and he said they got the name because "they just sit there and gnaw and gnaw." To understand the concern about Maude's nose, I would like to ask Dr. Johnson to describe the natural history of such lesions.

DR. LEBARON P. JOHNSON *(Director, Office for Family Practice):* Those of us who had the experience of seeing never-treated skid-row patients in our early training have the responsibility to interpret the far-advanced natural history of such diseases as this to those of you who may never see such a lesion.

I found it difficult to find a color atlas that showed terminal lesions. Apparently, photographic and printing technology came along after successful means of treatment. As a result, there is a dearth of good pictures of endstage lesions.[1] Even then, such pictures cannot stimulate the five senses for understanding the unrelenting pathological progression of a rodent ulcer.

It is because we have become proficient in treating basal cell lesions that we have very few examples of advanced disease to show students and residents today. Five-year cures should be expected in 100 percent of lesions of the size described here. If not treated, however, the central ulcer would deepen and ulcerate more within a few months. This progression would be accompanied by secondary infections with the borders becoming inflamed and itchy and painful. Basal cell lesions enlarge by relentless continuity. They do not metastasize to remote areas by lymphatic or hematogenous spread.[2,3] They do "gnaw" away. They have no respect for any tissue. Within two years I would expect there would be a doubling of the size and depth of this tumor. It would have eroded the ala of the bone, completely demolishing the skin on through to the mucosa. One would be able to see the mucosa of the septum through the hole in the side of her nose. The mucosa overlying the front of the turbinates would be starting to ulcerate. By the time the tumor invades bone or mucous membranes, there is no turning back its course. Attempts to excise beyond the tumor border in these tissues are very disappointing.

Within three to four years a horrible-looking, infected, and draining cavity large enough to hold a ping-pong ball would have grown. In spite of the total local destruction of tissues, there is little systemic effect. The patient's eventual death is rarely directly attributable to even the most virulent lesions. Respite from the progressive erosion usually comes from heart failure, kidney failure, or other complications of old age, not from the cancer.

DR. ROSS: This last point was one of many issues that arose when I first saw the patient in the nursing home, where she has been cared for the past five years. Does a relatively slow-growing tumor need to

be treated in a person who already is 90 years old? Another way to ask the question is, "What is the life expectancy of a 90-year-old lady?" From the United States Life Tables, I have found that on an average she could be expected to live over five years.[4] From Dr. Johnson's description one should conclude that treatment was indicated.

In addition, Dr. Gould's investigation found only two known risk factors: her kyphosis and dementia. There is some evidence that longevity in the elderly is inversely related to the kyphotic angle, but not in a calculable way. Her dementia has placed her in a controlled environment of care, and she receives better nutrition and more physical stimulation than when she was living at home.

Therefore, one cannot say that she is either too old or too sick to withstand treatment.

A RESIDENT: What about the Moh's chemosurgery technique used by plastic surgeons where the lesion is totally excised under guidance from the pathologist doing sections during the surgery? It sounds as if her general condition could tolerate an anesthetic.

DR. ROSS: After the excision down to normal tissue, the defect would have to be covered by a skin graft. I could not imagine this poor lady leaving the graft alone for six hours, let alone the 16 days or so needed for it to grow.

A RESIDENT: Then what about using some of these chemotherapy preparations such as fluorouracil in gel or colloidal suspension?

DR. ROSS: The problem would be the same as for postoperative care of a skin graft, only worse. She would pick off the agent, or more likely, spread it around. I believe she would have severe conjunctivitis within a week, and the usual course of such a treatment is daily application for 10 to 12 weeks.

A RESIDENT: Does one ever use electrodesiccation or electrocautery on a basal cell cancer rather than the x-ray procedure or the ways just mentioned? That would be a one-shot type of treatment.

DR. JOHNSON: I can answer that from experience. Electrocautery or desiccation is a way to treat a very small lesion, say 2 or 3 mm in size, though it may not be the best way. The goal of treatment is to eradicate the lesion completely and create a safe margin surrounding it. A word of caution about the desiccator, however. The energy of the spark may extend much farther than appears at the time of the procedure. I have seen sloughing of charred tissue for as much as 3 or 4 mm beyond my directed burning. It is very hazardous to use a desiccator where the underlying mucous membrane could be damaged by the scattered current, as over the nose. The same is true on the eyelid and to a certain extent over the cartilage of the nose or ear. Because of the cautious approach needed, an adequate depth of desiccation may not be obtained, and there is no way to know it until you get a recurrence.[2,3]

DR. THOMSON: I met with Maude's three daughters and the director of nursing at the Medina Nursing Center where Maude lives. We reviewed the issues we have discussed here. It was agreed that treatment was indicated to prevent progression of the lesion. One daughter is a nurse, and one has worked in a family physician's office for about 40 years. They knew the prognosis without explanation. The third daughter lived closest and would have had to provide transportation if required; she felt unable to handle Maude by herself if frequent trips for treatment were needed. The director of nursing said there was no way she could assure care for a skin graft or the chemotherapy routine without restraints and sedation. We all agreed that these were not appropriate options. Nursing care policy at Medina is no restraints. With all of her fighting nature, Maude has never been restrained.

The Medina Nursing Center is in a rural village, 25 miles from the tertiary hospital. I talked to Dr. Joel Busse, the Director of Radiation Oncology at the hospital, and described the lesion. Would he be willing to schedule a time to treat this cancer in the shortest time possible? He was very cooperative. Without seeing the patient and relying only on my clinical judgment, he scheduled four treatment sessions over a five-day period. He planned to see her at the first session, look at the lesion to ensure the plan was appropriate, and then start the precalculated 800 rad per treatment, which would require the patient to hold still for seven minutes with each treatment. Maude could have the first treatment Monday afternoon and the last treatment on Friday.

Hospital admission was planned by Dr. Ross, the daughters scheduled their shared role, the nursing center readied her for transfer, and Drs. Ross and Gould were waiting.

DR. ROSS: We had discussed the problem before Maude was admitted and decided we would use a sedation combination we find works well in our pediatrics practice. Maude weighs approximately 115 pounds, and we gave her 50 mg of Demerol, 25 mg of Phenergan, and 25 mg of Thorazine intramuscularly one-half hour before she was scheduled to be transported to Dr. Busse's department. This dosage was considered to be safe, and it worked so well we did not vary it for her three subsequent treatment sessions.

DR. GOULD: I did most of my examinations while Maude was still under sedation. She did not once strike out at me. The only noncooperation at any time in her care was on the part of the floor duty nurses, who felt that my doing a pelvic examination in her bed was more than such an old lady should have to endure. I wonder whether it was more the inconvenience to

them rather than their concern for the patient. I must admit I was not a dedicated team member until I had heard about the life expectancy data that Dr. Ross presented. It certainly changed some of my perspectives on geriatrics and influenced my reasoning so much that I now believe all physicians should keep available a copy of this table of average life expectancy of people over 80 years of age.

DR. THOMSON: For the healthy, ambulatory, cooperative, elderly patient with an early basal cell carcinoma, the family physician has several options at his disposal. In this instance they were very limited and costly, but I believe the results were worth the $1,600 total expense incurred by inpatient treatment of such a small lesion.

The treatment of Maude's cancer could not have been done without the understanding and cooperation of the family, the nursing home, the hospital, our training program, and Dr. Busse. There is one final lesson here that may have escaped your attention.

A respect for clinical judgment can be gained just as well by a family physician as a tertiary care specialist. To do even a small biopsy would have opened this lesion for the patient to pick. Dr. Busse assumed from my description and from my experience that he could be assured the assessment was correct. He said that if his clinical judgment matched mine, we would go ahead with the treatment plan. Therefore, Maude's little rodent ulcer is now gone, but we do not have a pathology report. Dr. Gould says this bothers her. Maybe I can allay some of her discomfort.

Most, if not all, family practice residencies use the problem-oriented medical record (POMR). This system was introduced by Dr. Lawrence Weed in his classical article entitled, "Records that Guide and Teach."[5] The crux of his idea was that the primary responsibility of the physician is to solve problems for the patient. If there is a sine qua non of family medicine, it is that the physician be a problem solver, even if without an established diagnosis. It is not necessary that all patients die in electrolyte balance, nor is it necessary that a pathological diagnosis be on every chart.

## References


1. Sharvill DE: Skin Diseases, Pocket Directory Guides to Clinical Medicine. Baltimore, Williams & Wilkins, 1984
2. Andrade R, Gumport GL, Popkin GL, Rees TD: Cancer of the Skin: Biology-Diagnosis Management. Philadelphia, WB Saunders, 1976
3. Helm F: Cancer Dermatology. Philadelphia, Lea & Febiger, 1979
4. Life Insurance Fact Book. Washington, DC, American Council of Life Insurance, 1984
5. Weed LL: Medical records that guide and teach. N Engl J Med 1968; 278:652