

# Tag! (That's Not It)



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**A** lifelong rancher, now 58, considers himself to be in “decent” health—except for a persistent rash on the back of his neck. Over the years, he’s tried a variety of moisturizers, antifungal creams, topical antibiotics, and a course of oral cephalixin. His wife even removed the tags from his shirts, assuming they were irritating the affected patch of skin. Nothing has helped. But aside from a little itching, the lesion is asymptomatic. It is purely the persistent nature that troubles the patient.

The problem spot is a 3-cm, ill-defined, pink scaly patch located over the C7 area of the upper back/neck. Closer inspection reveals moderated atrophy, faint scale, and multiple fine telangiectasias coursing over the surface of the lesion. No induration is felt on palpation, and no nodes are appreciated on palpation of local nodal locations.

Around the lesion, and elsewhere on the patient’s sun-exposed skin, is abundant evidence of overexposure to the sun, including multiple solar lentiginos, actinic keratosis (on the arms and face), and solar elastosis.

He has type II skin, blue eyes, and reddish brown hair.

Thorough examination reveals no additional lesions of note.

**What is the most logical next step to take?**

- Prescribe a two-week course of 1% hydrocortisone
- Prescribe a month-long course of 5-fluorouracil cream
- Prescribe a month-long course of topical imiquimod
- Perform a shave biopsy to establish the diagnosis

## ANSWER

The correct answer is to perform a shave biopsy (choice “d”).

## DISCUSSION

Given the context in which this lesion appeared, as well as its fixed nature, it is likely to be a superficial basal cell carcinoma (SBCC)—though the differential includes Bowen disease, lupus, and even psoriasis.

The fact is, we don't really know what it is ... and we really need to know in order to treat it correctly. While this may seem obvious, in many practices the emphasis is on "trying" this or that, rather than establishing a firm diagnosis.

In this case, shave biopsy proved that the lesion was an SBCC, which opened up several treatment options. Two of them were mentioned in the answer choices (imiquimod and 5-fluorouracil). In consultation with the patient, I chose another option:

electrodessication and curettage (ED&C), which leaves a scar but has the distinct advantage of "getting it over with." The ED&C was performed under local anesthesia with an electric needle and 4-mm scraper.

This case offers another take-home lesson: Pay as much attention to the patient as to the lesion in question. This is particularly true for those, like this patient, who are more prone to skin cancer. Any nonhealing lesion on such a patient should be considered cancerous until proven otherwise. **CR**