

Skin Cancer

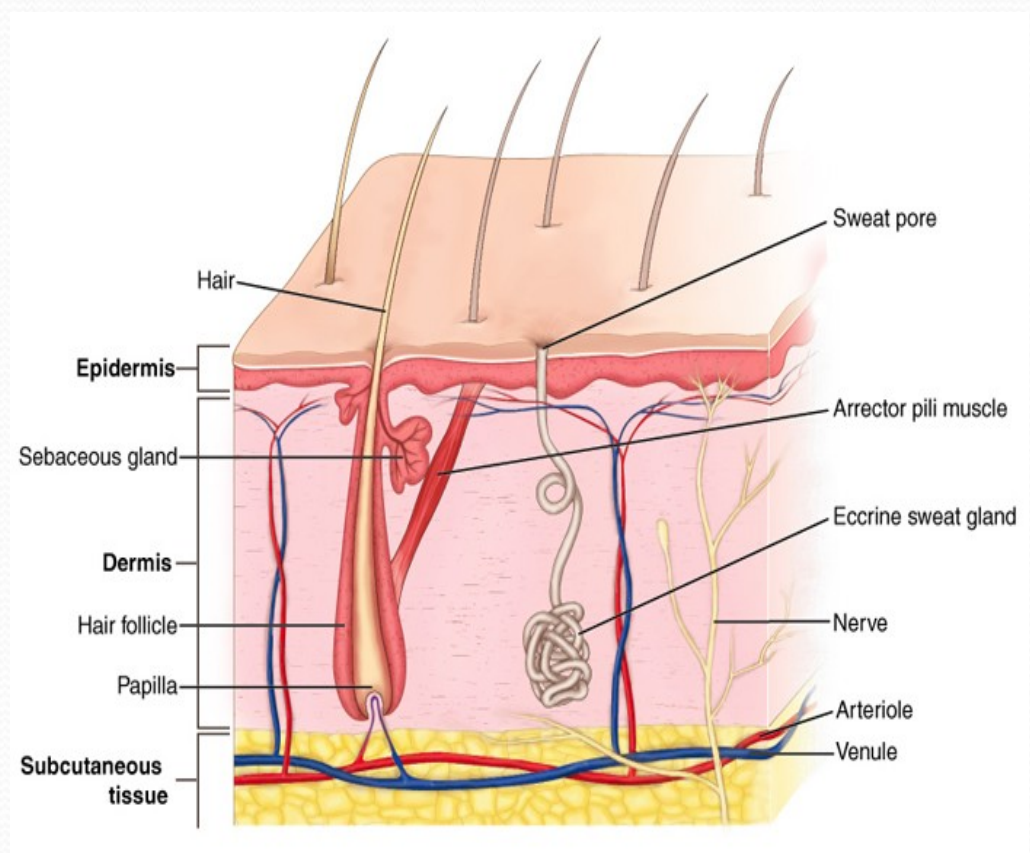
Instructors, please see note

Objectives

- Discuss function, assessment, and documentation of the skin
- Describe different types of skin cancer
- Discuss the signs and symptoms of skin cancer
- Utilize the ABCDE method of skin cancer assessment
- Discuss diagnosis and treatment of skin cancer
- Describe methods to prevent the development of skin cancer

Functions of the Skin

- Protection
- Body temperature regulation
- Psychosocial
- Sensation
- Vitamin D production
- Immunological
- Absorption
- Elimination



Skin Assessment Tools

- Eyes
- Hands
- Ears
- History taking and data gathering
- Braden Scale
- Nutritional assessment tools

Key Steps for Skin Assessment

- Health history
- Inspection and palpation
- Examination
- Documentation

Examination

- Head-to-toe
- Light source
- Compare
- Standard terminology
- Identify variables
- Braden Scale

BRADEN SCALE – For Predicting Pressure Sore Risk

SEVERE RISK: Total score < 9		HIGH RISK: Total score 10-12		MODERATE RISK: Total score 13-14		MILD RISK: Total score 15-18		DATE OF ASSESS					
RISK FACTOR		SCORE/DESCRIPTION				1	2	3	4				
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	1. COMPLETELY LIMITED – Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	2. VERY LIMITED – Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	3. SLIGHTLY LIMITED – Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. NO IMPAIRMENT – Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.									
MOISTURE Degree to which skin is exposed to moisture	1. CONSTANTLY MOIST – Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. OFTEN MOIST – Skin is often but not always moist. Linen must be changed at least once a shift.	3. OCCASIONALLY MOIST – Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. RARELY MOIST – Skin is usually dry; linen only requires changing at routine intervals.									
ACTIVITY Degree of physical activity	1. BEDFAST – Confined to bed.	2. CHAIRFAST – Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. WALKS OCCASIONALLY – Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. WALKS FREQUENTLY – Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.									
MOBILITY Ability to change and control body position	1. COMPLETELY IMMOBILE – Does not make even slight changes in body or extremity position without assistance.	2. VERY LIMITED – Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. SLIGHTLY LIMITED – Makes frequent though slight changes in body or extremity position independently.	4. NO LIMITATIONS – Makes major and frequent changes in position without assistance.									
NUTRITION Usual food intake pattern ¹ NPO: Nothing by mouth. ² IV: Intravenously. ³ TPN: Total parenteral nutrition.	1. VERY POOR – Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO ¹ and/or maintained on clear liquids or IV ² for more than 3 days.	2. PROBABLY INADEQUATE – Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. ADEQUATE – Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN ³ regimen, which probably meets most of nutritional needs.	4. EXCELLENT – Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.									
FRICTION AND SHEAR	1. PROBLEM – Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. POTENTIAL PROBLEM – Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. NO APPARENT PROBLEM – Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.										
TOTAL SCORE		Total score of 12 or less represents HIGH RISK											
ASSESS	DATE	EVALUATOR SIGNATURE/TITLE		ASSESS	DATE	EVALUATOR SIGNATURE/TITLE							
1	/ /			3	/ /								
2	/ /			4	/ /								
NAME-Last		First		Middle		Attending Physician		Record No.		Room/Bed			

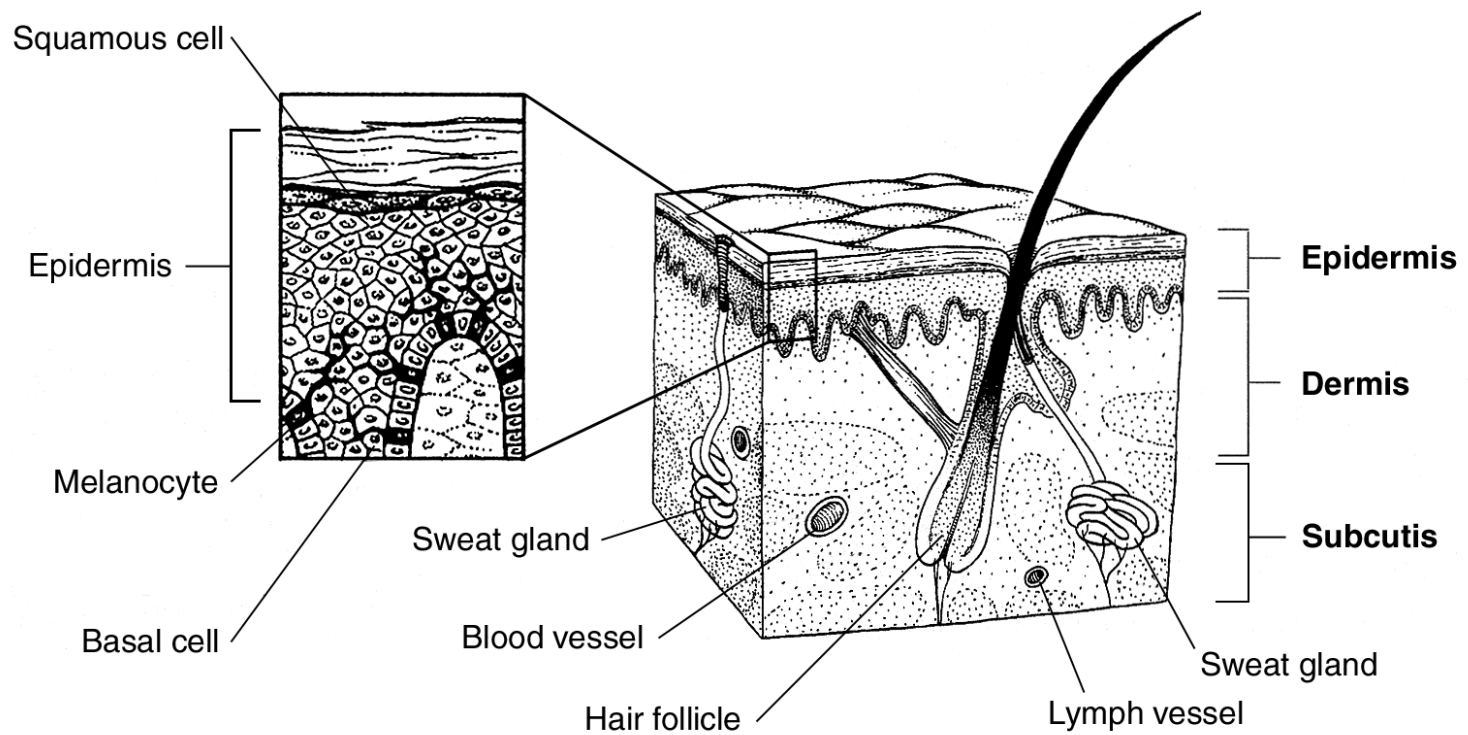
Documentation

- Document exactly what is observed or palpated
 - Appearance
 - Texture
 - Temperature
 - Turgor
 - Color
 - Moisture
 - Sensation
 - Vascularity
 - Lesions/Rashes
 - Size
 - Location and/or distribution

Sample Assessments

- “Skin is pink, warm, dry, and elastic; no petechiae, lesions or excoriation; multiple moles of small size and regular border and surface.”
- “Red, macular rash generalized over trunk and thighs; semi confluent lesions measure 1 to 2 cm; abrupt onset.”

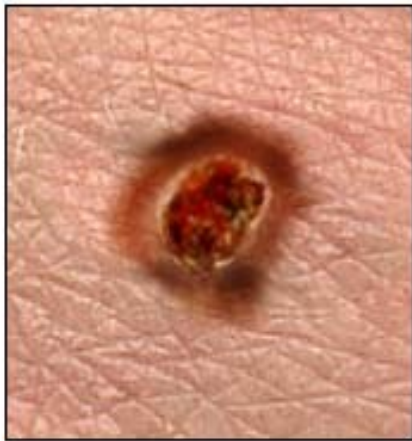
Skin Cancer



<http://www.youtube.com/watch?v=XPeoaOEE30k>

Types of Skin Cancer

Squamous cell carcinoma



Basal cell carcinoma



- Melanoma
- Basal cell skin cancer
- Squamous cell skin cancer

Basal Cell



Risk Factors

- Sunlight and UV radiation
- Severe and/or blistering sunburns
- Tanning (direct sunlight or tanning booths)
- Family history
- Fair (pale) skin that burns easily
- Medical conditions or medications

Signs and Symptoms

- Change in shape, color, size or feel of an existing mole
- Skin that is hard or lumpy
- The surface of the skin oozes or bleeds easily and does not heal
- Can be itchy, tender or painful

Recognizing Skin Cancer

- Use the ABCDE method of assessment
 - A - Look for asymmetry in a mole
 - B - Assess for an irregular border
 - C - Is the color a mixture of different colors or has it changed recently?
 - D - Is the diameter >6mm
 - E - Has there been an evolution in the mole size, shape, color?



Various Mole Sizes

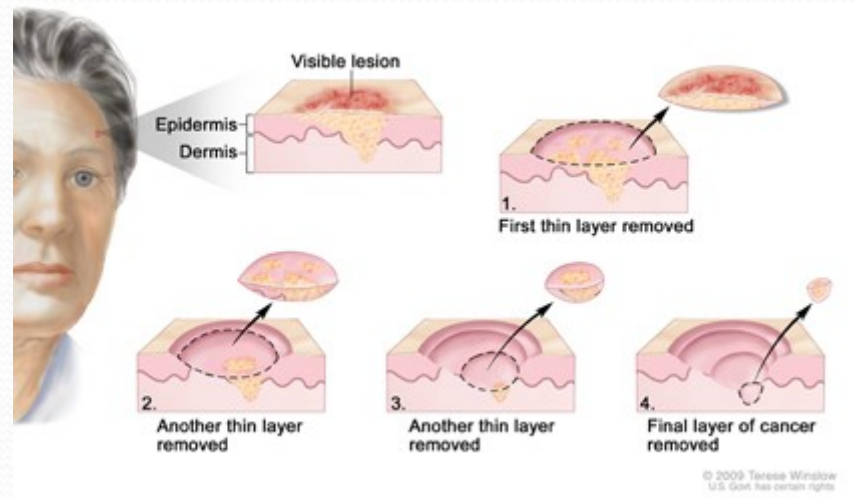


Diagnosis and Staging

- Biopsy: Shave, Punch, Incisional, Excisional
- Labs and imaging:
 - CBC, BMP, LFT's
 - Chest x-ray, CT, MRI, PET scan
- Sentinel node biopsy
- Staging is based on:
 - Size of the growth
 - How deeply embedded in the layers
 - Whether it has metastasized

Treatment

- Depends on:
 - Type and stage
 - Size and location of tumor
 - General health and medical history
- Excision
- Surgery
- Chemotherapy
- Radiation
- Biologic Therapy



Prevention and Education

- Limit sun exposure
- Stay away from sunlamps and tanning booths
- Avoid outdoor activities during the hottest part of the day
- Wear long sleeves and long pants
- Wear a hat with a wide brim
- Use sunscreen (SPF 30)
- Regularly check your skin for changes in moles

References

- Lewis, S.M., Dirkse, S.R., Heitkemper, M.M., & Bucher, L. (2010). *Medical-Surgical Nursing: Assessment and Management of Clinical Problems* (8th ed.). St. Louis: Mosby.
- Taylor, C., Lillis, C., LeMone, P., & Lynn, P. (2011). *Fundamentals of nursing; the art and science of nursing care* (7th ed). Philadelphia: Lippincott Williams & Wilkins.
- Southern Sun Clinic @ <http://www.southernsun.com.au/>
- http://www.in.gov/isdh/files/Braden_Scale.pdf
- <http://www.cancer.gov/cancertopics/wyntk/skin/page4>