

23

Basal Cell Cancer and Squamous Cell Cancer

I had this thing on my nose for about a year. I think it bled; then it healed up, so I figured it was a pimple. Then it came back. Now there's always a scab on it. I'm a golfer and I love tennis, so maybe I got it there. I know what it is. How bad do you think it's going to be?

—Ken, orthopedic surgeon, 43

A young, attractive woman was referred to me by her doctor, who had just diagnosed a basal cell cancer in the corner of her eye, at the root of her nose. She was concerned about the diagnosis and frightened about her long-term prospects.

“I don’t understand it,” she said, sitting anxiously on the examining table. “I’m too young for this. My father had many skin cancers, but he was so much older when he got them.”

Cheryl was a successful consultant in the banking industry who had grown up in New Jersey. “We didn’t know a lot about sun protection then,” she lamented. In our consultation, she told me about all those afternoons covered with baby oil, and baking in the sun with an aluminum sun reflector propped under her chin. “As soon as I heard the

word *cancer*,” Cheryl said, “I knew it was bad news.” In Cheryl’s case, fortunately, that wasn’t entirely true.

There are two principal kinds of non-melanoma skin cancers: basal cell cancer and squamous cell cancer. Basal cell cancer

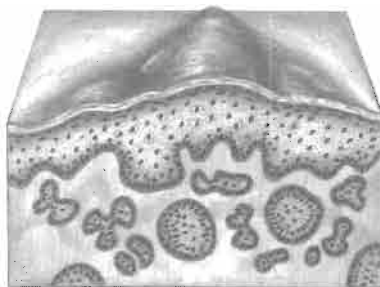
is the most common cancer in the world. Squamous cell cancer is the second most prevalent skin cancer. Still, basal cell cancer outnumbers it four to one.

The good news is that each is easily treated and cured in most cases. In addition, neither one turns into melanoma—the one skin cancer that most people fear because it can metastasize and can be deadly. Nevertheless, if you have had many bouts with either basal cell or squamous cell cancer, you are at higher risk for melanoma and should examine your skin regularly for changes in existing spots or growths and for new growths.

Both squamous cell cancer of the skin and basal cell cancer arise from the skin’s top layer, the epidermis. This layer, which is about twenty cells thick, or roughly the thickness of a sheet of paper, is our first barrier against all sorts of hostile environmental attacks, and as such is especially subject to the harmful effects of ultraviolet radiation from the sun.

EARLY SIGNS OF BASAL CELL SKIN CANCER

- A “pimple” that heals but continues to recur. True pimples heal after a week or two.
- A bleeding spot.
- A new bump with a pearly surface.
- An area that looks like a scar but there is no history of injury to the site.



Basal cell cancer

▪ BASAL CELL CANCER

The primary cause of basal cell cancer is overexposure to the sun and those with fair complexions are especially susceptible. For the same reason, it occurs most often on sun-exposed areas of the body, which include the head and neck, the legs in women, and the trunk in men.

Because sun exposure is its main cause, the rates of basal cell cancer vary according to occupation (those who work outdoors are generally more

at risk) and choice of recreational activities. The different styles of clothing that men and women wear, as well as changes in fashion, also have an impact on where on the body this cancer occurs.

The relation between the sun and multiple occurrences of basal cell cancer is vividly conveyed by an interesting pattern. In the days before most motor vehicles were air-conditioned, it was not uncommon for drivers to wind up with basal cell cancer on the left elbow and arm, and even on the left side of the face. We now believe that this was the result of drivers rolling their windows down all the way and comfortably resting their arm on the window frame of their cars or trucks. On long trips and over a lifetime of travel, the amount of sun exposure was indeed enormous, and the resulting skin cancer almost predictable.

Basal cell cancer is a cancer that has the least potential to spread in the bloodstream or metastasize. Worldwide there have been only about two hundred reported cases, in total, of basal cell cancer metastasizing, and those have usually been huge, neglected tumors. In part because it tends to be diagnosed early, basal cell cancer has a very high cure rate, if treated with the appropriate techniques,

The majority of basal cell cancers occur on the face. For this reason, the treatment that you select will have an impact on your appearance and on how you feel about yourself. In addition, this treatment choice must take into account first and foremost the cure rate.

▪ WHAT IT LOOKS LIKE

Under the microscope, in biopsy specimens stained with dyes to make the cancer cells visible, basal cell cancer appears relatively innocuous: purplish balls of cells organized symmetrically in a pattern that could be a design for interesting wallpaper. The microscopic tumor sits embedded in the normal epidermis and dermis. But this microscopic description does not tell the whole story. Just as cancer is a general term for a broad range of malignant growths, named for the organs from which they arise, and just as skin cancer itself has several different types, basal cell cancer has a variety of appearances and behaviors.

NODULAR BASAL CELL CANCER

The most common form of this condition is *nodular basal cell cancer*. It looks like a small bump and is often indistinguishable at first from a pim-

ple or a colorless mole. The classic appearance of nodular basal cell cancer is that of a pearly surface, throughout which course small spider veins. The tumor, because it is very slow-growing, has often been present for some time before becoming a problem. Most frequently, people with this type of skin cancer first notice the growth when it begins to bleed. The site then heals completely for a month or two, only to erupt a month or two later and bleed again.

This illustrates one of the cardinal signs of skin cancer, recited in dermatologists' offices day in and day out: *Bleeding lesions require attention*. People often believe at first that the tumor is bleeding because it has been scratched or accidentally traumatized, but the real reason is that the very blood vessels that aid in the growth and development of the cancer cause a small amount of bleeding and oozing. In other words, this is part of the process of the cancer's formation.

MORPHEAFORM BASAL CELL CANCER

Another form of basal cell cancer is quite different from the typical nodular variety and harder to identify. *Morpheaform basal cell cancer*, also termed aggressive-growth basal cell cancer, is usually present for many years before it comes to the person's attention. Like the nodular variety, it does not have the potential to spread in the bloodstream, but it has a totally different appearance on the skin and under the microscope. It is often flat, firmer than the surrounding skin, and white or yellow. It has the texture and appearance of a scar, but if no history of trauma can be recalled, then it is important to have it evaluated. Its slow growth can be noticed over time, especially if photographs of the area from earlier occasions are available.

Morpheaform basal cell cancer is not widely known among primary care physicians, so it can be overlooked. This type of skin cancer tends to grow with deep roots under the surface of the skin and is often larger than it appears to the naked eye. Once diagnosed, it is easily treated and cured—the trick is to *make* the diagnosis. A firm diagnosis can be made only by a skin biopsy (see Appendix 1, guide to dermatologic procedures).

SUPERFICIAL MULTIFOCAL BASAL CELL CANCER

Superficial multifocal basal cell cancer tends to be shallow but broad. Although it doesn't have roots that extend deeply into the skin,

AN AFTERNOON AT THE BEACH: HOW A SKIN CANCER IS MADE

*In recent years, through research done by our collaborative skin cancer group at Yale, and by researchers around the world, we have developed a clearer idea of exactly how the sun causes skin cancer. Before we go to the beach to see what happens, let me introduce you to a cancer gene called **p53**:*

p53 is a tumor suppressor gene. It functions like the brake in a car, controlling cells that may go off wildly and divide, turning into cancer. This gene is present in the DNA of all our cells, including the epidermis. When the p53 gene is functioning normally, it produces a small molecule or protein that keeps the cell from becoming cancerous by killing abnormal or cancer-prone cells. For this reason, it is called a *tumor suppressor gene*. This braking or *suppressor* effect protects against the development of cancer. The p53 gene is a very important cancer gene because it is found in a whole range of cancers, including those of lung, breast, colon, and liver.

What Happens at the Beach

You have been playing volleyball but forgot to reapply your sunscreen after a dunk in the ocean. By the time you sit down for dinner, your forehead is tingling and the nape of your neck is on fire. You are sunburned. In fact, sunburn is a sign that skin cells have been injured by the ultraviolet radiation from the sun. As a result of this sun exposure, ultraviolet radiation has actually targeted specific molecules in the p53 gene for damage. When cells experience such a mutation from ultraviolet radiation and part of the DNA of the p53 gene is damaged, the stage is set for the cell not to die, as it should, but to continue to live and divide, passing on the abnormal DNA that was caused by the sun.

Fast Forward . . . the Following Summer

The cells that were mutated by the sun the previous summer have continued to divide abnormally, encouraged by more mutations from continued exposure to the sun. From a single epidermal cell that was mutated, a whole clone of cells have now grown that are at least precancerous and may even eventually turn into squamous cell cancer.

This understanding of how the sun causes cancer gene mutations in the skin is the strongest case for protecting ourselves against the harmful radiation from the sun.

TOUCH ME NOT?

Current popular ideas about cancer result, in part, from the studies medical ancients made of skin cancers and tumors on the surface of the body. From the time of Hippocrates through the period of medical enlightenment in the Renaissance, the concept prevailed that if one touched or manipulated a cancer, any cancer, one would only make it worse. This led to the commonly held belief, which persists to this day in some quarters, that manipulating a cancer will cause it to spread and that biopsying it to obtain a diagnosis is fraught with danger since you may introduce the cancer cells into the bloodstream. Neither is true. In fact, a biopsy is absolutely necessary for the accurate diagnosis of a cancer.

So pervasive was the perception that manipulation of cancer only made it worse, that the term *noli me tangere* (touch me not) was applied specifically to basal cell cancer since the Middle Ages. This phrase comes from the New Testament. Soon after Christ arose after the crucifixion, Mary Magdalene reached out to touch him, but he stopped her, saying "Touch me not, I am not yet arisen."

In reality, it was not the touching of the cancer that failed to remove it or exacerbated it, but rather the failure to remove the entire cancer. Some more enlightened minds during the Middle Ages understood that cancer of the skin had roots and that unless it was removed completely by its roots, a cure would not result. To this day, basal cell cancer that is not adequately treated may recur and be more aggressive the second time around.

it can sometimes be as large as a fifty-cent piece or more. It is not unusual to see people who develop one such skin cancer develop others in the same area. This may be due to the fact that radiation from the sun mutates several clones of cells and each develops into separate skin cancers.

Superficial multifocal basal cell cancer appears like a red, scaly patch. It has sometimes been mistaken for eczema or even psoriasis. If you have such a patch of skin, and it does not heal completely with topical corticosteroid, it should be biopsied to make sure it isn't this form of basal cell cancer.

RODENT ULCER

A fourth type of basal cell cancer is called the *rodent ulcer*. It earned that graphic moniker in eighteenth-century England, when neglected tumors would grow, outstrip their blood supply, and the center of the cancer would die. The resulting ulceration would fester and be especially unsightly. This type of basal cell cancer often develops after the growth has been neglected for some time. In general, basal cell cancer grows very slowly, so it takes many years for the cancer to develop to the point that it appears as a large nonhealing ulcer.

Before we move on to squamous cell cancer, let me stress that basal cell cancer almost never metastasizes. It is considered a malignancy because it will continue to grow unabated and destroy the tissues around it, but in fact it has no practical potential to spread in the bloodstream. Although this ability to metastasize is a fearsome feature of malignant tumors in general, it's usually not true of basal cell cancer.

▪ SQUAMOUS CELL CANCER

Squamous cell cancer is another common skin cancer that is thought to result most often from sun exposure. It arises from plate-like cells in the epidermis. Unlike basal cell cancer, squamous cell cancer can metastasize to the lymph nodes and even to internal organs.

The risk of metastasis is low as long as the cancer is treated early. Once the cancer has metastasized, treatment options are fewer and, if surgical excision does not get all the cancer, other choices are limited. In general, though, even if the squamous cell cancer has spread, up to 50 percent of cases can be cured.

Another way squamous cell cancer can cause trouble is when it grows along nerves. This occurs in fewer than 1 percent of cases, but it is very serious when it does happen. Once a squamous cell cancer of the face or scalp has spread to the nerves of the skin, it can track along the nerves and even gain access to the brain.

As with basal cell cancer, some squamous cell cancers are more aggressive than others. They may grow rapidly and invade deeply, so they must be treated with respect. Squamous cell cancers occur more frequently in men than in women, by a 4-to-1 ratio.

Squamous cell cancer usually appears as a crusty, scaly, warty bump. It may range in size from pea-sized to chestnut-sized and is usually raised.

Although squamous cell cancers grow slowly, the sooner you see your doctor and the cancer is diagnosed and treated, the less complicated the surgery to remove it will be and the faster you will make a complete recovery.

The treatment for squamous cell cancer varies according to the size and location of the lesion. The surgical options are much the same as those for basal cell cancer. While the next section focuses on treating basal cell cancer, almost everything applies equally to squamous cell cancer.

▪ TREATING NON-MELANOMA SKIN CANCERS

If you have reason to believe that you have a basal cell cancer or a squamous cell cancer, first stay calm. Whether you have a growth that is nonhealing or one that looks just like the basal cell cancers I have described, reassure yourself by recalling that basal cell cancer does not spread in the bloodstream and is easily treated in the doctor's office. A variety of treatments are available, all of which yield a far less noticeable scar than you might fear—as long as the cancer is treated *early*. The most effective step you can take now is to make an appointment with a dermatologist you know, or one to whom your primary care physician refers you. He or she will evaluate the area you are concerned about and, if suspicious that there may be a basal cell cancer, will likely perform a small biopsy. This very brief procedure (it takes no more than a minute or two) will confirm or rule out the diagnosis.

Once a diagnosis of basal cell cancer has been made there may be several options for treatment. These include excision, scraping and burning, and Mohs micrographic surgery. At this point, however, you may wonder whether it's necessary to do anything. In fact, some of my patients ask, "If basal cell cancer does not spread in the bloodstream, why should I bother treating it?" The answer is clear and simple: *Basal cell cancer is a cancer*. Cancer cells divide abnormally and in an uncontrolled fashion, all at the expense of normal tissue. Basal cell cancers can be very destructive and, if they are not treated early, they will have to be managed sooner or later down the road. Squamous cell cancer can, in a low percentage of cases, metastasize.

The best treatment approach depends on the type of cancer, its location, your age, and whether the cancer is recurrent or not. Most of the treatment options are surgical and have varying cure rates. There are several new nonsurgical treatments currently under investigation, but they have either not yet been proven effective or have not been approved by the FDA.

Whenever basal cell cancer recurs, the risk of its being much larger than the original one is great because of the growth of the cancer cells within the scar bundles remaining from the previous surgery. It is important, therefore, to consult with your physician and determine what technique will provide the highest possible cure rate.

SURGICAL EXCISION

In surgical excision, which is really a simple form of plastic surgery, the skin cancer and the area around it are numbed with a local anesthetic such as lidocaine. The doctor then makes an incision through the full three layers of the skin around the obvious area of the skin cancer. The size of the

DOES BASAL CELL CANCER TURN INTO MELANOMA?

Basal cell cancer and squamous cell cancer do not turn into melanoma. They are not even birds of a feather. However, people who get many non-melanoma skin cancers are at increased risk of getting melanoma.

margin must be estimated and there is a risk that the physician may take too little tissue and not get all the cancer, or take too much, resulting in a bigger scar than necessary. Skilled dermatologists can often estimate quite well.

The specimen, roughly the shape of a football, is removed and the edges of the wound are pulled together using plastic surgery techniques. Two layers of stitches are used: a bottom layer that consists of an absorbable material, which is usually synthetic, and a top layer that uses nylon or other synthetic nondissolving stitches. The superficial top stitches are removed in approximately five to seven days depending on the location. The deeper set provide the wound support; these stitches usually dissolve in about four weeks, by which time the wound has begun to heal on its own. Once the stitches are removed, small tapes may be placed over the wound and remain in place for three to five additional days. It is important to note that there are many variations on the procedure just described and your doctor will select the technique he or she thinks is best for you.

You should expect that with time the surgical scar will improve. In the early months, however, there may be redness, especially if you are fair-skinned, as well as bumpiness related to slow absorption of the dissolving stitches. If the surgery was on the face, you must be very patient, since

facial wounds take approximately nine to twelve months to look their best. I know that waiting so long can be difficult, but it's only at the end of this period that the optimum result can be expected—try not to rush to judgment about the cosmetic appearance of a surgical wound. The benefits of surgical excision include an improved cosmetic result, compared with scraping and burning. The cure rate with this technique is in the 90 percent range for a first-time basal cell cancer. If, after the specimen has been removed and has been evaluated by a dermatopathologist, it turns out that residual cancer cells are present at the margin, meaning that it has not been completely removed, further treatment is often necessary (see “Mohs Micrographic Surgery,” page 262).

SCRAPING AND BURNING

For basal cell cancers that are superficial and confined to the top layer of the skin, a simple treatment is available that has an 80 to 90 percent cure rate. Scraping and burning, also known as *electrodessication and curettage*, is a quick and easy technique for removing a skin cancer. It should be used only for superficial basal cell cancer and small nodular basal cell cancer on the arms, legs, and trunk. It will usually leave an innocuous round pale scar.

The disadvantage of this technique is that no tissue is available afterward to evaluate whether the cancer has been completely removed. If the cancer should recur, treatment using the Mohs micrographic surgery technique is the preferred approach.

In the scraping and burning procedure, after the skin cancer and the area around it is anesthetized, a sharp curette, or scoop, is used to aggressively scrape the area and a small margin around the skin cancer. (The cells of the cancer lack the microscopic hinges that connect one cell to the other. Normal skin, which possesses these connections, does not scrape away, whereas the soft and mushy skin affected by basal cell cancer will yield to the curette.) The more aggressively one cures and burns the area, the greater the risk of an unsightly scar. So, through experience, an individual physician can identify whether a tumor requires multiple treatments or simply a single scraping and burning.

After the scraping, an electric needle is used to cauterize the base and edges of the skin cancer site. Some people believe the needle is a laser, but lasers play no major role in the management of skin cancer.

Scraping and burning is not appropriate for morpheaform basal cell

carcinomas, recurrent basal cell carcinomas, or large, nodular basal cell carcinomas.

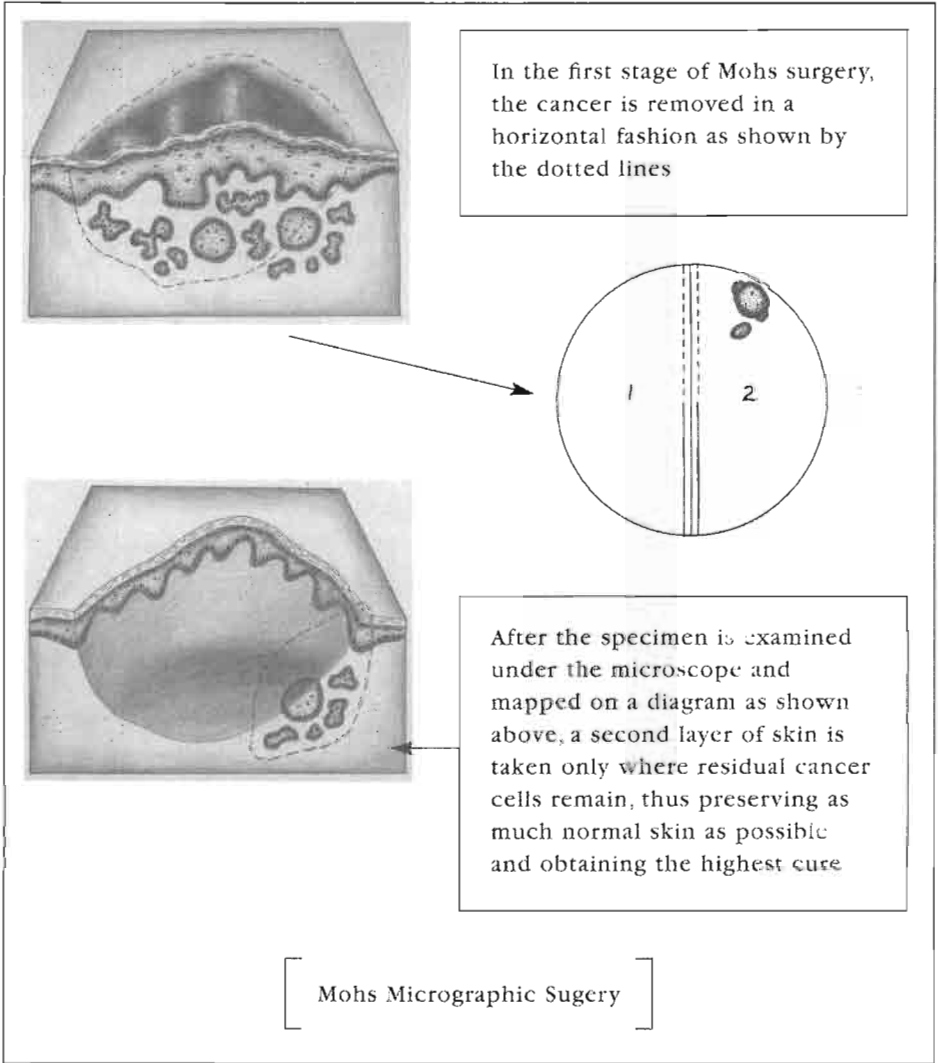
MOHS MICROGRAPHIC SURGERY

The most thorough method for treating basal cell cancer and squamous cell cancer is a technique called *Mohs micrographic surgery*. This office-based procedure, once not widely available because only a limited number of individuals had been trained to perform it, is now available at every major university center and in many communities throughout the United States, Canada, and Europe.

Named after Frederick Mohs, a general surgeon at the University of Wisconsin, the technique is based on the notion that normal pathology specimens, cut like a bread loaf, evaluate only about 3 percent of the total surface area of the margins of the cancer. By contrast, the Mohs technique allows evaluation of the complete surface area. This is important because many basal cell cancers grow with fingerlike projections or roots, and the random sampling of the specimens used by conventional pathology may not permit a thorough assessment of residual cancer. In addition, the Mohs technique requires that the dermatologist, *who must be specially trained*, not only excises the cancer from the patient but maps it out with special colored inks for purposes of orientation, and then evaluates the microscopic cancer. That one physician controls all three aspects of the process, I believe, is an important factor in the very high cure rate. Indeed, Mohs surgery has the highest cure rate of any of the methods mentioned, approaching 98 to 99 percent in most cases.

Because of the mapping technique, the complete cancer and only a minimal amount of normal tissue is removed, so Mohs micrographic surgery is a tissue-sparing method. Therefore it has the best cosmetic outcome, since there is often no need for the large plastic surgery reconstruction that would normally be done with traditional surgical excision. Often, simpler plastic reconstruction can be done at the same time that the Mohs micrographic surgery is performed. Moreover, because the cancer can often be removed in a very thin layer, the wound may, in some cases, be allowed to heal on its own, which can yield a better cosmetic result than plastic reconstruction. In cases where the cancer is large, Mohs micrographic surgery provides the assurance of the highest cure rate while permitting optimal reconstruction.

Under local anesthesia, the cancer is excised from the patient in a disk-



like shape (see box above). The specimen is divided into pieces and carefully mapped with different colors. The tissue pieces are then processed and studied under the microscope in such a way that it allows the complete peripheral surface and undersurface to be viewed at once. This enables the Mohs surgeon to determine whether there is any cancer at the undersurface of the specimen as well as at the periphery, an advance that is extremely important. If residual cancer is present, an additional specimen is removed, but only at the specific site designated by the map.

Once all the cancer has been removed through Mohs surgery, if a shal-

SKIN CANCERS THAT CAN BENEFIT FROM MOHS MICROGRAPHIC SURGERY

Basal cell cancer or squamous cell cancer that is

- located near the eye, ears, lips, or in the central face.
- the morpheaform subtype, that is, the doctor cannot easily tell the margins of the cancer.
- greater than one centimeter.
- in a location where tissue preservation is important and the best cosmetic result is desired.
- recurrent.

low wound results it can be allowed to heal naturally, without additional surgery. The wound will generally heal within three to four weeks, but may remain red for some time after that. Makeup can be applied, but one should not expect the best cosmetic result to occur until nine to twelve months have passed.

More often than not, the type of skin cancer that requires Mohs micrographic surgery will, upon its removal, need reconstruction of the wound area. The majority of Mohs surgeons in this country are specially trained in plastic reconstruction of facial wounds.

If your plastic surgeon or other reconstructive surgeon does not mention Mohs surgery as an option and describes a very complex reconstructive process, stop and question whether a simpler approach might not be acceptable. It is extremely important to have open lines of communication with your physician.

Because of the high cure rate, the logic of the procedure, and the opportunity to get the best cosmetic outcome, Mohs surgery is the method of choice for any recurrent skin cancer, any large skin cancer, and certainly any facial cancer where the best cosmetic result is desired.

RADIATION

Radiation therapy is a widely used treatment for the management of many cancers, and is best used only for very specific situations when it comes to skin cancer. Technologically, radiation therapy has improved enormously in the past two decades and the latest generation of X-ray

devices permit the delivery of finely tuned and specific doses. In this painless technique the tumor is identified and radiation is applied in a series of short daily treatments which usually span four- to six-weeks.

Radiation has some disadvantages, however. No tumor is excised, so the margins of excision cannot be identified. As a result, and to compensate, a radiation field, identified on the patient prior to treatment, may include a wide area of obviously normal skin, thus irradiating tissue unnecessarily.

In addition, if the radiation therapist is not that familiar with the particular type of cancer, such as a morpheaform basal cell cancer, and does not understand that its roots may extend beyond what is obvious, undertreatment may result, with recurrence of the cancer later on. Another disadvantage of radiation therapy is that it is delivered in small, fractional doses over a long period of time to get the best cosmetic results. For elderly patients, it is not often feasible to make the daily trips for treatment.

The principal advantage of radiation therapy is that when it is performed correctly on the properly selected cancer, it can yield a good cosmetic result. It should be noted that although no incision is made radiation therapy may still leave a scar. Radiation therapy is especially helpful for basal cell cancer and squamous cell cancer that is inoperable, or as an adjunct treatment after removal of a high risk cancer.

CHEMOTHERAPY

Chemotherapy has little role in the management of basal cell cancer and squamous cell cancer of the skin. However, for decades a form of topical chemotherapy has been used for precancers such as actinic keratoses and can be effective when used properly.

While the diagnosis of cancer is upsetting and the diagnosis of a cancer that occurs on your face may be of even greater concern than if it occurs elsewhere, it is important to remember that techniques are available that can result in the highest cure rate possible and the best cosmetic result. It is important to help your physician help you understand how the different options would best apply.

▪ A HAPPY ENDING

After extensive discussion about the various ways to treat her skin cancer, Cheryl elected to undergo the Mohs technique. She arrived at the

office for the procedure and, after the site was identified, my nurse anesthetized the cancer and the skin around it with lidocaine solution. Although that stung briefly Cheryl was amazed that she felt none of the rest of the surgery. I took the first layer of tissue, or *Mohs stage*, and after processing was able to study it under the microscope. I offered Cheryl a peek under the microscope and she was relieved to see just a small collection of cancer cells in the area that mapped out toward the eye. She returned to the procedure room, and with the area already numb, I removed a sliver of tissue smaller than the white of your nail. After studying this piece, it was clear no more cancer remained.

Cheryl was delighted that the cancer was completely removed and we turned our attention to the reconstruction. The option of skin graft, linear closure, where the edges of the wound are simply pulled together and sewn, and a skin flap in which a piece of adjacent tissue is elevated and transposed into the wound to fill it were discussed in detail. She asked about allowing the penny-sized wound to heal on its own. Because of its location I was concerned that it would pull on the corner of her eye and perhaps distort the tear duct, so we elected to perform a small skin flap. This surgery took only twenty minutes, and soon after, Cheryl, wearing a large pressure bandage, went home with her husband. When I called her at night to see how she was doing, she explained that she was a bit tired and a bit tearful but amazed that she had so little pain. I reminded her that she would probably get a black eye in a few days, but that after the stitches were removed, she would feel much better about the healing and the prospects for minimal scarring on her face.

WHEN IS MOHS MICROGRAPHIC SURGERY THE BEST ROUTE?

The high cure rates and tissue-sparing benefits of this technique are well suited to facial surgery where it is best to minimize the chance of recurrence and optimize the cosmetic result. An important benefit of Mohs surgery is that because a very thin layer of tissue is first taken, if clear of cancer cells, the shallow wound may be allowed to heal naturally and look better than if a skin graft or skin flap is placed. If plastic surgery is required, it can be performed at the time of cancer removal.

Cheryl's sutures were removed in five days and when I saw her for follow-up six weeks later, she was pleased that the scar had already begun to fade. She carried a bottle of sunscreen with SPF 15 and asked if it was the correct one to use. I told her that it was, and the hat she had taken to wearing in bright sun, with its wide brim, was likely to help as well. "I don't let the children outdoors without their sunscreen, either," she said, highlighting the strongest action step she could take to prevent skin cancer in the next generation.

