

Who benefits from calling a solar keratosis a squamous cell carcinoma?

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None declared.

Introduction

*Why didst thou promise such a beauteous day,
And make me travel forth without my cloak...*¹

At the end of 2004 a tidal wave swept through the Asian Pacific Region. By mid-January it became clear that around 300 000 people had died, and millions more were devastated by loss of home and environment. The after-effects will be felt in this area for at least a generation.

In mid-January I visited the Regional Dermatology Training Centre of the International Foundation for Dermatology in Moshi, Tanzania as part of my responsibilities in the International League for Dermatological Societies. I used the opportunity to visit the ward where a small proportion of the dermatology patients is admitted for more intensive care. There was a young man who had been admitted with severe progressive pyoderma gangrenosum of both legs which was unresponsive to the limited systemic therapy available. He was unable to be sent home to his village in rural Africa because of the high risk of secondary infection, which was likely to be lethal under these conditions. Consequently, he agreed to amputation of both legs, which was performed. By a miracle, he recovered well and the wounds healed.

Several weeks later, he was still occupying one of the scarce hospital beds. It had been realized that if he was now sent back to his rural village, he would be murdered. He was no longer able to contribute to the daily requirements of all males in ensuring survival of the family and the tribe. A well-meaning treatment had converted a medical problem into a social problem with the same potential outcome as the medical one.

This is the context in which I received the article by Bernard Ackerman and Joan Mones, to which I had agreed to respond.

What's new?

*Whenever anyone perceives that princes have the slightest desire to win, there is no partner who does not labour to see that they do so, preferring to betray his own glory rather than to attack theirs: we merely make just enough effort to enhance their reputation.*²

I have read the article. I congratulate the authors on a piece which has been carefully researched and magnificently written. It covers all the evidence from their perspective. As histopathologists, Drs Ackerman and Mones have come to the conclusion that a solar keratosis is a cancer, squamous cell carcinoma, and that we should rename it.

I have been asked to respond as I and a number of others have been involved in studies in recent years suggesting that these lesions may be evanescent, that they can remit (spontaneously or with the use of sunscreens), and that the likelihood of any particular lesion developing into what the community defines as cancer is very low. These studies have not been done on animals. They have not been done in a laboratory. They have not been done on pieces of tissue examined in various ways in an office. These studies have been done with the community, in the community.

This debate, in which I have been asked to participate, is not new. In fact, it has been well done in many places before. Drs Ackerman and Mones express cheer 'that progress actually is being made in our ongoing effort to convince colleagues of the authentic character of solar keratosis'. So what can I bring

to this debate that is new? First of all, let's not get into the 'tit for tat' approach that merely quotes one reference to counter another. This approach has been used in the debate since it started. The fact that we are having the debate again is clear evidence that this approach is not helping.

Let us allow Drs Ackerman and Mones to decide the direction by quoting from their piece. 'A histopathologist is not a diviner whose role it is to speculate about behaviour of pathological processes'. The medical profession is 'a noble, learned profession dedicated single-mindedly to a dependent, deserving patient'. I agree with these statements. So let us take that position. Let us try to see this question from the perspective of the community in general, and the 'dependent, deserving patient' in particular. It may help to explain the title that I have chosen for this piece.

Who am I?

*In the theatre bar they still talked, not hurrying over their drinks although an announcement had warned that the performance would begin in two minutes.*³

I am a clinician. I see patients. I am trained in the speciality of dermatology and I have a particular interest in patients with the disease named cancer. Let us start there.

A patient comes to see me with a red scaly spot on the back of the hand that, using history and examination as a clinician, I have decided is a solar keratosis. The patient asks me what it is and what needs to be done. But I know, as every clinician working in this area knows, that in a covert (and sometimes overt) way this person is actually asking me: 'Is this cancer?' Thus my task as a clinician is to answer this question and to give advice to that person.

What is cancer?

*Tonight, a first movement, a pulse,
As if the rain in bogland gathered head
To slip and flood: a bog-burst,
A gash breaking open the ferny bed.*⁴

Cancer is a community word. It did not start with the medical profession. It was developed and defined by the community over thousands of years. It arose well before the time of dermatologists and histopathologists. As it is a word that arose in the community, it is necessary to look to the community to see what people mean when they use this word. To quote from a community dictionary: 'A very harmful growth in the body that tends to spread and destroy the healthy tissues and organs of the body. Figurative: An evil or harmful thing that tends to spread'.

So the community came up with a word that defined a disease that destroys tissue, tends to spread and is life threatening. The community was bewildered by this disease. It sought help from people who said they were experienced in curing it. Historically, such persons have varied in communi-

ties from natural healers in areas in Africa to highly trained medical practitioners in countries like Australia.

These people were trained by the community and were given the responsibility to advise members of the community on what might be the best way to cure their cancer. These people were not autonomous. They were placed in that advisory position by the community—they were responsible to the community.

So, the patient has a perception going back centuries of what is cancer and has presented to the appointed medical practitioner with a solar keratosis saying, in one way or another, do I have this disease?

Who is defining cancer now?

*'Are you then Virgil, are you then that fount
from which pours forth so rich a stream of words?'
I said to him, bowing my head modestly.*⁵

It is fairly clear from the article to which I am responding that the meaning of the word 'cancer' has now been taken over, in their attempt to deal with the disease, by the professionals who were appointed by the community to serve it. It has even gone to the extent that the condition is being defined by a secondary group of people from whom the clinicians seek assistance, not by the primary people from whom the community seeks help.

In other words, we now have a state where those who have been appointed by the community to deal with the problem that affects them have taken the role of defining the disease for which the community has been seeking help. In doing so, they appear to have come up with a definition that does not seem to fit the community's definition of the disease. For example, a solar keratosis, as it is when the patient presents, is not 'a very harmful growth in the body that tends to spread and destroy the healthy tissues and organs of the body'.

It appears that the community-appointed advisors have decided on the basis of various *in vitro* investigations that a solar keratosis, which previously had not been called a cancer, is now a cancer—'squamous cell carcinoma, very superficial, solar keratotic type'. In response to the fact that a solar keratosis does not fit the criteria that the community uses to define their disease, the pathologist has quite predictably said that the community needs to change its definition. An eminently logical conclusion.

What's in a name?

*Unfortunately I was unable to set at rest by further talks with Bloch, in which I might have insisted upon an explanation, the doubts he had engendered in me when he told me that fine lines of poetry (from which I expected nothing less than the revelation of truth itself) were all the finer if they meant absolutely nothing.*⁶

In Australia, if a clinician makes a clinical diagnosis of solar keratosis and uses cryotherapy to treat it, the government-funded Medicare system will not pay for the cryotherapy. On

the other hand, if the patient has a biopsy of the lesion that the clinician diagnoses clinically as a solar keratosis and the pathologist reports it as 'squamous cell carcinoma in situ' the government will pay not only for the biopsy, but also for the histopathology and the subsequent visit and the cryotherapy, on the basis that the diagnosis is cancer. The clinician and the histopathologist will be paid by the Government an extra amount of around \$AUS300. The disease is the same. The treatment is the same. Who has benefited from this change in name?

Let us not forget what we all agree is the reason why we are here, and that is to be 'dedicated single-mindedly to a ... patient'. The solution to this debate needs to be underlined by that maxim. Will changing the name of this disease assist the patients in achieving their aim, i.e. by reducing the likelihood that this disease will prevent them living their lives in the way that they had expected, for as long as they had expected prior to its development? If we can answer 'yes' to that question, then let's go ahead and change it. However, if because of a change in name we change our practice in a way that does not necessarily serve the community's interest, then we are in danger territory.

What do I mean by that? If we change our practice substantially on the basis of a change in the name of a condition, we shall not only have to justify it to the patients, but also to the health policy-makers, the lawyers, the politicians, the health funders, the diagnostic services, the research community, the clinical practitioners, the insurers and everyone else who has an interest in the effects of cancer and how to reduce them in this community.

I shall give further examples to illustrate this. Try sending the label 'squamous cell carcinoma, very superficial, solar keratotic type' to the insurance company and ask them how they will assess for life insurance purposes a patient whose pathologist reported that diagnosis. Remember the effect on life insurance of a diagnosis of level I melanoma (melanoma in situ).

We now have examples of the flow-on effect of these changes on government, or other health service providers, and life insurance assessors. Let's have two more—one from the doctor's and the last from the patient's perspective. A patient was referred to me by a doctor who biopsied a red scaling lesion on an elderly man's finger that was reported as 'carcinoma in situ, incompletely excised'. He wondered whether I thought this man's finger should be amputated because of the 'cancer'.

That was the health professional; now for the patient. A 50-year-old woman was referred to me this week with a lesion diagnosed by the histopathologist as 'carcinoma—in situ'. She was told by her referring doctor that she was being sent to me for treatment of her cancer. During the consultation with me (2 weeks later) this woman told me that she had been thinking about arrangements for her funeral and care of her family after she died from this disease (an outcome highlighted in the article by Drs Ackerman and Mones and in articles by many other authors).

So where do we go from here?

'Did I not tell you, Sancho,' exclaimed Don Quixote at this, 'that we had reached a place where I have to show the strength of my arm?''⁷

If a name change is all that is being requested, let us change the name. However, if a substantial change in clinical practice as a result of that name change is the likely flow-on, then a little more thought and preparation is required before it goes ahead.

In skin cancer control education programmes, the first maxim is to teach the professionals how to diagnose early skin cancer and treat it appropriately. Once that has been completed, it is then possible to induce members of the community to seek attention from the professionals regarding lesions whose signs you have made them aware of as being risk factors for cancer (public education). Do it the other way around and you produce a potentially disastrous outcome.

For this change, a huge public and professional education programme would be required. And who would benefit? Has anyone shown that treating all solar keratoses has reduced mortality (or even morbidity) due to the disease the community calls cancer?

How will I respond, for the moment, to the patient who presents with a solar keratosis and who seeks my opinion?

*Primum non nocere.*⁸

If I am confident of my clinical diagnosis, I shall call it a solar keratosis. If I am not confident, I shall biopsy it to make sure it is not what I understand by squamous cell carcinoma. I shall advise the patient, on the basis of the evidence that has been presented on many occasions, that the likelihood of this lesion progressing to what they define as cancer in their lifetime is very low. I shall say to the patient that I can treat it if they wish. My treatment will be brief, not too damaging, not too expensive (in Australia, no charge) and I shall eradicate the lesion tenderly without too much disruption to the patient's life.

I shall also explain to them that having this lesion indicates a risk of having skin cancer somewhere now. I shall use it as an excuse to examine the patient thoroughly to ensure that they do not have some coexisting skin cancer that requires treatment. I shall point out that if I do treat the lesion, it will not reduce their risk of developing skin cancer somewhere else in the future. I shall explain carefully what skin cancer may look like. I shall encourage them to get to know their skin, examine it regularly, and seek early attention if they notice any of the signs that I have described.

I shall make it very clear that we now have longitudinal studies showing that a reduction in sunlight exposure can substantially reverse the process that has led to the development of their solar keratosis. This is just the same as the reversal in the bronchial mucosal dysplasia which occurs when people cease smoking. Fortunately, we are confident that we know the major carcinogen (sunlight) for solar keratosis and cutaneous squamous cell carcinoma. We have ways for reducing exposure

to this carcinogen that are simple and effective and have been shown substantially to reduce the risk. This can be done by the community at large as part of normal-day living in Australia. After all, it is the community at large that has asked us for the solution and it is a wonderful opportunity to put that solution back into their hands.

Conclusion

So, I have come back to where I started. That is, people in the community come to me asking whether they have a disease which they have defined and which terrifies them. I bear in mind that I was put there by the community to assist them in maintaining, where possible, a normal healthy and enjoyable life for as long as they had anticipated. That is what drives the response to their request for help that I have detailed above. Pray, may I never forget it.

Editor's Comment

This commissioned article for the *British Journal of Dermatology* has references of a solely literary style. These had been removed during the technical editing of the manuscript, but

at the request of the author have been reinstated at the discretion of the Editor. This should not be seen as setting precedence for the journal's referencing style.

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