Letters

A reply to 'Managing a plaque on the forehead'

We read with interest the recent case study on managing an intraepidermal squamous cell carcinoma on the forehead.[1]

It is unclear why a baseline image was taken. If this was for the purpose of monitoring, it nicely illustrates one of its hazards. The lesion would appear to have been clinically similar in both images and thus diagnosable without waiting for documented growth. Monitoring risks enlargement and invasion.

The history of cryotherapy is concerning as this can alter the clinical and dermoscopic features, thus broadening differential diagnosis. Amelanotic lentigo maligna is not mentioned as a differential.[2,3] There is no description or image of the dermoscopic features. Dermoscopy would likely eliminate some differentials proffered here.

The dimensions of the shave biopsy are not recorded. The author correctly raises the issue of possible invasive disease. This concern would be lessened, the larger the portion of tissue sample. A lesion of this size where the main differential is intraepidermal carcinoma (IEC) can be easily shaved off in its entirety with a very good cosmetic outcome should it have been benign.

A major issue with surgical excision would be margin involvement. Subclinical extension and/or the presence of separate foci of intraepidermal squamous cell carcinoma are likely, especially with a history of previous treatment. The image taken at three weeks' review shows an inflamed lesion above the brow possibly representing a second IEC. Closing the surgical defect with a complex flap before confirmation of clearance would make re-excision needlessly difficult.

A recent study showed 5-fluorouracil (5-FU) to be non-inferior to surgical excision, and associated with a better cosmetic outcome.[4] The author used a four-week regime of 5-FU with initial twice daily use reduced to daily for a total of four weeks.[5] It is worth noting that there is a paucity of published evidence for the use of 5-FU in the treatment of IEC. Described regimes range from one to two times per day for two to four weeks for solar keratosis and IEC.[6]

Radiotherapy is stated to be a 'good' option here as primary treatment or should the lesion recur. Although good cure rates can be achieved, regardless of her geographical isolation, radiotherapy would be an expensive, time-consuming treatment with significant short- and long-term morbidity. There is also mention of using a 'radioactive paste'. As far as we know, there is a paucity of long-term data to demonstrate the safety or efficacy of this treatment. Neither of these options would be 'good' unless other options were contraindicated or refused.

Follicular extension is deemed a risk with curettage and cryotherapy. This hazard escapes mention with 5-FU, where surely the same concern would apply?

We agree regarding the need for follow-up, but this would be true for any modality. All treatments here would have a significant failure rate, so recurrence and new primary lesions would be a concern regardless.

Authors

Miranda Wallace BBioMedSc, MBBS, MS, Clinical Associate Lecturer, School of Medical Sciences, Faculty of Medicine and Health, The University of Sydney, Sydney, NSW; Dermatology Senior House Officer, Department of Dermatology, Mater Hospital, Brisbane, Qld

Jim Muir MBBS, FACD, Head of Department, Department of Dermatology, Mater Hospital, Brisbane, Qld; Dermatologist, South East Dermatology, Brisbane, Qld; Associate Professor, School of Medicine, The University of Queensland, Brisbane, Qld

Competing interests: None.

References

1. Dicker T. Managing a plaque on the forehead. Aust J Gen Pract 2024;53(5):317–18. doi: 10.31128/AJGP-01-24-7097.
2. Abdulla FR, Kerns MJ, Mutasim DF. Amelanotic lentigo maligna: A report of three cases and review of the literature. J Am Acad Dermatol 2010;62(5):857–60. doi: 10.1016/j.jaad.2009.06.017.
3. Allan SJ, Dicker AJ, Tidman MJ, McLaren KM, Hunter JA. Amelanotic lentigo maligna and amelanotic lentigo maligna melanoma: A report of three cases mimicking intraepidermal squamous carcinoma. J Eur Acad Dermatol Venereol 1998;11(1):78–81.
4. Ahmady S, Nelemans PJ, Kelleners-Smeets NWJ, et al. Surgical excision versus topical 5% 5-fluorouracil and photodynamic therapy in treatment of Bowen's disease: A multicenter randomized controlled trial. J Am Acad Dermatol 2024;90(1):58–65. doi: 10.1016/j.jaad.2023.08.076.
5. Sturm HM. Bowen's disease and 5-fluorouracil. J Am Acad Dermatol 1979;1(6):513–22. doi: 10.1016/s0190-9622(79)80095-x.
6. Therapeutic Goods Administration (TGA). Australian Product Information - Efudix (Fluorouracil) cream. TGA, 2023. Available at www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2013-PI-01673-1&d=20240622172310101 (2023). [Accessed 22 June 2024].

Reply

I am truly thankful to Drs Wallace and Muir for their interest in my case study, which was published in the *AJGP* May 2024 issue.[1] They raise many interesting points that are often better addressed in a discussion forum rather than the monolog of a case report.

Regarding the baseline image, this exists as part of my practice of photo documentation of lesions, rather than as a plan for monitoring. It was (fortuitously) one of many images taken during that particular consultation, and other lesions deemed to be more significant were treated on that occasion. In managing the whole person, we must triage which lesions are to be managed first, and this is influenced by the patient's wishes. At the time the first image was taken, the forehead plaque was not the most significant lesion to either the patient or myself.

Regarding photo documentation, I would strongly encourage it. Not only does it create a very accurate medical record, it was also a useful tool to highlight to the patient at the subsequent visit that the plaque was continuing to grow and action was required. Even during the follow-up visits, this plaque was not of particular concern to the patient. Demonstrating the change in the lesion was helpful in encouraging her to partake in a treatment.

Thank you for referencing the article by Ahmady et al,[2] which unfortunately had not been published at the time that I was putting this case report together. It highlights many of the issues when trying to apply scientific rigor and study to the management of individual people. Nearly half of the eligible participants declined to be involved for mainly personal reasons or biases. Lesions ranged in size from 4 mm to 40 mm. I would have a very different clinical approach for an individual patient based on that factor alone, let alone other comorbidities, social factors and patient wishes. They have produced some excellent data of practical value despite having so many variables to consider.

The article you referenced by Sturm (1979) also highlights the various concentrations, length of application and frequency of application that is used for fluorouracil.[3] Its use for intraepidermal carcinoma has been shown to be effective, but the methods are quite subjective.

All of your comments are quite accurate and need to be considered when choosing a management plan for an individual patient.

Author

Tony Dicker MBBS, FSCCA, PhD, Course Co-ordinator, Postgraduate (Skin Cancer) Programs, Mayne Academy of General Practice, Medical School, The University of Queensland, Brisbane, Qld

Competing interests: None.

References

1. Dicker T. Managing a plaque on the forehead. Aust J Gen Pract 2024;53(5):317–18. doi: 10.31128/AJGP-01-24-7097.
2. Ahmady S, Nelemans PJ, Kelleners-Smeets NWJ, et al. Surgical excision versus topical 5% 5-fluorouracil and photodynamic therapy in treatment of Bowen's disease: A multicenter randomized controlled trial. J Am Acad Dermatol 2024;90(1):58–65. doi: 10.1016/j.jaad.2023.08.076.
3. Sturm HM. Bowen's disease and 5-fluorouracil. J Am Acad Dermatol 1979;1(6):513–22. doi: 10.1016/s0190-9622(79)80095-x.

Time to focus and manage the symptoms: Period and pelvic pain, not the lesions of endometriosis

I read with interest the articles on endometriosis and dysmenorrhoea in the *AJGP* January–February issue.[1,2] It is appropriate to focus attention on the pain and suffering that occurs in so many women, but we need to remember that only 50% of women with pelvic pain have endometriosis found at laparoscopy and that there are no symptoms specific to those with or without endometriosis.[3] Furthermore, 40–50% of asymptomatic women actually have endometriosis.[4]

Menstrual shedding is caused by inflammatory substances involving immune system activation and release of prostaglandins and chemokines, many of which are known nociceptor stimulators.[5]

Among menstruating adolescents, 30–90% have period pain, with 20% experiencing dysmenorrhoea severe enough to impede school, sport and social participation.[4,6] Adolescents report that they are told, 'It's only period pain. Get used to it!'.[7] Recurrent pain contributes to the development of chronic pain.[8] The failure to validate and optimally manage adolescent period and pelvic pain leaves these young women with recurrent pain for years. It is then no surprise that they seek a 'real diagnosis' that validates their pain, that of endometriosis. However, evidence that surgery helps pain associated with endometriosis is 'very low' to 'low'.[9] Recurrence of pain postoperatively and endometriosis are both reduced with the Mirena IUS® (Bayer Health Care Pharmaceuticals) or continuous oral contraceptive pills (but not cyclic continuous oral contraceptive pills).[10] Both approaches prevent the cyclic release of inflammatory mediators. A laparoscopy (with or without the finding and/or removal of endometriosis) *does not* influence emergency department attendances.[11] Most women return to analgesics use within months, and repeat laparoscopies within three years occurs in at least 50% of women.[12]

Although non-steroidals are valuable, recognising that stress, adverse childhood events and poor sleep affect pain is also important. Acknowledging that the abdominal wall and pelvic floor muscle are also sources of pain that can benefit from physiotherapy input is crucial.[13] Acknowledging that menses is a recurrent inflammatory process opens the option for this process to be suppressed.

Information and guidelines for pelvic pain should be reliable and valuable resources for clinicians. So let us focus and optimise the care of our patients with pelvic pain by providing reliable evidence and resources.

Author

Sonia Grover MBBS, FRANZCOG, MD, FFPMANZCA, Director, Department of Gynaecology, Royal Children's Hospital, Melbourne, Vic

Competing interests: SG declares MRFF funding for the Longitudinal Study of Teens with Endometriosis, Period and Pelvic Pain; and is a member of the document development group, FPM Position Statement *on the clinical approach to persistent pelvic pain including endometriosis- associated pain 2024*.

References

1. Crump J, Suker A, White L. Endometriosis: A review of recent evidence and guidelines. Aust J Gen Pract 2024;53(1–2):11–18. doi: 10.31128/AJGP/04-23-6805.
2. Christensen K. Dysmenorrhoea: An update on primary healthcare management. Aust J Gen Pract 2024;53(1–2):19–22.doi: 10.31128/AJGP/04-23-6815.
3. Conroy I, Mooney SS, Kavanagh S, et al. Pelvic pain: What are the symptoms and predictors for surgery, endometriosis and endometriosis severity. Aust N Z J Obstet Gynaecol 2021;61(5):765–72. doi: 10.1111/ajo.13379.
4. Rawson JM. Prevalence of endometriosis in asymptomatic women. J Reprod Med 1991;36(7):513–15.
5. Evans J, Salamonsen LA. Decidualized human endometrial stromal cells are sensors of hormone withdrawal in the menstrual inflammatory cascade. Biol Reprod 2014;90(1):14. doi: 10.1095/biolreprod.113.108175.
6. Parker M. The MDOT study: Prevalence of menstrual disorder of teenagers; exploring typical menstruation, menstrual pain (dysmenorrhoea), symptoms, PMS and endometriosis [Master's thesis]. The University of Canberra, 2006.
7. Munro CB, Walker EN, Schembri R, Moussaoui D, Grover SR. Periods shouldn't bring any adolescents' world to a full stop. Period. An online survey of adolescents' experience of menstruation. J Pediatr Adolesc Gynecol 2024;37(1)18–24. doi: 10.1016/j.jpag.2023.09.004.
8. Jarrell J, Arendt-Nielsen L. Evolutionary considerations in the development of chronic pelvic pain. Am J Obstet Gynecol 2016;215(2):201 e201–04. doi: 10.1016/j.ajog.2016.05.019.
9. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Endometriosis: Clinical practice guideline. RANZCOG, 2021. Available at https://ranzcog.edu.au/wp-content/uploads/2022/02/Endometriosis-clinical-practice-guideline.pdf [Accessed 8 April 2024].
10. Vercellini P, Frontino G, De Giorgi O, Pietropaolo G, Pasin R, Crosignani PG. Continuous use of an oral contraceptive for endometriosis-associated recurrent dysmenorrhea that does not respond to a cyclic pill regimen. Fertil Steril 2003;80(3):560–63. doi: 10.1016/S0015-0282(03)00794-5.

11. Joseph K. Emergency department attendances for persistent pelvic pain are not reduced following laparoscopic surgery for women with or without endometriosis. N Z Med J 2023;137(1591):49–54. doi: 10.26635/6965.6377.
12. Kuznetsov L, Dworzynski K, Davies M, Overton C, Guideline C; Guideline Committee. Diagnosis and management of endometriosis: Summary of NICE guidance. BMJ 2017;358:j3935. doi:10.1136/bmj.j3935.
13. van Reijn-Baggen DA, Han-Geurts IJM, Voorham-van der Zalm PJ, Pelger RCM, Hagenaars-van Miert CHAC, Laan ETM. Pelvic floor physical therapy for pelvic floor hypertonicity: A systematic review of treatment efficacy. Sex Med Rev 2022;10(2):209–30. doi: 10.1016/j.sxmr.2021.03.002.

correspondence **ajgp@racgp.org.au**