



SKIN CANCER:

A Cautionary Tale

Diagnosed with basal cell carcinoma, everything is called into question

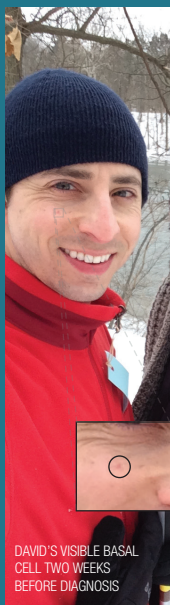
By David Himmel

You wouldn't have known it by looking at me—and it was barely visible in photos—but back in March, my face was being eaten alive by cancer.

I'm not sure how long the cancer had been making a meal of me, or even when I first noticed the small, red mark on my cheek just below my eye. I do remember saying to myself at some point, "Let's see if this thing clears up."

I used to pay better attention to my skin's condition. As a kid, I had several large moles removed before they could cause any possible sort of cancer-related problems. One mole, in the middle of my back, was so big that my mother lovingly referred to it as a chocolate chip. However, seeing my dermatologist every year was a habit I had fallen out of. But when that pea-sized red spot on my face didn't clear up, I scheduled an appointment for a long-overdue full-body exam.

Paula Shah Malhotra, MD, is a dermatologist at Chicago Lake Shore Medical Associates, a division of Northwestern Medical Faculty Foundation. This was my first time seeing her, so other than having access only to the info provided by my primary care physician and from what I told her of my past health, she was not familiar with my skin. Still, she took one concerned look at the red spot that I'd concluded was an age mark and said, "This looks like basal cell carcinoma. I'm going to numb you



up and cut some out and get a biopsy."

Abbreviated as BCC, basal cell carcinoma is an uncontrolled growth or lesion that lives in the skin's basal cells, which line the deepest layers of the epidermis, the outermost layer of your skin. It often looks like an open sore, razor bumps, red or pink patches, shiny bumps or scars. BCC is the most common type of non-melanoma skin cancer in the world.

According to the Skin Cancer Foundation, an estimated 2.8 million cases are diagnosed each year in the United States. Similar to BCCs are squamous cell carcinomas (SCC). About 700,000 of these cases are diagnosed every year in the United States.

BCC and SCC are a result of UV overexposure, the delayed detriment of a killer tan. While SCCs account for approximately 2,500 deaths each year in the United States, neither of these skin cancers are as deadly as melanoma, which the Skin Cancer Foundation says kills one person every hour, every day, every year. But that doesn't mean that non-melanoma skin cancers shouldn't be taken seriously.

They grow slowly. If left untreated,

BCCs and SCCs can become terribly disfiguring. They penetrate the subcutaneous tissue, muscle and bone. Because they're often on the face, head and neck, they can interfere with sensory functions by making their way to the eyes, nose, lips and ears. SCCs metastasize and move to other organs more often than BCCs, but a case of BCC can still be incredibly damaging.

Some cases that my doctors told me about sound like science-fiction horror stories: the one on the scalp about an inch thick and the width of a dinner plate that had grown through the skull. Once the tumor was removed, the skull had to be reconstructed. The one where the tumor invaded an eye that had to be surgically removed, resulting in partial blindness. The one on the man's nose that was treated improperly for years via holistic measures. By the time the tumor was extracted, it had infiltrated most of his face. The man's nose had been completely removed and the majority of his face had to be reconstructed, though he would never look the same, or like a natural human, again.

It was six days before Malhotra called me with the results, but I already knew what she confirmed. When I casually mentioned to my father that I had the biopsy, he shocked me by rattling off a long list of family members who had also had BCC. In addition to too much sunshine, BCC can be hereditary. And while I didn't know it when Malhotra first asked me, skin cancer is so rampant in the Himmel bloodline that getting BCC could be considered a rite of passage. Had I known, I would have made an appointment with Malhotra the moment I noticed that red spot.

She referred me to Murad Alam, MD, professor of dermatology, otolaryngology and surgery, and chief ►

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Mohs Procedure

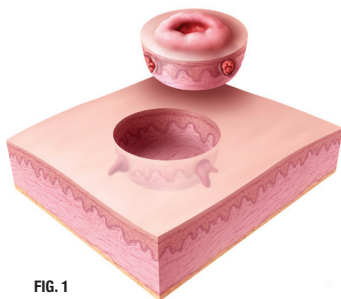


FIG. 1

- The site of the cancer is prepared and numbed with local anesthetic. The superficial part that appears to be cancerous, based on color, texture and other factors that distinguish it from the surrounding skin, is removed with a sharp scalpel. (Fig. 1) This piece is marked to determine which side is up, down, etc. The area from where the cancer was removed is cauterized and a temporary dressing is put in place.

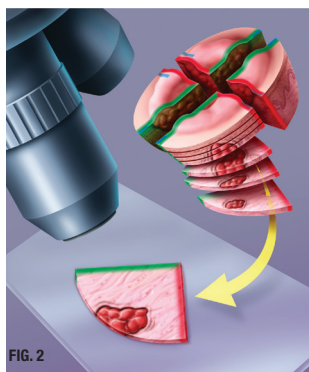


FIG. 2

- The patient waits while the removed tissue is taken to the lab to prepare. The tissue is separated and the edges are inked with different colors so that the orientation of each piece is preserved. Then, the tissues are frozen in a cryocast—a fast freezer. Once frozen, very thin slices, a few thousandths of a millimeter thick, are removed from the edges of each piece by a sharp blade called a microtome. These are then placed sequentially on glass slides. (Fig. 2) The slides are put through a staining machine, which turn healthy tissue red and cancer cells blue. Staining is necessary because tissue is otherwise transparent and distinguishing healthy cells from cancer cells would prove too difficult.

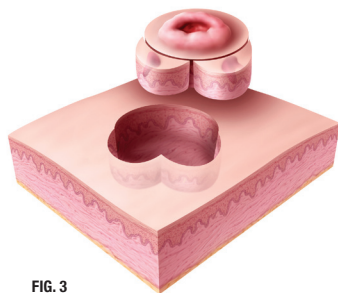


FIG. 3

- Dr. Alam functions as both the surgeon and pathologist, as it has been shown that this increases the accuracy of the procedure. He looks at the debulk specimen, the center of the lesion, to see the tumor, then he looks at the edges and base of the actual stage that was removed. (Fig. 2) He checks to see if there is any tumor of the type seen in the debulk specimen still present on the outside or bottom edge of the tissue specimen. If microscopic examination shows that the cancer has been completely removed, the patient's wound is repaired. However, if the doctor sees tumor cells on the edges, he marks them on a map—a physical drawing of the specimen.

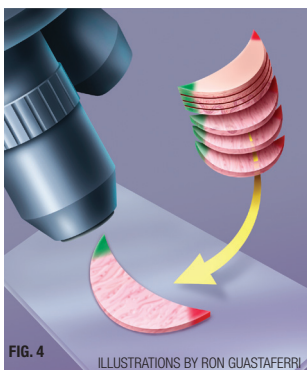


FIG. 4

- Bearing the map, Dr. Alam returns to the operating site and again prepares the patient for surgery. More skin is removed at just those points along the edges of the prior surgery where the map indicated that some of the tumor remained. (Fig. 3) Again, the wound is cauterized and bandaged and asked to wait while this tissue is processed and reviewed in the lab. These steps are repeated until all of the tumor is removed as evidenced by the tissue showing margins clear of cancer cells. (Fig. 4)

of the Section of Cutaneous and Aesthetic Surgery at Northwestern University's Feinberg School of Medicine, to have my cancer removed via Mohs surgery. Created by Frederic E. Mohs, MD, in 1938, it is a highly specialized method of removing the cancer using microscopic guidance to eliminate 100 percent of the tumor while saving as much healthy tissue as possible. Mohs is most appropriate for BCCs, SCCs and other rare non-melanoma skin cancers. Because BCC is so common, Alam was not available for another two weeks.

I never had body anxiety until I had skin cancer on my face and I wanted that thing gone, out of my body. It touched my pillow and my girlfriend Katie's face when we kissed. Actually seeing and touching cancer was strange and terrifying. I felt disgusting. I felt I was crumbling like rotten wood. I felt diseased.

I knew the cancer wasn't going to kill me. Malhotra framed the diagnosis with a silver lining by saying that as skin cancers went, BCC was the best kind. But the idea of having any kind of cancer at all was unsettling. It still is.

Perhaps this nondeadly, but destructive cancer was a warning shot across my bow. Perhaps the next cancer will be a viciously hungry melanoma. Perhaps this is the beginning of the long end.

But why? What had I done wrong other than having been born with susceptible genes? My skin cancer could be castigation for all that time spent on boats, swimming in lakes and pools, running around baseball diamonds, falling asleep in lounge chairs, enjoying burgers and brats at friends' barbecues and sunbathing with pretty girls and coolers of beer. I coveted the sunshine. Youth and free time had done this to me.

But wait—I had used sunscreen. Still, maybe I could have done a better job of protecting myself. Obviously I could have.

It's too late now.

I've already lost, well, face.

And then, finally, on a mostly gray morning, I arrived at Alam's office. I was prepped, numbed, and the first cut was made to remove the tumor.

"Your case was unusual in that the tumor was larger than anticipated," Alam said. "There was more tumor underground than visible on the skin surface, and we had to go back several times to remove all of these tentacles [underneath the surface]."

It was a good thing I blocked off the whole day and that my doctor-required ride home—my dad, showed up with the latest issue of *MAD Magazine* for me to read because there was a lot of waiting. I went through five rounds of the surgery.

Afterward, Alam said that on the surface my BCC "looked like a slightly angry pimple. Pinkish red, slightly

shiny, knobby and uneven skin that looked a little raw. It had distinct borders where it gradually became more normal-appearing skin.

"Microscopically, the tumor cells looked like bluish clusters of cells in the top two layers of the skin" he described. "In the dermis, the cells were arranged in small and large irregular, shared clusters; some that looked like tadpoles or large commas in shape. The clusters of cells pulled away from the surrounding skin, creating some gaps and also lined up slightly irregularly."

Alam was kind and funny, which made the smell of my own burning flesh less horrible as he cauterized the wound between rounds. When it was all done, I asked him if I could see the wound. He and the nurse looked surprised. They advised me against it. I insisted.

The nurse reluctantly handed me a mirror. "Holy [expletive]!" I said.

The larger-than-a-quarter-sized hole in my face looked like Alam had

applied "The Walking Dead" quality of zombie makeup. I asked if that was my bone that I was seeing at the bottom of the hole. I was reassured that it was not. The wound was deep but shallow enough that the scalpel never even touched muscle.

At about the third round, one of the nurses let me know that she had scheduled an appointment for me to meet with a plastic surgeon later that afternoon. It was clear before the tumor removal was completed that Alam would not be able to just stitch and bandage me up and send me on my merry way.

When I was through gawking at my deconstructed face, dressing was applied. Dad and I killed the 40 minutes we had before the plastic surgeon appointment by grabbing a bite at the TGI Friday's across the street from the hospital.

Douglas Sidle, MD, assistant professor in otolaryngology, head and neck surgery and facial plastic reconstructive surgery with ►



THE SITE OF THE BASAL CELL. POST-MOHS SURGERY. PHOTOS COURTESY OF DR. DOUGLAS SIDLE

The V–Y Island Advancement Flap Reconstruction

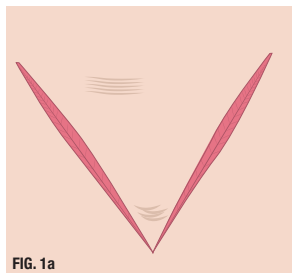


FIG. 1a

• The V–Y island flap is named because of the type of incisions made. First, an incision is made in the shape of a V near the wound. (Fig. 1a) The tissue is moved into place to fill the wound. (Fig. 2a) That V is then extended from the

bottom so it looks more like a Y, or a kite tail. That kite tail is like a zipper that helps push the fat in place and closes

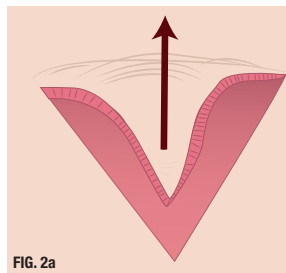


FIG. 2a

everything up. (Fig. 3a)

• In Himmel's case, he was under monitored anesthesia care (MAC), which keeps the patient in a deep sleep. Dr. Sidle marked Himmel's smile lines before he was completely asleep in an effort to get as

much of the scar line—the kite tail—to fall along the relaxed skin tension lines (RSTL). This was difficult to do with Himmel

Northwestern Medical Group was still in the operating room when we arrived at his office. Dad and I were greeted and tended to by Sidle's physician assistant, Erin Hoke, PA-C. She had a wealth of information, and while we waited for Sidle to finish up in the OR, Hoke removed my dressing and explained what might happen.

She said Sidle might be able to patch me up right there in the procedure room, but if not, they'd schedule me for the OR. She said my wound looked too big for a procedure-room stitching, but she had all the tools ready to go, should the doctor think otherwise.

When she left us to get an ETA on Sidle, I convinced Dad to snap photos with his phone of my face for posterity and to send to my mother.

Sidle arrived a few minutes later. A glance at the wound, and he knew he needed the full force of the OR to fix me up. Hoke quickly slipped me into the surgery schedule for the next morning. As he explained the surgical options, Sidle studied my face. He noted how it moved, the shapes it took, where the smile lines and wrinkles lay.

Due to the wound's location, there was risk of the surgery displacing my lower eyelid, so Sidle told me that a V–Y island advancement flap

reconstruction would likely be the best option. This type of reconstruction requires taking part of the skin from one place and moving it over to fill the void. The benefit of the wound's location is that there was plenty of tissue to use since the buccal fat in my cheek was so nearby.

"We essentially borrow from Peter to pay Paul," Sidle said. "Well, we take from Peter to pay Paul because Peter has so much extra that it doesn't make a difference. When you take from a chubby area, you may take 10 percent to fill much more that doesn't have much there anyway."

The stitching and scarring that would follow didn't bother me. I've had stitches in my face and other facial wounds that healed and scarred and mostly faded away or blended into my skin with time. It was the risk of having a droopy eyelid or a dip in the right side of my face because of taking Peter's buccal fat that terrified me the most.

"Why not a skin graft?" I asked.

"A graft means more incisions," Sidle explained. And a skin graft doesn't come with any fat. Skin grafts have to be thin. "To replace the volume, I have to bring fat with it. Most importantly, when you're reconstructing something, you want

the texture, color, sun damage and pore size to be as close to what you're replacing as possible. Grafts lose color because they come out of the blood supply, and pigment cells die. The best option is to pull from what's right next door. Otherwise it'll look like a patch."

I didn't sleep well that night. And in the morning, I took a good long look at my face in the mirror. It wasn't a perfect face, but it was the one I had grown used to. And I was frightened by the idea that it was already destroyed and that the repair would leave me with a new face that didn't suit me quite as well.

Katie came with me. We sat a while in the OR prep room. She looked at the small television hanging in a corner from the ceiling.

"Want to watch TV?" she asked.

I didn't. I wanted quiet and nothing to distract me from my internal panic telling me that this was but the first of many surgeries to repair me from the wrath of disease. As I aged, my body would only get worse; my organs would tire out, my brain would slow down, my bones would become brittle, my skin would log more hours of sun exposure. The only way I saw it was that this surgery was a precursor for the rest of

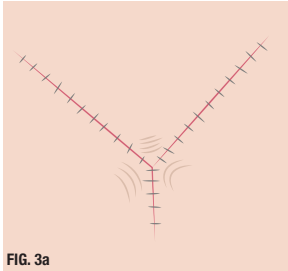


FIG. 3a

because he didn't have many RSTL on the high cheek—often the case with younger patients lacking wrinkles. Because there were no RSTL to follow, Dr. Sidle took extra caution to be sure he did not displace the eyelid.

• A local anesthetic is administered, which includes lidocaine and epinephrine. The lidocaine numbs and the epinephrine



FIG. 4a

causes the blood vessels to clamp down so there's less cautery and less bruising. Once the anesthetic has taken effect, the procedure is executed following the lines drawn by the doctor. When the tissue is

replaced, the wound is stitched up and the patient is sent to recovery. Swelling and tenderness do occur. (Fig 4a)

ILLUSTRATIONS BY HANNAH DOMINIAK. PHOTO BY KATIE DAVIS

my life. And as much as I love Katie, this was not something I wanted to talk about. Therefore, it was best to just stay quiet.

Besides, there's nothing good on TV at nine in the morning.

The only conversation was the chattering of my teeth as the cold saline solution made its way through my veins thanks to the IV hanging above my head. I thought about never stepping foot in the sunshine again.

When it was time to roll, Sidle arrived with a posse that moved around me like an Indy 500 pit crew. Katie was sent to the waiting room as I was wheeled down the hall. The anesthesiologist quickly introduced himself to me and said, "You're a scotch drinker, right?"

I nodded. Good God, I thought. Was that in my file somewhere?

"What's your favorite kind?" he asked.

"Well, if I have to pick the last thing that'll ever touch my lips... I guess I'd pick Johnnie Walker Blue Label."

"This stuff [the anesthesia] is just like that."

He fiddled with the IV bag, and things began to blur into strangeness as the cocktail took hold. I recall the hallway and then being lifted from the bed to the operating table. Sidle kept

saying, "Smile. Smile. Smile real big." Things touched my face. A needle. Maybe a pen.

People tell stories about dying on an operating table and seeing a bright white light just before coming back to life. I know what they mean. I, too, have seen this light. But it's not heaven, and no one is dead. It's just the light from above the operating table that barely conscious and deeply groggy eyes first see.

As I came to, I realized that the surgery was over. Nurses packed up. Sidle said to no one in particular, "This looks really good." I was never completely unconscious during the surgery. I was under monitored anesthesia care or MAC, which is also called being put in twilight. It was the best sleep I'd had in weeks.

I spent the next three days in bed consuming as much television as Netflix would allow me. Katie helped me change my dressings and clean my wound three times a day. She also fed and babied me as needed. I was sore and stiff and swollen. It was hard to talk to friends and family when they called, so I stopped answering the phone. Katie handled the text messages, too. A few times each hour, it felt like lightning bolts were trying to

shoot through the two layers of stitches holding my face together.

A week later, I was in Sidle's exam room to have my stitches removed. He was happy with how the wound had healed so far. I was, too, considering how things looked a week before. The kite-shaped scar was knitting up well, and there was no sunken face or droopy eyelid at all. I no longer had to wear the large, uncomfortable bandage. Although, I had to tape a small silicone sheet over the wound for at least 12 hours at night. The gentle pressure helped mold and soften the scar.

Six weeks later, I was back in his procedure room for dermabrasion. This is not to be mistaken for the common and aesthetic-specific microdermabrasion. Dermabrasion requires serious local anesthetic. A power tool that resembles a Dremel uses bits with varying degrees of texture to essentially sand the scar down, blend it in and smooth it out. Sidle was aggressive with the tool to make sure that the final result of the scar would be as miniscule as possible. Thanks to the numbness, I didn't feel much more than the vibrations of the bit blasting away the topography of my face. There's something to be said about seeing the dust of your skin fly off of ►

“ We’re not supposed to be afraid of the sun. And I imagine my fear will fade with the scar.”

your face like sawdust in a woodshop... that something is, disturbing.

It looked like the right side of my face had been dragged across a highway at 60 miles per hour. I was wearing a bandage again. Once that healed up, about a week later, my face was closer to having character rather than a wound.

It’ll be another year before this scar is like all the others I’ve amassed over the years—a vague-looking memory. A reminder to be more careful.

I won’t call myself a cancer survivor. That’s a title reserved for

those who warded off life-threatening tumors. But I am cancer-free and slightly worse for the wear. I still prefer bright days to cloudy ones, but I find myself treating my time outdoors the same way I handle a gun—with extreme caution and care. I apply 110 SPF broad-spectrum sunscreen to my face, neck and ears every day, every two hours—more often if I’ve been sweating or swimming.

Despite my fondness for the Van Morrison song, “Bright Side of the Road”, I now walk on the shady side. I keep a notepad by my bathroom sink

to track the date and condition of any new marks on my face or body. My hypochondria will kick in, and on any given day, I’m sure I have four new face tumors. Malhotra wants me to check in at least every six months. I’m OK to see her every three.

We’re not supposed to be afraid of the sun. And I imagine my fear will fade with the scar. But I’ll always be aware that cancer is waiting for me, begging for a reason to jump in and take over. Skin cancer didn’t kill me this time. However, I did have to lose a little face to save it. ✚

A Few Simple Ways to Prevent Skin Cancer from Causing You Too Much Harm



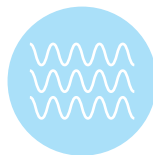
- Wear sunscreen. Like voting in Chicago, apply early and often. Make sure the type you’re using is broad spectrum with UVA and UVB protection and with a sun protection factor (SPF) of at least 30.



- Reduce your time exposed to the sun during the danger hours of 10 a.m. – 4 p.m.



- If being outdoors during the danger hours is unavoidable, take the occasional break and seek shade. Reapply your sunscreen every two hours or immediately after drying off after swimming, and wear a hat and sunglasses.



- Being in the water does not protect you from sun damage. Just because you’re not hot, doesn’t mean you’re not being cooked. UVB rays bounce off of reflective surfaces like water, and even snow and ice, which means you’re getting double the exposure.



- Apply sunscreen to the face, ears and neck (and head if bald) throughout the year even if you’re inside sitting next to a window. UVA rays will penetrate glass.



- Be vain. Pay attention to changes on your body. If something new arrives and isn’t gone, or at least getting smaller—like a pimple—within a week, have it checked by a dermatologist. And keep an eye on existing beauty marks, moles or freckles. Any changes? Get it checked.



- See your dermatologist at least once a year. Even if things look OK to you, your dermatologist may see something else. Statistically speaking, there’s a good chance you will end up with some form of skin cancer. Catching it early is always best.