

Skin Cancer Complications

Generalised complications of skin cancer surgery include:

- Scarring
- Anaesthetic complications
- Injury to adjacent structures, such as nerves
- Infection
- Graft or flap failure
- Incomplete excision
- Recurrence
- Reoperation
- Asymmetry

They are influenced by:

- Your general health
- Previous treatment
- Preoperative planning
- Skill of the treating team
- Postoperative care
- Compliance with advice

Scarring:

It is impossible to excise and reconstruct a skin cancer defect without causing scars. Through good preoperative planning, minimising tension, meticulous technique, and good postoperative care I will try and minimise them. Please read my scar management page in the patient information section of my website. If a scar becomes problematic there are options available.

Anaesthetic complications:

Many simple procedures can be done under sedation and local anaesthetic, minimising the anaesthetic risks. Anaesthetic blocks and general anaesthesia may be required and will be tailored to your needs.

Injury to adjacent structures:

This is rare but if the lesion is attached or very close to an underlying structure (such as a nerve) it may be unavoidable. I will warn you before the operation if I think it is possible. It is more common in re-do surgery, if you've had previous surgery in the same area.

Infection:

Infections are more common if there is poor blood supply to the area, such as the lower leg. Skin grafts have no blood supply until small vessels grow into them, making them more susceptible to infection and failure.

Graft or flap failure:

Grafts fail because of poor underlying blood supply, movement of the graft, bleeding and infection. Flaps are less likely to fail because they have their own blood supply rather than relying on vessels growing into them. I will maximise the survival of your reconstruction with preoperative planning, meticulous technique and good postoperative care. You can help by reading and following my postoperative instructions.

Incomplete excision:

I can only use magnification and good lighting to help me judge where the margins of your skin lesion are. Once excised it is sent to the pathologist with a marking suture. They examine it microscopically and report if the margins are clear. In $\leq 5\%$ a margin is involved or very close and further excision is required to prevent recurrence. Occasionally radiotherapy may be used instead of re-excision.

Recurrence:

Despite clear margins recurrence can occur. It is never clear if this is a true recurrence from a satellite lesion or a new malignancy. You need surveillance with your GP or dermatologist after having a skin cancer excised.

Reoperation:

Incomplete margin, failure of reconstruction, complication or poor cosmetic result are reasons for reoperation.

Asymmetry:

Excising lesions from symmetrical structures such as the eyes, nose, mouth or ears can lead to asymmetry. It is usually a cosmetic issue but it can be a functional problem, particularly for eyes, noses and the mouth. I will warn you before the operation if I think it is possible and minimise it with preoperative planning and meticulous technique.

