So…podcast – Episode 21

Dr Edward Upjohn – Skin Cancer Specialist Dermatologist

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John: Greetings. John McKenna, So…podcast. My guest today is Dr Edward Upjohn, a skin cancer specialist dermatologist. G'day Ed, welcome to the show.

Edward: Hi John, thanks for having me.

John: Ed, like I say to a lot of my guests, especially when they've got huge titles and heaps of experiences, I'm going to ask you perhaps to introduce yourself, please.

Edward: Sure, so I'm a skin doctor, so that's a doctor who specialised in dermatology. I'm based in Melbourne, Australia. I've been doing this for about 10 years, so before that I was training to be a dermatologist. All up, I've been a doctor for about 20 years, and I've got a special interest in skin cancer.

John: Let's talk about the word "dermatology" for a start; what does that mean?

Edward: Dermatologists treat everything to do with the skin, including hair and nails, so basically anything you see when you get undressed is something that a dermatologist will see and treat.

John: Ed and I got to know each other, Ed, didn't we, because of my scenario in relation to fair skin, the boy from Ireland? Irish skin, of course, is very likely to have issues with sun damage, etc, so I guess my connection with you Ed has been as a patient, and so it's really great to be able to talk heart to heart about my own journey. I think that's what brought us together. Ed, let's get stuck into it;

Australia has had a really bad reputation about being famous for cancer. What do I mean when I say that? What are you hearing at a professional level?

Edward: Australia certainly is top of the league table when it comes to numbers of skin cancers that we diagnose and treat each year, particularly the big skin cancers that people may have heard of, so melanoma; Australia and New Zealand unfortunately fight it out for which country has the most per capita, so per head of population. But there's other skin cancers too, which are actually more common, and we certainly have the most of those as well, and they're the so-called non-melanoma skin cancers, so they're skin cancers that are not melanomas but are actually more common and perhaps less well-known by people in general, but are actually the ones that people are more likely to get.

John: Quite often in interviews I say, "Let's dig a bit deeper." Saying this to a dermatologist is really scary. [laughter] But let's dig a bit deeper, Ed, when we talk about, we'll go straight to the really serious one which is a melanoma. Why is it serious? What's it look like? And what can we tell the audience about a melanoma?

Edward: Melanoma's a serious one because I suppose it can be sneaky in as much as sometimes they just look like a mole, an ordinary mole, and they can occur in young people as well as old, although to be honest, they're more common in older people, but they can occur in younger people too. And they're concerning because they can spread, and sometimes they spread at an early stage when you don't realise that even you've got any problem, and so it's important to get onto those ones as quickly as possible because we know that early diagnosis can save lives. There's been a lot of good news about melanoma recently, so in the past when a melanoma had spread it was very difficult to treat, and in fact, when I say "difficult" I'm meaning patients died. And some patients do still die of their melanomas, unfortunately, but many are being treated with

some of these new drugs, and they're living normal lives, whereas 20 years ago that wouldn't have happened. But it's still a very serious diagnosis, and it affects large numbers of Australians every year; probably about 10,000 Australians every year get diagnosed with a melanoma.

John: You described a melanoma as a mole; for other people might know it as a piece of black freckle on their skin…

Edward: Mm.

John: …it's raised.

Edward: Yeah. And people often get very nervous when we start talking about melanomas because they think, "I could easily have one of these and not know it." Often we talk about the ugly duckling mole, so that's a mole that really stands out from the others. All of us have moles, they're almost universal; some of us have more than others, but some people are more prone to melanomas, if they've got very fair skin, exposed to a lot of sun, or have a high number of moles, or maybe a family history of melanoma. But it's really, mostly it's your own sun exposure rather than a family history situation. And it's typically the mole that is new or changing; that's the ones that we get concerned about and that we want people to come along and see us about.

John: Obviously different times where I've been with you, Ed, a lot of photos are taken because you're able to monitor what change has happened on your skin. That's pretty important, I guess.

Edward: It is, and that's the great thing about dermatology and the skin, as it's very easily assessed. It's a bit embarrassing getting undressed in front of someone, but apart from that, it's much easier to examine someone for skin cancer than for pretty much any other cancer that we're talking about. And photographs are a great way of

monitoring things because I've got a good memory, but after a year I might forget what I saw, and so it's good to have a photograph there to compare back to.

John: Melanomas can be rounder normally, they can be raised; can they be square? Can they be other shapes?

Edward: [laughs] They can be a number of shapes, and to be honest, they sometimes aren't raised, sometimes they're quite flat on the skin. I suppose the key thing about a melanoma is usually a history of change, so there's been something about them that is not staying constant, so they might be getting darker, they might be getting bigger, they might be changing colour. A sensation or a change in sensation is actually pretty uncommon, but we do see people who say, "This one's come to my attention because it's itching," or, "I've just noticed it and just something doesn't feel right," and even if it's just that "something doesn't feel right" feeling, that's an important thing to pay attention to.

John: Let's go down the scale; there's something called an SCC. What's that?

Edward: An SCC, and in medicine we love acronyms, so we love shortening things as much as possible. It stands for a squamous cell carcinoma, and they're actually the second commonest skin cancer that we see and diagnose. They're much more common than melanomas, so melanomas would probably be about the third commonest skin cancer. Squamous cell carcinomas, or SCCs are more common than melanomas. They can be serious if they're allowed to grow and spread, but most of the time we treat them at a stage when they are just confined to the skin. But they're often, they grow fairly quickly usually, and they sometimes start off like a pimple but they very usually rapidly turn into something that's noticeable, maybe tender, sore, not healing, that sort of thing.

John: And then a really common one is the BCC.

Edward: That's right, that's the most common skin cancer, so common that the government unfortunately doesn't even collect statistics on it, so I can't tell you exactly how many were diagnosed in Australia last year but to put it in perspective, if you're fair-skinned and you've grown up in Australia all your life, by the time you're 70 you've almost got a 50% chance of getting a BCC, or basal cell carcinoma. But the good news is that they're very rarely life-threatening, but they can be problematic because they often occur on the face, and they can occur in sensitive areas like on the nose or ears, or around the eyes. Basal cell carcinomas, they're not as dangerous as the others, but they're more of a nuisance, just because they're so common.

John: We seem to be talking about treatments, but before we do Ed, I'd like your thoughts on the pandemic at the moment, and how that's having impact on people thinking about their own skin checks.

Edward: Absolutely. Unfortunately, it is the case that people are anxious about going to the doctor, anxious about going to hospitals, and they might put off going to the doctor to get a spot checked, but we know that skin cancer doesn't stop, unfortunately, and every year a certain percentage of people are going to get a skin cancer. It's very important that people still do get that spot checked out that they're worried about, or if they're at high risk of a skin cancer, that they keep their appointments as best they can, because skin cancer is, the clique of "early detection saves lives" is very true with skin cancers, and unfortunately there has been a reduction in people coming along. I work at one of the big public hospitals in Melbourne, and we know that a lot of patients have rescheduled, or put off appointments, and that's fine but they've got to make a plan to get along and make up that appointment and not just let it fall by the wayside.

John: Ed, a lot of people go to their GP, of course, all the time for different ailments, and that's normally probably their first point of contact when they want to start talking about what they've discovered on the skin. Let's describe a normal scenario where a good average GP will look and make the call on sending it away or calling a dermatologist; what goes through a GP's mind when deciding on the next thing to do?

Edward: We're very lucky in Australia in that we've got excellent GPs, and because skin cancer is so common, they're excellent at skin cancer too. You're quite right, a GP is definitely the first point of call, your family doctor, and I always tell people the thing to do is if you're worried about a spot on your skin, don't go to your GP and have a list of all the things you want done, the repeat scripts for this or that, get your blood pressure checked and then, "Oh, by the way, can you check my skin?" You've got to give them the time and the opportunity to do it justice, and they will. Basically, I think it's good for any Australian who's worried about their skin or whether they've had too much sun in the past to get their GP to see them to just check their skin, and even if it's just a once-off, that's an excellent stocktake. The GP will examine their skin, look at their moles; almost all GPs now are trained up in examining moles with what we call a dermatoscope, that's just like they listen to your chest with a stethoscope, there's a special instrument for looking at the skin, and that can help them diagnose skin cancers. And if they're anything they're worried about, they're well-trained to take a biopsy, take a sample of it. Or if they're not sure if it needs a sample, they can certainly refer on to a dermatologist for an opinion about a spot.

John: I'm sure there's lots of GPs nodding their heads right now as they listen to you, because yes, it seems to be a bit of an afterthought, doesn't it? As you said, scripts, "And I need this. Oh, by the way, have a quick look at this hand, would you?"

Edward: Yeah, that's right. I mean look, of course, I'm going to think the skin is important because that's what I [laughs] like to treat and see, but it is important, as is all parts of our health, but you've got to give everyone the opportunity to concentrate on it.

John: It's Catch-22 treatments, Ed. There are many types of treatments for different types of cancer, we hear the word "chemo". Chemo is more blood-related, is that right?

Edward: Chemo traditionally has been treatment for, yes, it's usually a drug that's given to the whole body to treat a cancer, and oftentimes that's for a cancer that is affecting many parts of the body or has spread. Fortunately, with skin cancers we can usually be very direct with our treatments, so the skin cancer is almost always confined to the skin, and that means that it can usually, more often than not, just be cut out and the lesion removed, the area stitched together, and that piece of skin, and this is very important too, is sent off and usually examined in the first instance by another doctor called a pathologist, who will give a diagnosis. And certain skin cancers, if they're very early and just in the surface of the skin, can be treated with creams even, and that's been a excellent advance for treating, and avoiding in many cases, a scar in an area where you might not want one, for example, on the chest or something like that. The creams are not always indicated for every single skin cancer though, so sometimes people are desperately hoping that we can treat their skin cancer with a cream, but unfortunately we still have to do surgery on it.

John: Sure. Obviously another reason you and I have caught up for this podcast is I've just been through a treatment which is called Mohs surgery, and I'm very happy to hand it over to you about our journey between you and I about what happened, and because I think I was really excited about what Mohs surgery is, how it works, and it's got some great outcomes. But I'll throw it to you, Ed.

Edward: Sure, John. Mohs surgery is a special type of skin cancer surgery where I mentioned before when we cut something out often we send something off to the pathologist to get looked at down a microscope, particularly for a diagnosis. With Mohs surgery, we can do both the surgery and the examining the tissue then and there in real time, and it's particularly useful for a subset of skin cancers, so cases like yours, John, we remove a lesion and it's actually almost invisible on the surface of the skin, we can't see it with our eyes. And so then you're really trying to work out, well, how much do we take? We don't want to take too little, don't want to take too much; we only want to take the skin that we have to to get rid of the skin cancer. And by having the opportunity to examine the edge of the skin that we remove pretty much in real time, it means that we can do the surgery, check the margin, and if we find that there's still skin cancer there, go back immediately and take some more until it's all out, and then we know it's all out and we can put the stitches in and do a repair, and not have to worry about finding out a week later that we have to go back again. I always say it's a great thing for patients, it's also good for people like me who are a bit of a control freak and want to know that the skin cancer's all gone before, and see it with my own eyes before I do a repair.

John: Sure, and from a patient perspective, Ed, I can say there were many times where I've had a sample taken from my skin, and then it's the waiting four or five days to get the result. Those four or five days are terrible, waiting for that.

Edward: Yeah, I know. I think you're right, John, and look, we often don't think about that often enough; the waiting game is terrible, and the days really stretch on when you've got that hanging over your head.

John: But I will share the audience, so I went there and had my injections, and ow, no one likes injections anyway, but obviously it's a local anaesthetic so it numbs the area that's going to be taken out, and it's cut open and I'm sure you'll, look, a good dermatologist surgeon

is going to talk to the patient all the way through it, explain what goes on. From my patient perspective, it went well, and I compliment you and other dermatologists who are talking to their patients about the procedure and how it works. And there's lots of videos and information, if people want more, about Mohs surgery. I may as well spell that; it's M-o-h-s, is that correct?

Edward: That's correct. It's actually, everyone asks, the most common question is, "Why is it called that? Does it stand for something?" But it's actually the name of the man who first did it, and he was an American surgeon way back in the '40's and '50's who started it off, and like many things, it started off small, he trained people who then trained people how to do it, and it's grown from there. Fred Mohs was the first, literally, Mohs surgeon.

John: Obviously GPs will know about this surgery, do you think?

Edward: Yeah. It is now more widely known, and not every skin cancer needs to be treated with Mohs, I'd like to say that first up. But it's certainly a great treatment for a subset of skin cancers. And look, not just GPs know about, but thanks to the internet there's a lot of information out there, and people sometimes come across it off their own bat, they've got a diagnosis of a BCC or SCC, and then they come across Mohs surgery in their own research on it; that's not uncommon these days. I think in all areas of medicine people are much more self-aware.

John: In Australia we're talking about dermatology and skin cancer; is there enough dermatologists out there at the moment?

Edward: Look, I guess the short answer is no. I don't know, when we first caught up, you can probably tell me, you were probably waiting a little while to get in, get your appointment.

John: I was.

Edward: Yeah, and if you're waiting for a skin cancer and all that, we'd love it to be as short as possible. The short answer is, we're training, I always say dermatology is like a country with lots of young people, we're training lots of dermatologists for the future, and so there's a large proportion of our workforce is actually in training at the moment, so in the future it will be better, there will be more dermatologists. And not all dermatologists do Mohs surgery, so you have to do an extra year or two years of training beyond that to do Mohs surgery, so unfortunately the number of Mohs surgeons is smaller again. There's probably about 50 or so of us in Australia, so it's not perhaps as widely available as ideally it would be, but there are, again, people training in Mohs in Australia, so that's going to change over time too.

John: I don't think we could have an interview about skin cancer without you giving a message to everybody about the importance of slipping, slopping and hatting, and all of that sort of stuff. I know the Australian government really focused on a campaign about keeping out of the sun, and you've been doing this for 10 years; is that making a difference?

Edward: It is. We're just starting to get the signals of that effect in the statistics of skin cancers coming through, and it's, look, I always tell people I'll be spending my life treating the Baby Boomers, but I'm very hopeful that the dermatologists in the future will not have the same numbers of patients coming through from every since the Slip, Slop, Slap campaign started in the '80's, that generation growing up, hopefully will not be as sun damaged and at as high risk. Yeah, we are seeing the numbers just starting to improve from that point of view, and I'm sure as time passes that that will continue to pick up. And on an individual level, it's also never too late to start protecting your skin because we know that at any stage when you start wearing sunscreen, sun protecting, that individual also benefits; it's not just a community-wide thing.

John: Thank you Dr Edward Upjohn. It's been a lovely conversation to have with you, a very important one, and it's been lovely just talking, as a colleague, as a patient who's worked with you, and made me feel more comfortable with regards to my skin, so thank you for coming onto the So…podcast. I'd like to remind the audience that if they'd like more information about my podcast my website is johnmckenna.com.au. All my episodes are transcribed, and transcriptions are available. If people want to find you, they could go to Google or is there a website you'd like to mention?

Edward: Yes, well I do have a website, so edwardupjohn.com, John, is my website.

John: Very good. Ed, thanks for joining me today.

Edward: No, thank you for having me, John.

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