My experience of malignant melanoma

This article tells the story of one clinician's experience of receiving a skin cancer diagnosis and the subsequent surgical excision of a malignant melanoma.

'Being told that I had a malignant melanoma came as a surprise and was even more poignant as I had been a dermatology nurse for many years'

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It won't happen to me, is what I told myself. However, when you receive a cancer diagnosis life takes on a different perspective. Being told that I had a malignant melanoma came as a surprise and was even more poignant as I had been a dermatology nurse for many years and now I was about to embark on a skin cancer journey myself.

Malignant melanoma is the most serious type of skin cancer and the incidence among the UK population is rising faster than any other form of cancer (Cancer Research UK, 2011). Melanomas develop from melanocytes, which are found in the basal layer of the epidermis and are responsible for the production of melanin, which gives the skin its pigment. Approximately half of melanomas start with a change in normal-looking skin, with the other half developing from an existing mole or freckle. The earlier the diagnosis, the better the chance of survival and less risk of spread throughout the lymphatic system.

Storytelling

Hawkins and Lindsay (2006) suggest that writing is more powerful than talking and that written stories create pathways to memories, feelings and thoughts. As an experienced tissue viability nurse, managing patients with wounds was second nature, but having never experienced a large wound myself I did not fully appreciate the physical and mental impact that this would have on me.

As clinicians, we try to understand what it is like to have a wound — the impact on our patients' body image and the ability to cope with the wound and the dressing regimens — but unless you experience the symptoms how could you really know?

Relating personal stories allows us to create knowledge by transforming experience (Day, 2009) and can increase health literacy. I hope that by writing about my personal journey I will build on the body of tissue viability knowledge and develop a shared meaning for all involved.

Personally, it has enabled me to make sense of the experience and I hope that sharing my thoughts and expectations may also help others.

Diagnosis

My journey started in April 2011 when I noticed that a mole on my lower leg looked different in shape and colour. Having been a dermatology nurse for many years, I was well aware of the potential for this to be malignant and the need to seek advice promptly. On reflection, however, if I had not worked as part of the dermatology team with direct access to a dermatologist I'm not sure how long it would have taken me to seek advice from my GP, as I would not have wanted to bother him just to look at a mole. I wonder how many patients have said this and then wished that had sought advice sooner.

Health promotion aims to raise people's awareness of altered moles or new areas of skin change in the hope that skin cancers are detected at an early stage. I would now advise anyone who is concerned to seek advice for both diagnosis and reassurance. In my case, early detection was critical to my prognosis.

Following a consultation with a consultant dermatologist, the mole was immediately removed under local anaesthesia. The procedure was quick and the only discomfort was during the administration of the local anaesthetic. I was left with a small 3cm suture line, which was OK

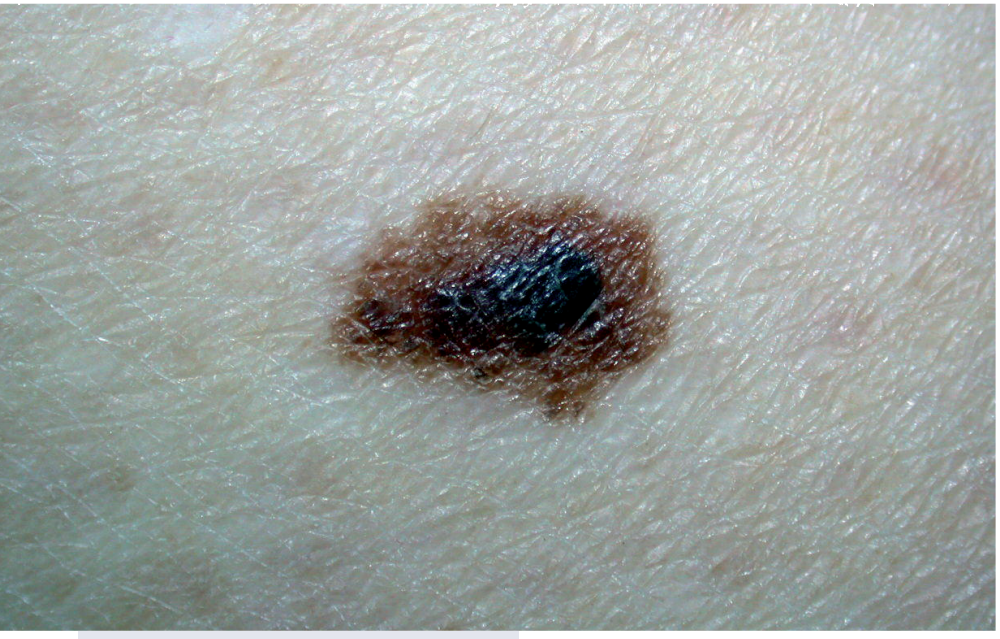

Figure 1: The changing mole – note variety of colour and shape.

cosmetically. However, 10 days later I received the histology report, which confirmed that I had an invasive malignant melanoma. Initially I was shocked, but, I was also relieved that it was shallow and had been completely removed with the first excision. Due to the fact that the melanoma was deeper than 1mm, I was advised that I would need a wide local excision to ensure that all the cancerous cells within the vicinity of the melanoma had been removed.

Malignant melanoma

Melanomas develop from melanocytes — cells found between the basal cells of the lower part of the epidermis of the skin. Melanocytes produce a pigment called melanin, which is responsible for our natural skin colour.

On exposure to the sun, melanocytes increase the amount of melanin to absorb more ultraviolet (UV) rays, thus making the skin darker in colour. Many people do not realise that this effect shows that the skin has been damaged and that it is trying to protect itself from the sun's harmful rays.

Moles are a collection of melanocytes, which lie close together on the skin's surface and are a normal part of the human body. Approximately half of melanomas start with a change in a normal-looking skin, with the other half developing from an existing mole or freckle.

Malignant melanoma is a cancer that develops from the melanocytes. The cells grow and divide more quickly, spreading into the surrounding surface layers of the skin. At this stage they look like a dark spot on the skin's surface or a mole that starts to change in shape and colour. The longer they are left undiagnosed the greater the risk of spreading to the lymphatic system.

More than 10,000 people in the UK are diagnosed with malignant melanoma each year, with numbers continuing to rise (Office for National Statistics, 2011). In the UK it is more common in women and in 2008 was the sixth most common cancer in females. More than two people aged 15–34 are diagnosed every day and it is the second most common cancer among this age group (Cancer Research UK, 2011).

The main cause of malignant melanoma is exposure to UV light and surveys in the UK show that the majority of people regard a suntan as a sign of health, with few understanding the dangers of UV radiation. However, recent research has highlighted a genetic link where genes that normally control cell growth can also stimulate cancer development when they malfunction (Institute of Cancer Research, 2010).
It is important to recognise the signs and symptoms of malignant melanoma

Table 1
Signs and symptoms of malignant melanoma (Polsky, 2005)

A	*Asymmetry*	*Irregular shape to an existing mole or a new mole*
B	*Border*	*Irregular border to an existing or new mole*
C	*Colour*	*More than one colour. Brown/black/red/bluish*
D	*Diameter*	*Usually more than 7mm in diameter*
E	*Evolving*	*Changes in size, colour and shape*

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Office for National Statistics (2011) Registration of Cancer Diagnosed in 2008. Available at: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Cancer (accessed 31 May, 2012)

Polsky D (2005) The ABCDE's of Melanoma: an evolving concept. Available at: http://archderm.jamanetwork.com/article.aspx?volume=141&issue=8&page=1032 (accessed 31 May, 2012)

WEB RESOURCES

SunSmart:
www.sunsmart.org.uk
Macmillan cancer support:
www.macmillan.org.uk

'Reality hit me on the day of the surgery when the area for removal of the skin on my leg was highlighted with a marker pen. It looked a lot bigger than I first imagined'

and these are described in *Table 1*. It is suggested by Polsky (2005) that using the ABCDE tool to assess a mole can aid early diagnosis. Moles are normally symmetrical with a well-defined regular border. They are usually one shade of brown and are no bigger than 6mm across. Changes in colour, shape and size are all significant. The earlier a melanoma is diagnosed and treated the higher the chances of achieving a cure.

Post diagnosis

Once the diagnosis was confirmed a detailed plan was put in place by the dermatologist, plastic surgeon and skin cancer specialist nurse. Written booklets were invaluable in supporting the verbal information and to explain the diagnosis and subsequent treatment. I was referred to a plastic surgeon for a wide local excision due to the depth of the melanoma.

Surgery is the only curative treatment for melanoma and a wider excision ensures complete removal of the primary lesion and removes any micrometastases. My cancer had not spread beyond the skin, therefore chemotherapy was not required.

Surgery

Plastic surgery was undertaken 20 days after diagnosis. Reality hit me on the day of the surgery when the area for removal of the skin on my leg was highlighted with a marker pen. It looked a lot bigger than I first imagined and the surgeon informed me that it would look ugly for a while and would never be the same colour as the rest of my leg. This was an understatement and I am still trying to come to terms with the way my leg's appearance has changed.

The injections of local anaesthetic into my lower leg and thigh were the worse part of the procedure. Everything else went smoothly and the whole process took less than an hour. The benefit of having local anaesthesia is that there are no 'groggy' after-effects. I took a supply of silicone non-adherent dressings with me and asked that they be used on the grafted wound. I was worried about dressing adherence and pain, and felt that at this stage I could influence this aspect of my care.

I was surprised that I was not given any dressings to take home as I know from other patients' experiences that donor sites can leak. In hindsight, I should have asked but I thought they must know what they were doing and I certainly did not feel like the 'expert' at this stage. I was the patient and as such put myself in the hands of the clinicians looking after me. On reflection, I remember being told that the donor site was not to be touched for two weeks! Maybe there was an assumption that dressings were not required?

The next day my donor site was still bleeding and I struggled to find any local healthcare provider to review my wound and supply dressings. In the end I had to be driven to the local dermatology unit. My surgery was undertaken in another hospital one and a half hours away and was not easily accessible, especially with a bleeding thigh wound. This experience has made me question and share my concerns with the local skin cancer team about what would happen to elderly patients or those who live alone if they were faced with the same situation.

On reflection I can now understand why donor site dressings stick and are difficult to remove. The exudate levels were high and if these dressings are left in situ for two weeks eventually the pads will dry up and become crisp and difficult to remove.

After 10 days my clips were removed (*Figure 2*), and my graft was deemed to have been 'a perfect take.' This may have been the opinion of the surgeons, but to me it looked a mess. However, as time has gone by, the wound has become shallower

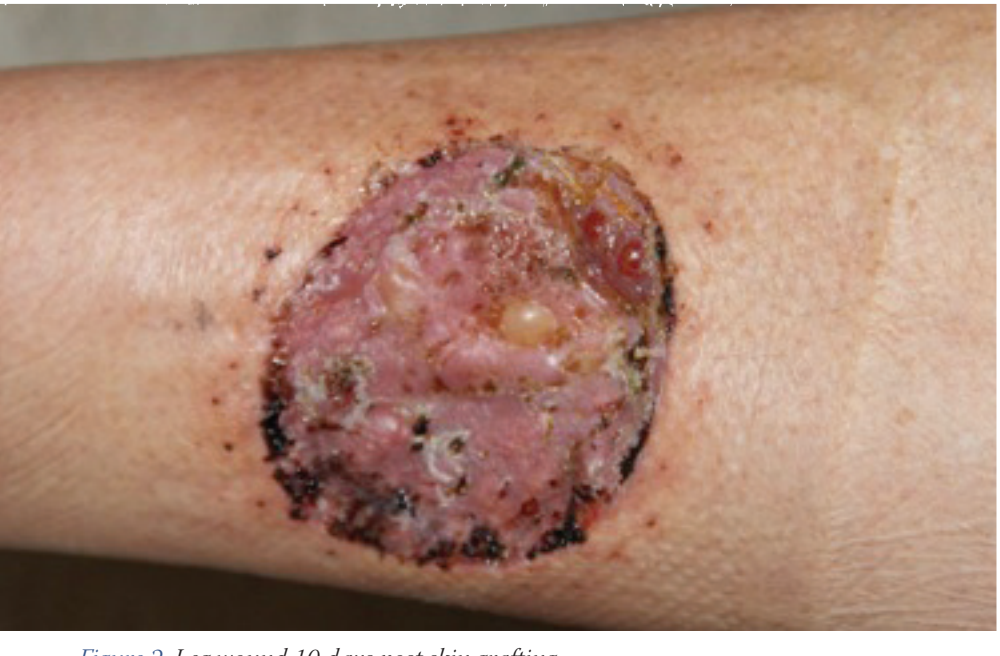

Figure 2: Leg wound 10 days post skin grafting.

'The donor site was a different story as bleeding saturated the primary dressing and in the end I had to remove it and reapply a silicone-based product'

and the colour lighter. I was told this at the time, but it was hard to take in as all I could see was an ugly hole in my leg. The donor site (*Figure 3*) was also in good condition and healing well. *Figure 4* shows the wound healing after four months.

Pain

It would be wrong to say that I had any real acute pain from either the wound or the donor site, however, I did and still am experiencing the effects of the nerve damage. In some areas of the wound there is still no sensation at all, while in other areas there is hypersensitivity, a sensation akin to when your skin is attacked by stinging nettles.

There are also occasional bursts of energy from the nerves, which results in the shooting pains often described by patients. The lower section of my leg between the wound and my ankle feels very unusual as it only has partial sensation. Advice given to me by the plastic surgeon was to tap the area above my wound in order to stimulate and reprogramme my brain. As strange as this sounds it appears to have worked.

Wound dressings

This is one area where I felt I had the most knowledge and could influence my treatment. To an extent, I did, but equally, I felt vulnerable when the donor site was bleeding. There was conflict centering around what I had been told by the surgeons and what I wanted to do to make the wound feel more comfortable. Typical nurse!

The plastic surgeons' standard practice was to use a paraffin-based dressing on the grafted area with an alginate dressing on the donor site, however, as previously described, a silicone dressing was applied to the graft because of my concerns about adherence. Thankfully it did what it said on the packet and removing it was a painless experience.

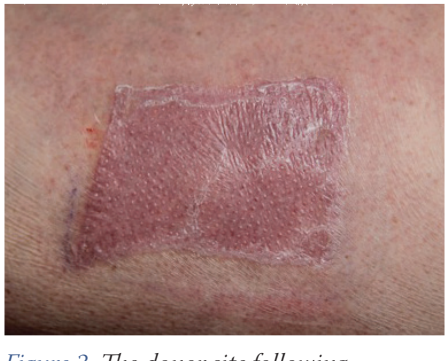

Figure 3: The donor site following dressing removal.

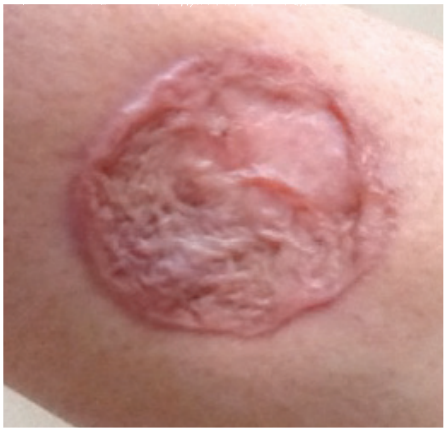

Figure 4: Healed leg wound after four months.

The donor site was a different story as bleeding saturated the primary dressing and in the end I had to remove it and reapply a silicone-based product. I was then able to change the secondary gauze and film dressings on alternate days. The best moment was when I was allowed to shower and get all the areas wet. I felt human again.

I was fully prepared to use below-the-knee compression hosiery after the surgery to help minimise postoperative swelling of my lower leg. However, this was not to be the case. The grafted area was very tender and application of tight stockings was certainly not an option I was prepared to consider.

Conclusion

The experience of having been given a diagnosis of skin cancer and progressing through the journey to recovery has made me realise the impact this has had on the physical and psychological aspects of my life. I will be followed up for five years so the journey is still continuing, but at least the worst part is now over. This experience has made me reflect on my prescribing practices and also given me a heightened awareness of a patient's inability to tolerate recommended therapy, even though we know it will make a difference.

I hope that through sharing this experience, others will learn from it and raise the profile of prevention and early detection of malignant melanoma in order to save lives. Hopefully the cancer has gone forever, but the scars will remain with me always. WUK