

Dermatology With Olivia Stevenson

- APM: So that is everything that needs said about housekeeping. If there are any problems, call the helpline number and one of our team will sort you out even as we're going on. Well, this evening, we have a slightly unusual CPD for manual therapists such as us. We have a dermatologist with us and of course, it's not one of those conditions we have people coming to us primarily for in clinic but of course, skin comes into our clinics pretty much all the time. Our guest this evening is Olivia Stevenson. She has been the lead consultant dermatologist at Kettering General Hospital in Northamptonshire since 2005. She works in private practice across Northamptonshire and she has a particular interest in myeloma and psoriasis. So she's got a lot to say about a variety of skin conditions and I've already worked out that she's quite passionate about this specialist subject of hers. Olivia, welcome to APM.
- OS: Hi.
- APM: Thank you for joining us. Great treat to have you with us. As I said in that intro, people don't come to osteopaths and chiropractors primarily for their skin problems but they do bring their skin in with them. So are we likely ever to be the first person to spot a problem, do you think?
- OS: Absolutely. Patients don't like going to see their GP with sometimes what they think of as minor. Sometimes, obviously, if it's on their back, they may not even be aware that they have it. So yeah, definitely.
- APM: I know you've worked with...well, you've briefed some osteopaths around the county and you've had osteopaths shadow you. In your own experience, are osteopaths referring to you for things like that?

OS: Yes, I do get...mainly privately because if they have been seen on the NHS, they would...normally, you'd be recommending them to see their GP for that referral but I do get osteopaths advising their patients to come and see me privately if there's a particular concern, a rash or a lesion.

APM: We discussed GPs before we went on air and as I said then, I mean I'm not one to try to put down GPs because they do have to know an immense amount of things but how good is that normal first point of contact, the GP, recognizing skin problems?

OS: It is completely variable. Because GPs actually have so little commitment to have dermatology training within their curriculum, it's very much a personal thing. So some GPs will be very good because they have a passion. They've taken special interest and they've learnt and others know very little. Unfortunately, even basic dermatology is rocket science if you've never seen it before.

APM: Indeed. Actually, I mean you are quite unusual, I imagine. I mean is it a popular specialization, dermatology?

OS: It has now become the second most competitive specialty in all of medicine because I think people are fed-up of working themselves to death more than anything. We are second only to cardiologists in the number of applicants per post. Obviously, we don't have as many posts. There's far more applicants to other specialties but we're still a fairly small specialty. There are I think over 200 empty consultant posts in the country because we're not training enough dermatologists but it's a very nice pace of life because we don't have an awful lot of emergencies but it's so diverse. It really interests people like me because we deal from infants to 105-year-olds. We do some operations. We do medicine and surgery, you know. It's just very diverse and so I just really love it.

APM: In your bio, as we were discussing earlier on, you got a particular interest in cancer and on your website, it says you have a 95% surgical success rate. Have I got that right?

OS: Yeah, that's —

APM: That sounds really impressive.

OS: Yeah. It's actually pretty standard. If you excise skin cancers properly, the gold standard treatment should give you 94% to 96% clearance rates and we order ourselves all the time to make sure we fall within that. So if we're removing a skin with the appropriate margin then we're getting good clearance rates and our program. I did want to pick up though, because you did introduce me as lead clinician at Kettering and I am not. I am cancer lead though.

APM: Cancer lead. I do beg your pardon, yes.

OS: I didn't want to suggest that because my fantastic, wonderful colleague—

APM: They won't be watching. They won't know —

OS: Johan is clinic lead.

APM: Lead cancer clinician, I beg your pardon. So what are the main things that come through your consulting then? I mean obviously, you have a specialization in psoriasis and cancer but you must see all sorts of —

OS: Well, there's only the two of us so we see everything. Unfortunately, everything from the mundane to the ridiculous. We get referred in blackheads as skin cancer and infants with total body eczema that haven't been referred and it really is very, very diverse. We see every rash, allergy rashes, sort of eczema, psoriasis type rashes, acne and all the skin cancers, various lumps and bumps. Yeah, and a lot of sun damage. Incredibly diverse, I just love it.

APM: Let's talk about sun damage for a minute because there's been a lot in the news about the potential damage of ultraviolet light to the skin. I mean just how bad is it given how little we get in this country? Is the —

OS: We get loads. Well, I think we have to appreciate how much sun we get. Because it's so intermittent, it's even more dangerous because we all love it, don't we? You know, as soon as the sun shines out, we leap out in our shorts and t-shirts and forget the sun cream because we're not in Spain and we burn and people like you who have a slight follicular challenge, you need to be aware of your head and chaps over 30 are probably starting to thin already and they don't realize —

APM: Stop there. I'm wearing this little bit of sunburn with pride because I earned this at Glastonbury this year and I'm —

OS: Well, I think you should be very proud. However, a hat next to it please.

APM: I'm trying to master of the technology of the hat, I must admit.

OS: I think that is one problem because chaps lose the protection of their hair probably 10 or 15 years before they lose their hair because if you have fine, sparse hair, it's doing you no good, whatsoever and you can't put sun cream on a hairy head. So you do need a hat. And so we see an awful lot of skin cancers, especially in the 70's and 80's on the top of their head.

- APM: So actually, it's that binge sunbathing rather than constant exposure which is —
- OS: It's both. We have different sorts of skin cancer. We know that melanoma, sunburns under the age of five are the biggest risk factors. So people like you and I who still burnt regularly as children because there weren't sun creams about are still very much at risk. Sun creams probably didn't really get introduced well into the '80s. We had Piz Buin factor two type things when I was young and it's only now that we know that you have to sun protect. So we know that sunburn under the age of five is something you can't turn the clock back and it's there, it's done. We know that constant sun throughout your life...so if you work outdoors, puts you at very high risk of skin cancer especially squamous cancers but your basal cell carcinomas, actually we can all get them just from enjoying being outdoors. If you're very, very fair, you're actually almost less likely because you hide or it's those people who think, "Oh, well, I only go a little bit red and then I get a lovely tan," you know. They are still burning. It's DNA damage.
- APM: You said the basal cell carcinomas are the pretty ones earlier on I think. We'll have a look at that. As you said, yours is a very visual specialization so we've got 64 on slides I think of various things from the pretty to the rather —
- OS: Ugly.
- APM: Rather like smoking, not everybody who goes out in the sun gets cancer, do they?
- OS: No.
- APM: So how can you predict who is going to get cancer?
- OS: Well, you can't predict exactly just like you can't predict the smokers. However, it's all about...I'm not a typical dermatologist. I have colleagues who don't tan at all. I feel that life is living everything in moderation. I go on holiday. I don't go on holiday abroad in the summer because it's impossible to protect yourself from Spanish heat at 40 degrees in July. It's a lot easier in November, December when it only gets up to 22, 24 and you're escaping a miserable winter but if you are fair and freckly and you burn easily, you are at much higher risk of developing skin cancer. If you have hundreds of moles, especially if you have funny looking moles, you are at much higher risk of developing melanoma and if you work outdoors, of course you're more at risk of developing skin cancer.
- APM: And family history? Is that a good indicator as well?

OS: Melanoma, actually, very little family history. There are a few cancer prone genes in skin cancer but they are actually very rare. What's more runs in our family is both our skin type and our habits. If you come from a very outdoorsy family, chances are you're an outdoorsy sort of person and if your mum and dad are redheads, probably don't have that much melanin in your skin.

APM: So you could be forgiven for thinking it's a genetic trait but actually, it's the—

OS: It's a risk —

APM: --behavioral trait that you inherit, the outdoorsy. Where should we start then with your wonderful pictures of dreadful things?

OS: Well, we're on skin cancer. We might as well start with skin cancer I guess.

APM: So the normal thing that I think most of us would have been told is if someone's got a mole and it's growing or it's bleeding or it's itching or something like that then we should immediately get all worried about it and refer to someone or refer back to the GP. Is that a fair approach for us?

OS: It is a fair approach. I really think it's not leaving common sense at the door which I think is really hard with a little bit of medical knowledge and I think probably you might be even better able than me...well, then GPs do that because I sometimes feel the GPs have so little dermatology training that they assume they will know nothing, you know. If they've never seen a melanoma and someone says, "My mole has doubled in size," they're going to go, "Oh, my god, I better refer," and if they had a really good look at the mole, they might see that it looks completely perfect in every way except the patient's told them it doubled in size. Do you know what I mean? Whereas when you have less medical knowledge, you might use your common sense a little bit more and I think there is a lot of that. There's symmetry, you know. If you look at something and you wouldn't look twice at it on your sister, why would you look twice at it just because your patient asked you about it?

APM: Because we're desperately frightened that we're going to miss something important.

OS: It is —

APM: That's what I imagine.

OS: Absolutely.

APM: Well, I presume. I mean —

OS: We're all going to miss something.

APM: It's better to refer to someone than getting wrong, isn't it?

OS: Absolutely. We see a lot of normal to catch the bad stuff and I don't mind that at all.

APM: When you talk about moles increasing in size, I mean they're obviously not going to double in size overnight. So it's quite possible that a patient is going to not notice that gradual increase. What's the sort of time scale in —

OS: It's really difficult because that's the thing, patients do say it's virtually doubled in size overnight. So you know that either something's happened to it, like it got caught or got inflamed or else, it obviously didn't and they've only just noticed and if they've only just noticed that it's twice the size it was, when was it? Was it last year or was it actually 5 or 10 years ago? So history is really difficult when it comes to gradual change and I always tend to think that the ugly duckling side is the best one. If you look at someone's mole then you're on a good position where you're going to be looking at all of their moles all at once whereas a GP might be tempted to just look at the one on the hand or just the one on the shoulder rather than strip the patient off. You've got your patient relatively unclothed, you can see if that mole looks different from the rest. If there are five other moles that look virtually identical to it, it doesn't really matter what that mole's done because it's behaving exactly like all of its brothers and sisters whereas if that mole...patient might not be aware it's changed but it doesn't look like a single other mole on the body, it's behaving in a funny way in a suspicious manner.

APM: So what is the normal for a mole? What's acceptable for a mole?

OS: They will grow gradually throughout our life. They will darken initially and then probably lighten from 40 or 50 and actually, they start to disappear. So we have very few moles when we're old. We get new moles well into our 40's. So 20's and 30's, patients come to me, "I keep getting moles. I'm getting more moles." That's completely normal and so steady gradual growth at the same rate as all of the other moles, really.

APM: You said you had blackheads referred to you for cancer as well. I mean I find it difficult to imagine mistaking a blackhead for cancer but presumably, you get some pretty nasty looking blackheads.

OS: I think it goes back to the not using your common sense because you've seen something black and the patient says it's new and it looks very black. And so probably not looking as hard as you might because you think you don't know it anyway, so what's the point, you know. I think if you get a good bright light on a blackhead, you can see that there's this sort of grayish, you know, halo around it where all the stuff's clogged underneath and you can give it a squeeze and it pops out but I suspect that some GPs are so scared of getting it wrong, they don't even look that hard because they don't have the confidence to think they're going to know even if they do look that hard and we get 3 or 4 a year, blackheads.

APM: Well, rather you got them and they were safe than the other way around.

OS: Absolutely.

APM: One of the things that goes through our minds, I imagine a lot of physical therapists' minds is you get a skin condition, you think to yourself, "Am I allowed to touch that? Do I need to stick on my Nitrile gloves before I go near this patient? Am I going to make the patient worse or irritate the patient or whatever or am I going to then transfer that condition to another patient?" What's your advice there?

OS: It is tricky. I would first ask the patient if they know what the skin condition is because obviously, if they know to have eczema or psoriasis, you could start by saying, you know, "Do things irritate your skin? Does it, you know, bother you, you know, if I touch you?" Obviously, they come to see you, they should know but also, is it sore or itchy? Because touching skin that's sore or itchy is obviously going to aggravate. As far as contagious, there's actually very few conditions which you're going to be able to transmit to somebody else, even yourself, you know, if you just wash your hands between patients, really, as you do. We all touch patients who have bacteria all over the skin. We all do all the time and so unless you've got something obviously very florid, pustular or...scabies would be the only other one I would probably think of.

APM: How would we recognize scabies?

OS: That would be a tricky one, really. So scabies could look a bit like an eczema but they tend to have spots and burrows in their web spaces and on the soles of their feet and on the palms of their hands and quite a spotty eczema. So sort of lots of little scratch marks without much rash. So if you see someone who's got lots of scratch marks —

APM: Scratch marks from their own fingers.

OS: From their own fingers because it's an intensely itchy condition then that's something you'd probably definitely want to be aware of because scabies is —

APM: Something like that could easily be something that...we are the first point of contact.

OS: Absolutely.

APM: Because, you know, if they just think they're itchy and come to us and they might be worried.

OS: Absolutely. No and people assume that, you know, you have to be, you know, terribly grubby to get scabies. It's not. It's just like head lice in school. You just have to have mixed with the wrong person, you know.

APM: Is it common these days?

OS: It's still fairly common, especially people who work in institutions, so schools, prisons, you know, would get...prison officers who catch it, hospital workers, people like that and then, of course, youngsters who maybe sleep with people that they shouldn't. They could catch it very easily by close physical contact.

APM: How do you fix it?

OS: It's just the same as the head lice treatment. You paste it on, leave it for a few hours and wash it off. So it's —

APM: That's enough?

OS: Yeah, for most.

APM: And if we have a patient who we suspect has scabies, comes into our clinic, we think, "That's scabies, I'm sending you away," what's the consequence for our waiting room and for our treatment tables? Do we need to do something to protect other patients as well?

OS: Theoretically, it doesn't live off the skin for long at all but obviously, you just make the normal precautions of wiping down the bed with an alcohol wipe, you know. You wouldn't need to do any more than that.

APM: The seats in the waiting room are OK because they've had clothes on and the rest of it.

OS: Yes, exactly.

APM: So you were going to take us into skin cancer, I think and we're going to start **with moles**. You got some pictures of moles as well?

OS: I have some pictures of a normal mole. We can start with some normal moles.

APM: Let's look at some normal moles so we know what we don't have to refer.

OS: Where are we going to start? We'll go for Diddly Diddly Dee. OK.

APM: So this is Diddly Diddly Dee.

OS: This is Diddly Diddly Dee. Next one is Diddly Diddly Dum. So **there's a symmetry in a mole**. So we can see that patients might get worried because it's got two colors, "Well, my mole has developed a dark spot in it," but if you chop that mole in half anyway...so you can cut it down here or you can cut it down there or down there and the top looks like the bottom, the left looks like the right. Every bit of it looks like each other. So that's symmetrical. So **we like symmetry in a mole** and we also find that all moles aren't round. And so even if this was a funny shape, we can say that this bit here looks like this bit there which looks like this bit there. On the image, people say, "Well, it might be a bit spiky," but actually, it's still evenly scalloped all the way around. There's no bit of it that looks particularly different. So that's the perfect mole, symmetry, only two shades of brown, nice and even. If we went on, we can see another one that's a little bit more tricky because you've got little bit black bits all over the place, haven't you? But again, most of it...if we just ignore that little black speck there because that is a bit of a funny spot but this bit looks just like this bit which looks just like...do you know what I mean? All of it looks the same and you'd be very interested in the history of change because obviously, if it had changed and these black specks were new, you might be concerned but it all in likelihood....

APM: That all looks actually quite small. Am I right in thinking that?

OS: It's difficult, isn't it? It's probably about **5mm**, so yes, it is small but **melanomas, early melanomas, if we pick up them, we do mole screening and we pick up melanomas early. Average is 4 to 5 millimeters. We can pick up melanoma. So they don't have to be big.**

APM: So we have to be able to tell the difference then between this normal mole here and the potential melanoma which is slightly smaller.

OS: That you could do. Most —

APM: And we're going to know that by the end of this evening, don't we?

OS: You might be better than you were before.

APM: I had a question in about moles actually. It was, “Should we be worrying about dry and scabby moles?”

OS: Almost certainly not. It’s a tricky one because it is one of the things...if your mole is scabby or itchy then it is alarming but the point is most things that are scabby and itchy weren’t moles to begin with. So they normally the warts, I’m sure especially as osteopaths, you would’ve seen loads of these older patients with quite crusty, warty, some carbuncle type things, some of them are flat, some of them are quite raised and they often get caught and they often get crusty and itch and they do all the things we’re told to look out for in skin cancer. They grow, they itch, they bleed and then hopefully, they frequently drop off too but...so they are quite tricky because once you recognize that it’s a wart, you’re happy but otherwise, it is doing all the things you’re told to look out for. If it was definitely a mole and it’s suddenly crusty, it probably got caught and if it has gradually changed and become crusty then yes, obviously. It’s not a very sensitive —

APM: And we know that the pictures you’ve shown us are moles simply because...and they’re not anything else, simply because they are symmetrical, they’re not scabby unless, you know, they’ve been caught, as you say and that’s enough to sort of more or less define a mole, is it?

OS: A mole is a collection of melanocytes in a little area. So this is a collection of pigment cells in the skin. So it can be anything from pink to nearly black, depending on the amount of melanin we produce. So you produce fairly pale moles, pinky brown moles and I produce darker moles. Dark skin people produce moles which are nearly black and redheads produce moles which are generally pink because they don’t have much melanin on board. So if you have someone of my skin type who has suddenly got a pink mole, you’d be concerned and vice versa, someone fair skinned who has suddenly a black mole amidst all the pinky moles. So it is, as I say, that sort of ugly duckling thing but yeah, it’s all about pattern recognition, really.

APM: Which is hard when you don’t see as many as I’m sure you do.

OS: But you do. You see them all the time which is why I think it’s a great opportunity. If you start looking, you’ll actually start recognizing, won’t you? It’s just that we don’t. You’re dealing with what you’re dealing with. You’re dealing with the discomfort, the pain, the stiffness, whatever it is but actually, obviously, you’re seeing moles all the time. So if you’re just always making yourself aware if these look normal, when you then see something that looks identical for the last 48 moles you’ve just seen but the patient says it’s changed,

you'd think, "Well, it looks like every other mole I've seen this week." Do you know what I mean?

APM: From what you said just now, does that mean it's very difficult to spot skin conditions in black people?

OS: Absolutely, it is very difficult. Redness doesn't really show up well in the dark skin. So rashes can look very different. Skin cancer is very rare in dark skinned people but presents very late because it's so difficult to pick up. So yeah, there are some difficulties with that. I work in Kettering. It's 98% Caucasian. So we don't get an awful lot of exposure to that but more towards Northampton, certainly, you know. In a whole, the country's becoming, you know, ethnically diverse. Dark skins are tricky for dermatologists.

APM: So we've dealt with a couple of relatively normal moles. What comes next?

OS: Well, OK, we could go to some melanomas, couldn't we? I'm not entirely sure whether it's a nice melanoma or a bad one but we'll have a look. OK, so this shows everything that is asymmetrical, just before I marked a 2mm and cut it out. So we've got asymmetry. So you cut it in half, every bit doesn't look like another bit. We've got a bit in the middle that's lost its pigment completely. We've got a pink area, light brown, mid-brown, dark brown and nearly black. So that ticks every box, really, for melanoma. And also, these are the normal moles. It's also 10 times the size of all these other moles.

APM: The area around the outside, the clearing that you've drawn around is two millimeters, so that's, you know...what's that, 10, 15 millimeters across?

OS: Yeah.

APM: Thank you.

OS: That I would hope...well, thank you very much. I would hope would be pretty obvious to anyone, whether you were medical or not medical, that that doesn't look like a nice mole but you'd be surprised when change happen slowly. The patients say to you, "Maybe it's only changed over 4 or 5 years. So, you know, it's not doing anything so I haven't really worried," but of course, all of us, as well, have a huge amount of denial on board. So, you know, if you saw something like that, you'd want to get straight to the doctor.

APM: Do you see that? I kind of feel that when people have skin problems, they might be more eager to get them sorted out than, say, heart problems where denial is –

OS: Well, I've got some wonderful pictures of people who have demonstrated the complete opposite of that. It surprisingly isn't. I think symptomatic skin conditions present very early because patients are very uncomfortable with itch or soreness, you know. They want to get that sorted. Acne is a big issue because spots are both sore and unsightly and right there, you know, everyone to see when they're dealing with their friends, family, especially at work but moles and lesions on the body, it's often out of sight, out of mind, especially on the back. We have the highest risk of skin cancer in men is the back and they don't really look at their backs and increasingly, as men get older, they don't show their backs to anyone else either. So it's surprising. We often get a little flurry after the summer because people whipped their shirt off on holiday and they assume they've done something whilst abroad but it's only because they've noticed suddenly that that mole doesn't look quite as it is.

APM: And therefore, quite a few people are coming to you younger because presentation of the acne, for example, is much more significant for them. Yeah, and they will probably be more keen to get undressed than the older generation. I got a couple...I got a whole load of questions come in actually. One is how deep do they go and it didn't say which they were referring to.

OS: I guess you're talking about moles, so we go to some more melanomas. So that only has the two shades but you can already see it's damn ugly, isn't it? You've got black at the top and red there... sorry, black at the bottom and red at the top and it just looks very mean. We don't really like anything that black, especially...you can look at that patient, that skin type and he's relatively fair. Black is never any good, really. Melanomas grow from the layer of the skin between the epidermis and the dermis which is just the very top layers of the skin and it grows up to produce a mole and down as well and then cancer cells will then descend into the dermis and that's when they can start to become cancerous and have the potential to spread just like any other cancer and that's something we measure in millimeters called the Breslow thickness and it's very important.
Depth –

APM: How do you do that?

OS: Histologically. So obviously, we can't tell. If you've got something that's already raised above the skin, chances are it's quite thick below as well but with these flat, you know, you probably...something like that's going to have a Breslow somewhere between 1 and 3 because you can feel it but you don't know how far it goes and that is very, very strongly linked to prognosis, so thick melanomas do poorly.

APM: There's some other questions, if I may, while you're looking at those. One is about lipomas which is what causes lipomas and is surgical removal successful for stopping recurrence at the same site.

OS: We don't really know what causes lipoma. Some people are prone to them, little fatty lumps. If they're painful, they can be removed. If they're so large that they stick through clothes then they should be removed. Otherwise, you're best off ignoring them because if they're not completely removed, they do just recur and you do need a surgeon who's experienced from removing them because they're not a cyst where you can sort of pick up the whole thing and take it out very easily. It's all just fatty tissue amidst more fatty tissue. It is easy to leave a little bit behind and then they do re-grow.

APM: So surgical outcome is not for them.

OS: Well, it's better than leaving lumps because it probably took 10 years to get to that size. So I mean I had one on my back that started to show through clothes, you know, time to have it removed, you know. Whether it'll be back within 10 or 15 years, I'll have it removed again but they're benign, they're harmless and increasingly, we don't do much on the NHS until they reach a good size because they're cosmetic.

APM: Well, I'm getting the sense...not least because the NHS has closed down the contract in Northamptonshire for the AQP contract for back and neck pain which we have. They closed it for everybody, not just for us I should add but the NHS is closing down an awful lot of its services at the moment, isn't it? So are you badly affected by that?

OS: No, I don't think so, actually. I mean there are a few things that we happen to be a little bit more strict. We would probably have removed something we'd have classified as a nuisance before and we can't now just because it's a nuisance. I've always had a fairly high threshold. If someone says, "I don't like this mole. I want it removed," we say, "Well, that's bad luck on you. The private health service is there for you if you'd like to have it removed," but if it's something on a patient that I would think, "Damn, I wouldn't want that," and I'm not that vain and not that bothered by stuff, I'd think, "Well, you know, maybe that's justified," and we can't do that anymore. So we can't remove things just because they catch on a bra strap or they catch when they brush their hair but other than that, if you're not sure what it is, it's removed because we need to biopsy it and we treat virtually everything the same way.

APM: What about the psychological impact of having these things? I mean do you take that into account as well? If someone is desperately concerned because they've got an unsightly something which isn't terribly significant, I mean does that enter into the NHS equation?

OS: Not personally because it doesn't matter to us because it still won't be funded. The hospital has a contract with the CCG. The CCG have to say yay or nay. So it's up to them. So the patient has to be referred and has to fill in an individual funding request or something along those lines that basically say this patient is different from everyone else, who's got a mole at the end of their nose, this patient's life is being made a misery by it and they may or may not agree to remove it.

APM: So back to your slides.

OS: It's just another slightly less ugly melanoma. So symmetry again, irregular edge, little black specks coming towards the edge here, areas of pallor within it and just lack of symmetry, really.

APM: When you're treating patients, do you wear gloves to do all of these things?

OS: I very rarely wear gloves. We all vary. I have to wash my hands in Alcolgel, you know, 87 times a day. I don't really see the need of wearing gloves all the time unless I'm examining a personal area or something that's clearly grubby. So no, I don't tend to wear gloves. We have so much physical contact with our patients. I think it's a comfort to them to know that they haven't got something contagious. So many of our patients would've been really made to feel like their eczema or psoriasis is —

APM: It sends a message putting your gloves on, doesn't it?

OS: Absolutely, I think it does and I really rely on the feel of stuff as well, to be fair, you know. We need to know what a rash or a lesion feels like and that's difficult with vinyl gloves on.

APM: Indeed. So is this one significant that you've got up on your screen now?

OS: Well, hopefully, most of us recognize that is a melanoma. So that's a fairly young chap. He was in his late 30's. No, I won't say was. He is. He's still fit and well. So that was a pre-cancerous mole. So this one is starting to develop and this one, he'd left for a good 3 or 4 years.

APM: So if we see the one on the right, the little one, we should be thinking he's a fair skinned chap. That's a very dark mole.

OS: And these are his normal moles, inky brown moles and this is not right and even in that, it's dark and even if we got close enough, we could see that that edge here, you can see the three little spiky bits coming right up to the edge. We don't like it when pigment comes

right up to the edge. Every mole should fade out gradually towards the edge. So if you look carefully with a bright light, you should see that eventually, it's actually fading away.

APM: One of the questions that's been sent in is that with benign moles, what would you consider to be the most effective treatment for their removal? Obviously, it's going to be privately —

OS: With insurance or not.

APM: It's going to be private because you won't do it on the NHS, obviously.

OS: I discourage people from removing moles a lot because first of all, a lot of people who want moles removed tend to be young and they're going to get a load more moles. So what's to stop them wanting the next mole and the next mole removed? Secondly, a mole is...normal people will always know it to be a mole as soon as you have a scar. People say, "What's the scar?" So I actually think that in the majority of cases, a slightly funny looking mole looks better than an ugly scar. However, if you've got these big sort of squidgy coco-pop-type moles which can be, you know, rather unsightly then having them sliced off leaves you with a very tiny little chickenpox kind of scar which, you know, they do very well and it's cheap, yeah.

APM: And I've got this person who said, "I use the Pelleve Surgitron RF device and the results are fantastic." Do you know what that is? I'm not sure —

OS: Not a clue.

APM: Not sure if I can read the writing but give us some more information about that from whoever sent that particular question.

OS: "I use the Pelleve Surgitron RF device."

APM: It's a radiofrequency device of some sort which none of us knows anything about. If that person could send in some more information, that would be interesting.

OS: We will try.

APM: Or if anyone else knows anything about it, that'd be great. You're not required to know the answers to all the questions that get sent.

OS: Good, I'm glad because I know virtually nothing about anything except skin.

APM: So what happened to this one then? You —

OS: He had that one cut out, the Breslow thickness of that was over 4mm I think. And so that was over four millimeters. So he had to have three centimeters of skin removed around that scar. So he ended up with, you know, scar about that size across his back. So yeah, surgical removal. He's still well but this is a high risk melanoma. He's probably got about 50-50, you know, chance of coming through with that long term.

APM: Chance of recurrence or chance of —

OS: Demise.

APM: Demise, yeah. So OK, how often do you monitor?

OS: We monitor three monthly for five years.

APM: And what does he do to try and prevent recurrence? Is there anything in lifestyle —

OS: No, absolutely not. The damage is done. Obviously, if you recover from a melanoma, you're going to be really sensible and try not to get another one. Most of our patients don't get a second melanoma. It's not a cancer that you're particular likely to get more of but the sun damage was there to cause the one. They do get others, yeah.

APM: But he's got two.

OS: He had a pretty cancerous one and I've probably got at least 20 patients who've had more than one and probably a dozen patients who've had more than 3 or 4. So it does happen but we have hundreds and hundreds of patients with one melanoma.

APM: In that particular picture, how did that get so far advanced before anybody picked it up as, "Good lord, go to see your GP or a specialist"?

OS: That's young man syndrome. I think you'll find that was on his back and he refused to accept that there was anything he needed to see the doctor about, to be fair. Young men do present late, you know. We do find that and especially a lot of young men who maybe worked outdoors in their 20's, when there weren't such strict regulations about wearing appropriate clothing or so if they're self-employed, they don't need to wear any of the safety vests.

APM: And so genuinely, this is something which could come across our treatment table for the first time. When he comes in...if he's a bricklayer, he comes in, he's got a bad back and we think, "Hmm, my god, that's something that's a bit more serious than your bad back."

OS: Absolutely.

APM: It might even be connected to your bad back.

OS: Well, hopefully not but quite, absolutely. Yeah, you know, I would've thought that someone who allowed skin cancer to get that bad probably is not going to present to an osteopath either because he's probably a bit phobic of all medical practitioners but you do see these things slightly less obvious than that and you will come across them, you know. Fortunately, melanoma is still incredibly rare, so most of us won't actually see one.

APM: Now, I have some more. Two questions have come in. Have you got any pictures of scabies?

OS: I haven't but I've got one that could do for scabies.

APM: So, one that's not!

OS: Exactly. Let's have a look. Where was it? I think it was...yeah. So this patient here actually has a nice background, a sort of red rashy eczema but if that red rashy eczema wasn't there and you were just seeing little sort of itchy, excoriated blisters and papules, that would do for scabies, especially if it was over the web spaces, the backs of the hands or on the palms and soles. There are very few rashes that affect the palms and soles, actually. It doesn't tend to affect the face. If they've got a nice rash on their face, you kind of think, "Well, then it's not going to be scabies." So often, around the joints, wrists and tiny little red spots like that with maybe, if you're lucky, I don't know if this comes across but tiny little lines where the track is. So what's happening with scabies is the little mite is pooing as it moves and it leaves a trail of feces in the skin which your body's allergic to. So you then produce histamine and it makes you itchy but you can still see the little track that the scabies is in and they often come in web spaces, wrists.

APM: Did you say a rash on the face would indicate that it's not scabies?

OS: It very rarely affects the face except in babies and very old people. So yeah, if you had a rash on the face, you might be sort of fairly reassured that it wasn't scabies.

APM: What do you know about red spots? Because I've got a question here that says, "Regarding red spots, are there any yellow or red flags to observe and how many in one area is normal or not alarming?"

OS: So we're talking about cherry angiomas, I guess which are the Campbell de Morgan, little red spots that we've all got 1 or 2 of and sometimes you see patients who have dozens or even hundreds and

sometimes they're one millimeter in size and sometimes they're really almost as big as a little red berry or red currant. So no number is a worry and nothing about them is a worry as long as they all look like each other. They are so deeply red and typical that I can't really imagine that they could be confused with anything except, of course, if there was only one and it wasn't quite as red. Is it actually a red spot? Is it a melanoma or something like that? But normally, you have that comfort of actually, this patient's got hundreds.

APM: "And what about sort of the liver spots that people develop as they get old?" he says, with a certain amount of self-interest here. I mean easy to distinguish from anything that's more of concern?

OS: Yeah. OK, I think we've got a nice sort of ...yeah. So would that be what you might a liver spot? I never know what patients mean by liver spots. Everyone means something different.

APM: Well, just think of those sort of patches of sort of darkish brown skin that more elderly patients will get.

OS: Absolutely.

APM: Quite lots of them quite large, generally.

OS: Absolutely. So there are two things that people might call liver spots. One of them is seborrheic keratosis, these senile warts that we talked about on the back and on the face. They can get quite crusty but especially on the hands and arms, they might be very, very flat and they can look just like a large freckle and then there is just large freckles and it can be very difficult to tell between but as you say, as long as they have got lots of them and they all look about the same then they are completely harmless. There is a pre-cancerous freckle which can happen but it tends to be head and neck and again, it won't be beautiful and symmetrical like that. It'll start doing all the things we looked at before with asymmetry.

APM: Quite clearly, some of our audience wants to know what we do about this. We as osteopaths, chiropractors and so on, can we refer directly to someone like yourself or do we have to refer via the GP?

OS: Privately, you can refer. Anyone can go. However, patients who are insured still need to go through their GP for their claims and yes, the CCG I think in virtually all areas now demands that all referrals come through the GP. Otherwise, the funding stream just isn't there.

APM: What's your experience when that happens? I mean you said earlier on that GPs are perhaps not particularly experienced with skin conditions. Will they take a referral seriously from an osteopath, a

chiropractor, a sports therapist who, dare I say, a lot of GPs may not normally take seriously?

OS: I think that you probably fall into two categories. I would suggest that if they know very little about skin, if someone else was worried, they would be unwilling to be unworried. However, a lot of practices will have someone within the surgery who knows a bit more than them. Most of the practices will have nominated someone or someone will be getting special training. And so if they really think it's nothing but it's been mentioned as a possibility, they might ask a colleague to come and have a look. There are a fair amount of GP surgeons out there who see more than their fair share of lesions. And so obviously, asking to do a biopsy or to have a look at that is often what happens if they are sort of slightly more mundane looking.

APM: Another question for you, I'll read it out, are you finding the rates of vitamin D deficiency increasing in patients diagnosed and treated with skin cancer as they may use more sun avoidance or UV blocking agents?

OS: That's a tricky one because it is a balance and we've even had preschools refusing to put sun cream on children because of vitamin D deficiency, you know. It is a real balance. Having said that, we've always been vitamin D deficient in the winter, all of us, you know. The average Brit is vitamin D deficient in the winter and just about scrapes above in the summer if you don't work outdoors, you know. We don't get that much sun, do we? We walk across the car park to work or we do a bit of shopping at the weekend. We're not out that much but you don't need a huge amount of light. So I suggest that people who are at risk of skin cancer get plenty of non-sunlight. So you don't need to be out in bright sunlight but you can be out in a bright day without too much sun protection. A hat is really good because you've got a lot of radiated or reflected light around you and everything in moderation, as I say, you know. You don't want to be so over protective that you are vitamin D deficient. However, if you've had more than one skin cancer, chances are you'd rather be vitamin D deficient, take a supplement and stop yourself getting another skin cancer.

APM: So is there a national guideline? Is there a nice guide on how much sunshine you should get per day? Just like you're supposed to eat five bits of fruit and vegetable per day or –

OS: No. There's a guidance on how much vitamin D should be, your levels should be and we know that...especially our aging population are vitamin D deficient throughout most of the year because for the majority, they don't absorb much on the skin because of their melanin and they are more clothed as well.

APM: Because the average Joe can't measure his vitamin D or her vitamin D. So what do you suggest? They just all take vitamin D supplements or —

OS: No, vague symptoms of fatigue, you know, myalgia, these sorts of things can be a suggestion. If you know you are a sun avoider then it's worth having your GP measure it. The trouble is we've had such a huge flurry in the press of everyone going on about vitamin D deficiencies that GPs are very loathed to measure vitamin D just willy-nilly unless you've got a good reason but if you have had a couple of skin cancers and you are avoiding sun completely then you probably will need supplements.

APM: And are across the counter vitamin D tablets effective?

OS: Not unless you pop 8 or 10 a day probably. That's a quite high dose.

APM: So would the GP recommend? What would the treatment be for someone who is at risk?

OS: It's 800 international units three times a day I think is the dose.

APM: What's an international —

OS: I don't know. It's how it's dosed up on the various vitamin D products that you can prescribe.

APM: So we couldn't go into a shop and say, "I want things that are 800 international units strong —"

OS: You might well be able to. You find it with like folic acid. If you buy folic acid when you're pregnant, you take 400 micrograms. If you're taking it for medical reasons, you're taking five grams. That means you need to take 20 a day, you know. It would be cheaper to get your GP to prescribe it.

APM: What's the danger of taking too much vitamin D?

OS: I don't know.

APM: Anyone know out there in the audience? Because that'll be an interesting one to find out because having been told —

OS: Probably very little and probably not much study on it either.

APM: Having been told that I've got to take 20 vitamin D tablets a day just to make sure I get my vitamin D. My little pot won't last very long but...yeah. Some questions and one of them was do vitamin D tablets work.

OS: They certainly do, not as well as sun.

APM: No but sometimes you have to make the most of it, don't you? How would you recommend treating scabs in the scalp that were extremely irritated?

OS: There are so many reasons people get scabby scalps and so with that diagnosis, the first thing to do are anti-fungal shampoos and a calming shampoo. There are a couple of products that aim particularly at itching in the scalp. There's a Eucerin licorice shampoo, Eucerin DermoCapillaire which is really nice for just itching but if people have actually got scabby, itchy spots, they've either got an infection or they've got a type of eczema or psoriasis. They probably need steroids. So they do need to see their GP if a simple medicated shampoo isn't helping. However —

APM: Go on, yeah.

OS: One of the commonest reasons people say that they've got a scabby scalp is actually with a non-hair bearing scalp. So for you, on top of the head and it's sun damaged. It's not anything to do with the scaling or dandruff or crusting. It's actually sun damage that feels quite sharp and gritty and can be quite itchy.

APM: I'm getting the message. Wear a hat.

OS: Wear a hat.

APM: So let's move on to psoriasis then. I mean we see a lot of that in clinic. I presume you see an awful lot. What do you do about it? I mean is there an effective remedy?

OS: There are a huge amount of effective remedies for psoriasis. Patients are very verbal. I'm sure you get that experience as well. Some patients will be totally mortified by the three patches and others will come with it virtually covering their body and they're not really fussed. So it's treating the patient. For some, it's very itchy which obviously is a discomfort but a lot of it is it's just very disfiguring and it's very messy, you know. Scaling everywhere, your patients complain about having to change their bedding, having to Hoover their house every day because of the amount of scale and socially, it's not acceptable to leave a flurry of dust behind you. So we do treat it very seriously and there are an awful lot of treatments available, luckily. We have —

APM: And these are available on the NHS?

OS: Gosh, yeah. Everything with the psoriasis is available. All the creams, you know...and unless you're looking towards homeopathy and alternative medicines. All the creams are available on the NHS through tablets, injections. We have a huge host of treatments available. We have a group of drugs called biologics. Have you come across these drugs?

APM: I haven't.

OS: Biologics are agents that are used primarily in colitis, arthritis, psoriasis and autoimmune diseases, things like infliximab, etanercept and these are agents which affect the immune system. And so they've been, over the last 5 or 10 years, huge development because they're working to really turn off the disease in these really severe inflammatory diseases like rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, Crohn's disease, half of such drugs which work really well for people whose life is ruined by their skin.

APM: So do you grade arthritis...not arthritis. Do you grade psoriasis according to its extent or its severity or —

OS: We have something call PASI, the psoriasis activity and severity index and we also use the DLQI, the dermatology life quality index. So we ask people to measure how much their psoriasis is affecting their day to day life. Does it stop them working? Does it interfere with their relationships? How long does it take for them to apply medicines? It's all those sorts of things and also, how much the extent is? I even got an app on my phone. So I just pop through how much psoriasis, how thick, how red, how scaly and we score them. Anything over about five is considered to be moderate to severe.

APM: And is that something that patients could download for their own phone?

OS: If they wanted to.

APM: Would that be helpful should they know about that? Should we be telling them about it?

OS: No, I don't think so. To be honest, a lot of dermatologists won't use it. It's very much a research tool but it's very helpful when you put people on toxic drugs to have an unbiased idea of whether how much better they're getting because if we're going to be spending £30,000 on a medication, if the patient says it's much better and actually, there's no significant difference, you're giving a placebo effect really, aren't you?

APM: What's the consequence for untreated psoriasis then? Is it purely a lifestyle —

OS: Mostly discomfort.

APM: So it's purely lifestyle. It's not going to lead to anything –

OS: There are a couple of things. You're more likely to get secondary infection if you've got regularly broken skin and patients with psoriasis are much more likely to get psoriatic arthritis. Now, treating their psoriasis isn't going to stop them from getting it but if they have got psoriatic arthritis, we need to treat that promptly to prevent joint damage.

APM: What's the mechanism for that, for the psoriatic arthritis? What's the connection? Is it just the inflammation which is –

OS: It is, absolutely and through the interleukin pathway, causing inflammation on the joints, in a similar way to rheumatoid.

APM: So you have pictures of psoriasis then. Let's have a look at something that we might come across in clinic.

OS: Totally do. OK, right, so that's nails. Let's go forward a bit. So that's the typical patch of psoriasis. It's quite silvery scale, fairly well demarcated. If you pick off the scale, you see little bleeding points underneath.

APM: Is that what you do, you go and pick off their scale?

OS: No but often, they would've scratched it away. Very rarely, if you're not sure between eczema or psoriasis, it can help differentiate but no, not normally.

APM: Because that's not possible with eczema. It's just –

OS: No, it doesn't happen in the same way. It's because psoriasis promotes the proliferation of blood vessels higher into the skin and so they're reaching up right up to the top and then you can make the skin bleed. This is psoriasis in the scalp, again, pink and scaly, fairly standard. That's flexural psoriasis, so very common particularly under the breasts, under the armpits, in the bottom. Well, they don't produce scale. They just have a red patch and that will often be treated with anti-fungals and of course, without the steroid addition, you're not going to get clearance there. So that can be a bit of a nuisance for people. I don't know...yeah, so that's a guttate picture of psoriasis, a small plaque psoriasis, pink, scaly patches. That might be triggered suddenly by a strep throat. So that could happen out of nowhere. So it would more likely to present to you because just by coincidence, this happened last week as well, you know.

APM: That type of psoriasis, I mean presumably, is that going to happen quite regularly to this patient? So they'll get strep throat –

OS: It might be a one off or it could happen regularly. If that happens regularly, chances are, at some point, they're going to develop standard psoriasis all the time and just have guttate flares.

APM: Because that does look quite distinct from the other pictures that you showed.

OS: Little raindrops of psoriasis. Absolutely.

APM: Is that the same thing up close that we've got there now?

OS: Yeah.

APM: I've learned from one of our viewers that vitamin D toxicity will lead to hyperkalemia, at least I think that's what it says.

OS: Right.

APM: And I will take that at face value.

OS: So that's the dangerous...we don't want high potassium in the body. So that would be a dangerous thing.

APM: So it leads into next person's comment which is reference to vitamin D, "I don't think you can overdose if you're deficient."

OS: No, absolutely. It'd be really, really had to overdose if you're deficient because you can rarely get just above normal if you're –

APM: But it's knowing when your levels are right because as you said, if you're tired and, you know, you're getting symptoms that might be associated with it and they go away then stop taking as massive as doses.

OS: Absolutely. Most people will need maintenance though because unless you change your lifestyle, you will just become vitamin D deficient again.

APM: So the hand that you've got up now, that's –

OS: That's the psoriasis hand, sometimes difficult to differentiate from an eczema hand but really thick scale which splits in fissures. Now, this is an awkward because patients don't like to shake hands when they have very bad hand dermatitis, whether it's eczema or psoriasis, mainly because people wince or cringe when they do, you know. They

feel like they're contagious and I think it's really nice to have that confident handshake with someone that, you know...

APM: From our perspective in clinic, is it important to be able to distinguish between eczema and psoriasis?

OS: No.

APM: It's important, clearly, to recognize that it isn't going to harm us and therefore, we can shake hands with a patient—

OS: Exactly.

APM: --who looks like this because it's better for them. What about if we got broken skin ourselves? Is there any danger to us at all?

OS: People with these conditions might be more likely to carry a higher quantity of staphylococcus on the skin but, you know...so if you have a rawer area, I suppose there would be a risk, that you'd be thinking, "I could have..." Getting vertigo in it from the amount of staph on the skin but actually, normally, normal flora which is your standard bacteria doesn't actually infect. It just sits there very nicely and, you know, we can transfer it and it doesn't do any harm. Abnormal staphs would start to infect. So yeah, you obviously have really low risk and if you did have a big burn on your hand, you probably would be covering it up before you treat someone anyway.

APM: Indeed.

OS: At a thought.

APM: A question going back to moles here. I mean is mole mapping common practice for most dermatologists? Is it only done in private consultations and are there lots of ways to do it?

OS: I think we'll start in the bottom. There are lots of ways to do it. I get a lot of emails, "Do you do mole mapping?" because there are websites that offer mole mapping and in America, it's a big thing and they use vastly expensive computer technology where every mole is photographed and the size of every mole is measured. There is no NHS institute in the country that does that. It's just way too expensive technology and so time consuming and even privately, I've looked at getting this offer but it's the time involved when you compare with just having the clinical skill of a dermatologist to look at the mole. So we use something called the dermatoscope and we examine each mole individually and we use our clinical skills to decide if a mole needs to be mapped. So we would photograph it, measure it but we don't tend to. We can take photographs of people

with lots and lots of moles but strict mole mapping, computer mole mapping is available only privately and only in very few units.

APM: Purely for research purposes or mainly for research purposes?

OS: In the big hospitals, yes, for research purposes. However, it's available on the High Street in places like Superdrug but they don't... even they don't do proper mole mapping. They'll take photographs of the mole that you're worried about and then some computer adds up the pros and cons and then if it's classified as a funny looking mole, it gets sent off to Switzerland for some dermatologists to look at and I don't really understand –

APM: The picture, not the mole.

OS: The picture and then inevitably, they come to me and say, "I went to Superdrug. They told me this mole was funny." And sometimes, it will be something so innocuous, I, you know...I think if you're worried, go and see a dermatologist. There's no point asking a computer, you know. Better off seeing someone who has 20 years experience.

APM: Do you get lots of referrals from Dr. Google as well?

OS: A fair few. Not too many. I bet the GP suffer that more than me.

APM: But in skin conditions, I mean if somebody Googles something and thinks, "This could be horrible. I've obviously got cancer," when it's actually just a mole then the GP doesn't know about it.

OS: We don't get too much of that because it is so hard to pin down. We get it more with rashes, that they've been searching the Internet, desperate to find out what their rash is and they've come up with, you know, all sorts of weird and wonderful, from leprosy to, you know, tuberculosis but yeah, we don't...it's not too bad. I think patients are very well informed these days and most of them are fairly sensible.

APM: I'm beginning to regret that we've got you in tonight because we're getting loads of questions and they're all big, long words in them. This one says, "Do you feel that photobiomodulation, LLLT is useful for skin conditions?"

OS: I have no idea.

APM: Good. That's an answer I like.

OS: Someone cleverer than me, I told you.

APM: So that's another one to throw back at our audience. If there's someone out there who knows about this, tell us what it is, tell us what it does, tell us how you heard about it and so on. And this one says, "I'm a manual practitioner." For heaven's sake, "Can pompholyx eczema be aggravated or helped by aqueous cream?" and, "Any problems continuing to work while having to use industrial strength steroids to relieve itching?"

OS: That's really helpful because actually, Northamptonshire have basically banned aqueous cream as being nasty, toxic stuff although –

APM: Really?

OS: Yes. It's an adequate soap substitute and I use the word "adequate". I do not tell people not to use it if they like it and they get on with it but I never ever suggest it. It's like forty pence a tub so it does get dished out. People buy it over the counter and GPs who are less aware will use it. It is not a good moisturizer. It contains soap-like chemicals and actually, washing in aqueous cream has been demonstrated to be slightly more dry than washing with water alone.

APM: Doesn't that contain the aluminum as well or is it...some of the component which I think we were worried about. Somebody might know more about that in our audience.

OS: I think it used to. I think there is something there but...yeah. So no, I don't like aqueous cream. You want a urea based moisturizer like Calmurid, Eucerin, Balneum or even just any good hand cream. They normally contain urea or a foot cream. You need to soften that hard layer on the skin but inevitably, the bigger thing about pompholyx is habit. Most pompholyx's aggravated by wet work and you'll find a lot of people will not be doing their soap avoidance in their moisturizers. They'll say, "I moisturize every day," or once a day. It's not really enough. You need to moisturize every single time your hands are wet and try to avoid soaps. So using it...for you, you want to make sure that you're not...you're cleaning your skin really well but if you wanted to avoid soap, you could use something like Dermol which is antibacterial but has no soap in it. So you know you're clearing all your bugs off but you're not dehydrating your skin barrier.

APM: Excuse me, I apologize for that. I used one of those scanning machines recently. I was made to use one of those scanning machines where they put some cream on your hand and then you have to go and wash your hands and you stick them under the –

OS: And you still got them all around.

APM: And like everybody I washed my hands as I would normally wash them. I didn't think, "Oh, I'm going to catch these buggers out," and

there was loads of this stuff all over the place. I mean if that is the case and then you aren't going to get the stuff off your hands by... even thorough washing still leaves a cake into the folds of the skin, doesn't it around the nail beds and so on, is that something that we should be worried about? I mean —

OS: Well, no. I mean I've had the same test. They come through...and test us and I was the opposite to you, I did it properly. I did my thumbs and...but who washes like that? Nobody washes like that, do they? And have you caught anything from your patients? No. I think you have to be sensible, don't you?

APM: Well, I always feel slightly...I mean it's not a waste of time but we are directed we must leave the room when our patients get undressed. So we leave the room. So we leave the room and, you know, we've got the door knobs and we got to wash our hands and we get to touch all the door knobs on the way back in again —

OS: Exactly. That's why I quite like Dermol because it's an antibacterial moisturizer. It doesn't really matter if you leave it on. It's doing its work as an anti-staph and all the rest of it on your skin. This chap or lady asked about the steroids? So that's worth using. So absolutely not except just before your...so he said, "Any problems continuing to work while having to use industrial strength steroids to relieve itching?" So steroids are great stuff that work really, really well and people often are very frightened of using them but this person, obviously, realize that sometimes they do need to use very strong steroids like Dermovate to alleviate the itch but chances are, you're using it first thing in the morning and last thing at night. So yeah, no problem an hour later from treating the patient.

APM: And from the patient's point of view, are there adverse side effects from industrial strength steroids —

OS: They thin the skin. You rarely can get hold of enough off your GP to do that because they're so cautious. We see very little steroid-thinning. You have to use an awful lot of steroid. The phobia around it is so well entrenched amongst us all and all the GPs and pharmacists that...we just don't see it. We see a lot under treating.

APM: Are there conditions that give red, thickened skin on the palms and soles without scales and which aren't itchy and this person's asked particularly if this is the case in elderly patients. And they've got me in mind again.

OS: Let's have a look at your hands. There are lots of conditions. It's one of my passions. For dermatology, it's so diverse. One of the conditions that particularly comes to mind is something called Pityriasis rubra pilaris which causes a red, yellow thickening of the hands and soles

with or without a rash, with or without itch but actually, anything thickening of the skin can just be a very interex moral psoriasis even without the itch. Just thickening up. Elderly people just get hyperkeratosis which just means the skin thickens. After the menopause, you could get something called keratoderma climactericum where —

APM: I'm really sorry you came here. We've got to write all these words out later for the summary.

OS: I know. It's wonderful. Where the skin becomes very thick and scaly and cracks on the soles after menopause but again, without an itch. So yeah, there are lots of conditions and fungal infections. If it's only in one hand or only in one foot, always think of a fungal infection.

APM: Someone wants to know the name of that app you mentioned earlier on.

OS: It's now called Psoriasis 360 but it's produced by Janssen, J-A-N-S-S-E-N.

APM: So we will put a link up on the website to it anyway, provided we can find it when we get the stuff done. This person says they'd be interested in treating patients with psoriasis. What's the role of manual therapy in helping these conditions, do you think?

OS: Well, I think bearing in mind you can't prescribe anything, often one of the things that's done very poorly is all the background to treating eczema or psoriasis which is what I've said before, moisturizing and soap avoidance. If you're not doing that, your eczema and your psoriasis but especially your eczema doesn't get better. So you can certainly...if someone's got very dry skin, even without much symptoms, I always encourage people to moisturize, to start looking, you know...especially chaps who've never been in the habit of moisturizing, so, "Yes, I know my skin's a bit dry." If you don't deal with it, actually, maybe next year, it won't just be dry. It can be itchy as well. Dry skin tends to get itchy as you get older.

APM: I'm just worried that moisturizers aren't actually very effective and that it's just a beauty con to —

OS: No. The expensive moisturizer is definitely a beauty con but any one that feels good on your skin, that soaks in and makes your skin feel, over a period of weeks, waxy and more sort of waterproof is doing you real good.

APM: What about the increased circulatory effect of soft tissue work, for example? Is that going to be beneficial?

- OS: No evidence that it is, no.
- APM: No research or evidence or there is a lack of those evidence —
- OS: I think there is lack of evidence that it is important except in conditions where you would expect it to be like lymphedema or pyloritis. We see inflammation in blood vessels which can be helped by keeping blood circulating but otherwise, I don't think there's much evidence either way.
- APM: Now, I've got a question which I think you've answered already. "We have many patients with dry skin on the lower legs. What creams are the most effective to use?"
- OS: The ones they like.
- APM: Because they'll most likely use them.
- OS: Exactly. The thicker, the better. If it's very dry, you want something quite waxy but actually, you know, E45, anything standard, you know, cocoa butter, anything they like to use but more than once a week, that's the big thing. It's every morning when you get dressed and every evening when you undress. It's twice a day.
- APM: So twice a day is enough then for —
- OS: For most. I mean if you've got, you know, a skin condition, you might need to use it more often than that and again, if you have moisturizers containing urea, they last longer. So your Eucerin type products, they'll be better at lasting the whole day.
- APM: We've actually got an answer to one of our question and it must be the person who sent in the question. LLLT stands for low level light therapy and it's when you use red light and infrared light via laser diodes or LED. One of the largest companies in the world is called Thor Laser based in Hertfordshire and is a tool promoted to chiropractors for various conditions. I'm not sure what the various conditions would be other than what we've got here but you're not aware of LED, red light, low level laser —
- OS: No, we use high level red lights to treat skin conditions by using a a portable releaser that is activated by the light but no, I don't know about that for joint conditions.
- APM: Well, actually, I mean maybe not right now but if there is some evidence behind that, that that particular viewer can share with us, I'd be very intrigued to see them and I would like to put it up on the website and make it more widely available. And we go to birthmarks.

Now, do they change shape? Are you asked to deal with birthmarks in what you do?

OS: Yes, mainly because —

APM: Because people are worried about them or —

OS: Yeah, mainly because mums worry that the birthmark has changed over time and normally, there are different sorts of birthmarks. The birthmark that appears very much like a mole will only grow with the child. It doesn't tend to change shape. However, a giant congenital nevus, one of these big, black, hairy things, they can change shape as they grow and also, Becker's nevus which you sometimes see as a hairy patch on the shoulder. I come across those sometimes. They can develop later in life. So that looks like they're changing in shape but they tend to grow with the patient.

APM: And the large sort of skin discolorations that you see in some birthmarks, I mean are they perfectly innocuous?

OS: You have to be careful. There's a lot of conflicting evidence. A few years ago, we thought that all birthmarks have an increased risk of skin cancer and then they decided that you had to be a giant, congenital melanocytic nevus, so over about 10 centimeters to be a high risk but actually, we now know that probably all congenital nevi are a high risk of developing melanoma than a normal mole. Still rare but yes, probably riskier than any other mole. So if there's a change then it's risky.

APM: So what we're looking at is change and the usual things, OK. You mentioned fungal conditions earlier on. I mean do you deal with a lot of fungal conditions?

OS: Something like that on one hand, not the other would be virtually guaranteed to be fungal because all our inflammatory diseases tend to be very symmetrical whereas infections enter in one place and they stay in one place.

APM: And what's your preferred treatment then for...if that were a fungal condition, what would you be —

OS: If it's that bad, I'd give them oral Lamisil or oral terbinafine. If it was less horrid, you send them over to buy some Daktarin or terbinafine cream.

APM: Are those prescriptions or they over the counter?

OS: You can buy them over the counter, athlete's foot type preparations. They do. They're all much the same.

APM: Somebody's got it in for me in this audience. I'm not sure who it is. I'm going to change our system so the questions cease to be anonymous but it says here for patients with onychomycosis —

OS: Fungal infection of the nails.

APM: See, I knew we'd get that one right.

OS: I got one.

APM: Is surgical treatment successful?

OS: It can be. It's rarely needed. So we could normally treat it with oral antifungals. Occasionally, if the infection just keeps coming back, we remove the nail and treat with an oral antifungal but you need to treat the infection which is lying in the nail bed. So just removing the nail doesn't really sort it out.

APM: A lot of people seem to carry on without bothering to get any treatment for things like that. Is there any risk to that? I mean is that going to spread your fungal infection elsewhere?

OS: Athlete's foot is the commonest cause for developing cellulitis when you get infection in the skin especially of the legs. So there is a rationale. If you have a single gammy toenail and your feet are otherwise pristine then the idea of taking 3 or 4 months of some fairly toxic medication might not really...the benefits might not really outweigh. However, if you've got slightly crumbly feet, you're diabetic, you're obese or you have any other risk factors for developing infections in the legs then yes, you really need to treat your fungal infection so that you're not a port of access for infection to come into the skin because cellulitis is nasty.

APM: So even athlete's foot is something to take seriously if it doesn't clear up.

OS: Absolutely. Splits between the toes where infection enters.

APM: I must say...and to expose these things live on air as it were but I used to be a Royal Marine, obviously lots and lots of work in boots and so on and, you know, it gets very sweaty and humid in there —

OS: Trench foot.

APM: Well, it wasn't trench foot. I mean I had athlete's foot and I went to the doctor so many times, same old cream. Eventually, I saw a podiatrist who said, "Yes, there's two types of athlete's foot and you

don't need that cream. You need this other thing,” and it went like that when I saw somebody who knew what he was talking about.

OS: My problem is that GPs very rarely take a scrape. I think you've tried the standard, it's fair enough to try a very cheap antifungal to treat something because 90% of the time, it'll clear but if it hasn't, take a scrape and find out what it is you're growing. We've had problems with patients getting fungus from strange...from their pets or from the hedgehog in the garden which are not going to be susceptible to our normal antifungals. So, you know, if you've tried a normal, standard course and it hasn't gone then take a scrape. So get someone to actually take some skin, send it away and find out which fungus it is but again...and then the real difference is mainly between yeasts and funguses. So if you've tried your Daktarin, you can go for of your sort of clotrimazole canesten type creams, your thrush type creams.

APM: Again, over the counter?

OS: Yeah.

APM: This is an interesting one for us because if a patient comes to see us with one of our standard list of complaints that they come for and we're busy down at the foot end of the patient and it just smell bloody horrible, we have to raise to question of, you know, “Have you got a fungal infection?” and so on. I mean how do you approach that? I mean I suppose people come to you because they've got a skin complaint. It's not difficult to raise the issue, is it?

OS: No.

APM: But at the same time, we don't want to embarrass patients. We don't want to alarm patients but we do need to have the conversation.

OS: Well, “Do you get athlete's foot?” is a fairly, you know...everyone's heard of it and most people are not particularly sort of put off by the name because it sounds like you're quite fit rather than lanky and scabby. So most people will know if they have it and if they say no and you can clearly see their feet are so gammy, you could say, “Have you noticed that you have splits in between your toes?” you know, and just if it is...really, it's when it's soggy and split then really, chances are you have athlete's foot.

APM: And is there a greater chance of us then spreading that infection? Because I mean now, we're dealing with a fungal infection which we can presumably carry around on our hands and –

OS: Well, as long as your washing your hands. Yeah, no, I don't think so. Not a big deal. I mean let's face it, they're washing their hands and

they're washing their face, they're not getting it even on, you know... we spread our bacteria and yeast all over us all the time.

APM: Indeed. Somebody says that they have a patient who has a birthmark which is very pale but it itches and obviously, they know that you can't diagnose on the basis of something someone sent through on a question while you're live on air like this but is it something you think they should refer on, get it —

OS: Well, it might not be a birthmark. I think that's the barn door. Depending on the age of the patient and the site, there is one type of birthmark which can turn into a skin cancer, a rodent ulcer, especially on the head called a sebaceous nevus and they turn into basal cell carcinomas, about 20% lifetime risk of developing skin cancer.

APM: Any pictures of those or —

OS: Well, I've got the end result. Basal cell carcinomas are my favorite on skin tumor and they grow very slowly and they're often itchy and sometimes when they grow so slowly, patients, especially older patients will say, "It's been there all my life," and that might be 15 years. It's not actually all their life. So I think really getting a good idea of whether it is actually a birthmark...if it's definitely a birthmark and all it does is itch then probably all you can do is moisturize.

APM: How are we going to know it's definitely a birthmark?

OS: Well, exactly. Was it there when you were a baby? If they can't say, "Definitely yes," then yeah, they need to see their doctor, don't they? You know, little stubborn patches of eczema can be perpetuated by constant scratching and they may have had it since they were a teenager, constantly sort of scratching at one particular area so that it basically just is always there.

APM: And you said you had an image to show an example of this.

OS: Basal cell carcinomas. I have lots of basal cell carcinomas because they're my favorite.

APM: What intrigues you about basal cell carcinomas then?

OS: Well, I see thousands a year, first of all. They're just incredibly common and we'll see some of them present ridiculously late because they creep up. They grow very slowly and they have this typical history of as they get mature, they start to scab and crust and weep but then they heal over and the patient thinks, "Oh, it's gone. I won't go and see...I'll cancel that appointment to doctor's next week," and then a month later, it's back again and that's very typical

history of, “It’s almost gone and I’m wasting your time, doctor,” but it’s still there because they can look just like a normal little intradermal nevus, like this little mole that you got on your cheek, you know. These little normal flush colored moles that don’t do anything except that it is shiny. Can you see how beautifully shiny that is? So we’ve got this translucency and the shimmer over the surface which is called the pearliness in the textbook and it’s got arborizing telangiectasia. That means tree-like branching vessels and that’s typical of a beautiful pearly BCC and we’ve got quite a few. I mean look, isn’t that gorgeous? How could you...you can have that hanged on your wall, a lovely arborizing telangiectasia. This beaded, rolled, typical pearly edge and you can see it’s eroded. They’re ulcerated. So it scabs, weeps, it heals over. So when it’s like this, patient ignores it completely. Especially, this sort is often on the back and it’s only when it starts to weep and leave blood on the shirt that they notice or the wife complains.

APM: More common in men then?

OS: Definitely but still very, very common. Not common on the trunk in men because men are more likely to get their shirt off regularly throughout their life whereas women tend to only on holidays. So this is another basal cell carcinoma. You can see that lovely rolled edge and it’s ulcerated in the center. Another typical one on the lip, so round, rolled, ulcerated center and rolled pearly edge and this one...I mean this lady was adamant. You can see she’s quite old. She’s in her late 80’s and she says it’s only been there a few weeks but with older people...she’s only been aware of it for a few weeks because it’s only been scabbing for a few weeks. When it was intact, she was ignoring it. It’s just one of life’s little blemishes. So that’s what happens when you ignore them and he was adamant but that was because his glasses were rubbing behind his ear and then —

APM: Which is probably an easy conclusion to draw, isn’t it?

OS: What about this one? Do you think that’s an easy conclusion? So this is the typical you’d have thought —

APM: Glasses were rubbing on your nose —

OS: Well, actually, he couldn’t get a new pair fitted. So that’s why he decided that eventually, he had to come.

APM: Sorry but —

OS: And this one wasn’t sore so she left it. This is a 50-year-old lady, so not someone...someone who really should know better but, you know, she wasn’t sore. It didn’t hurt her so she just ignored it.

APM: But the last fellow, the fellow with the nose problem there, was that the stage at which you first saw that?

OS: Yes, he presented like that on a two-week wait. So his GP automatically assumed that that was one of the higher grade tumors because it's very difficult to imagine that anyone would leave a slow growing tumor that long. So the GP referred it in as a squamous carcinoma which they grow quite rapidly over a period of months and they are referred in on this two-week wait. This urgent cancer—

APM: That's fast.

OS: --pathway. Actually, it's a basal cell carcinoma because it's been there for 15 or 20 years but yes, they're actually presented like that and we persuaded him to have it removed but of course, he's going to lose some eyelid.

APM: But at least he'd probably be able to see a bit more.

OS: You'd hope especially now his glasses fit.

APM: Had he not come to see you, other than not being able to fit his glasses, what's the outcome for this?

OS: I didn't actually put the picture which is the outcome of that which is one of our other patients who's lost her eye for it, you know. There are very rare instances of basal cell carcinoma spreading like a cancer, so metastatic basal cell carcinoma. It's very, very rare and there are chemotherapy-type treatments for that but for most, it's disfigurement and one of the biggest disfigurements in there...like this is of a patient who has a nose prosthesis, this lady who has an eye prosthesis because it's tracked down into the canthus, got behind the eye and then the concern is that it'll just keep going back into the brain. So take the eye out.

APM: We've got some really sad people in our audience because somebody wants to know if you've got any pictures of malignant moles.

OS: We haven't even done them. Yes, we have plenty of pictures of melanomas. I'll do that. In fact, didn't I...have we? I don't know that we do. We didn't have, uh yes, 33. So we did that one. So this is a nodular melanoma. Now you can see this lady —

APM: That's a hell of a nodule.

OS: That is a hell of a nodule because nodular melanoma grows much more rapidly. So if you've got something that is growing week by week and looks like a tumor then obviously, it doesn't really matter what it looks like, you'd be worried, you know. You wouldn't need to

know anything to know that that's not right especially...you can see that lady's...it's a young looking back, isn't it? And a relatively un-sun damaged back. She was just unlucky. So that's the nodular melanoma and they grow probably over maybe 8 weeks, 2 months.

APM: Eight weeks, gosh.

OS: So this is another melanoma. So we've got asymmetry. We've got dark patches here. We've got these fading out nicely here but you can see over here, we've got little spiky bits of pigment coming right up to the edge. Do you see that? These little lines of pigment and again, here, it's got dark areas coming all the way up to the edge. We've got almost skin colored, light brown, mid-brown, dark brown, darker brown. So we've got all the tick boxes there for a melanoma as well. That's a little bit blurry but again, beware of the pink thing with black spots in it because this patient's producing pink moles and all of a sudden, this pink mole has produced some dark spots. So that would be —

APM: Is that a scar running through the middle of that or is that just —

OS: I think it's the clothing line that was pressed I think. This is a tricky one we have. When we're dealing with chiropodists—

APM: Chiropodists.

OS: --who remove toenails when they're painful. Unfortunately, this is removing a toenail when it wasn't painful. So this patient had the toenail removed because of what was felt, being an ingrown toenail because there was this red tissue sticking out from the side of the nail. However, it was never painful and if you've ever had an ingrown toenail, it damn hurts. When the nail was removed, it wouldn't heal. So then they were sent up to me and we can see the little...oops, two little black specks of...little black speck there, a little brown speck here and this whole toe —

APM: So once again, the giveaway here is these distinctive differences —

OS: Absolutely and it's behaved wrongly, hasn't it? It's not behaving like you would expect in an ingrown toenail. But hey, what's this coming down onto the toe? OK, fair enough, the nail bed is sore but we've got abnormal skin on the toe and —

APM: And that was there before the nail came off, was it?

OS: Yeah.

APM: So that's possibly not an excusable misdiagnosis then because —

- OS: I don't think so but I suppose when you've got someone young and melanoma risks are rare, you know, it is really tricky, you know. We have another lady who produced a large squamous cell carcinoma on her heel. It was treated as corn, soft corn but of course, it was growing the more it was treated and that's the sort of red flag. I think that's probably it for melanoma. Let's have a look.
- APM: I'm tipping you around with these questions because they're coming in thick and fast.
- OS: That's all right.
- APM: Let's move on through three of these. With small basal cell carcinoma, is excision the only option or can liquid nitrogen be used or not?
- OS: Flat. Small, flat basal cell carcinomas, yes. So we have lots of flat BCCs which we can treat with cryo, liquid nitrogen or with topical chemotherapy, 5-fluorouracil or imiquimod, Aldara because they can treat very well. Something that size, I'd probably treat with a cream because cryo burns can be quite painful.
- APM: And that looks really unremarkable for me.
- OS: Exactly but look how beautifully shiny and shimmery it is, nice translucency and again, so something is not healing. So these are treated as a patch of eczema but this patch of eczema, it's been there for five years. Eczema will come and go at least but this is stubborn now and you start looking at the edge. You can find it does have this sort of rolled, beaded edge and it's starting to ulcerate. Here, again, you've got that little rolled edge, some shine, especially here. It's always difficult with photographs which is why we don't run an awful lot of telly dermatology but when you've got something and you rock it in the light, you can see it just reflects the light in a different way to normal skin. Normal skin's quite matte whereas BCCs have this, they shine back at you. And so yes, something like that. If it was 5 or 6mm then yes, cryo. Any bigger, I'd probably treat with creams.
- APM: One of our viewers wants to know what causes the ulceration and weeping in BCCs.
- OS: Because the tumor is no longer doing what skin should do. That's the bottom line. It's not producing an intact epidermis.
- APM: Simple as that.
- OS: Yeah. Multiple, you see sometimes people have lots. They assume it's got to be eczema or psoriasis because you can't surely have, you

know...we have patients who have a dozen superficial basal cell carcinomas from a lot of sun abuse as teenager and in their 20's

APM: But in that last one, we're looking at, what? Just the unevenness of the coloring, the asymmetry, the –

OS: The fact that they're itchy and they've been there for years and that they scab and that they don't come and go really. They're there all the time.

APM: One of our practitioners says they've seen a lot of patients with white, small patches on their skin especially more noticeable after being out in the sun. What do you think those are? Are they contagious?

OS: If you're talking about mainly on the trunk then usually, that's pityriasis versicolor which is a yeast infection that lives mainly on our scalp that falls down on to us. And so you often get little shower of patches around and under the breasts and down the back and the yeast gobbles up the pigment which is much more obvious when they tan. Sometimes it's pink and scaly and other times it's white. So just use an anti-fungal shampoo. It's not contagious to you because it's actually just normal balance. It's like having dandruff. It's that balance. There are, unfortunately, another 20 reasons why people might have white patches but I'm guessing that's probably more of the one they were thinking of.

APM: And this one came in ages ago. Do you have a view on Bio-Oil for scar treatment?

OS: Most of the evidence suggests it's the massaging of the scar rather than what you're massaging it with. That is the biggest benefit. I would advocate using silicon gels if you are concerned really about a scar. Stretch marks, it doesn't seem to make any difference except softening the skin before they stretch to try and prevent it but once you have a scar, if it is lumpy, massaging and using a silicon gel which can...

APM: Which answers the second part of the question which is have you ever seen patients with painful and old or healed scars and do you have a view on treatment for that? For example, scar massage.

OS: Yes and we also inject them with steroid if they're very lumpy and very itchy. That can dampen down the inflammation if it's a keloid type scar.

APM: I think that we asked this one earlier. With ulceration or vascular related skin discoloration, how do we know when referral is necessary?

- OS: Anyone with ulcers on the lower legs needs to be referred especially if the foot is cold or painful. If you're talking about ulcers anywhere above the knee, they're probably not vascular related but if it's an actual ulcer rather than an erosion, you know, rather than rawer area...rawer areas tend to be very low grade skin cancers. There's a time that they need to be referred but if it's an actual ulcer then we're looking at something either nastily infected or nastily cancerous. So they need to get in quick.
- APM: We're taking you now back to shingles again, back to almost to where we started. Someone says here, "By the time skin lesions are visible in shingles, is it not then not contagious?" and, "Is there an obvious sign you can look for beforehand?"
- OS: People who've had shingles before or even a cold sore will know that you sometimes get the tingle and burning before the rash comes out. So they might know it's going to come but there's very little on the skin. Yes, whilst it's blistered, it's still contagious. The blister fluid contains enough virus to be contagious. However, you don't catch shingles, you catch chicken pox. So if you've already had chicken pox, you can touch your shingles, you can...no problem because you don't catch chicken pox. Shingles comes because your immune system is low.
- APM: We'll make a mental note to our staff. We are never having a dermatologist on this again because now, I'm being asked to ask you, "Do we understand what causes pityriasis rosea?"
- OS: No.
- APM: Excellent. Did I say it right?
- OS: You did, pityriasis rosea. It's one of the viral trigger rashes that just comes out. They got the herald patch, the big, red patch and then they get a sort of a wash of dry, scaly red patches which may or may not be itchy and then 6 or 8 weeks later, it's gone. Now, we have a million conditions just like that and luckily, the NHS wait is longer than eight weeks. So most of them have gone before they get to see us.
- APM: That's very handy. I have been asked and I'm not sure if perhaps we covered this but what common fungal infections are we likely to see and do you have any concerns about spread of infection? And we talked about athlete's foot, obviously.
- OS: Well, I mean mainly we're talking about tinea which is your athlete's foot type, one that causes ringworm. It causes athlete's foot. It can cause crotch rash. It's those sort of sweaty areas that get infected.

You can also get candida in the same areas which is like a thrush infection. Again, you don't tend to catch them off your patients because it's more something that...with candida, more something that you have in you but tinea is contagious. Tinea is ringworm. Ringworm spreads. So if someone has scaly patches that look a little bit like a ring then you need to be a little more —

APM: How common is that?

OS: In children, pretty common. In adults, pretty rare, much more likely to have eczema or skin cancer.

APM: You have got some pictures of tinea, haven't you?

OS: I've got some pictures. I have pictures of things that...OK. So this is discoid eczema which would often be treated as ringworm because it's circular but actually, with ringworm, you'd find that the edge is darker and it pales in the center and it turns to be slightly more blistery but anyone who's only got a few patches of a rash which is circular and clearing in the center, you'd be concerned about tinea. We do have...if it's treated, unfortunately, with the wrong treatment though, it just gets bigger and bigger which I think is where we are. So this is tinea incognito. I love the names, we use. Tinea in disguise. So this has been treated as eczema, so we've been whacking steroids on it. Steroids reduce the inflammation so the rash that the tinea causes settles down but the tinea's still growing. So the patch just gets bigger and more lumpy as it grows.

APM: But not ring-like at all.

OS: Well, is it not? Is it not? Like it's still got a growing edge and my next one is a real lovely ring. So this has been treated probably for psoriasis because it had a natal cleft rash and so the tinea just spreads.

APM: You have some very kind patients who allow you to take these photographs.

OS: You'd be surprised how few of them say, "No, thank you," to my camera.

APM: What would you say...somebody's taking you back again to something you said earlier on. What is the most effective treatment for stretch marks?

OS: No mirror. There is no treatment, whatsoever that does any good. Time is the only thing. They gradually fade.

APM: Adequate clothing.

OS: Exactly. There is no treatment. There's very little you can do about it, you know. We've all grown and some of us will get stretch marks very easily and some of us will get none. Young chaps who grow very suddenly will get lines just right up their back. Other ladies get them all over when they're pregnant, you know. It's just how stretchy your skin is.

APM: I think anyone who has a stretch mark should watch the film Shirley Valentine actually because there's an excellent line in there about stretch marks.

OS: Is there?

APM: From Tom Conti. I'm not going to go through it now but...

OS: I think there are pros and cons. It's like, you know, I have an olive skin. So people say what a nice, glowing complexion I have but unfortunately, olive skins, we tend to wrinkle much earlier. So, you know, it's the same with stretch marks. I never got any stretch marks because my skin is not bouncy like some. If you have a nice bouncy skin, you're going to be much more likely tone yourself up and look fit but you might have the stretch marks to show for it.

APM: Well, I mean we are getting very close to the end of our time here and the comment that's just come in is that it's brilliant to hear so much common sense spoken which is...that's always nice to hear from the viewers, I must say and apparently, it says here you said fungal confections, not infections but I suspect that's me, not you. Did I say that, really?

OS: You. You said myeloma instead of melanoma but I didn't want to pick.

APM: Ah whatever.

OS: But never mind.

APM: It's so much to think about.

OS: Yeah it is.

APM: Probably they're in stitches

OS: Confections, yes. Well, it's —

APM: I'm struggling with all the words I've been given to pronounce this evening.

OS: So we're going to show you some pretty more pictures running out of time because this one's beautiful. This is necrobiosis lipoidica. So this happens in diabetics.

APM: Necrobio...

OS: Necrobiosis—

APM: Thought I got that one.

OS: --lipoidica diabetorum where they get orangey patches that are a bit dented in the center and that's pustular psoriasis. So that's what I wanted to show...because we have looked at basal cell carcinomas and we have looked at melanomas but we haven't looked at the middle grade cancer which is a squamous cell carcinoma. And so the big thing about squamous cell carcinomas, they grow quite rapidly so they do need to be picked up quite early. Otherwise, they get to quite a size.

APM: Distinguishing feature then?

OS: A lump.

APM: Lots of people have lumps.

OS: But not ones that are growing month by month, not ones that are scabbing and crusting. So this one started off like that. So you probably wouldn't think twice about it. If in a month it's got to that, you need to be considering. So there are lumps that grow faster than basal cell carcinomas and aren't pretty like basal cell carcinomas. You do need to have a lot of sun to get them. So this chaps got some actinic keratosis here, these little sun damaged areas. He's got a nice sun damaged scalp and most patients are well over 60 because you need a lifetime of too much sun to get a squamous carcinoma and this is someone who didn't like doctors. So his squamous cell carcinoma got rather larger than we normally see.

APM: Fixable?

OS: Yes, although at that size, a much higher risk of metastatic spread.

APM: Olivia, this has been great fun. Quite apart from anything else. Challenged my vocabulary, apart from anything else as you've obviously pointed out to me. I'm really glad we got you in. I think as somebody said, a lot of common sense talk.

OS: It is.

APM: And this is an area, as I said, we don't cover but we do need to have some reassurance that we can make some sensible diagnosis and approach our patients in a sensible manner. So thank you very much for coming in and for sparing the time.

OS: It's been a pleasure. Thanks for —

APM: And you had to come all the way back from Birmingham to do this and then you're going back again for another...is it a conference you're in?

OS: I'm not going back tomorrow. I've decided to go and do cancer clinics instead because —

APM: So we've helped the population of Northamptonshire by getting you here.

OS: Absolutely.

APM: Excellent. Thank you again.

OS: No problem.