Curettage and cautery of skin conditions

Sir,

I followed with interest the letters from Dr Jackson and Dr Sundle,[1-4] about treatment of skin cancer and in particular about curettage and cautery. I am writing because I cannot agree that recurrence is 'easy to treat again' and that 'further recurrence, certainly in basal cell carcinoma, is virtually unknown'.

As a general practitioner who also worked in a hospital as a hospital practitioner, I recorded details of all primary lesions treated between 1959 and 1979. I was able to make a four year follow-up study until 1983 of the treatment of basal cell carcinoma by various methods. Use of curettage and cautery was found suitable for small well defined tumours with an arbitrary limit set at tumours less than 10 mm in diameter. It was not suitable for morphoeic type lesions of any size, or for recurrent tumours.

Over the four year period 1483 basal cell carcinomas were treated by curettage and cautery. A total of 1151 were followed up for four years and of these 174 (15.1%) recurred. This compares with an 8.9% recurrence of tumours treated by excision. When recurrent tumours were treated by curettage and cautery the recurrence rate in these re-treated tumours was considerably higher. Of 113 recurrent tumours treated over the period 53 (46.9%) recurred. This compares with a 25.6% further recurrence for excised lesions. Similar results were reported from a study in New York,[5] where following re-treatment almost half the tumours (47%) recurred a second time. A review of follow-up studies from six different centres[6] found the recurrence rate for basal cell carcinoma treated by curettage and cautery to be 33.3% when followed up for less than five years and 40% when followed up for more than five years. All of these results indicate that recurrent basal cell carcinomas should be treated by surgical excision.

A recurrence may be the result of inadequate initial treatment or it may be a fresh lesion arising in an area of potential tumour growth. As part of the four year follow-up study I reviewed the interval between the first identification of a primary tumour at consultation and the first identification of the recurrence, in a series of 209 recurrent tumours treated by various methods — 16 tumours recurred after three months, 36 after six months, 50 after one year, 41 after two years, 34 after three years and 32 after four years.

Between the end of the four year follow-up period and 1987, 38 further recurrent tumours, which had been initially treated either by curettage and cautery or by excision, have been seen, for example a completely excised basal cell carcinoma on the scalp, a solitary tumour of 10 mm diameter, had a recurrence at the edge of the scar 10 years later.

These figures suggest that recurrent tumours may arise in a field of potential growth at any time and that there really is no time limit for desirable follow up.

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GP contract: the slippery slope

Sir,

I was interested to see in the May issue of the *Journal* an announcement of a conference on community care to be held at the London School of Economics in June 1992. In addition to Roy Griffiths the speakers included two academic social scientists and representatives from social services and the private sector. Could the absence of a general practitioner be an example of the slippery slope described by David Hannay in his excellent editorial in the same issue (May *Journal*, p.178)?

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Video recorded consultations and fellowship by assessment

Sir,

The paper by Huygen and colleagues on the observed working styles of general practitioners and the health status of their patients (April *Journal*, p.141) may be useful in the current process of fellowship of the Royal College of General Practitioners by assessment. The general practitioners demonstrated three styles of practice (integrated, interventionist and minimal diagnostic) and the research showed that each style had different health outcomes in the patients, some more desirable than others.

As these styles could be detected by objective analysis of videorecorded consultations, it would seem appropriate to use such an objective evaluation in carrying out assessment for fellowship of the RCGP. We now have the evidence that certain styles of practice can be termed 'good' and therefore desirable in somebody who is seeking election as fellow of the RCGP.

The present method of viewing videorecorded consultations in the fellowship by assessment process does not appear to determine adequately whether this is a good doctor who is being observed. The application of Huygen and colleagues' findings may prove useful here.

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Acute herpes zoster, postherpetic neuralgia, acyclovir and amitriptyline

Sir,

David Bowsher's retrospective study on the treatment of acute herpes zoster and postherpetic neuralgia (June *Journal*, p.244) raises interesting and important questions, but the findings need to be interpreted cautiously. It cannot be concluded from the study that 'the nature of postherpetic neuralgia is changed by acyclovir treatment of acute herpes zoster', though this might be so. The fact that the mean ages of the group treated with acyclovir and the others were similar does not mean that they did not differ in more important characteristics. Whether the nature of the pain is changed, and in what way, can only be determined by a well controlled prospective trial. Amitriptyline does seem worth trying promptly when postherpetic neuralgia is identified, but it would have been interesting to know the dose of drug used in the study and the duration of therapy.

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