

# Summary of guidelines for management of cutaneous Bowen's Disease

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**Bowen's disease** (BD) is an intraepidermal (in situ) squamous cell carcinoma (SCC) with a small potential for invasive malignancy. In the UK, it occurs mainly on the elderly female lower leg where tight skin and risk of poor healing are the main therapeutic limitations. Direct comparison between treatments is difficult as there are few randomised clinical trials with comparable patient subgroups.

## Summary of recommendations

- A link with internal malignancy has been postulated but there is no convincing evidence to support screening for internal cancer in patients with BD.
- The risk of progression to invasive cancer is in the order of 3%.
- There is a significant frequency of multiple lesions and 30-50% of patients have other previous or subsequent skin malignancies (mainly basal cell carcinoma).
- Genital, and particularly perianal, BD have higher risks of invasive cancer.
- Treatment options for BD all have recurrence rates in the order of 10%, and no one treatment modality appears to be superior for all clinical situations. Treatment-related morbidity and the costs, availability and time required to administer each therapeutic option need to be considered.
- Required duration of follow-up is uncertain. In uncomplicated cases of solitary BD we suggest review at about three months to confirm clearance and healing. The requirement for subsequent review should take into account the presence of multiple lesions, previous recurrence, other skin neoplasia, and the degree of primary care support.

## Treatment options (with strength of recommendation, quality of evidence and comment) include:

**Cryotherapy** (Strength of recommendation A, evidence II-i) most studies have used liquid nitrogen, optimal freeze duration is between 1 x 15 sec and 2 x 20 sec, simple to administer.

**Curettage with cautery/electrocautery** (A, II-i) Has advantages over cryotherapy of quicker healing and less pain.

**Excision** (A, II-iii) Low recurrence rates but limited by tight skin at some sites. Excision is the treatment of choice for perianal BD.

**Photodynamic therapy (PDT)** (A, I) The currently reported overall initial clinical clearance rate for ALA-PDT is 90-100%, and recurrence rate is 12%. It is the treatment of choice for large lesions or at sites of potential poor healing, but availability is limited.

**5 Fluorouracil (5FU)** (B, II-iii) usually applied once or twice daily as a 5% cream for 1 week to 2 months to achieve disease control, and repeated if required at intervals.

**Radiotherapy** (B, II-iii) High cure rate is offset by poor healing of larger lesions, should be avoided on the lower leg.

**Laser** (B, III) Mainly small studies and anecdotal reports

**Topical imiquimod** (B, III) Open studies only, some using combined treatments.

**Other treatments** Systemic retinoids and interferons - few cases only.

**No treatment** An option for slowly progressive thin lesions where poor healing is a concern.

**Possible audit points:** Residual disease rate, Local recurrence rate after apparent clearing, Time to healing, Side-effects or complications of the intervention, Progression to invasive malignancy if treatment is observation or disease control only, Cost-benefit analysis.

## Key to Evidence and Recommendation gradings is in the full reference:

Br J Dermatol 1999; 141: 633-41

This summary includes revisions to February 2002

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