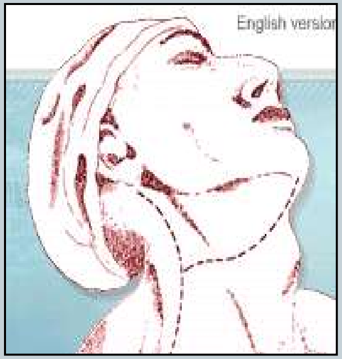
Diagnóstico e Tratamento dos Tumores Cutâneos em Cabeça e Pescoço

FRANCISCO BOMFIM JUNIOR


English version

CIRURGIA DE CABEÇA E PESCOÇO

DEZEMBRO – 2011
HUWC

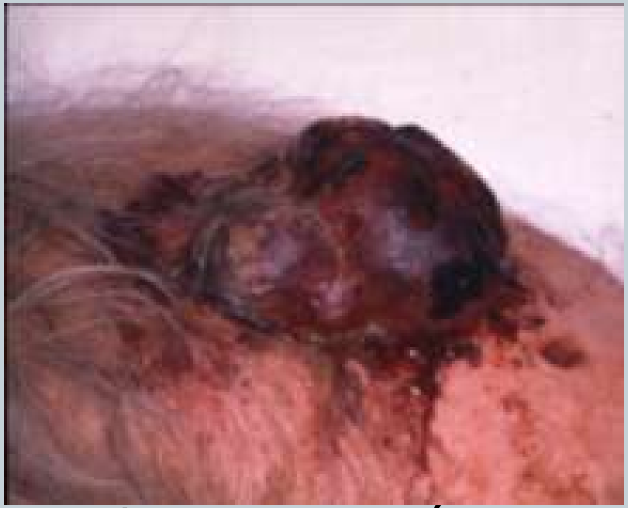
Introdução

- Pele : maior órgão humano e principal barreira contra o meio ambiente
- Local de origem mais comum de neoplasias
- Embriologia: ectoderma, neuroectoderma e mesoderma

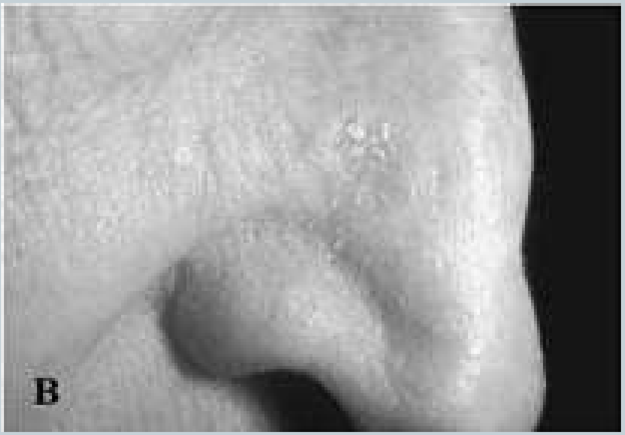
Introdução

- Tumores epidermóides benignos
  - Pólipo fibroepitelial
  - Ceratoacantoma
  - Ceratose actínica
- Tumores anexiais
  - Tumores benignos
  - Malignidades
- Lesões melanocíticas
  - Nevus displásico
  - Melanoma maligno
- Tumores dermóides
  - Histiocitoma maligno fibroso
  - Dermatofibrosarcoma protuberans
  - Sarcoma de Kaposi
  - Hemangioma
  - Xantoma
  - Angiosarcoma
- Tumores epidermóides malignos
  - Carcinoma de células basais
  - Carcinoma de células escamosas
- Outros
  - Carcinoma de células de Merkel

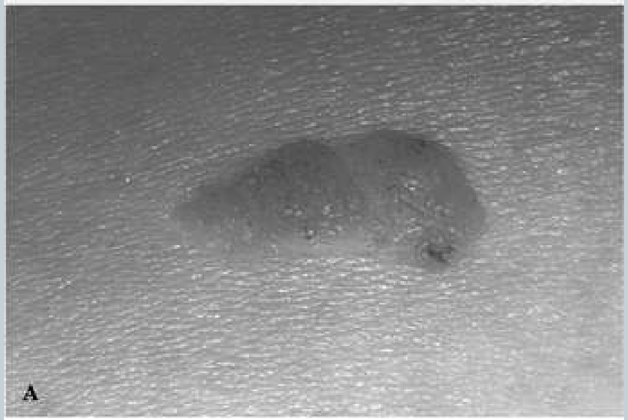
Introdução



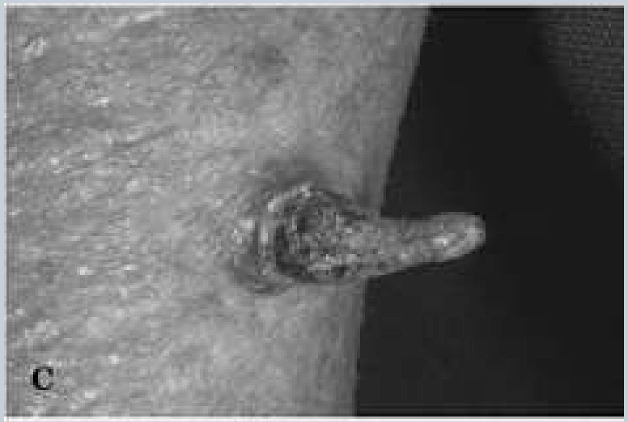
Fibroxantoma atípico



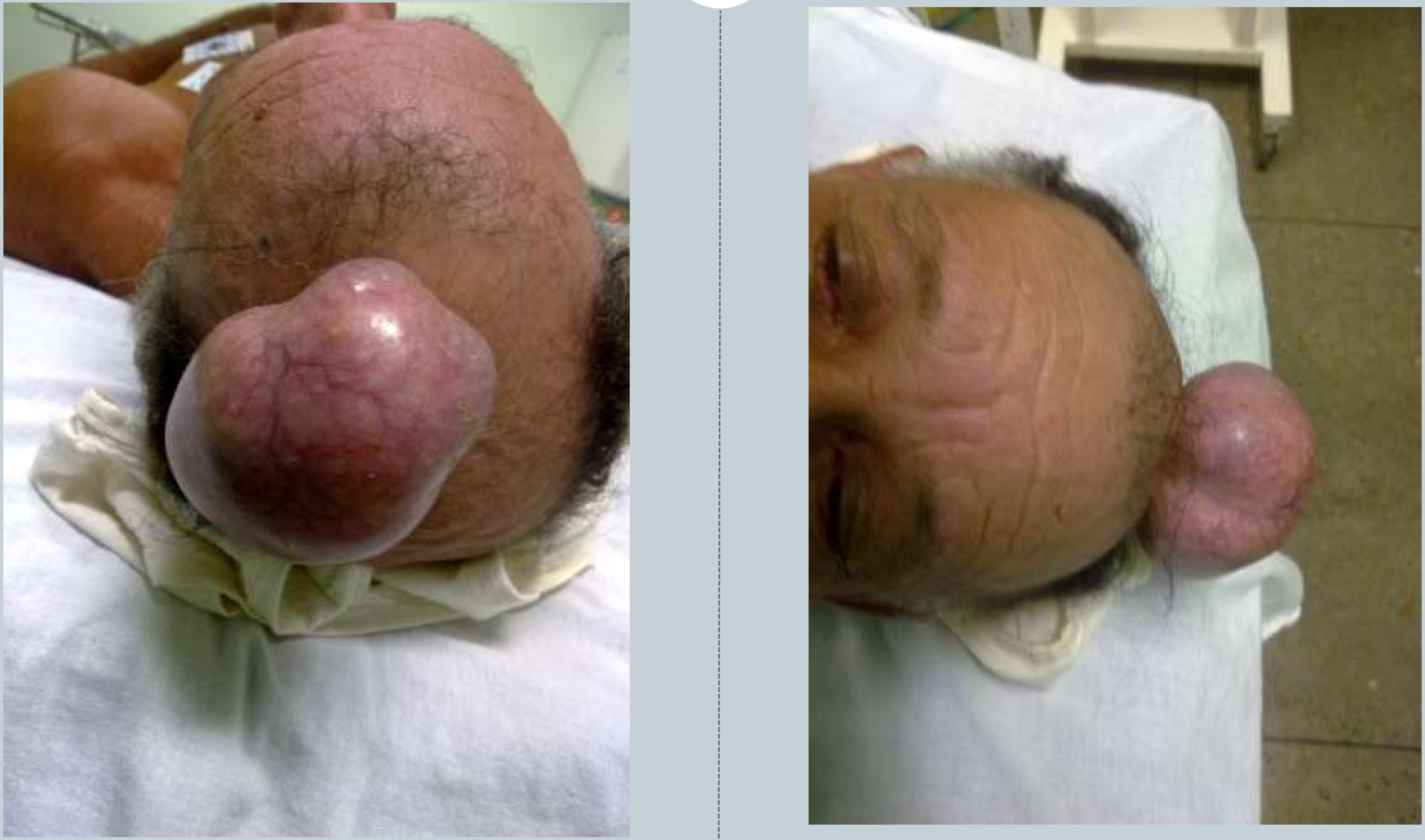
Ceratose actínica



Ceratose seborréica



Corno cutâneo



Epidemiologia

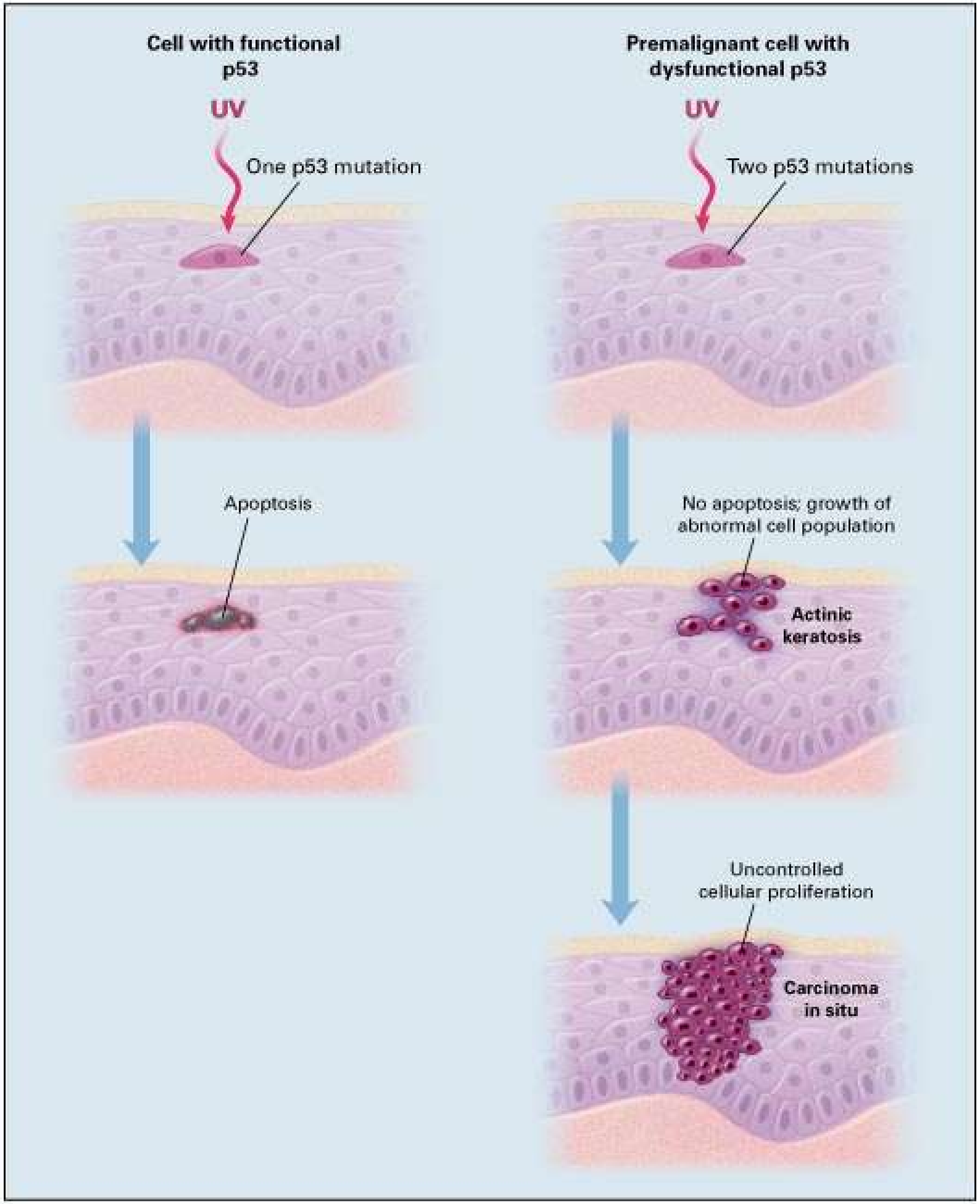
- 1.000.000 de neoplasias ao ano, sendo 80% localizadas na cabeça e pescoço
- 50.000 melanomas e 5.000 sendo outros diagnósticos
- 90% dos tumores de pele são Carcinoma Basocelular ou Carcinoma Escamoso
- Freqüência homem: mulher (3:1)

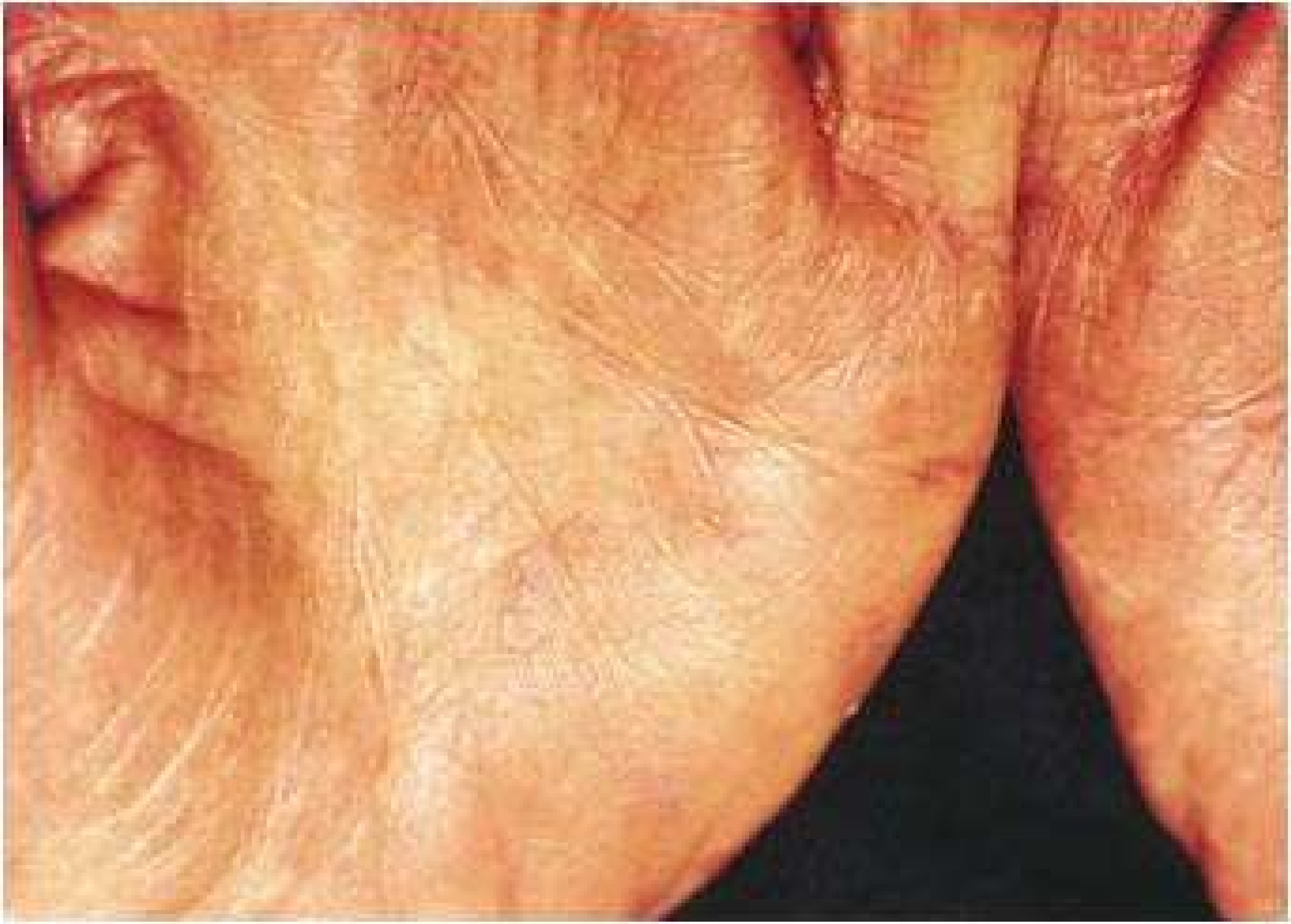
Epidemiologia

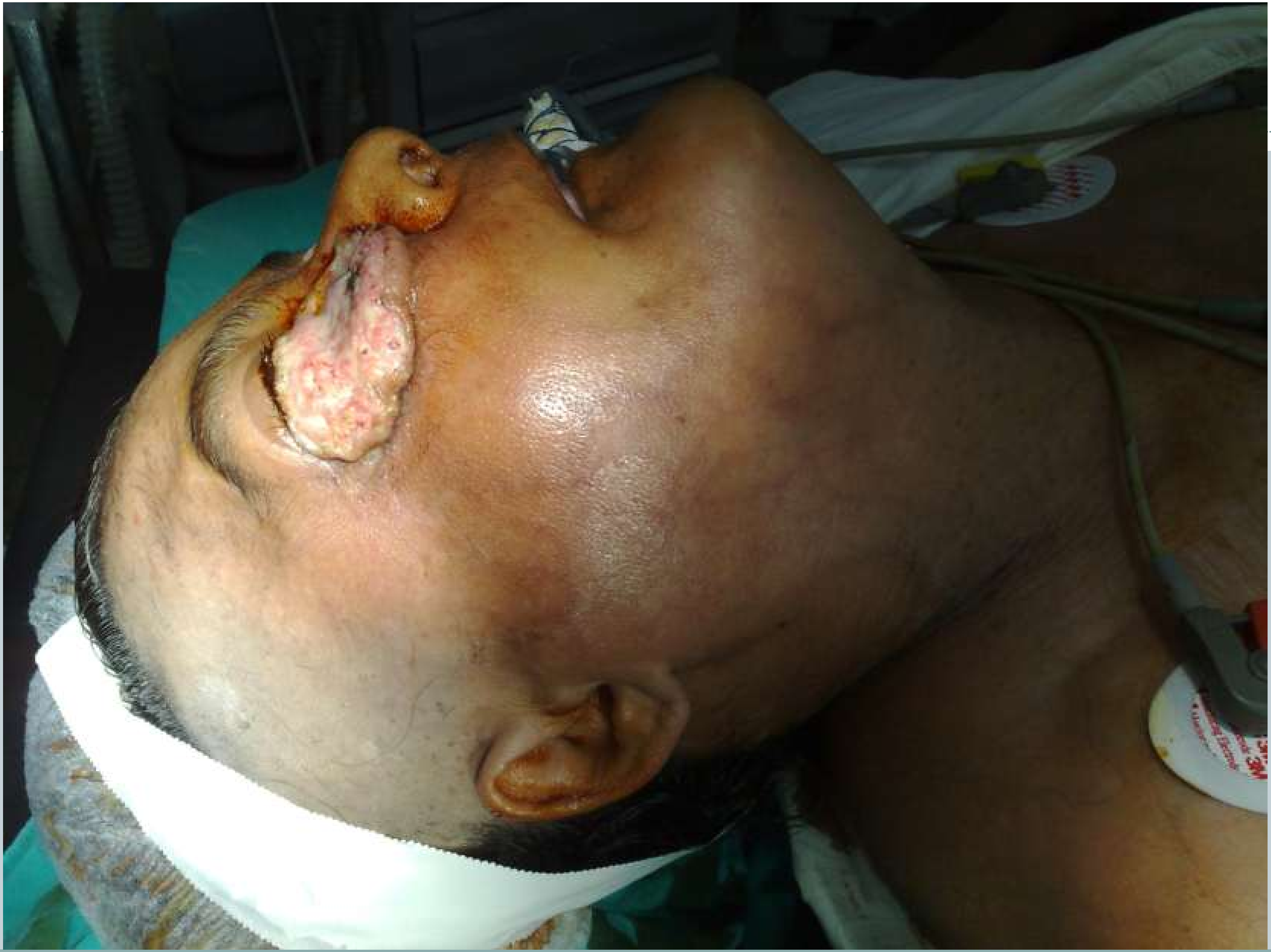
- Países com grande exposição solar
  - Sul dos EUA, Austrália e Reino Unido com predominância de CBC
  - África, Japão e Indonésia com maior predominância de CEC

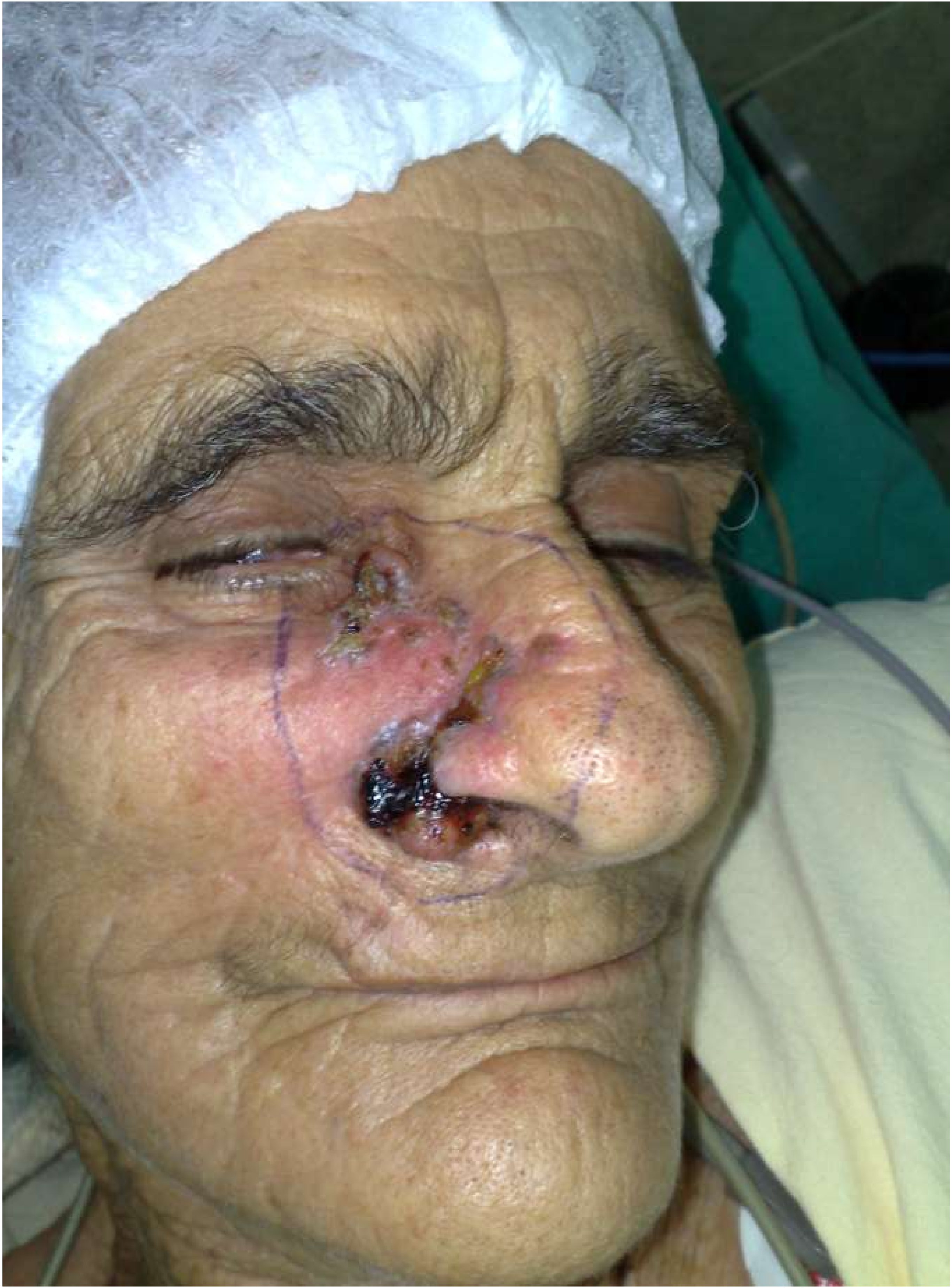
Fatores de Risco

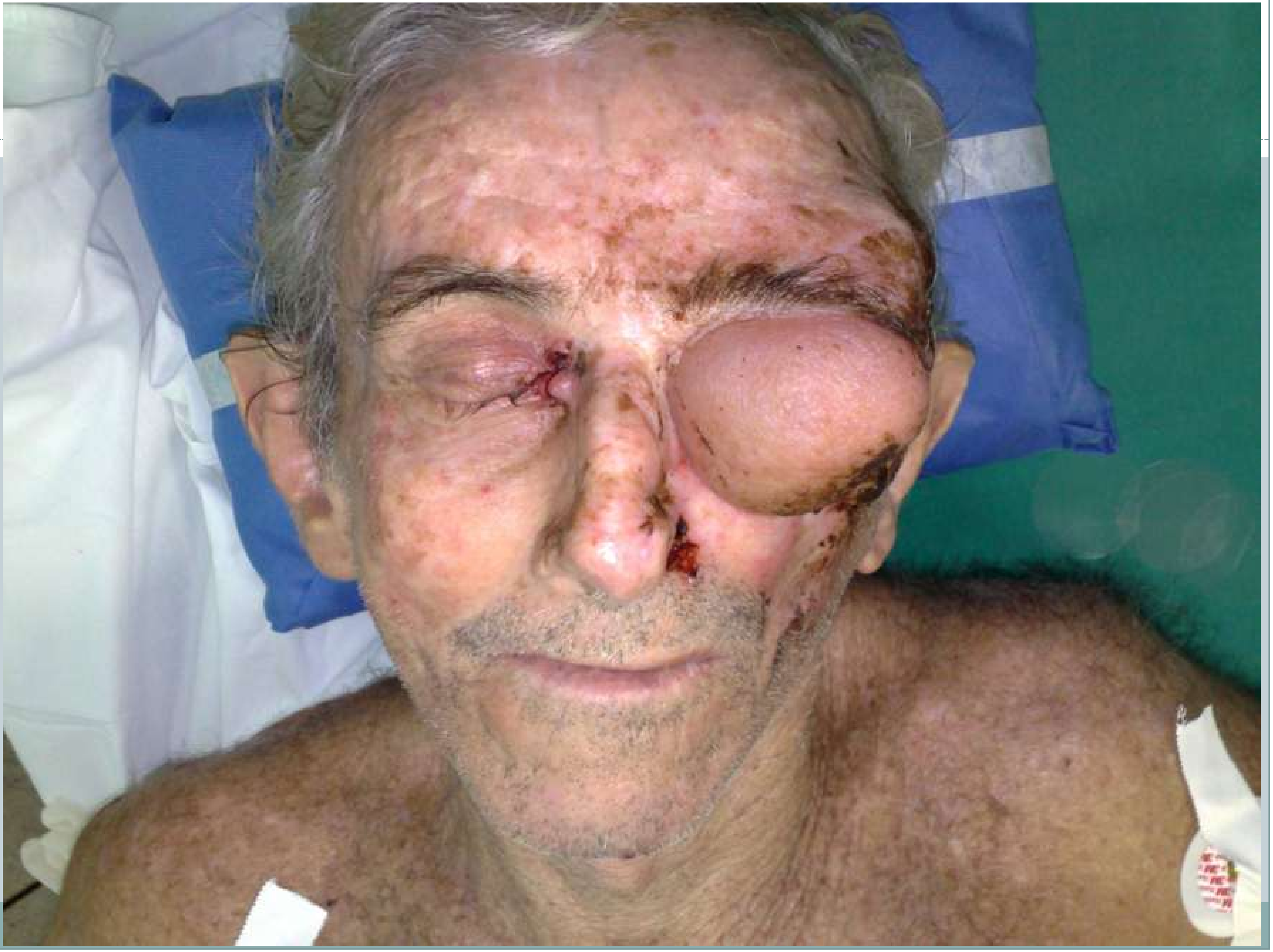
- Radiação ultra-violeta (UV)
  - Imunossupressão
  - Infecção por HPV (16 e 18)
- Produtos químicos
  - Percival Pott e os limpadores de chaminé
  - Parafina, alcatrão e outros hidrocarbonetos

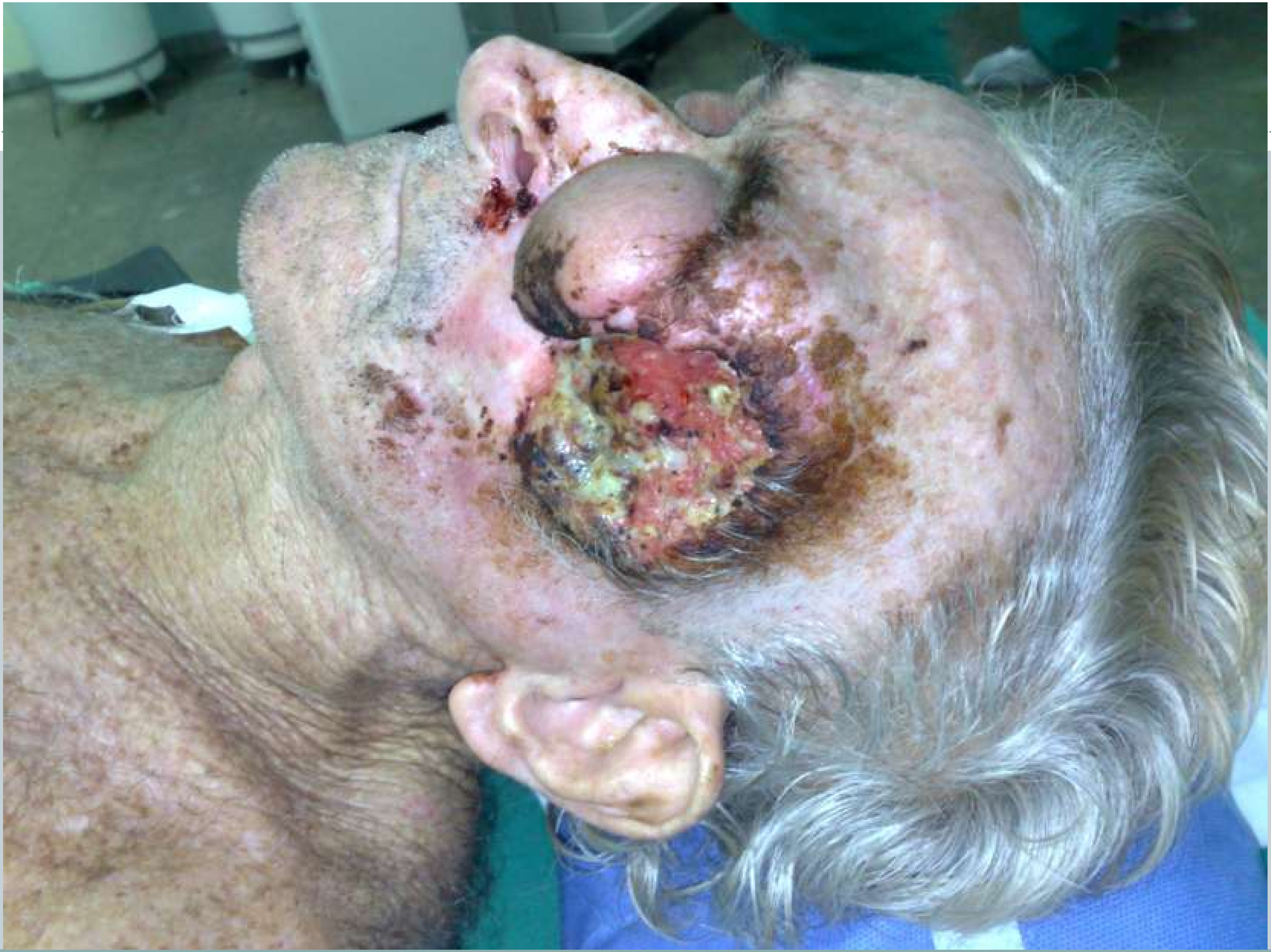

Cell with functional p53
Premalignant cell with dysfunctional p53
UV
One p53 mutation
UV
Two p53 mutations
Apoptosis
No apoptosis; growth of abnormal cell population
Actinic keratosis
Uncontrolled cellular proliferation
Carcinoma in situ

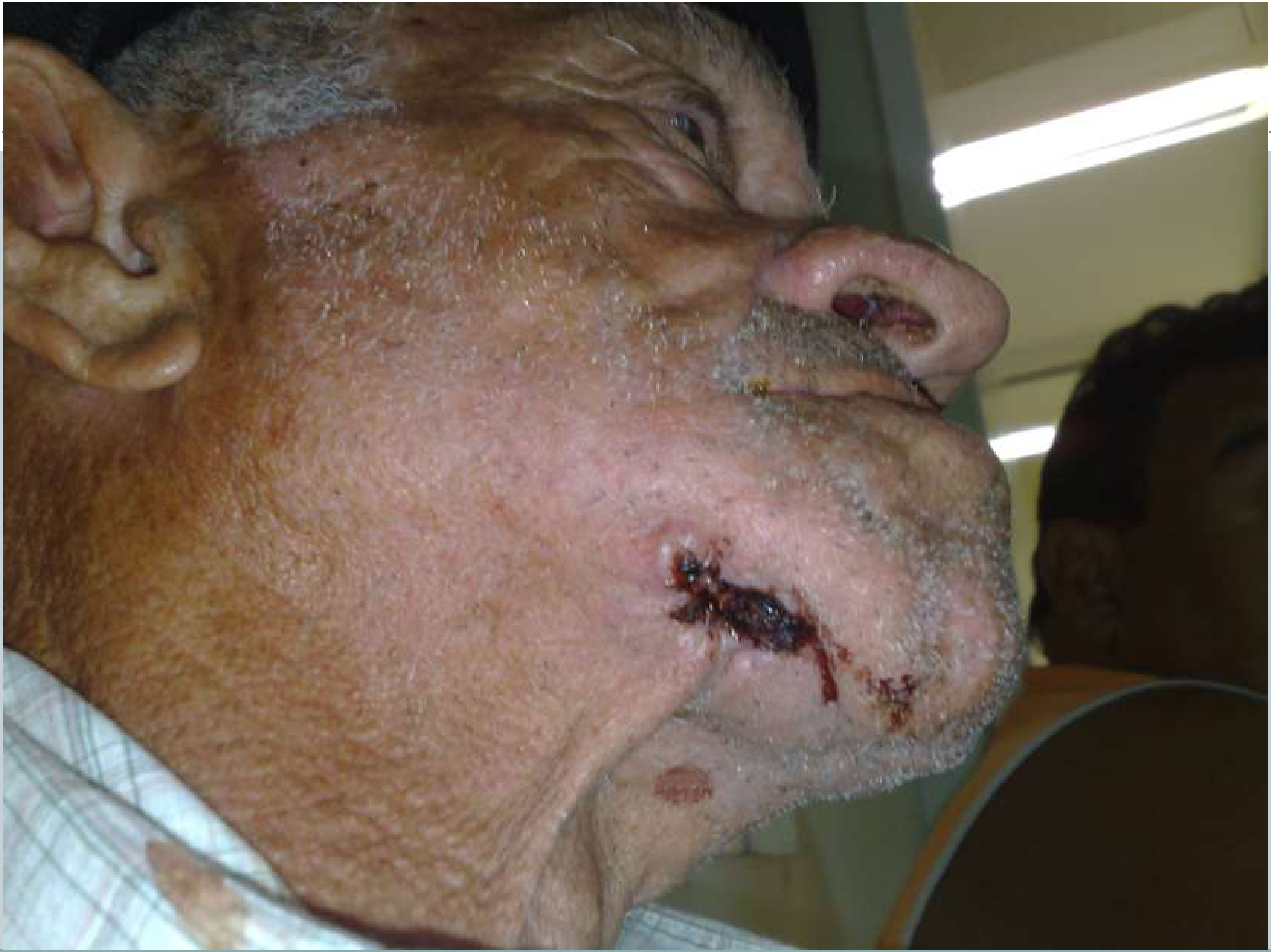


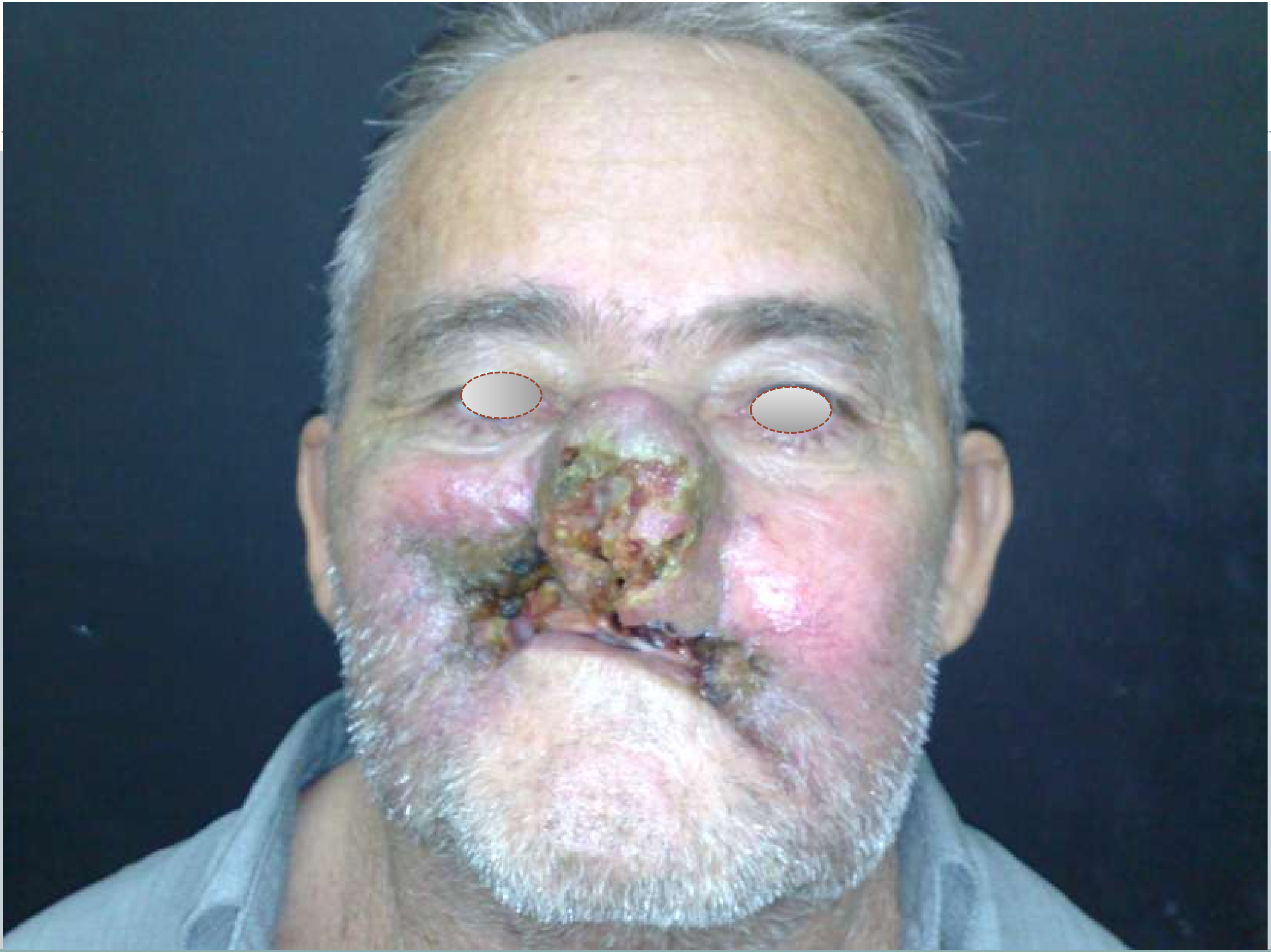


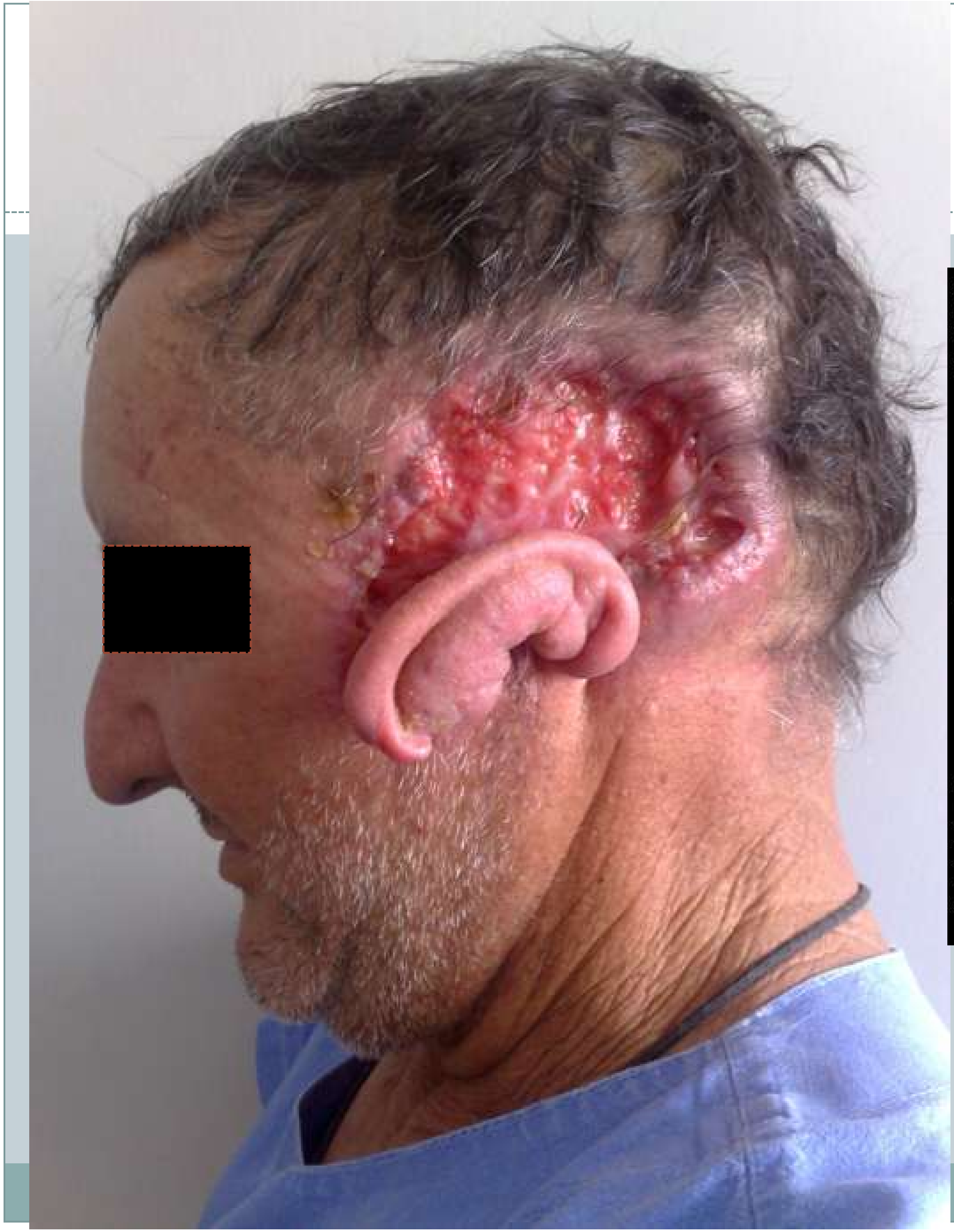












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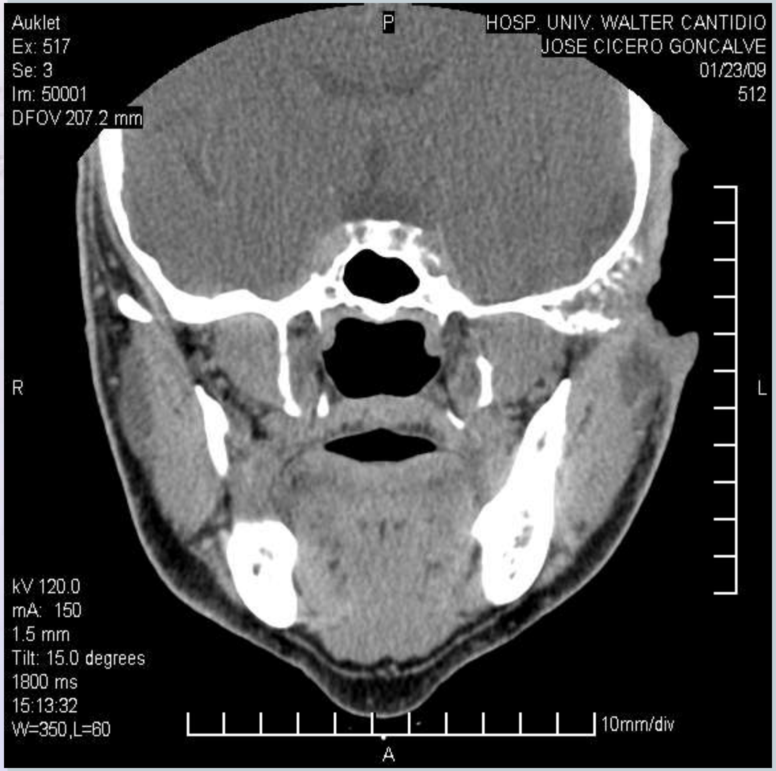

Auklet
Ex: 517
Se: 3
Im: 50001
DFOV 207.2 mm
P
HOSP. UNIV. WALTER CANTIDIO
JOSE CICERO GONCALVE
01/23/09
512
R
L
kV 120.0
mA: 150
1.5 mm
Tilt: 15.0 degrees
1800 ms
15:13:32
W=350,L=60
10mm/div
A

Fatores de Risco

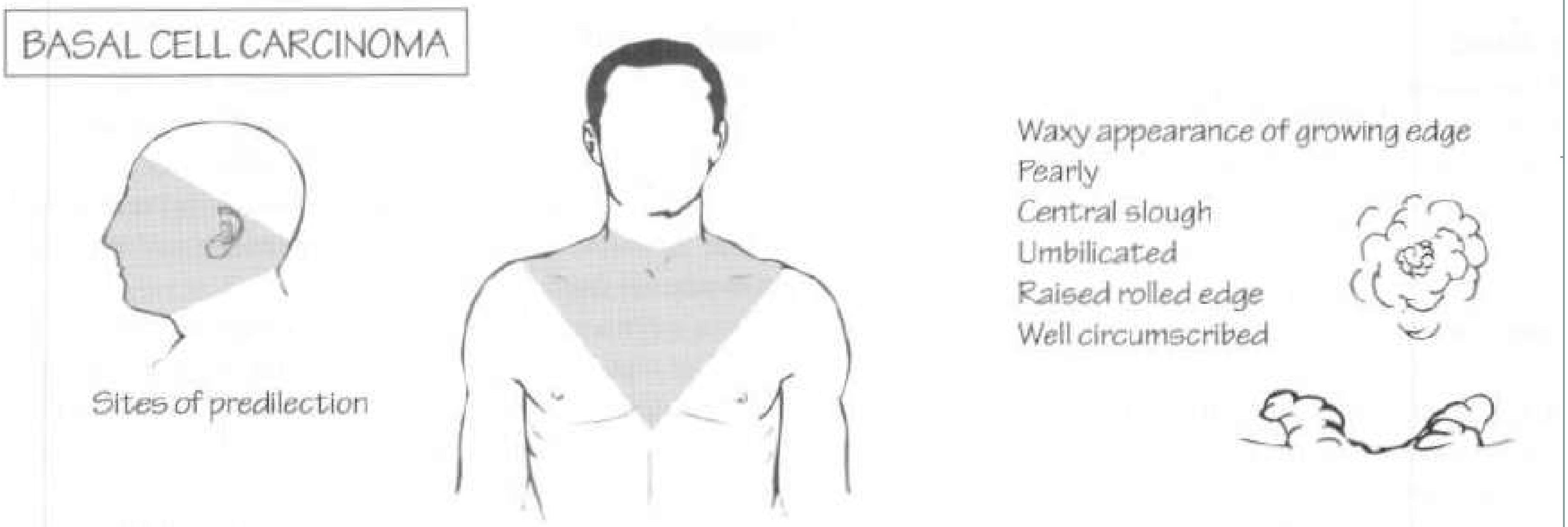
Inflamação crônica

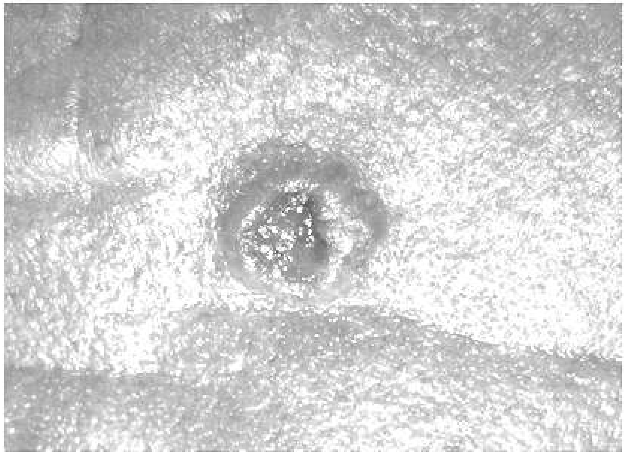
  - Queimadura, hidroadenite, sífilis, hanseníase, Lúpus

- Predisposição genética
  - Xeroderma pigmentoso, displasia epidermal, epidermólise bolhosa distrófica recessiva e albinismo, síndrome nevóide e síndrome de Bazex
- Uso de álcool e tabaco

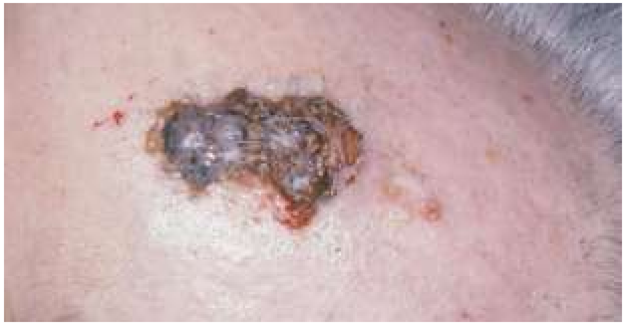
Quadro Clínico

- Carcinoma Basocelular
  - Neoplasia mais comum do mundo
  - Tipos
    - Nódulo-cístico
    - Pigmentado
    - Superficial
    - Micronodular
    - Infiltrativo
    - morfeaforme
  - Crescimento lento e raras metástases
  - Lesões bem definidas, cor creme, bordos perolados, podendo ter ulceração central e telangiectasias

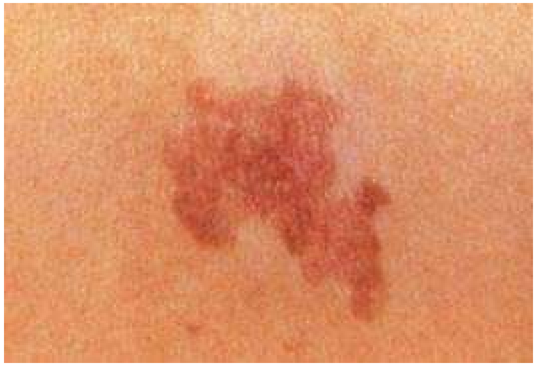

BASAL CELL CARCINOMA
Sites of predilection
Waxy appearance of growing edge
Pearly
Central slough
Umbilicated
Raised rolled edge
Well circumscribed



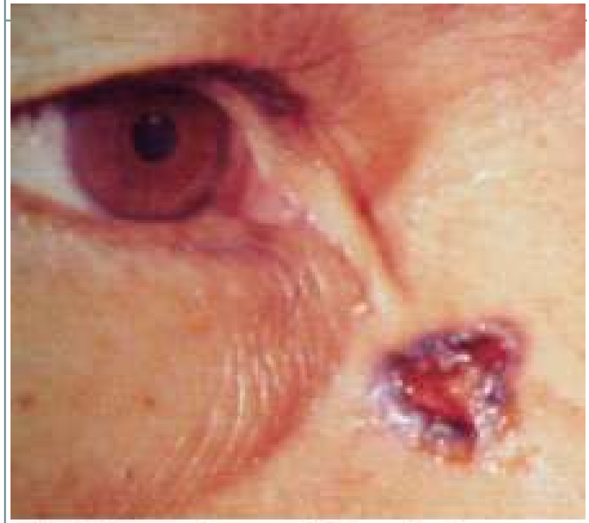
CBC nodular



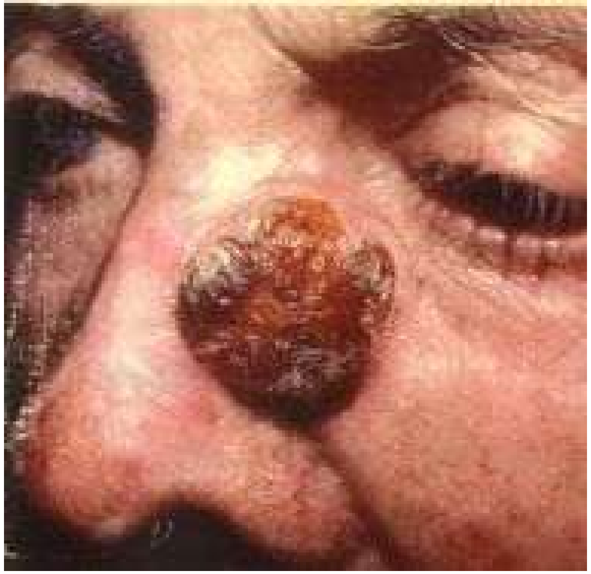
CBC pigmentado

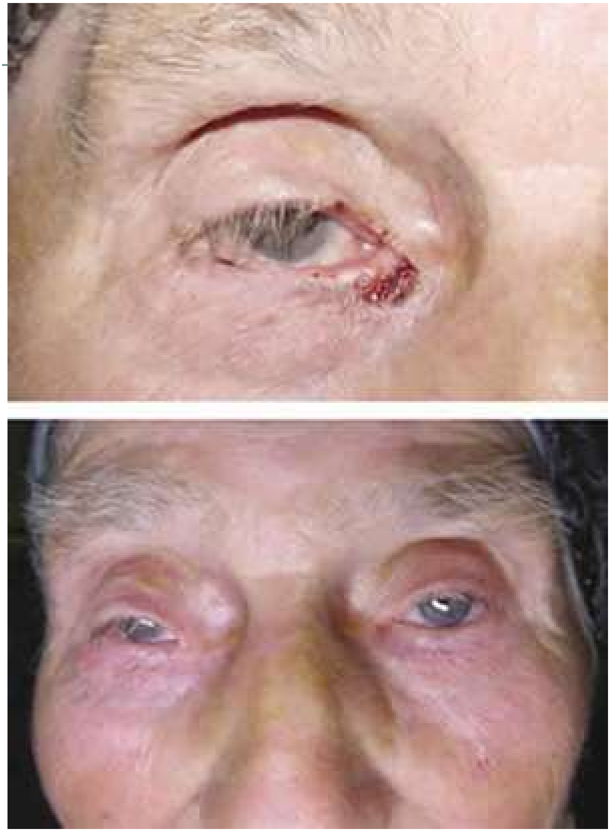


CBC plano superficial



Carcinoma basocelular - foto retirada do site da Universidad Autónoma de Querétaro (México) http://www.uaq.mx



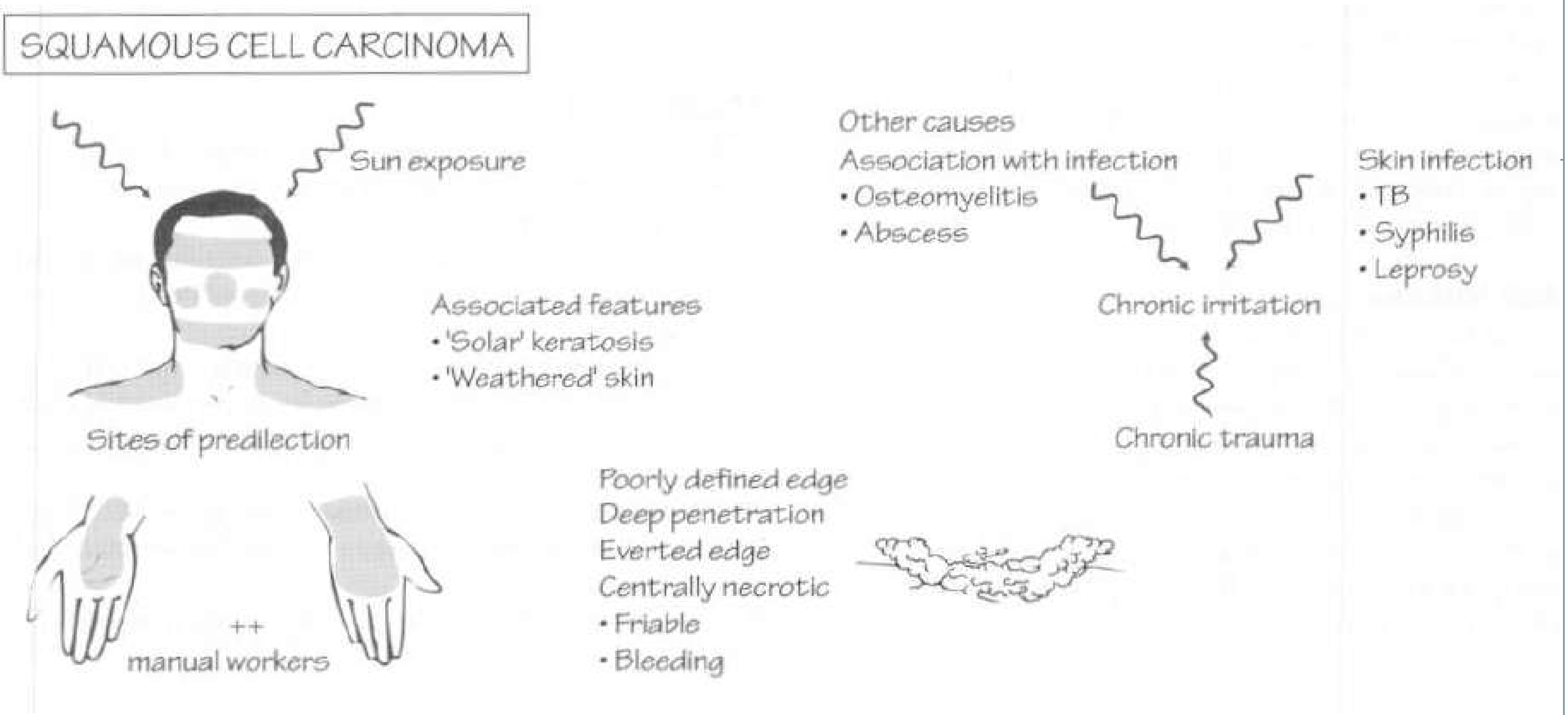


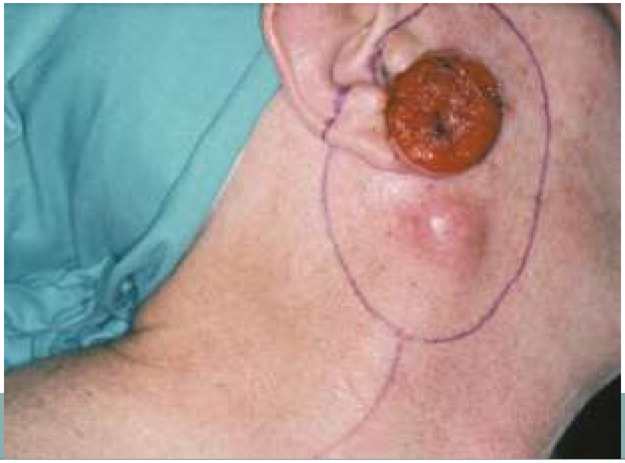
Quadro Clínico

- Carcinoma Escamoso
  - Pior prognóstico por invasão e metástase
  - Típico de peles claras expostas ao sol
  - Originado nos queratinócitos e em áreas de cicatrização e inflamação crônica
  - Lesão pápula, nódulo ou placa, hiperqueratinizada ulcerada ou fungóide de bordos elevadas, rósea ou pigmentada

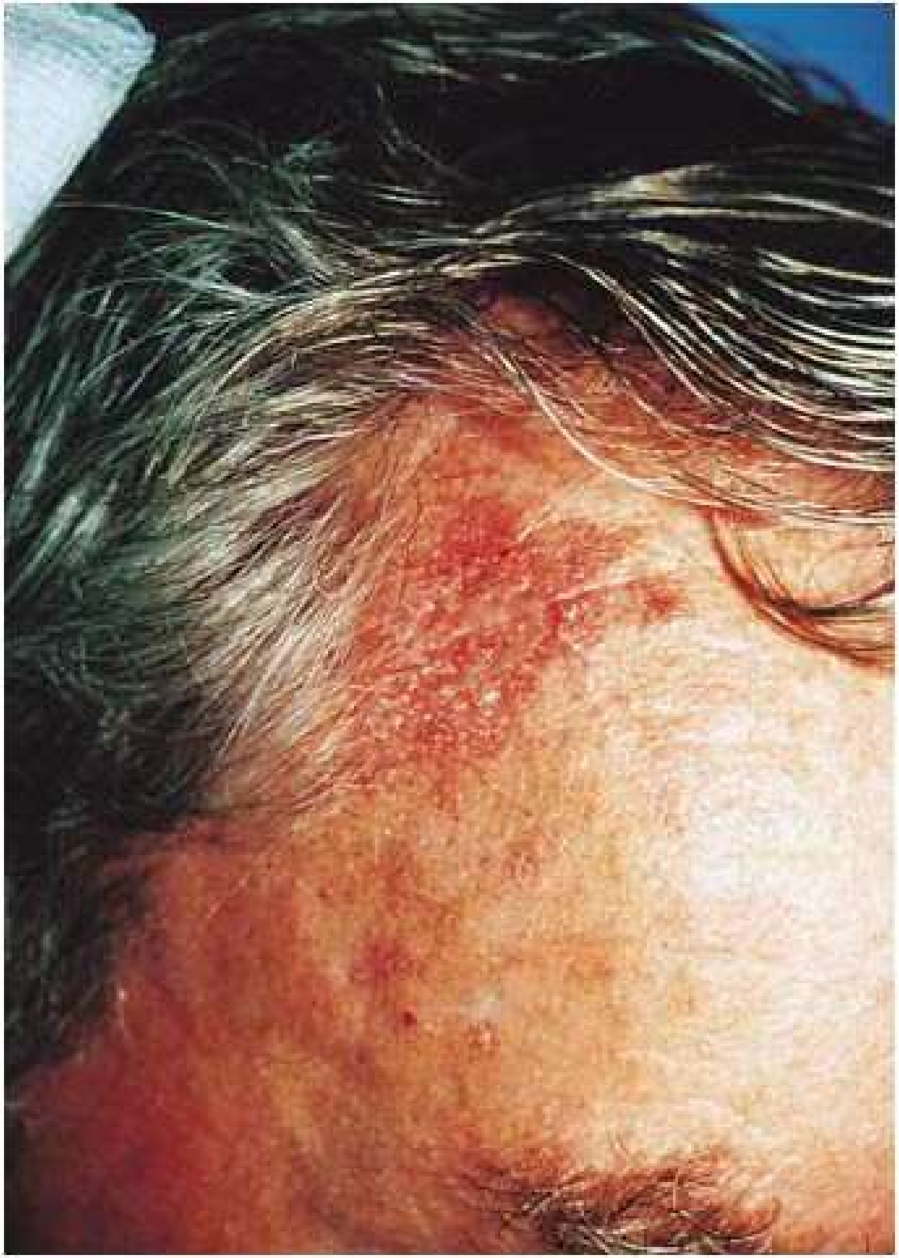
Quadro Clínico

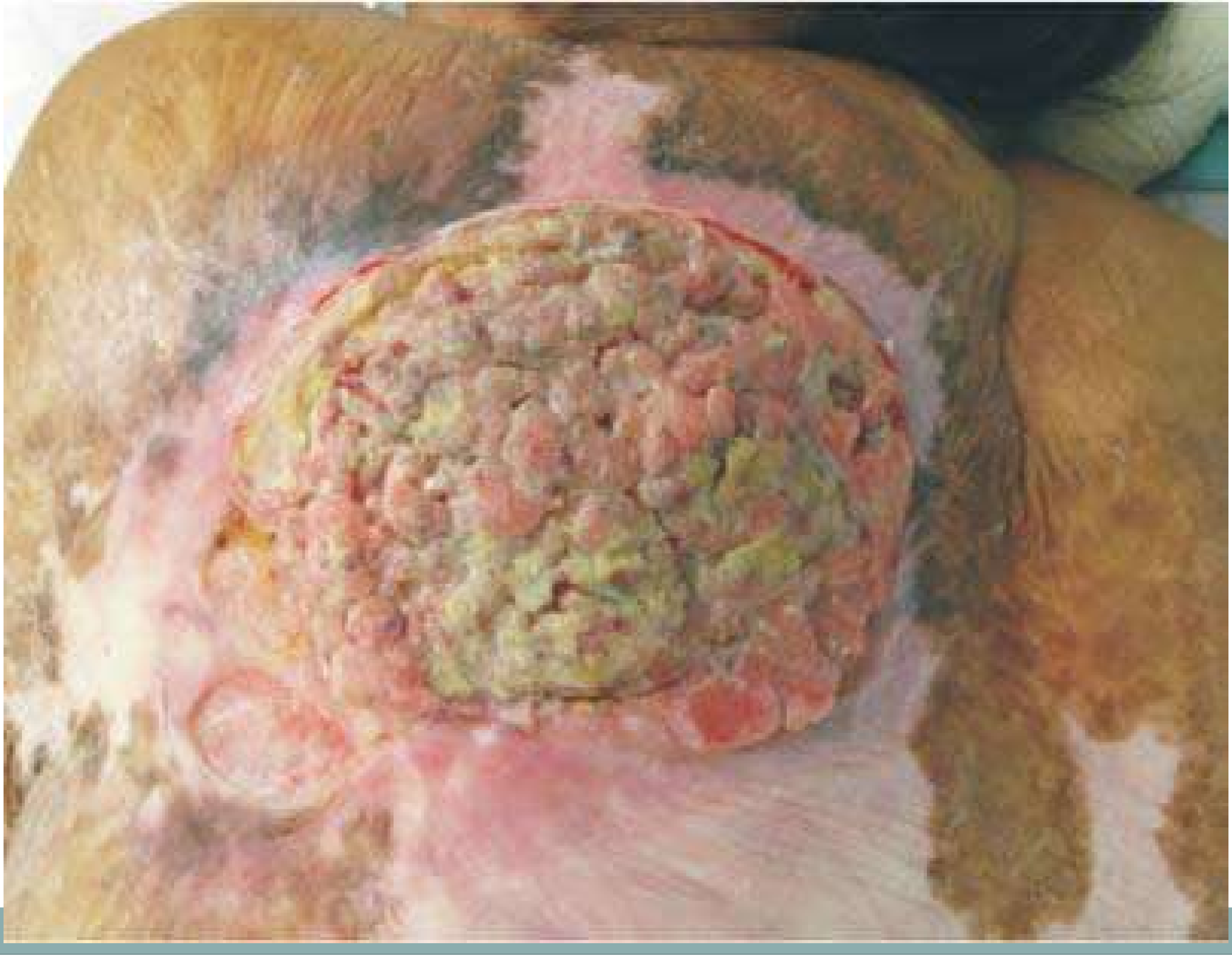
- Variantes
  - Espinocelular
  - Adenóide (acantolítico)
  - Carcinoma verrucoso
  - ceratoacantoma


SQUAMOUS CELL CARCINOMA
Sun exposure
Sites of predilection
Associated features
• 'Solar' keratosis
• 'Weathered' skin
++
manual workers
Other causes
Association with infection
• Osteomyelitis
• Abscess
Chronic irritation
Chronic trauma
Skin infection
• TB
• Syphilis
• Leprosy
Poorly defined edge
Deep penetration
Everted edge
Centrally necrotic
• Friable
• Bleeding



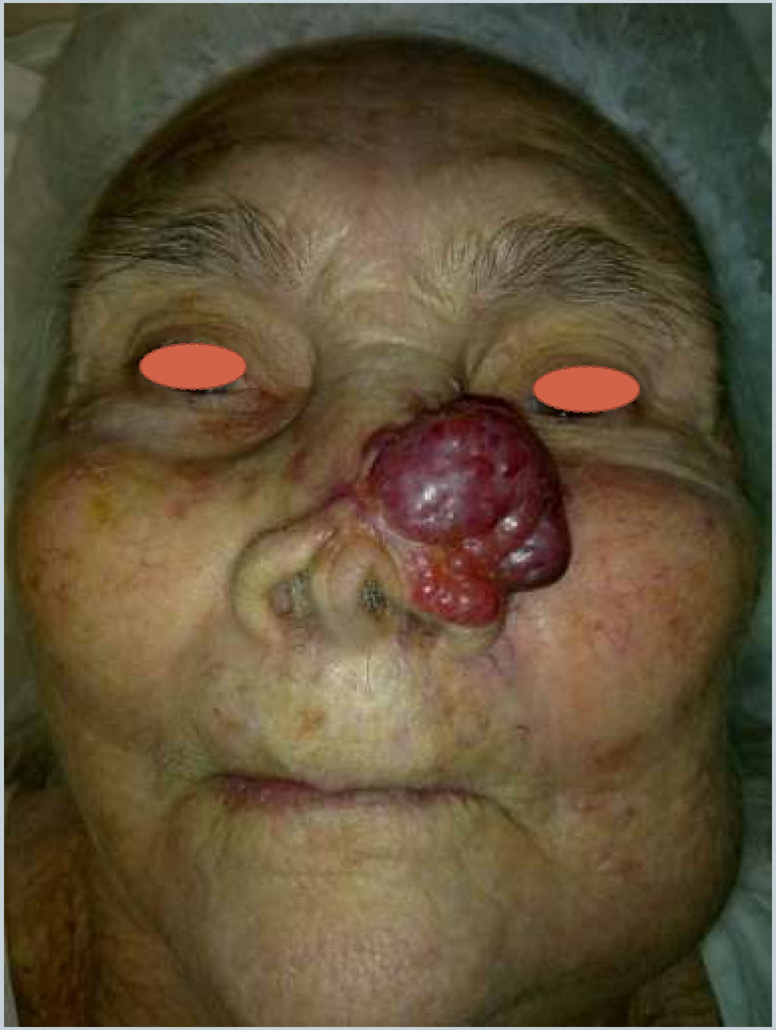
Carcinoma Espinocelular

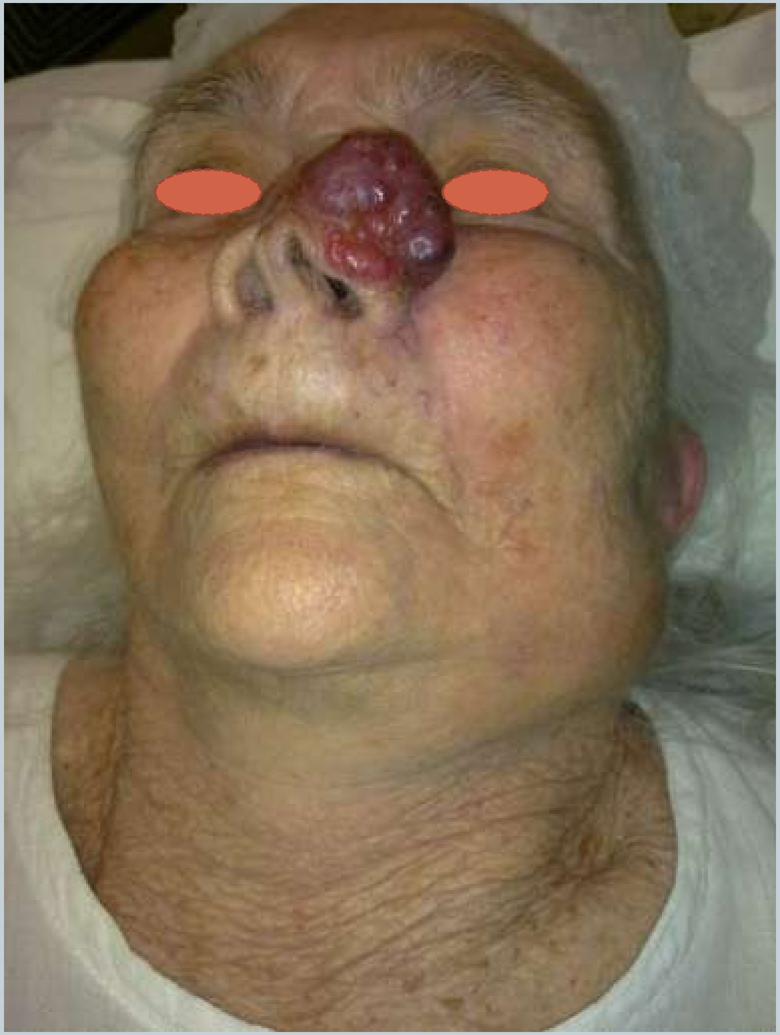




Carcinoma de células de Merkel

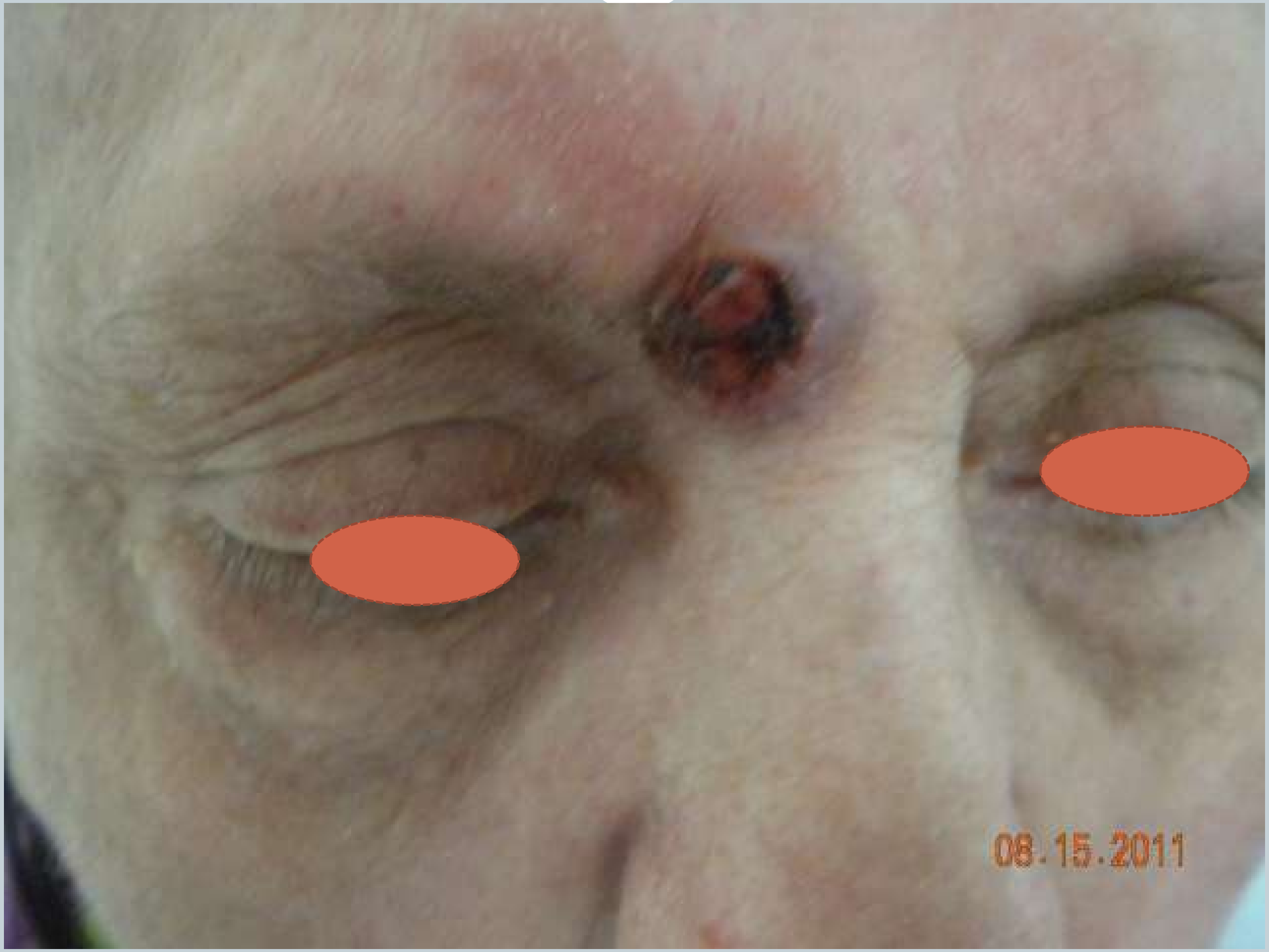
- Lesões em forma de domo, com telangiectasias, vermelho-violáceo
- 50% dos casos na cabeça e pescoço
- Doença agressiva de tratamento cirúrgico





Dermatofibrosarcoma protuberans

- Sarcoma de grau baixo a intermediário, que envolve cabeça e pescoço em 14% dos casos
- Tratamento cirúrgico



08.15.2011

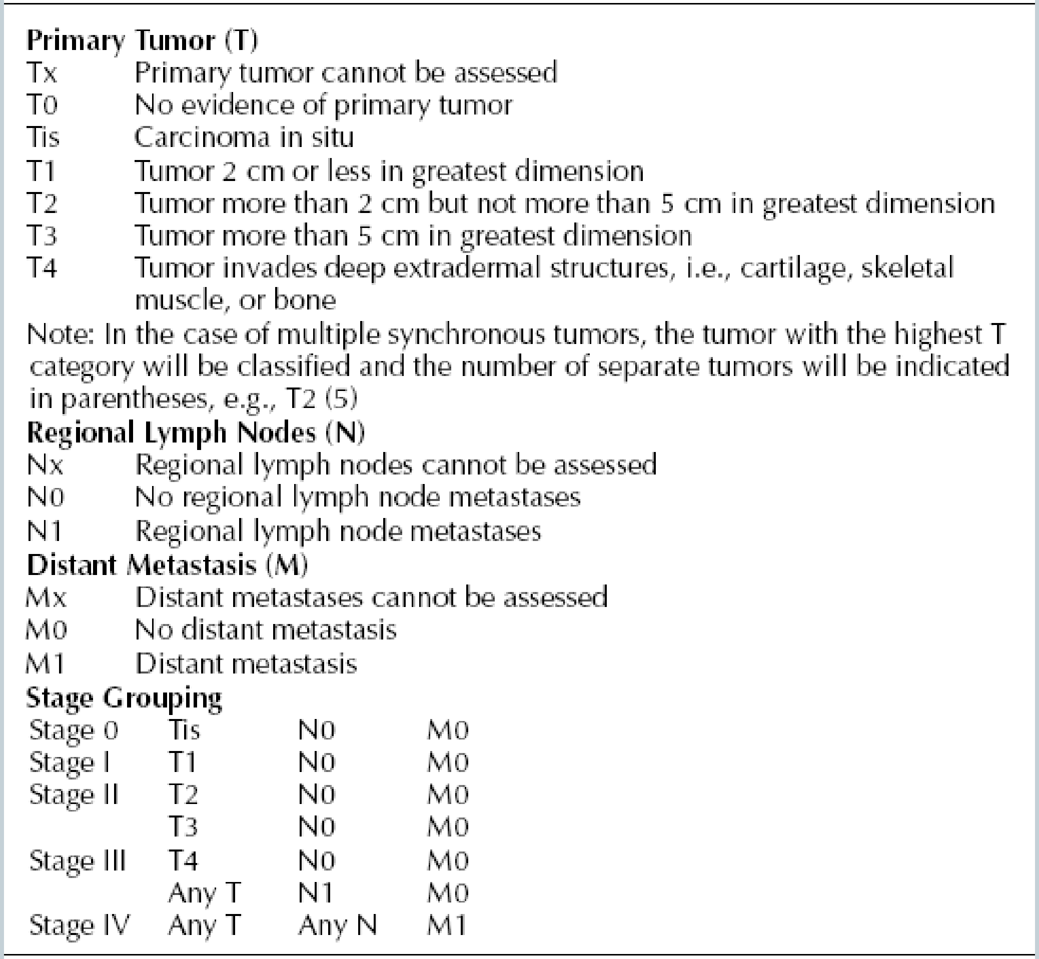
Quadro Clínico

- Histiocitoma fibroso maligno
  - Tumor de partes moles mais comum em adultos, mas envolve cabeça e pescoço em 1 a 3% dos casos
  - Corresponde só a 0,01% das malignidades cutâneas

Histopatologia e Tratamento

- Localização
- Extensão para além de planos de resistência
- Tamanho
- Profundidade de invasão
- Grau histológico
- Tipo espinhoso e tipo acantolítico

Estadiamento



Primary Tumor (T)

Tx	Primary tumor cannot be assessed
T0	No evidence of primary tumor
Tis	Carcinoma in situ
T1	Tumor 2 cm or less in greatest dimension
T2	Tumor more than 2 cm but not more than 5 cm in greatest dimension
T3	Tumor more than 5 cm in greatest dimension
T4	Tumor invades deep extradermal structures, i.e., cartilage, skeletal muscle, or bone

Note: In the case of multiple synchronous tumors, the tumor with the highest T category will be classified and the number of separate tumors will be indicated in parentheses, e.g., T2 (5)

Regional Lymph Nodes (N)

Nx	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastases
N1	Regional lymph node metastases

Distant Metastasis (M)

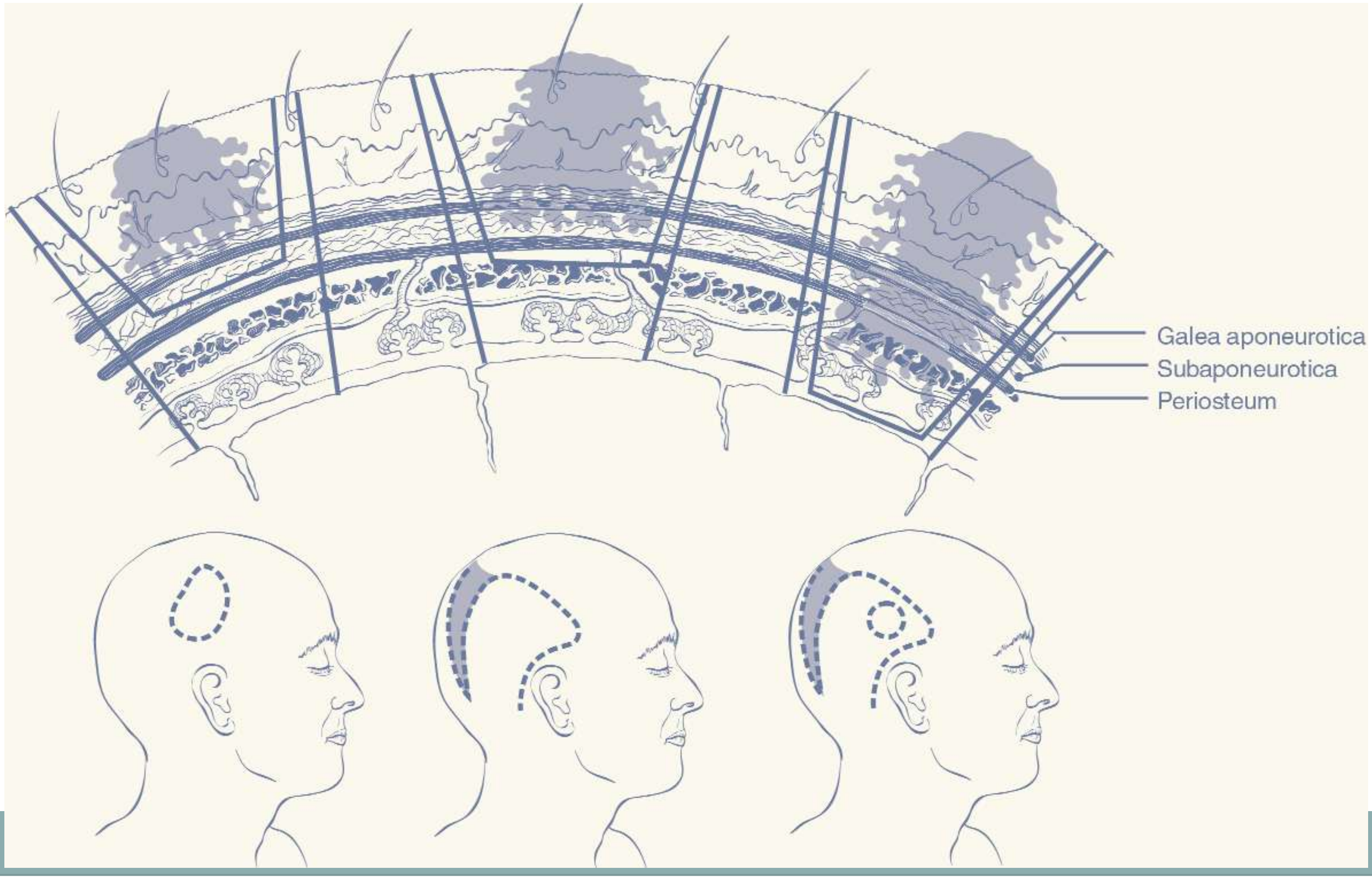
Mx	Distant metastases cannot be assessed
M0	No distant metastasis
M1	Distant metastasis

Stage Grouping

Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage II	T2	N0	M0
	T3	N0	M0
Stage III	T4	N0	M0
	Any T	N1	M0
Stage IV	Any T	Any N	M1

Tratamento

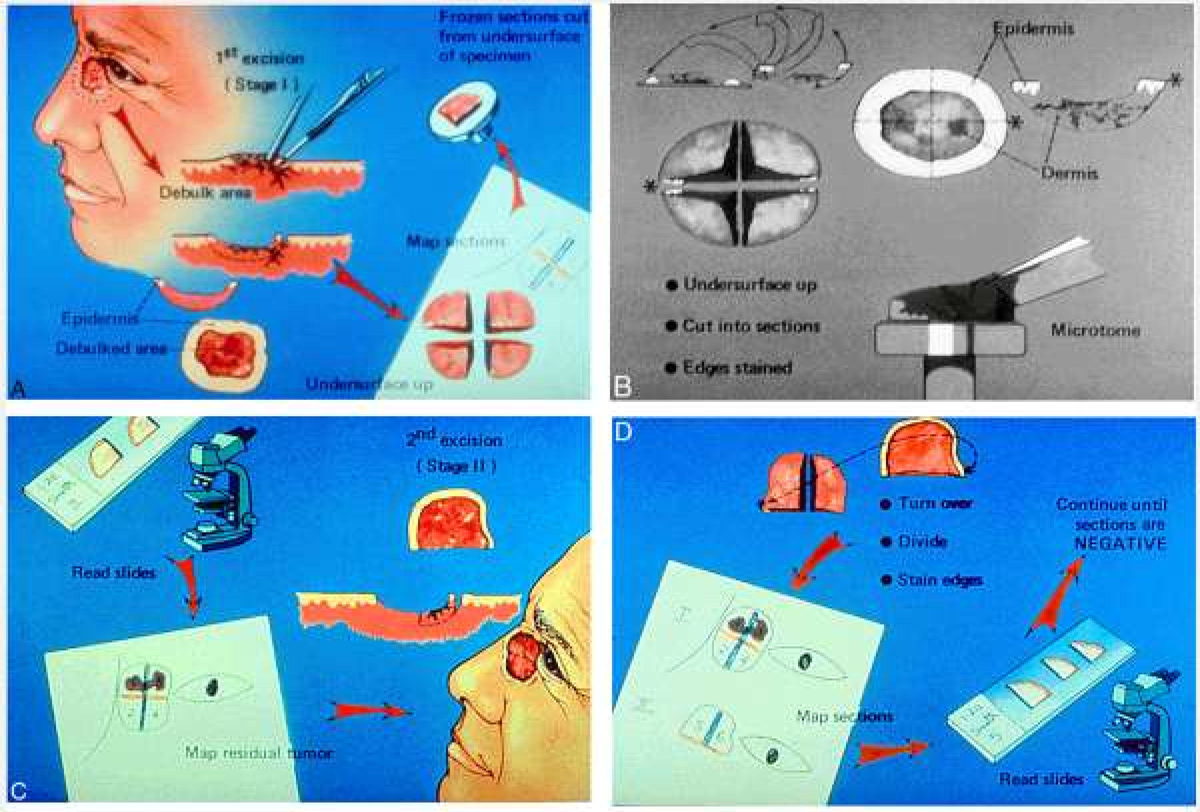
- Princípios

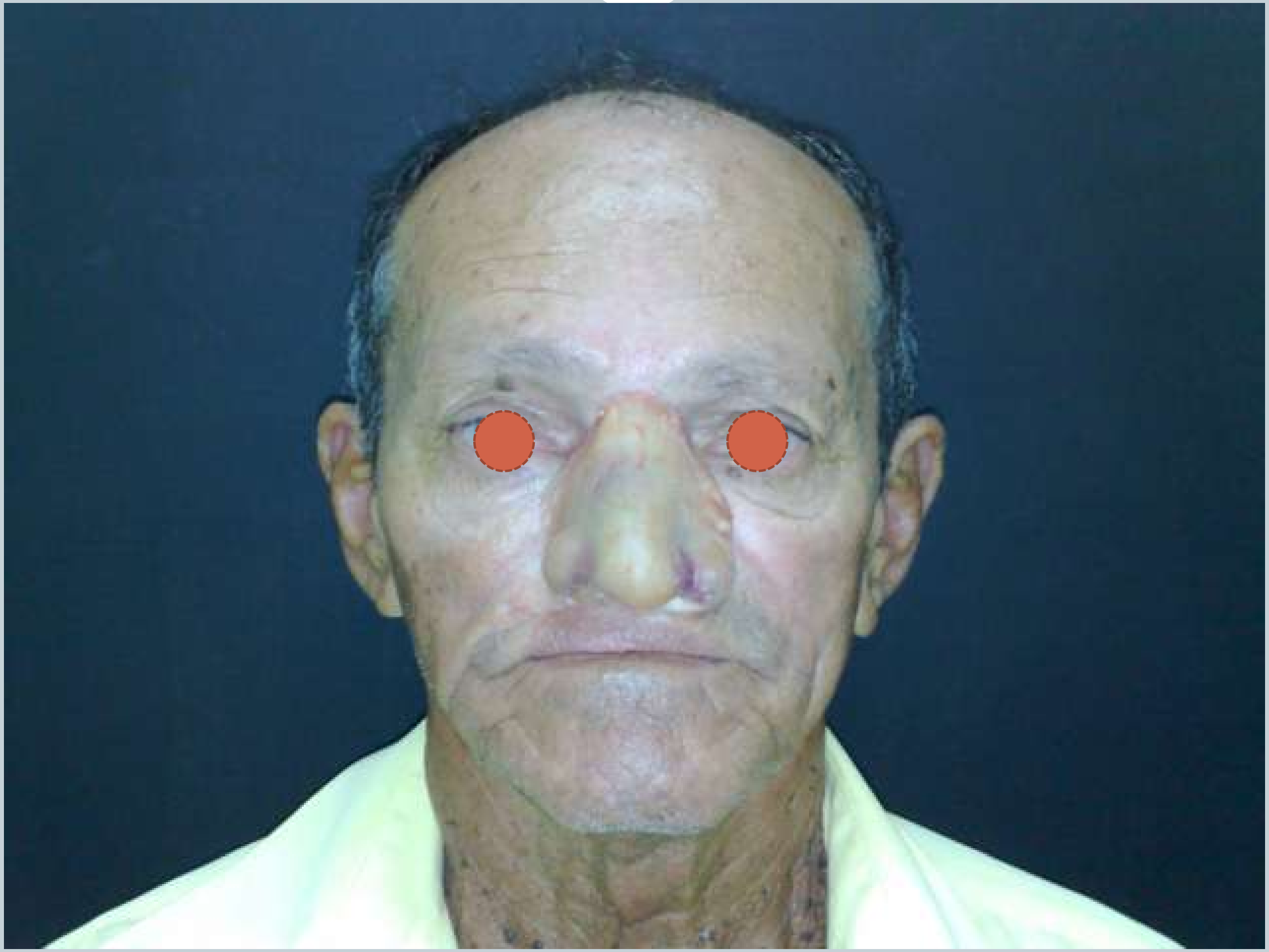

Galea aponeurotica
Subaponeurotica
Periosteum

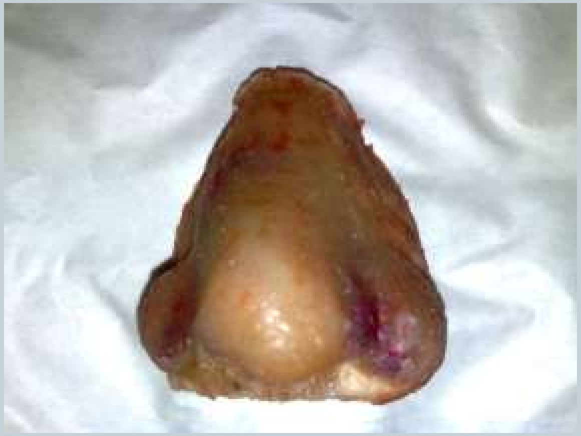
Tratamento

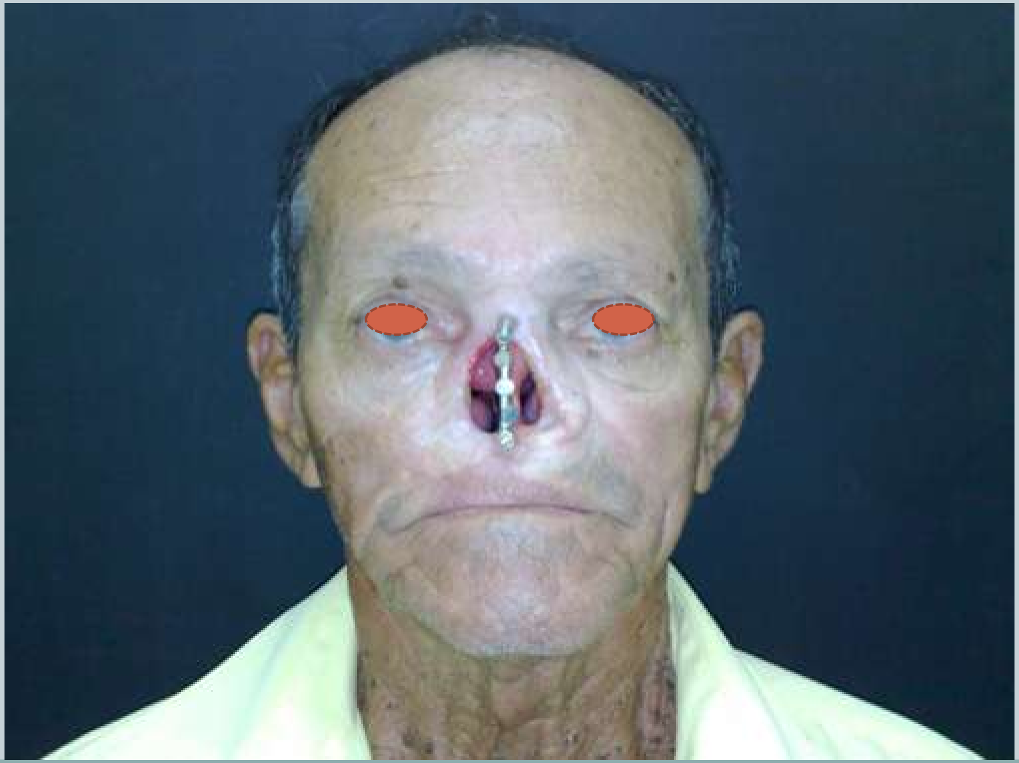
- Excisão
- Curetagem
- Eletrodissecção
- Crioterapia
- Radioterapia
- Terapia microcirúrgica de Mohs

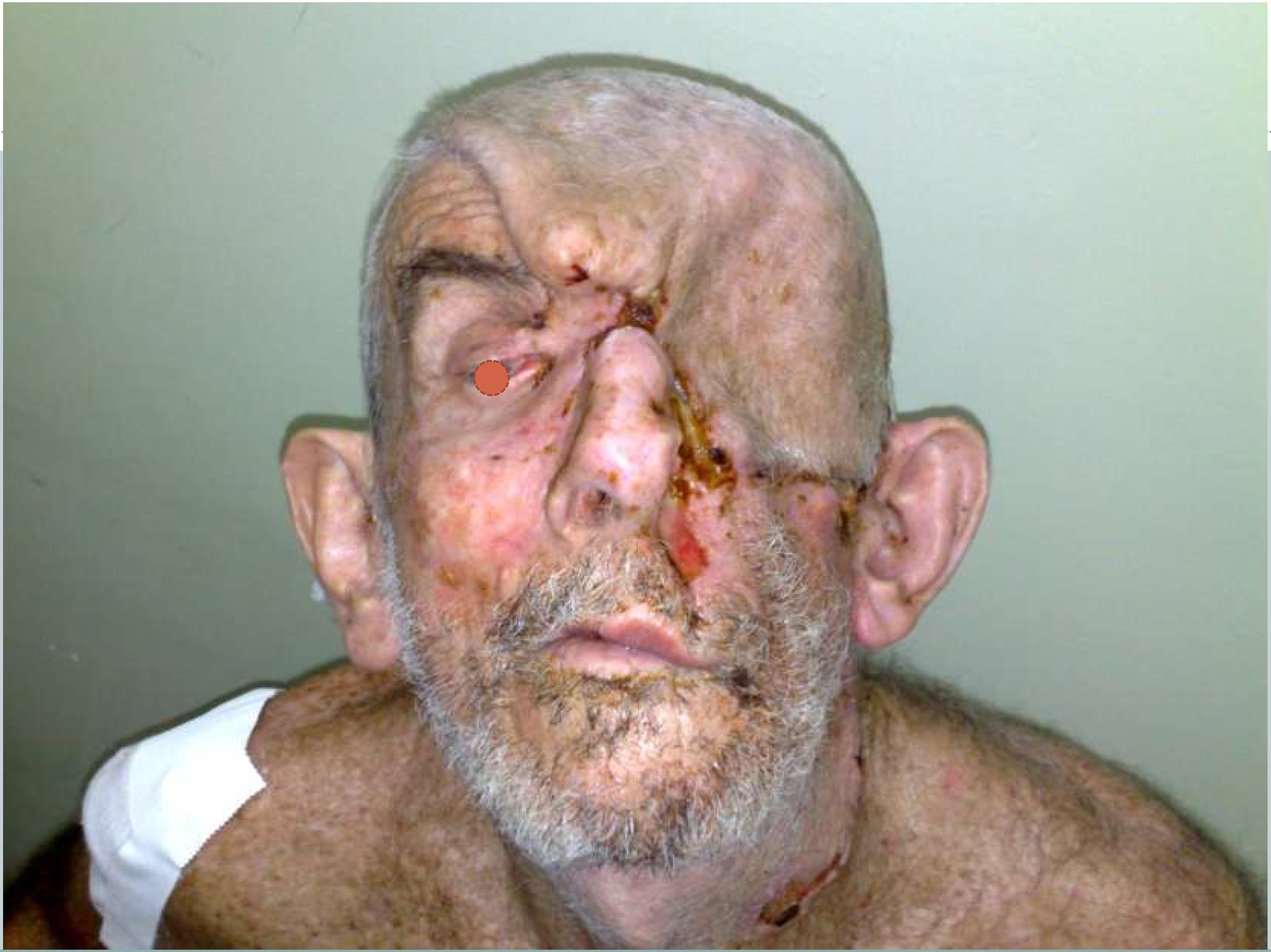
Tratamento

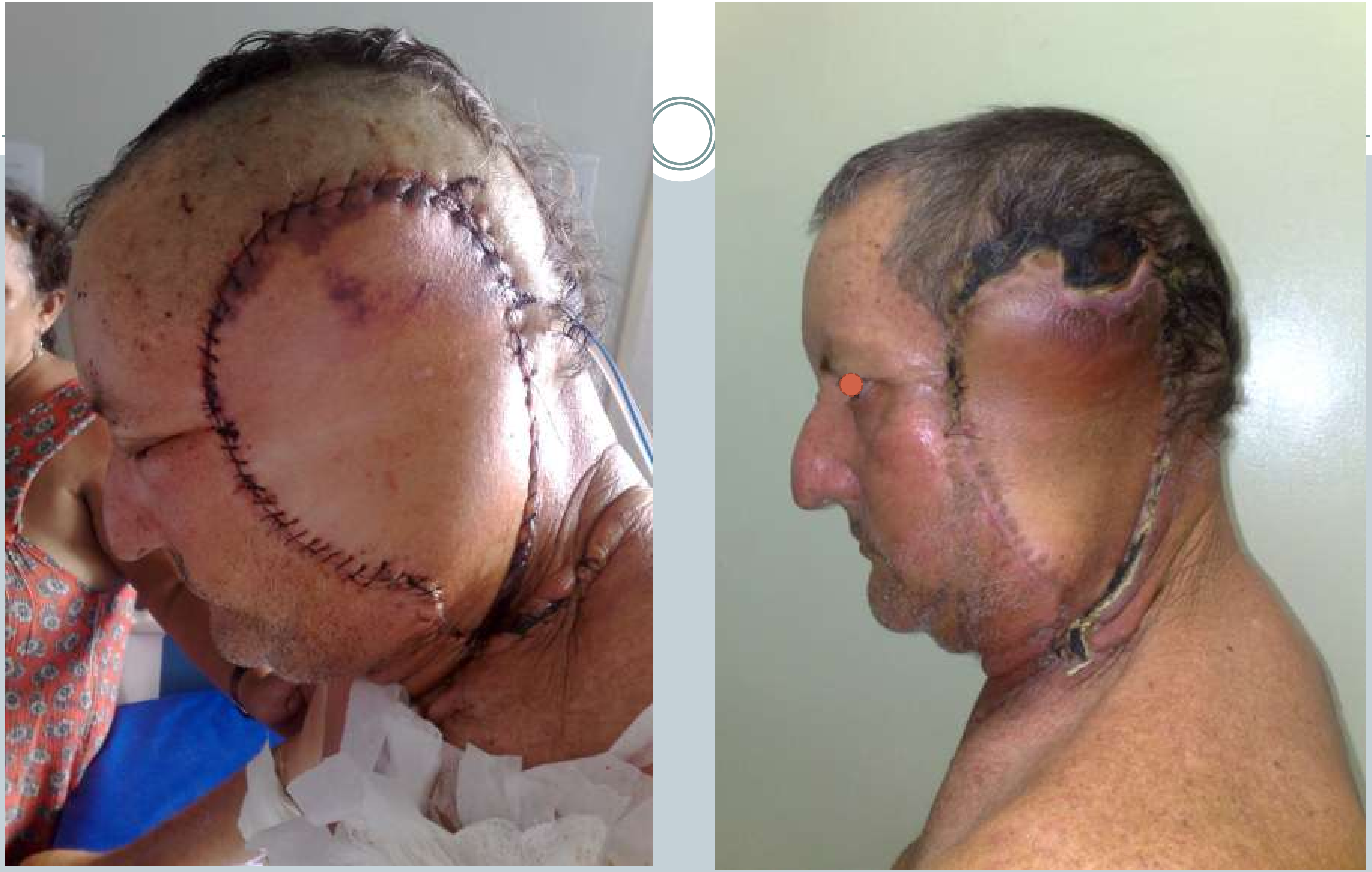

A
1st excision
(Stage I)
Frozen sections cut from undersurface of specimen
Debulk area
Map sections
Epidermis
Debulked area
Undersurface up
B
Epidermis
Dermis
● Undersurface up
● Cut into sections
● Edges stained
Microtome
C
2nd excision
(Stage II)
Read slides
Map residual tumor
D
● Turn over
● Divide
● Stain edges
Continue until sections are NEGATIVE
Map sections
Read slides

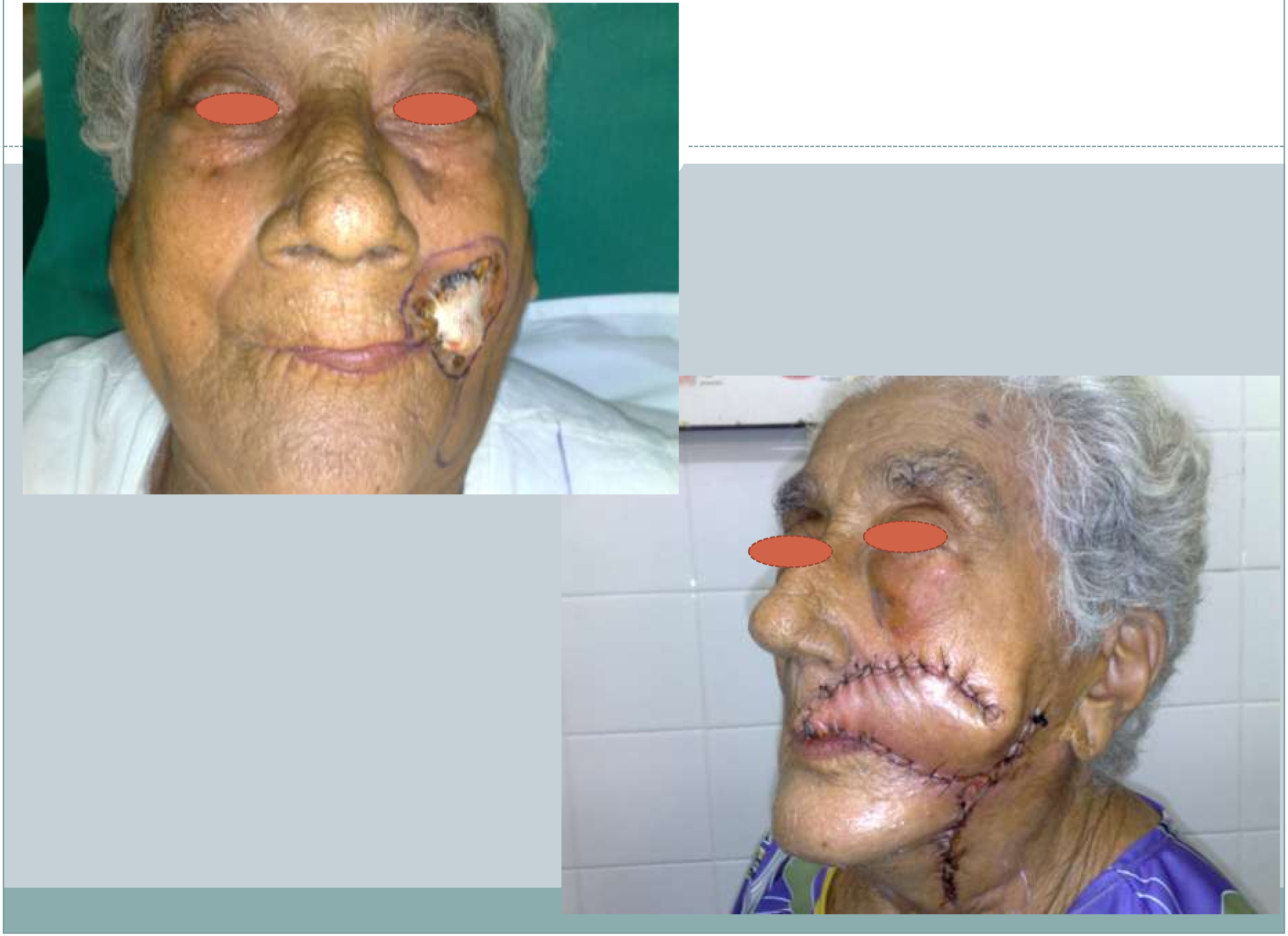


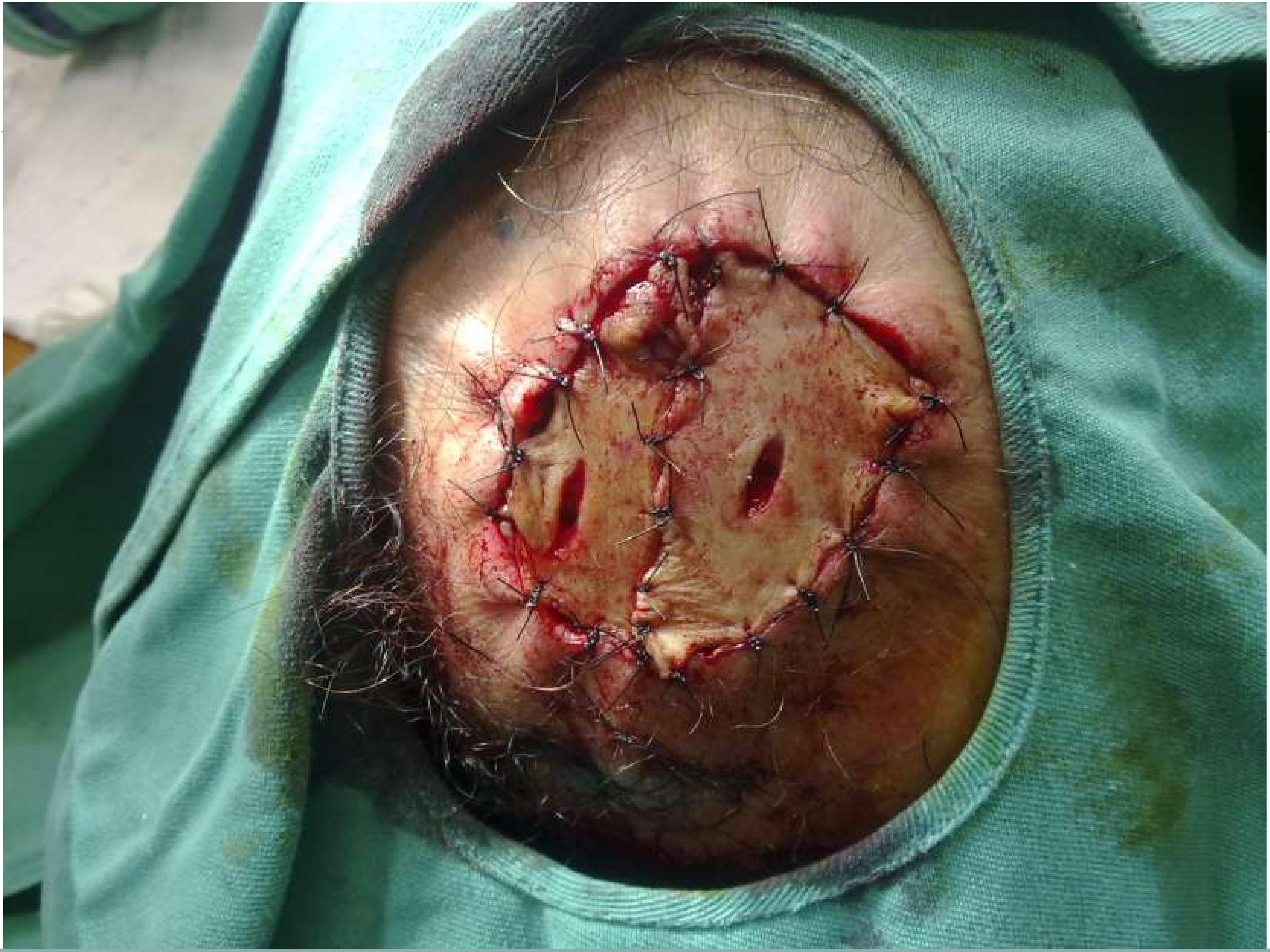


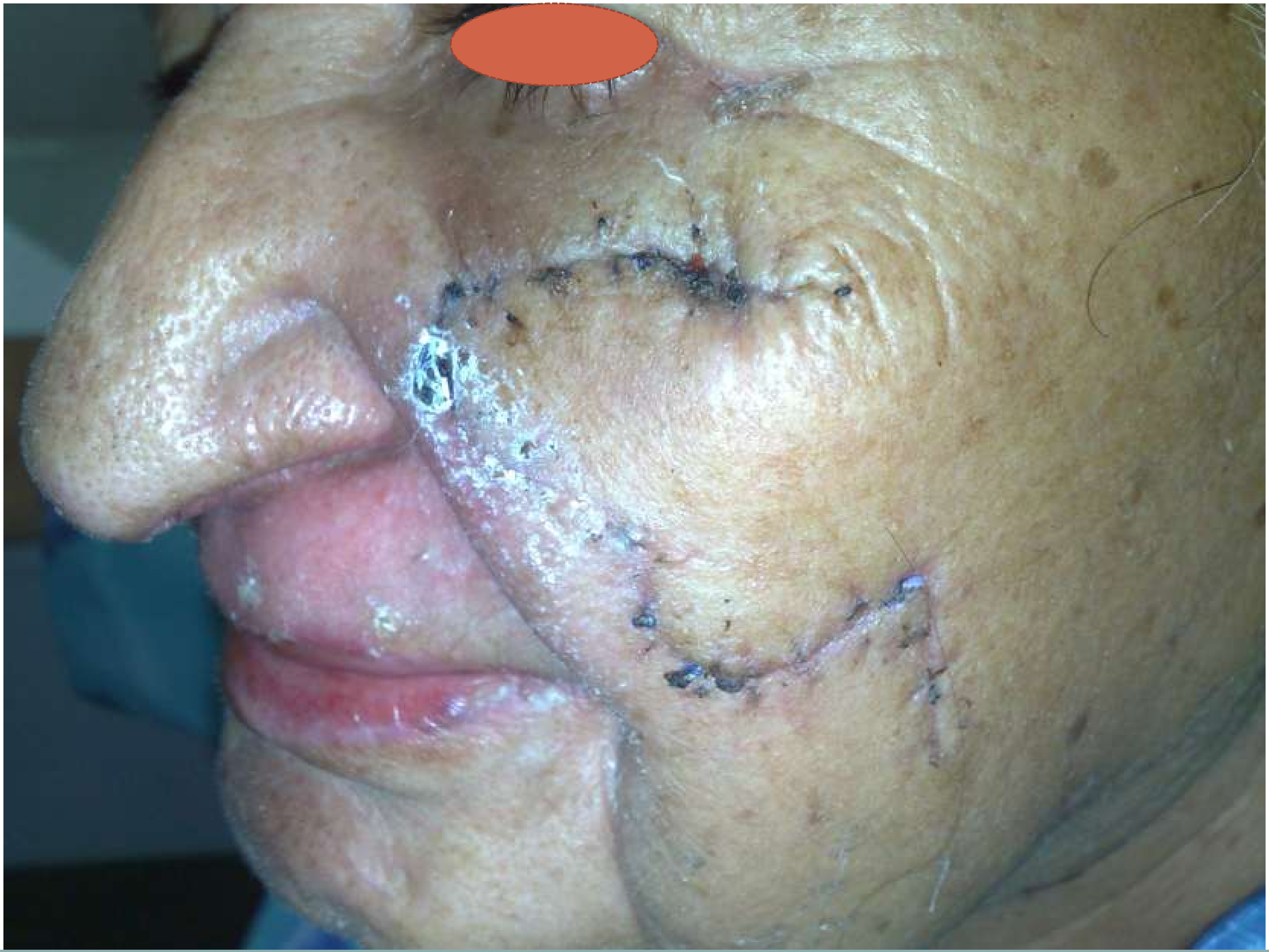


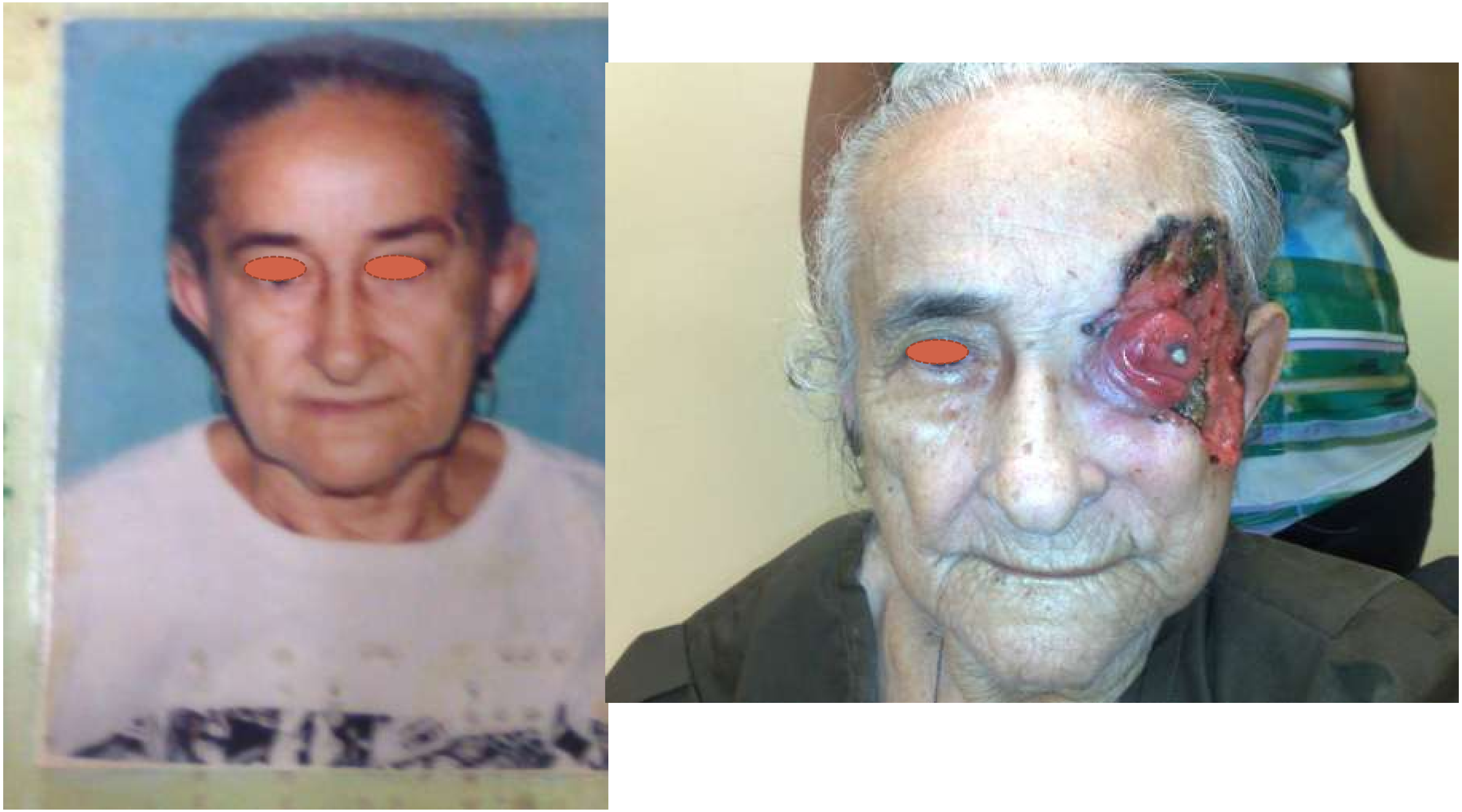


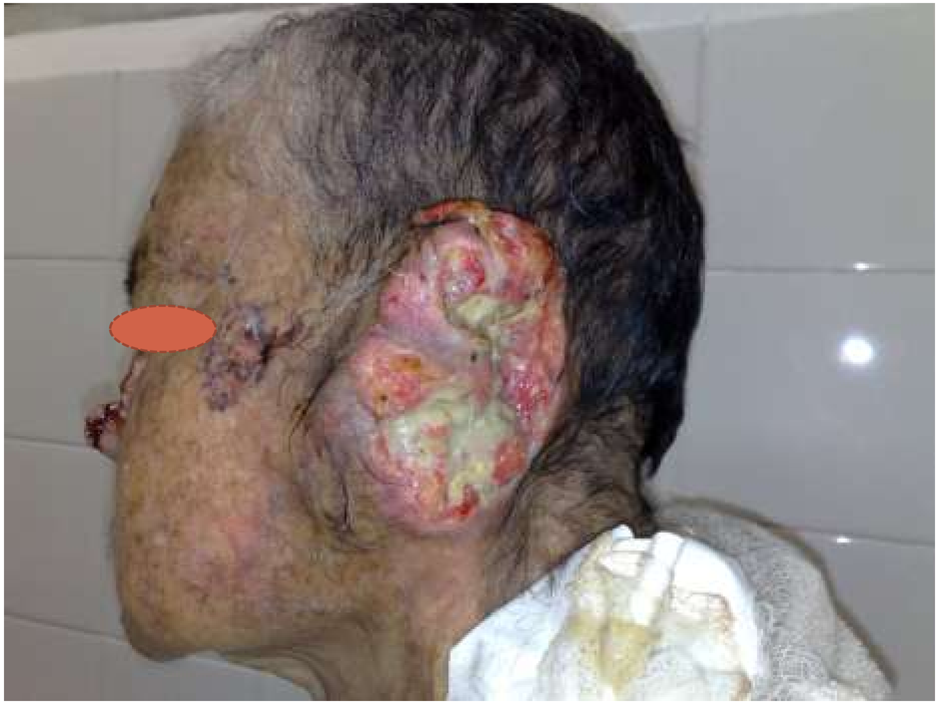


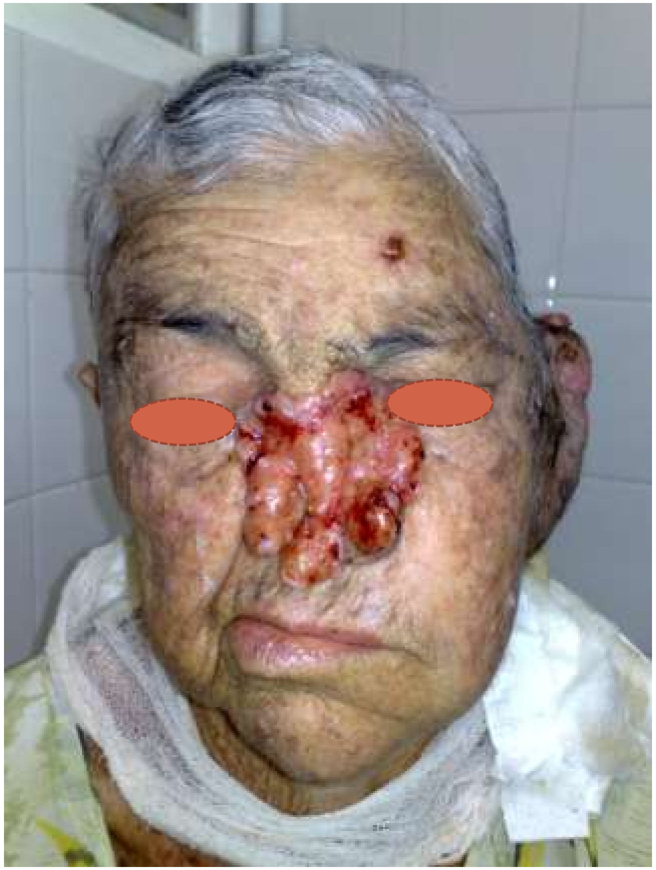












Prevenção

- Proteção solar (óculos, chapéu, creme FPS 15)
- Diminuição do uso de álcool e tabaco
- Correção de imunossupressão

Seguimento

- Carcinoma escamoso deve ter seguimento por pelo menos 5 anos
- Baixa mortalidade

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- *Atlas of Clinical Oncology Cancer of the Head and Neck*. Jatin P. Shah, MD, E.W. Strong Memorial Sloan-Kettering Cancer Center. BC Decker, New York, 2003

Obrigado!!!

PARA QUEM QUEIRA VER, HÁ LUZ SUFICIENTE; PARA QUEM NÃO QUER, HÁ BASTANTE OBSCURIDADE.

BLAISE PASCAL