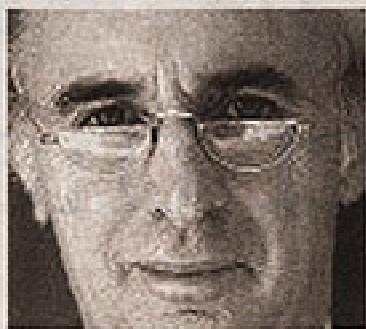
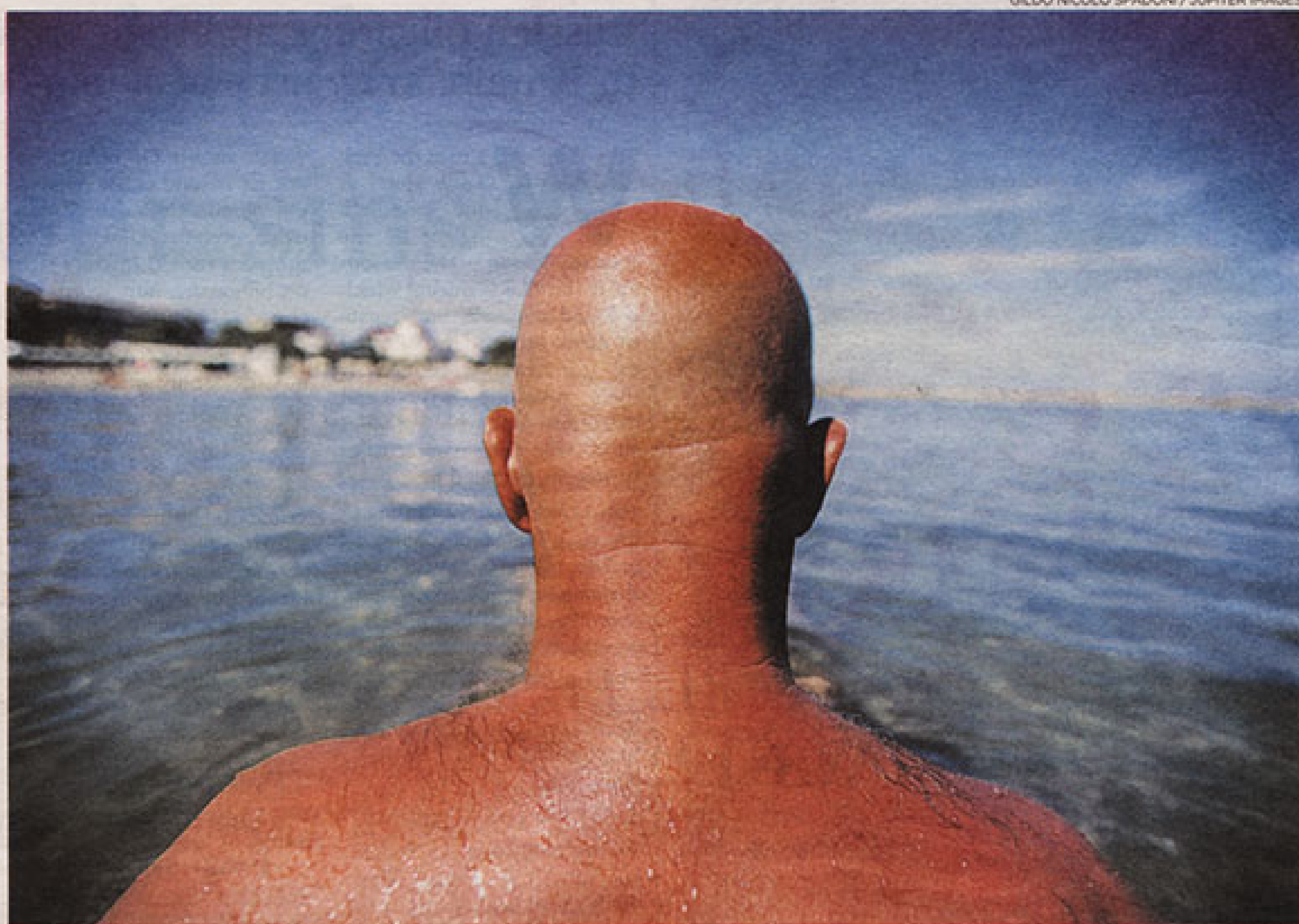
Dr Thomas Stuttaford answers your health questions



The skin-cancer danger for a sunburnt scalp

GILDO NICOLO SPADONI / JUPITER IMAGES



Not every woman finds premature baldness a turn off. One of our readers has been happily married to a man for 44 years who was already going bald in the sixth-form. Many women discover that although early baldness is often genetic it is also frequently associated with high levels of testosterone. This is possibly the reason why our reader has found her husband unusually, and presumably attractively, sensitive. Unfortunately, her husband suffers from a common disadvantage of baldness. His scalp has been damaged by the sun, and has been vulnerable to it in the recent hot spell.

Any skin that is exposed to excessive sunlight (especially if burnt) in childhood or youth, is more liable to develop one of the three common skin cancers — rodent ulcers (basal cell carcinomas), squamous cell carcinomas and/or melanomas (malignant moles).

It is now recognised that although too much sun can be dangerous so may be too little. The type of vitamin D created naturally in the skin by exposure to sun has a protective action against some cancers, including prostate cancer. Only 20 minutes a day during the summer months is needed to stock up. Scientists are busily measuring the amount of sun pigmentation under the arm and comparing it to the person's complexion elsewhere so that they can judge the amount of sun they are having and the incidence of various cancers thought to be associated with too little vitamin D.

The reader has mentioned the damage that her husband's scalp has suffered. Localised areas of skin damage, as distinct from the generalised skin ageing that follows exposure to the sun, are known as solar keratoses. Other areas as well as the scalp frequently affected by excessive sun are the forearms in men, the lower legs in women and the ears and the back of the neck in both sexes.

Solar keratoses are more common in fair-skinned, blond, or red-headed people, especially of Scottish, Irish and less often Welsh descent, who are likely to have pale skin and blue eyes as well as fair hair. The scalp damage is enhanced in these Celts as their hair tends to be finer and sparser than the black hair of more olive skinned people or dark Cornish or Welsh Celts. The incidence of solar keratoses in Australasia, where the sun is strong and a large percentage of the population is of Celtic descent, is high partly because of their fondness for beach life, and partly because of their skin type.

Other than staying indoors, or in heavy shade, from 11.30am to 2.30pm in the summer months how can the reader save her husband's scalp from increased damage and possible malignant change? He should wear a broad-brimmed felt, rather than Panama, hat. The ventilation holes may need covering with tape. Clothes should be loose, long-sleeved and of close woven cotton and it may be necessary to emulate Arabs and wear more than one layer. Powerful sun screens, against UVA and UVB, should be renewed after sweating or swimming.

Solar keratoses may be rough and thickened, or scaly and thin. The colour of the keratosis may vary from brown or pink to greyish white. Malignant change may be heralded by increased thickening and hardening around the edges of the patches, which also become inflamed and tender.

Patients with a sun-ravaged skin need to consult a dermatologist regularly so that any early changes may be detected and suspicious lesions treated with cautery and Solaraze gel. Nodular lesions may need excision. The dermatologist will also give an opinion on any pigmented skin lesions and distinguish between common moles, dysplastic or other naevi, or melanomas.

Fortunately, rodent ulcers don't spread to distant spots; even after malignant change solar keratosis spreads late; and melanoma if detected early has a good prognosis.

It is not only sunburn on a sensitive skin that is going to cause trouble this weekend. A reader has written about her husband's proclivity to attract insects, and his severe reaction to their stings. He has been sensitive to bee stings since childhood and is stung at least once a year. Recently he developed a swollen, inflamed cheek after a bee merely touched it after being trapped behind his spectacles. He wasn't stung. What should he do?

Patients distinguish between bee, wasp and hornet stings because the bee leaves its sting behind, but in other ways all three insects may create a similar reaction. Surprisingly, people who suffer recurrent stings from these insects are more likely to become rapidly sensitised after wasp stings than bee stings. If someone has developed a severe allergy to one of this group they should assume that they are sensitised to the others.

As the bee that touched the reader's husband's cheek set up such a marked reaction, although there was no sting, it seems that the reader's husband's sensitivity is increasing, and is now high. Any subsequent sting might induce anaphylaxis. In future carrying everywhere an easy-to-give adrenalin injection, such as EpiPen or Anapen, would usually be recommended. Antihistamines by mouth help irritation from stings, but for local application steroid creams, rather than antihistamine creams, are needed.

Insects have chemical sensors that enable them to home in on their victim along the CO² vapour pathways emitted by the warmth of the victim's skin. The sensors detect the faintest hint of carbon dioxide or lactic acid, but the sensors can be confused by insect repellents. Arnywear, a fabric impregnated with a long-lasting, natural insect repellent, will keep most of the 3,000 different varieties of gnats, mosquitoes and midges away. Arnywear is ideal for Scottish or Icelandic midges but in a high-risk malarial zone it would be as well to use Deet as well. Insects are not only attracted by CO² vapour pathways but also by scents, bright colours or the smell of jam and other sugary substances.

Helpline: 01707 228646; www.arnywear.co.uk info@arnywear.co.uk

www.timesonline.co.uk/talkingpoint
E-mail Dr Stuttaford your questions on insect bites

ASK DR STUTTAFORD

Send your questions to drstuttaford@thetimes.co.uk or to times2, The Times, 1 Pennington Street, London E98 1TT. Please include the following: the symptoms (and how long they have been present), the person's age, sex and marital status. Dr Stuttaford's replies cannot apply to individual cases but should be taken in a general context. Readers are always advised to consult their GP, because only he/she will be fully conversant with the background. We regret that Dr Stuttaford cannot enter into personal correspondence.

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