the patient reported had appeared within the previous six months with some itching and bleeding. Two individual lesions were noted, a 1 cm diameter cystic lesion at the nasal tip, and a 0.5 cm diameter nodular lesion at the left nasal alar. Both had a pearly edge, firm border and central telangiectasia, suggestive of basal cell carcinomas (BCC) (Fig. 1).

Fig. 1
Presentation
of the BCCs
at initial
consultation

Histology from biopsies revealed nests of BCC displaying a nodular growth pattern. The lesions were excised with a margin of normal tissue under general anaesthesia and the defect repaired using cartilage from behind the ear. Healing was uneventful and the patient is under review. The tip of the nose BCC was found to be of the nodular and infiltrative type with perineural invasion; that from the alar was of nodular type with no perineural invasion.

The most common malignancy in Caucasians is BCC, a slow-growing, locally invasive epidermal basaloid cell cancer presenting in patients of over 40 years. Family history of skin cancer, overexposure to sun, blonde hair, blue or green eyes and immunosuppressive therapy are all risk factors for developing BCCs. Moreover, the risk of further BCCs, as well as other skin cancers, is increased in patients with existing BCCs.¹ Early detection can improve functional and cosmetic results of resection surgery, by limiting facial tissue involvement.²

Usually presenting as pearly or waxy papules, features typical of BCCs include telangiectasia and rolled borders, crusting, oozing or bleeding. They have low morbidity and most follow a fairly indolent pattern. However, aggressive BCCs may ulcerate frequently and lead to destruction of surrounding areas on the face: of particular concern are those present-

ing around the nose, ears and eyes. They may be treated with a variety of methods including surgery, radiotherapy, imiquimod, fluorouracil and photodynamic therapy. Prevention of BCCs is mainly by reducing exposure to sunlight, avoiding sunbeds, wearing sunscreen of factor 15 and above, covering exposed skin and regular follow-up for patients with previous BCCs.⁴

The purpose of this letter is to raise GPs' awareness of the risk factors, incidence and appearance of BCCs as despite their prevalence, dentists may not be aware of the risk factors, diagnosis or benefits of early detection.⁵ Provision of preventive advice can be easily carried out in the dental surgery. Further education of GPs on the appearance of skin cancers is warranted to ensure prompt referral.

F. Aga, London

1. Wong C S M, Strange R C, Lear J T. Basal cell carcinoma. *BMJ* 2003; **327**: 794–798.
2. Baxter J, Patel A. Facial basal cell carcinoma. *BMJ* 2012; **345**: e5342
3. Crowson A N. Basal cell carcinoma: biology, morphology and clinical implications. *Mod Pathol* 2006; **19**: S127–S147.
4. Basal cell carcinoma. A.D.A.M. Medical Encyclopedia.
5. Neville B, Day T. Oral cancer and precancerous lesions. *CA Cancer J Clin* 2009; **52**: 195–215.

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MY NON-JOB

Sir, reluctantly I have found that I now have two jobs. The first is a real job: providing dental services to my local community. If I do this job well I am a significant asset to that community. If you wanted to, you could assess how well I do this job by judging the quality of advice I give and technical quality of treatments provided. You might also wish to confirm that my cross-infection control measures are effective and applied with diligence.

My second job is what is commonly known as a non-job. That is one that involves many hours of mind numbingly dull work, producing reams of documentation that rarely if ever get read.

Several government bodies are now charged with assessing how good I am at my job. Inspectors from these various agencies are now appearing with monotonous regularity at my practice wanting to see my policies and risk assessments on this, that and the other. All of this is

extremely time consuming as I am inevitably given more homework to do; such and such a policy has to be rewritten so as to be in the particular format that that inspector likes to see. Or, as a matter of urgency, training has to be undertaken on some peripheral or irrelevant topic.

The various inspectors' visits are inevitably preceded by a letter proclaiming particular agencies' commitment to driving up standards of dental care, yet none show any interest, whatsoever, in how well I do my real job. This is a shame because I'm much better at my real job than I am at my non-job.

My real job is full time, therefore to do my non-job I have to moonlight, which means to do it even to an average standard I have to give up most of my spare time. Like all people who do two jobs, and therefore spread themselves too thinly, there is a danger that I cannot do both well.

I recently had the opportunity to see, first hand, how state interference of this sort has affected another profession. We had a break-in at my practice premises and the police response was interesting. There was a lot of paperwork where much information was recorded, right down to such details as the religious affiliation of all members of my staff. What became apparent, however, was that nobody expected this process to lead to the arrest of the burglar. As an outsider, it appears to me that the police investigation of burglary has been made a non-job.

Could this happen to the dental profession? Could it become common for a patient to attend an appointment with a dentist for say, the relief of toothache, only to find that after much paperwork, and all policies and procedures have been complied with, they are sent away still in pain? Time will tell, but I believe that that is precisely what is going to happen, and with it our value to the community will be lost.

J. R. Mackay, Chalfont St. Peter
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