Department of Dermatology, Queen Margaret & Victoria Hospitals

Management of primary skin cancer

A copy of these local guidelines, national guidelines, information leaflets and other useful information is available in the ‘cancer folder’ at both VHK and QMH.

Diagnosis

Patients with single lesions suspicious of melanoma or single lesions suspicious of SCC or high risk BCC\textsuperscript{1} should be booked into a skin tumour clinic (STC). For West Fife patients this is currently on Monday mornings at QMH, this clinic is currently being done by Dr Yvonne Mathie, Dr Sheena Allan is currently the overseeing consultant. For East Fife patients, Dr Mowbray is running a STC on Monday mornings at VHK. Both STC’s have nurse skin surgery backup. If there are no STC spaces available within 2 weeks, patients should be appointed as urgents on other clinics.

Patients referred for "mole checks", cosmetic lesions and multiple lesions should go through general clinics as routine referrals.

Make a note of the size, site, duration of pre-existing lesion in the case notes together with past or family history of melanoma. Record skin type, residence > 1 year abroad and service abroad in the armed forces. Photograph lesion with full consent if possible. A SYC proforma will be used for patients attending an STC, this will negate the need for a letter to be dictated. Two copies of the proforma should be made: original – case notes, copy 1 – GP, copy 2 – secretary to file in proforma box.

After clinical assessment excision of all suspect pigmented lesions should be done with 2mm margins and a cuff of dermal fat. When doing the surgery bear in mind the possible need for wider excision - generally excise along relaxed skin tension lines, limb excisions should be along the long axis. Incisional biopsy may be needed if lentigo maligna, lentigo maligna melanoma or acral melanoma are suspected. Otherwise all suspicious pigmented lesions should be completely excised.

Non-pigmented lesions such as BCC or SCC should be excised with 4mm lateral margins and a cuff of dermal fat. If they are completely excised with good margin clearance, all BCC and completely excised low-risk SCC on sun-exposed skin do not require follow-up. High-risk SCC\textsuperscript{2} require follow-up\textsuperscript{3}. If referring a patient for a nurse biopsy slot please indicate clearly the excision margins that you would like.

The surgeon performing the excision should document the excision margins in the patient’s notes.

If required, generally arrange a review appointment once the pathology report is available. If contacting the patient by telephone, record in the case notes what you have said to the patient and what arrangements you have made.

For melanoma and SCC patients, all correspondence must be copied to the GP, to Gillian Smith, SMG data co-ordinator and Laura McLean, MDM co-ordinator. Please also let Laura McLean have a copy letter regarding any follow up appointments made.
**Wide Local Excision of Melanoma**

Below is current reasonable approach:

**In situ lesions/ Clark level 1**
Refer to a dermatological doctor surgical list for 0.5cm wider excision if lesion on limbs or trunk. Arrange one off review thereafter to discuss implications, advise patient on self monitoring and sun protection. Remaining skin should be checked for other suspicious lesions. This clinic visit can occur before or after wider excision.

**Invasive lesions**

If Breslow thickness < 1mm and on straightforward surgical site refer to a dermatological doctor surgical list for 1 cm wide local excision. If in doubt speak to Dr Mowbray first. If surgically more tricky, refer to the Fife plastic surgery service for wide local excision (Mr Hamilton, Mr Raine, Mr Anderson or Mr Jawad). All referrals to plastic surgery should be sent to plastic surgery at QMH where referrals are triaged.

If Breslow ≥ 1mm, refer to Mr Butterworth at St John’s Hospital for wide local excision and consideration of sentinel lymph node biopsy. Sentinel lymph node biopsy should also be considered for lesions <1mm with a mitotic rate ≥ 1/mm², and ulcerated or regressed lesions. Referral to Mr Butterworth should be faxed along with a copy of the pathology report and the ‘hard’ paper copy send by post. Give full drug and relevant medical history in your referral. Currently all patients are seen by Mr Butterworth at his clinic and surgery organised for a later date. Most wide excisions are done as day cases. Sentinel node evaluation may require a GA and overnight stay. Those with positive node(s) may progress to clearance of involved node basin.

**GP excisions**

If a GP gets in touch by phone or letter to say he / she has removed a melanoma explain that the patient will require a wider excision and registration and discussion at the MDM. Ask the GP to urgently fax a referral and appoint patient to the next appropriate STC or urgent appointment. Try to ascertain from the GP whether they have discussed the result with the patient.
Follow up

In situ melanoma does not require follow-up.

Plastic surgery usually follows up patients immediately after excision before referring patients back to dermatology.

It is worth making the initial 3 month follow-up appointment for the patient for the dermatology clinic at the time when you refer to plastic surgery, to ensure that they do not become ‘lost’, particularly in cases when they are being referred outwith Fife. Please copy this letter regarding dermatology follow-up to Laura Mclean.

At the first follow-up appointment, arrange for clinical photography of all the patient’s skin on trunk and limbs, anterior and posterior, to act as a reference for future examination. Stage IA melanoma (appendix IV), 3 monthly follow-up for 1 year to teach self examination. All patients with invasive lesions, IB - IIC are followed up 3 monthly for 3 years then 6 monthly for 5 years.

Further investigations e.g. scan or X rays are generally only needed if patient has any symptoms. Such patients should be discussed at the MDM.

Patients with new primary lesions or metastatic disease should be referred back to the MDM via Laura McLean to be discussed with regard to further surgical or oncological treatment, eligibility for current clinical trials will be discussed at the MDM with Dr Ewan Brown of the Western General Hospital, Edinburgh.

Scottish Melanoma Group

This group has been collecting clinical and pathological data for more than 20 years. Please copy all letters on melanoma patients to Gillian Smith the SMG Data Manager to facilitate this.

Multi disciplinary meeting

There is a bi-monthly multi disciplinary meeting (MDM) with dermatology, oncology and plastic surgery input. Speak to Dr Mowbray if you wish to refer to this. All new diagnoses of melanoma should have an MDM referral form completed as soon as possible after receipt of histological confirmation – email Laura Mclean (laura.mclean@faht.scot.nhs.uk) to have a form sent to you if you have not already received one.

All new invasive melanomas, those with recurrent / metastatic disease, high risk SCCs and other difficult skin malignancies are discussed at the MDM. All are welcome to attend. Dr Mowbray will regularly attend this meeting, if you have any management points you would like discussed at the MDM please contact Dr Mowbray in advance of the meeting.

Updates are emailed usually a day or two following the meeting if you have been unable to attend. The MDM does not replace need for usual referral onwards.

Skin cancer specialist Nurse

There are 2 ‘skin cancer link nurses’ at each site, QMH and VHK. The role of the link nurse is to provide patient support following cancer diagnosis. When discussing the diagnosis of
malignant melanoma with a patient and their family, they should be introduced to the ‘link nurse’. An appointment should be made for 7-10 days for them to return and discuss any concerns that they have with their ‘named nurse’. Please let Una Donaldson (QMH) or Gail Mitchell (VHK) know if you are going to discuss the diagnosis of a malignant melanoma with a patient so as a ‘link nurse’ can be allocated. QMH – Tina Shepherd, Lyn Crickmore. VHK – Gail Mitchell, Elaine Bernard.

Sister Sheena Dryden works as the regional skin cancer nurse specialist. She offers support and advice to melanoma patients across south-east Scotland, usually by telephone. She will see most Fife patients attending Lothian for SLNB and WLE. She has access to other sources of information so please ask her about any of your patients.

**Pathology sent for a second opinion**

In order to keep a check on all atypical pathology sent for a second opinion please take the following precautions. VHK – ensure details are recorded in the biopsy ledger in the secretaries office and copy a letter to Laura Mclean. Laura is happy to keep a check that the pathology returns. Laura is automatically sent pathology results if the word melanoma is mentioned on the form but not if it just states atypia. QMH – let Mary Henderson know so as she can keep a record, in addition copy a letter to Laura Mclean.

**War veterans pension agency**

Patients diagnosed with skin cancer who have served abroad in the forces may be eligible to claim from the war veterans pension agency (WVPA). Leaflets with the phone number for the WVPA are available at both QMH and VHK.

**Cancer support services**

We are currently in the process of developing our cancer support services. We are focusing on educating all our dermatology nursing staff. Initial sessions have taken place with regards to cancer support services that are available to patients, for example social work and benefits. Thereafter, we will include sessions around general palliative care in both the community and hospital setting.

For patients in whom referral to palliative care is a consideration we propose that we approach each patient individually. We will ensure, through the above mentioned education, that all nursing staff are aware of the cancer and palliative care services available. When the situation arises access to palliative care services should be through the most appropriate route for the patient. This could be referral to the palliative care team within the hospital, or through their GP to the community service.
Appendix 1

BAD Definition of a High-Risk BCC
1. Tumour size greater than 2cm in diameter.
2. Tumour site: central ‘H’ zone of face, especially around eyes, nose, lips and ears.
3. Poorly-defined clinical edges.
5. Recurrent tumour.
6. Immunocompromised patients.

Appendix 2

BAD Definition of a High-Risk SCC
1. Tumour size greater than 2cm in diameter.
2. Tumour site: lip, ears, non-sun exposed skin, in area radiation or thermal injury, chronic draining sinus, chronic ulcer, chronic inflammation, arising from Bowen’s disease.
3. Tumour depth: greater than 4mm in depth or extending into subcutaneous tissue.
4. Histological pattern: poorly differentiated, acantholytic, spindle-cell and desmoplastic types. Evidence of perineural, lymphatic or vascular invasion.
5. Recurrent tumour.
6. Immunocompromised patients.

Appendix 3

Follow up of SCC

<table>
<thead>
<tr>
<th>Tumour</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1cm diameter</td>
<td>Excision – none</td>
</tr>
<tr>
<td></td>
<td>C&amp;C - once at 3/12</td>
</tr>
<tr>
<td></td>
<td>Cryo – 6/12, 1 year</td>
</tr>
<tr>
<td>1-2cm diameter</td>
<td>1 year</td>
</tr>
<tr>
<td>&gt;2cm diameter</td>
<td>Yearly for 2-5 years</td>
</tr>
<tr>
<td>High risk</td>
<td>Yearly for 2-5years</td>
</tr>
</tbody>
</table>
Table 4. The 2009 AJCC staging system

<table>
<thead>
<tr>
<th>Stage</th>
<th>Primary tumour (pT)</th>
<th>Lymph nodes (LN)</th>
<th>Metastases (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IIA</td>
<td>Any Breslow thickness</td>
<td>Micro-metastases ≥ 2 nodes</td>
<td></td>
</tr>
<tr>
<td>IIB</td>
<td>Any Breslow thickness, with ulceration</td>
<td>Micro-metastases ≥ 2 nodes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Breslow thickness, no ulceration</td>
<td>1-3 palpable metastatic nodes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Breslow thickness, no ulceration</td>
<td>No nodes, but in-transit or satellite metastasis/es</td>
<td></td>
</tr>
<tr>
<td>IIC</td>
<td>Any Breslow thickness, with ulceration</td>
<td>Up to 3 palpable lymph nodes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Breslow thickness, with or without ulceration</td>
<td>4 or more nodes or matted nodes or in-transit disease + lymph nodes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Breslow thickness, with ulceration</td>
<td>No nodes, but in-transit or satellite metastasis/es</td>
<td></td>
</tr>
<tr>
<td>IV, M1a</td>
<td>Any Breslow thickness</td>
<td>Skin, subcutaneous or distal nodal disease</td>
<td></td>
</tr>
</tbody>
</table>

References

5. SIGN guidelines: [http://www.sign.ac.uk/guidelines/published/index.html](http://www.sign.ac.uk/guidelines/published/index.html)

Updated by Dr Megan Mowbray 12th January 2010, meganmowbray@nhs.net