SCAN
South East Scotland Cancer Network

NHS SCOTLAND

Working regionally to improve cancer services

SOUTH EAST SCOTLAND CANCER NETWORK
PROSPECTIVE CANCER AUDIT

MELANOMA 2013
COMPARATIVE AUDIT REPORT

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Report Number: SA Skin01/15

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SCAN COMPARATIVE MELANOMA REPORT 2013

PATIENTS DIAGNOSED
1 JANUARY – 31 DECEMBER 2013

Contents

INTRODUCTION AND METHODS

This report presents analysis of data collected on patients newly-diagnosed with primary invasive melanoma ICD-10 C43 (>Clark Level 1) or secondary melanoma with no known primary, except those with melanoma of the eye, between 1 January and 31 December 2013 in the four health board regions comprising the South East Scotland Cancer Network (SCAN) i.e. Borders, Dumfries and Galloway, Fife and Lothian. Numbers include private patients as well as those treated in the NHS.

Basis of Analysis

There are currently no nationally-agreed standards for melanoma cancer care. Measures presented are draft clinical items within the SIGN Guideline on Management of Cutaneous Melanoma (No 72; Date published: July 2003) and items from the Core Standards for Cancer published by NHS Quality Improvement Scotland (NHSQIS) in March 2008. In addition data is presented on recurrence in the format required by the Scottish Melanoma Group and the Scottish Dermatological Society.

Patients included in the Report

All patients diagnosed with Primary Invasive Melanoma or secondary melanoma (no known primary) 1 January – 31 December 2013

Network/Health Board/Hospital	Lead Clinician	Audit Support
SCAN, NHS Lothian and Borders	Dr V Doherty	Jon Pullman
NHS D&G	Dr J Norris	Laura Fair
NHS Fife	Dr M Mowbray	Jackie Stevenson
NHS Lothian – Department of Plastic Surgery	Mr M Butterworth	

Datasets and definitions

The dataset collected is the Scottish National Core Minimum dataset as published by ISD Scotland in April 2005. This may be viewed on the ISD website (www.isdscotland.org). Further information on the dataset and definitions can be obtained from Jon Pullman, SCAN Cancer Audit Facilitator, Dept of Dermatology, Lauriston Building, Edinburgh EH3 9HA. Jonathan.Pullman@luht.scot.nhs.uk

Data Quality

Estimated Case Ascertainment

An estimate of case ascertainment (the percentage of the population with melanoma recorded in the audit) is made by comparison with the Scottish Cancer Registry five year average data from 2008 to 2012 (see Table 1). High levels of case ascertainment provide confidence in the completeness of the audit recording and contribute to the reliability of results presented. However, levels greater than 100% may be attributable to an increase in incidence. Allowance should therefore be made in reviewing results where numbers are small and variation may be due to chance.

Quality assurance of data

All hospitals in the region participate in any Quality Assurance programmes provided by the National Services Scotland Information Services Division (ISD) but QA of the full Primary Invasive Melanoma dataset has not yet been undertaken.

Process for reviewing and reporting the results
To ensure the quality of the data and the results presented, the process was as follows:

- Individual health board results were reviewed and signed-off locally

- The report was reviewed by the lead clinicians with the assistance of the audit staff. Arising from these discussions a number of items of data were checked and amendments made so that there was agreement on the results shown.
- The results and the issues raised by the results will be considered by the Lead Clinicians at a SCAN group meeting on 03/10/2014 and comments added to the report
- The Lead Clinicians agreed to circulate the report for final sign off by the SCAN Skin Group on 31/10/2014.

Actions for Improvement
After final sign off, the process is for the report to be sent to the Clinical Governance groups within the four health boards and to the Regional Cancer Planning Group. Action plans and progress with plans will be highlighted to the groups. The report will be placed on the SCAN website once it has been fully signed-off and checked for risk of disclosure of personal information.

Action points for 2013: as part of clinical sign-off areas for improvement are highlighted in the Action Plan 2013 results. Information is also provided on progress with Action Plans following on from the previous year (2012)

Action Plan Melanoma 2012

Report Section	Possible area for improvement	Proposed action	Progress with Action
Table 2	Continuing higher incidence of thicker melanomas in Fife and rising incidence in Dumfries & Galloway	Megan Mowbray said late presentation affecting all tumour types in Fife: **Clive Preston**, Lead Cancer Clinician for Fife, liaising locally with public health in Fife **Kate Macdonald** to explore possible alternative funding source for Breslow depth data analysis. Megan Mowbray, Val Doherty, Alex Holme to discuss options for further investigating these observations. Will enquire regards funding options.	Funding for study confirmed by chief scientist office. Study to be undertaken in collaboration with ISD in 2015. Roll over to 2013 actions.
Table 5	High number of pathology reporting histogenetic type as "unspecified"	Marie Mathers pointed out that "unclassifiable" is distinct from "not stated" and suggested that an additional column be included on the table to reflect this.	Marie to check 2013 "unclassifiable" for Lothian/borders. MM has looked at Fife data and forwarded to JS.
Table 6	Use of sample biopsy method	**Alex Holme** currently looking at impact of punch biopsy (as against incision/excision) on 5-year survival	Alex to produce written results
Table 8	Mitotic Rate reporting	Once melanoma QPIs published, **Megan Mowbray** to write to all SCAN pathologists detailing required pathology and requesting use of a pathology minimum data set such that necessary information is included and easier for audit staff to record.	Megan to write. Roll over into 2013 actions.
Table 10	Pathological T stage reporting	This will be included in letter to all SCAN pathologists following melanoma QPI publication.	Megan to write. Roll over into 2013 actions
Table 11b	GP Excisions	**(Alex Holme), Megan Mowbray** to provide feedback to Fife GPs about 2012 audit paper.	Achieved.
Table 17	CNS contact in Borders/D&G	Check for role of Glasgow referrals in low contact % for D&G **Sheena Dryden** to progress establishment of more support links in Borders/D&G	Roll over to 2013 actions

Action Plan Melanoma 2013

Report Section	Possible area for improvement	Proposed action	Progress with Action
Table 2	Continuing higher incidence of thicker melanomas in Fife and rising incidence in Dumfries & Galloway	Funding for study confirmed by chief scientist office. Study will be undertaken in collaboration with ISD in 2015.	Megan to report
Table 5	High number of pathology reporting histogenetic type as “unspecified”	Comment from pathology required.	Comment from Fife and Lothian added
Table 6	Use of sample biopsy method	Comment required from **Alex Holme** required.	comment on p17
Table 6	High level of partial biopsies in D&G	Review data and feed back	Dr Jon Norris to feed back
Table 7a/7b	Median wait for pathology	Pathology report date should continue to be recorded to inform timeline breakdown for QPI7 analysis. Inform eCase users	Megan to remind audit staff
Table 8	Mitotic Rate reporting	**Megan Mowbray** to write to all SCAN pathologists detailing required pathology and requesting use of a pathology minimum data set such that necessary information is included and easier for audit staff to record.	Done January 2015
Table 10	Pathological T stage reporting	**Megan Mowbray** to write to all SCAN pathologists highlighting the need to document pathological T stage.	Pam emailed Marie re form
Table 11 (and QPI 1)	Specialty of clinician performing diagnostic biopsy	Draw up a list of designated skin cancer clinicians in SCAN	Fife done. Jon emailed
Table 12	Mode of referral	Ecase users to be reminded to continue recording this info	done
Table 13	Excessive waits for second treatment	Amend wait measurement to >84 days, to bring in line with QPI 7 Include supplement using JS template summarising pathway for outliers >84	done

Table 13	Excessive waits for second treatment	New outliers template required for circulation to clinicians and MDT, based on a table as per JS for Fife	done
Table 14	SLNB eligibility	Ensure that eCase users continue to record SLNB eligibility	Megan to remind audit staff
Table 14a/15		Merge these two tables	Jon to include in 2014 data
Table 16	Discussed at MDM	Lothian and D&G to report on missed patients	Added to report
Table 17	CNS contact in Borders and D&G	Sheena Dryden to check D&G patients Recommend CNS or link nurse role in Borders Consider dermatology link nurse role in Lothian as back up for CNS	36 D&G patients identified by Sheena Dryden
QPIs 1, 6, and 7	QPI review	Confirm that patients diagnosed with cutaneous mets should not be included in these surgical QPIs Query to ISD and include in 9 month review.	To take to 9 month review

Comment by SCAN Skin Group Chair

I would like to thank all clinicians and audit staff involved in the compilation of the 2013 SCAN melanoma audit report. In particular I thank Jon Pullman (Lothian) who has compiled the full report and regional audit leads, Jackie Stevenson and Martin Keith.

Overall case ascertainment is 102% providing confidence in the reliability of results. Fife continues to see a higher number of thick/poor prognosis melanomas compared to SCAN and in particular Lothian. A similar trend is observed in Dumfries and Galloway.
Megan Mowbray has been awarded £5,000 funding from the chief scientists office for a study to be undertaken by ISD looking at these observations and comparing with Scotland wide (2005 – 2012) and SCAN regions (1979 – 2012).

The majority (80%) of melanomas occur in those above the age of 45in both males and females. The incidence in the working age population remains significant but has dropped over the past 3 years from 52%. The gender incidence is now equal between men and women. The top 3 anatomical sites have remained the same over the past 3 years. In 2013 the commonest site in women was the leg below knee and in men the head and neck.

Table 5 shows a high number of lesions reported as pathology unclassifiable, It is not always possible for pathologists to stipulate the melanoma subtype. Despite this the numbers listed as unclassifiable seem high.
All regions to look at lesions listed as unclassifiable and provide feedback – supplementary report 1.
Marie Mathers to comment on the above observation – supplementary report 2.

72% of melanomas are fully excised at the time of diagnosis, this is regarded as the gold standard. 27% were diagnosed by 'sample biopsy', these lesions require further excision before treatment can be documented as complete.
We await with interest results of an audit performed by Alex Holme looking at the impact of sample biopsy compared with excision on 5 year survival.
Dumfries and Galloway will comment on the high number of sample biopsies performed in this region – supplementary report 3.

In mid-2014 data collection commenced for the melanoma Quality Performance Indicators (QPIs). This will see a change in the style of the comparative melanoma audit report. We hope to be able to report QPI data in conjunction with the data that we have found useful over the past years of producing this report. A small number of data items have been omitted from the QPI dataset. It has been agreed that all regions will continue to collect the following data items in addition to those listed on the QPI dataset. This will better inform us regarding delays in the patient pathway and capacity planning for SLNB.
Audit staff to continue to record:

1) Date of issue of pathology report.
2) Mode of referral (table 7a/b)
3) SLNB eligibility (table 14)

QPI 2 and 5 require that all surgical pathology reports for cutaneous melanoma and SLNB respectively should contain a full set of data items (as defined by the current RCP dataset). Tables 8,9, and 10 show that reporting of mitotic rate and ulceration is high but pathological T stage reporting is less well reported.
Megan Mowbray to write to all pathologists in the SCAN region informing them of the requirements of the melanoma QPIs 2 and 5.

QPI 1 details that melanomas should have their diagnostic excision carried out by a skin cancer clinician. The definition of which includes: dermatologist, plastic surgeon, locally designated clinician who attends the MDT. This is an interesting definition considering the majority of trunk and limb lesions are excised by dermatology nursing staff. Complicating this further is the fact that the person recorded as performing the biopsy is the consultant under whose name the biopsy is listed, this person is often not the person performing the surgery.
In order to provide clarity for audit staff all regional leads to provide a list of 'designated skin cancer clinicians' to be used by regional audit leads.

QPI 7 requires that all patients with cutaneous melanoma should have their wide local excision (WLE) within 84 days of their diagnostic excisional biopsy. Table 13 has been amended compared with previous reports to detail the number of patients in each region waiting more than 84 days. Table 22 shows that this is the QPI that all SCAN regions are most at risk of failing.
A supplementary table to be provided detailing the time points in the pathway for all patients waiting more than 84 days for definitive treatment – supplementary report 5.

The majority of patients with melanoma had their case discussed at the MDM. This is listed as a requirement for QPI 3. Unfortunately 4 patients in Dumfries and Galloway and 1 in Lothian were not discussed such that Dumfries and Galloway would have failed this QPI. Looking at the Dumfries and Galloway patients in more detail revealed that 3 patients were initially managed by maxillo facial and therefore not listed for the skin MDM.
Discussion to be had with Dumfries and Galloway as to how they will ensure all melanomas will be discussed at the MDM in the future.

An invaluable support service for both patients and clinicians is provided by the regional skin cancer nurses (SCN) in Lothian and Tayside. In addition Fife patients have the opportunity to meet with local dermatology skin cancer link nurses (SCLN) who are dermatology nurses based in Fife. Patients from Dumfries and Galloway or the Borders would only have contact with a CNS if they are referred to Lothian for WLE +/_ SLNB or oncology. In Fife 96% of patients were seen by a CNS and or a dermatology SCLN. In Lothian 87% were seen by a CNS and in Dumfries and Galloway and the Borders only 36% were seen by a CNS.
Ideally, if staffing allowed, it would be good to see Dumfries and Galloway and the Borders follow the local model of a dermatology SCLN to offer local patient support. This is a model which could be introduced in Lothian to provide 'back up' to the regional SCN.

I conclude by once again thanking all those involved in the compilation of this report. We await the changes that will take place with the commencement of the melanoma QPI data collection. We will observe with interest the impact these will have on the quality of the service offered to melanoma skin cancer patients

Document History

Version	Circulation	Date	Comments
Version 1	Draft circulated to Lead clinicians ahead of pre-sign off meeting	19/09/2014	
Version 1	Lead Clinicians and Audit Staff for pre sign-off meeting	03/10/2014	Suggested amendments and action points discussed
Version 2	Draft circulated to SCAN Audit manager	17/10/2014	
Version 3	Draft circulated to SCAN group	24/10/2014	
Version 4	SCAN Skin Group discussion	31/10/2014	Await additional input from Dumfries
SA Skin01/15	Clinical Governance Groups, Lead Managers and Chairs in the four health boards and to the SCAN Regional Cancer Planning Group	31/03/2015	Report number assigned and lodged on SCAN Reporting Index.
	Lodged on SCAN website		

Table 1: Estimate of Case Ascertainment

Health Board	2013 SCAN Registrations	2008 - 2012 Average Number of Cancer Registrations per year^	Estimated Case Ascertainment
Borders	30	26	115.4%
D&G	45	33	136.4%
Fife	47	63	74.6%
Lothian*	187	182	102.7%
SCAN	**309**	**304**	**101.6%**

^ historical figures from ACaDMe

*Lothian includes 6 patients diagnosed in private sector

High levels of case ascertainment provide confidence in reliability of results. However, allowance has to be made in reviewing the results where numbers are small and variation may be due to chance.

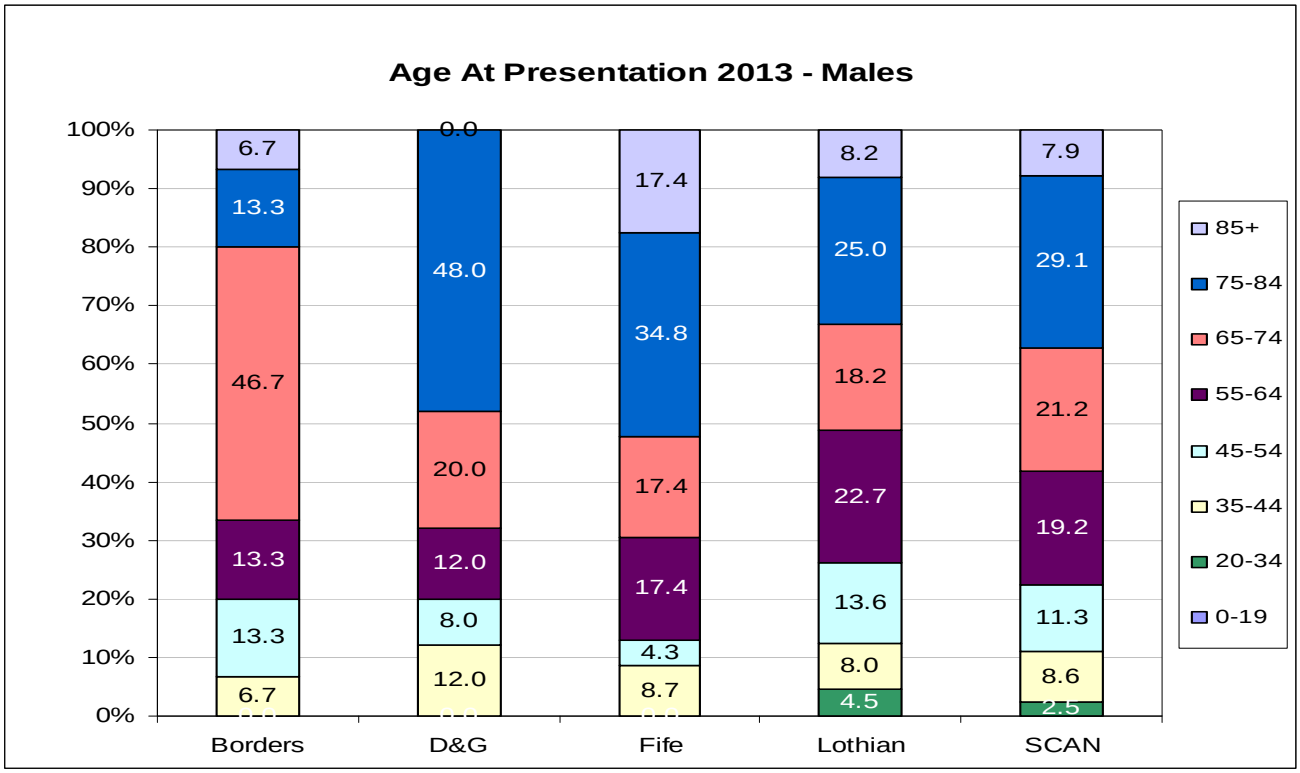
Table 2: Breslow Depth n303 lesions

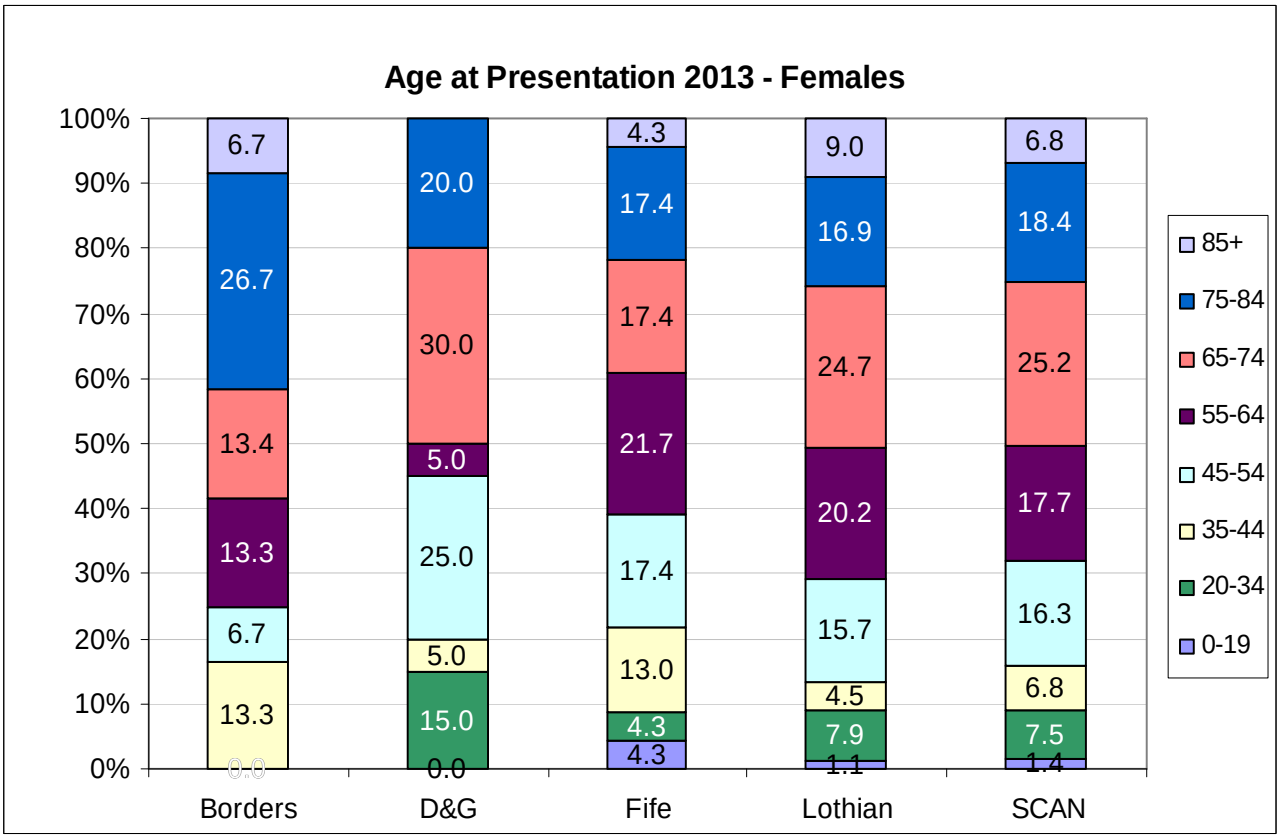
Male	Borders		D&G		Fife		Lothian		**SCAN**		**SCAN 2010-12**	
mm	n	%	n	%	n	%	n	%	n	%	n	%
0-0.99	10	66.7	10	40.0	12	50.0	55	61.1	87	56.5	*240*	*55.2*
1-1.99	1	6.7	4	16.0	1	4.2	14	15.6	20	13.0	69	15.9
2-2.99	0	0.0	1	4.0	3	12.5	5	5.6	9	5.8	34	7.8
3-3.99	0	0.0	3	12.0	1	4.2	4	4.4	8	5.2	20	4.6
≥4	3	20.0	5	20.0	6	25.0	10	11.1	24	15.6	60	13.8
Mets	1	6.7	2	8.0	1	4.2	2	2.2	6	3.9	12	2.8
Total	15	100.0	25	100.0	24	100.0	90	100.0	154	100.0	435	100.0

Female	Borders		D&G		Fife		Lothian		**SCAN**		**SCAN 2010-12**	
mm	n	%	n	%	n	%	n	%	n	%	n	%
0-0.99	10	66.7	13	65.0	15	65.2	59	64.8	97	65.1	292	61.7
1-1.99	3	20.0	4	20.0	1	4.3	12	13.2	20	13.4	85	18.0
2-2.99	0	0.0	1	5.0	2	8.7	2	2.2	5	3.4	33	7.0
3-3.99	0	0.0	0	0.0	3	13.0	3	3.3	6	4.0	16	3.4
≥4	2	13.3	2	10.0	1	4.3	13	14.3	18	12.1	41	8.7
Mets	0	0.0	0	0.0	1	4.3	2	2.2	3	2.0	6	1.3
Total	15	100.0	20	100.0	23	100.0	91	100.0	149	100.0	473	100.0

NB: Persistent thick lesions in Fife will be investigated and analysed by ISD in a collaborative study using SCAN data and comparing Fife data with SCAN and with the rest of Scotland.

Age at Presentation n298 patients (adjusted for 5 patients x multiple primaries)





NB: Fife and Lothian figures both include 1 female patient <20 years

Table 3: Age at Presentation n298 patients (adjusted for 5 patients x multiple primaries)

Male	Borders		Fife		Lothian		D&G		SCAN	
Age	n	%	n	%	n	%	n	%	n	%
0-19	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-34	0	0.0	0	0.0	4	4.5	0	0.0	4	2.6
35-44	1	6.7	2	8.7	7	8.0	3	12.0	13	8.6
45-54	2	13.3	1	4.3	12	13.6	2	8.0	17	11.3
55-64	2	13.3	4	17.4	20	22.7	3	12.0	29	19.2
65-74	7	46.7	4	17.4	16	18.2	5	20.0	32	21.2
75-84	2	13.3	8	34.8	22	25.0	12	48.0	44	29.1
85+	1	6.7	4	17.4	7	8.0	0	0.0	12	7.9
Total	15	100.0	23	100.0	88	100.0	25	100.0	151	100.0

Female	Borders		Fife		Lothian		D&G		SCAN	
Age	n	%	n	%	n	%	n	%	n	%
0-19	0	0.0	**1**	4.3	**1**	1.1	0	0.0	2	1.4
20-34	0	0.0	1	4.3	7	7.9	3	15.0	11	7.5
35-44	2	13.3	3	13.0	4	4.5	1	5.0	10	6.8
45-54	1	6.7	4	17.4	14	15.7	5	25.0	24	16.3
55-64	2	13.3	5	21.7	18	20.2	1	5.0	26	17.7
65-74	5	33.3	4	17.4	22	24.7	6	30.0	37	25.2
75-84	4	26.7	4	17.4	15	16.9	4	20.0	27	18.4
85+	1	6.7	1	4.3	8	9.0	0	0.0	10	6.8
Total	15	100.0	23	100.0	89	100.0	20	100.0	147	100.0

Table 3a: Incidence in Working Age population (18 to 64, M/F) n298 patients

	Borders		D&G		Fife		Lothian		SCAN	
Number	n	%	n	%	n	%	n	%	n	%
Incidence	10	33.3	21	45.7	86	48.6	18	40	135	45.3

Table 3b: Incidence in Working Age population Year on Year (18 to 64, M/F)

Year	no of working age people	% of Tot
2013	135	45.3
2012	155	48.6
2011	156	51.5

Table 3c: Median Age at Diagnosis 2013

Borders		D&G		Fife		Lothian		SCAN	
Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
70	66	74	62	75	59	66	66	68.5	63.5

Table 3d: Median Age at Diagnosis (2002-2013)

Year	Male	Female	Area
2013	68.5	63.5	B F L D&G
2012	66	66	B F L
2011	65	61	B F L
2010	65	54	B L
2009	64	53	B L
2008	64	56	B F(6/12 only) L
2007	64	55	B F L
2006	58	58	B F L
2005	61	57	B F L
2004	61	48	B F L
2003	61	55	B F L
2002	64	51	B F L

Table 3e: Gender incidence ratio (2007-2013)

Ratio of male to female

Year	Male	Female
2013	1	1.0
2012	1	1.2
2011	1	1.0
2010	1	1.1
2009	1	1.1
2008	1	1.4
2007	1	1.7

Table 4: Anatomical Site n303 lesions

Site:	SCAN 2013		2010 -12		SCAN 2013		2010 -12	
	n	%	n	%	n	%	n	%
	Male		Male		Female		Female	
Head and Neck*	49	31.8	115	26.0	25	17.0	98	20.4
Trunk anterior	16	10.4	48	10.8	10	6.7	36	7.5
Trunk posterior	37	24.0	132	29.8	24	16.1	64	13.3
Arm (unspecified)	4	2.6	1	0.2	5	3.4	5	1.0
Arm above elbow	6	3.9	23	5.2	10	6.7	50	10.4
Arm below elbow	12	7.8	42	9.5	13	8.7	38	7.9
Leg (unspecified)	3	1.9	1	0.2	4	2.7	3	0.6
Leg above knee	4	2.6	21	4.7	15	10.1	43	9.0
Leg below knee	13	8.4	21	4.7	33	22.1	93	19.4
Acral	4	2.6	15	3.4	6	4.0	29	6.0
Mucosal	0	0.0	7	1.6	1	0.7	10	2.1
Subungual	0	0.0	4	0.9	0	0.0	4	0.8
Mets at presentation	6	3.9	13	2.9	3	2.0	7	1.5
SCAN	154	100.0	443	100.0	149	100.0	480	100.0

Top three anatomical sites for SCAN 2013			
Male	Head & Neck (31.8.%)	Trunk Posterior (24.0%)	Trunk Anterior (10.4%)
Female	Leg below knee (22.1%)	Head & Neck (17.0%)	Trunk Posterior (16.1%)

Top three anatomical sites for SCAN 2010 - 2012			
Male	Trunk Posterior (29.8%)	Head & Neck (26.0%)	Trunk Anterior (10.8%)
Female	Head & Neck (20.4%)	Leg below Knee (19.4%)	Trunk Posterior (13.3%)

NB: *the increased profile of Head & Neck reflects a growing incidence of Lentigo Maligna Melanoma on the face and scalp (see Table 5).

Table 5: Histogenetic Type of Melanoma n303 lesions

	SCAN		SCAN	
	n	%	n	%
	Male		*Female*	
Lentigo maligna melanoma(lmm)	20	13.0	21	14.1
Superficial spreading (ssmm)	79	51.3	91	61.1
Nodular	22	14.3	10	6.7
Acral	7	4.5	7	4.7
Mucosal	0	0.0	0	0.0
*Other	0	0.0	0	0.0
Unclassifiable	21	13.6	16	10.7
Desmoplastic	1	0.6	2	1.3
Spitzoid	1	0.6	0	0.0
Secondary	3	1.9	2	1.3
SCAN	154	100.0	149	100.0

*Other: animal type (), polypoid (), naevoid ()
Unclassifiable includes Melanoma NOS (not otherwise specified)

NB: As noted on page 14, Lentigo maligna melanoma is increasing in proportion to other types. This trend is partly demographic and may also reflect changes in biopsy practice and pathological reporting.

Unclassifiable 2013

Fife		Lothian & Borders		D&G	
n	%	n	%	n	**%**
6	12.8	18	9.9	13	**28.9**

NB: Fife and Lothian have both reviewed their cases in the above table.

Consultant pathologist Marie Mathers has stressed that It is not always possible for pathologists to stipulate the melanoma subtype – either because of partial sampling of the tumour, or because the tumour itself doesn't fit neatly into one of the recognised categories.

Out of Fife's 6 "unclassifiable" cases, 1 was actually a Lymph node biopsy and three were mixed or complex samples.

Of Lothian and Border's 17 such cases, the majority were due to the quality of the sample or difficulty in definitive assessment. Only three were the result of incomplete documentation.

Adoption of the standard pathology reporting form should mean that melanoma type should be more accurately specified in the future. Additionally, Table 5 will be amended to include a separate category for "not assessable". This will distinguish incomplete recording with difficult cases as described above.

Table 6: Method of diagnosis n303 lesions

	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
*Sample biopsy	6	20.0	18	40.0	14	29.8	43	23.8	81	26.7
Excision/Amputation	23	76.7	27	60.0	32	68.1	136	75.1	218	71.9
FNA	1	3.3	0	0.0	0	0.0	0	0.0	1	0.3
Metastectomy	0	0.0	0	0.0	0	0.0	1	0.6	1	0.3
Other	0	0.0	0	0.0	**1**	2.1	0	0.0	1	0.3
Not recorded/Inapplicable	0	0.0	0	0.0	0	0.0	1	0.6	1	0.3
Total	30	100	45	100	47	100	181	100	303	100

* incision, shave, curettage

1 Fife Other = Lymph Node Biopsy (LNB)

Note1: Sampling of suspect lesions is used when there is diagnostic doubt or for planning/staging purposes in larger lesions or those on cosmetically challenging areas.

Note2: Incomplete removal may compromise subsequent measurements of tumour thickness. Suspected melanomas or suspicious melanocytic lesions should not be treated with curettage and cautery

Note3: Research findings. In recent research projects involving two medical students, and supervised by Edinburgh consultant dermatologist Alex Holme, statistics showed no difference in recurrence or mortality after 5 years between partial biopsies compared to full excisions when carried out at the diagnostic biopsy stage.

Table 6a: Sample biopsy

	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
2013	6	20.0	18	40.0	14	29.8	43	23.8	81	26.7
2012	5	15.2	8	27.6	15	23.1	49	25.5	77	24.1
2011	5	25.0	8	34.8	12	21.4	58	28.3	83	27.3
2010	Breakdown of individual Health Board data not available								60	20.0
2009 (excl D&G)									55	19.4
2008 (excl D&G)									60	21.3

Table 7a:Time from Diagnostic Biopsy to issue of Pathology Report

N303 lesions

Time interval in days	Borders		D&G		Fife		Lothian		SCAN	
	n30	%	n45	%	n47	%	n181*	%	n303	%
0-14	14	42.4	38	84.4	36	55.4	103	56.9	191	62.0
15-28	11	33.3	5	11.1	5	7.7	48	26.5	69	22.4
>28	4	12.1	2	4.4	6	9.2	26	14.4	38	12.3
Data n/a	1	3.0	0	0.0	0	0.0	4	2.2	5	1.6
Median	15		6		10		14			
Range	0- 77		1 - 45		2 - 47		0 - 129			

* excludes private patients (Lothian)

Borders and Lothian histology: NHS Lothian, University Hospitals Division Pathology Department, Western General Hospital, Edinburgh

Fife histology: Fife Area Laboratory, Kirkcaldy

D&G histology: Pathology Department, Dumfries & Galloway Royal Infirmary, Dumfries

Spire Pathology Services, Spire Murrayfield Hospital, Edinburgh

NB: It is recommend that SCAN Audit users of eCase continue to record the pathology reporting date as it assists with understanding delay points in the breakdown of statistics which are used in relation to QPI 7 (time between first and second treatment)

Note on outliers: some tissue samples processed off site result in an inbuilt delay, eg St John's samples may be sent to RIE and then onwards to WGH before being reported. Additionally, some samples are more difficult to assess. These cases sometimes require secondary opinion and can slow down release of the lab report.

Table 7b:Median Wait Time from Diagnosis to Pathology Report (Year on Year)

Time interval in days By Year of Report	Borders and Lothian	D&G	Fife
2013	14	6	10
2012	14	7	9
2011	13	5	8
2010	14	9	7
2009	15	n/a	6
2008	15	n/a	7

Table 8: Pathology: Mitotic Rate

Mitotic rate per mm²	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
*zero	17	56.7	17	37.8	13	27.7	102	56.4	149	49.2
≥1mm²	12	40.0	26	57.8	32	68.1	75	41.4	145	47.9
Nr/na	1	3.3	2	4.4	2	4.3	4	2.2	9	3.0
Total	30	100.0	45	100.0	47	100.0	181	100.0	303	100.0

*zero includes those reported as <1mm²

NB: high % volume of greater mitotic rate in Fife corresponds with its figures for thicker melanomas (see Table 2)

Table 9: Pathology: Ulcerations

Ulceration reported	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
Ulceration	5	16.7	43	95.6	30	63.8	20	11.0	98	32.3
No ulceration	23	76.7	2	4.4	17	36.2	155	85.6	197	65.0
Nr/na	2	6.7	0	0.0	0	0.0	6	3.3	8	2.6
Total	30	100.0	45	100.0	47	100.0	181	100.0	303	100.0

Melanoma National Data Definitions revised February 2012 (for implementation January 2013) are as follows:
Not identified (includes incipient ulceration); present; indeterminate; not applicable

"Notes for Users: Ulceration is an integral component of AJCC staging system and independent predictor of outcome in patients with clinically localised primary cutaneous melanoma."

Table10: Pathology: Pathological T Stage

T stage reported	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
Reported	20	66.7	30	66.7	11	23.4	119	65.7	180	59.4
Not reported	10	33.3	15	33.3	36	76.6	62	34.3	123	40.6
Inapplicable	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	30	100.0	45	100.0	47	100.0	181	100.0	303	100.0

Table 11: Specialty of Clinician performing diagnostic biopsy of melanoma

	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
Dermatology	26	86.7	32	71.1	41	87.2	161	89.0	260	85.8
Plastic Surgery	1	3.3	0	0.0	0	0.0	11	6.1	12	4.0
Oral surgery	0	0.0	4	8.9	0	0.0	0	0.0	4	1.3
ENT Surgery	0	0.0	1	2.2	1	2.1	1	0.6	3	1.0
General Surgery	1	3.3	1	2.2	0	0.0	1	0.6	3	1.0
GP	2	6.7	7	15.6	3	6.4	3	1.7	15	5.0
Medical Oncology	0	0.0	0	0.0	0	0.0	1	0.6	1	0.3
Other	0	0.0	0	0.0	2	4.3	3	1.7	5	1.7
Not Known	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	30	100.0	45	100.0	47	100.0	181	100.0	303	100.0

Table 11a: GP-performed Diagnostic Biopsy (Year on Year)

	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
2013	2	6.7	7	15.6	3	6.4	3	1.7	15	5.0
2012	4	12.1	6	20.7	7	10.8	4	2.1	21	6.6
2011	4	20.0	3	13.6	10	17.9	9	13.6	26	8.6
2010	3	10.7	9	22.0	2	4.1	6	22.0	20	6.6
2009	1	3.8	n/a	n/a	3	5.9	13	n/a	17	6.0
2008	12	52.2	n/a	n/a	4	5.8	17	n/a	33	11.7
2007	11	39.3	n/a	n/a	6	11.3	17	n/a	34	12.6

Table 12: Mode of Referral

	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
GP referral	23	80.0	40	88.9	40	87.0	149	84.2	252	84.8
Self referral to A&E	0	0.0	0	0	0	0.0	2	1.1	2	0.7
Incidental	3	10.0	2	4.4	4	8.7	19	10.7	28	9.4
Review	3	10.0	1	2.2	2	4.3	7	4.0	13	4.4
Not Recorded	0	0.0	2	4.4	0	0.0	0	0.0	2	0.7
Total	29	100.0	45	100.0	**46**	100.0	**177**	100.0	297	100.0

NB: 1 x Fife 1 x borders and 4 x Lothian patients had 2 simultaneous primaries.

Table 13: wait in days from diagnostic biopsy to second stage of treatment

Second stage of treatment includes a wide local excision (WLE) +/- sentinel lymph node biopsy. A patient whose diagnostic biopsy was a sample biopsy will have their residual lesion excised at the time of WLE.

Time interval in days	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
≤28	0	0.0	6	17.1	4	8.9	18	10.7	25	9.6
29-56	9	37.5	17	48.6	10	22.2	81	48.2	114	43.8
>56	15	62.5	12	34.3	31	68.9	69	41.1	121	46.5
Total	**24**	**100**	**35**	**100**	**45**	**100**	**168**	**100**	**260**	**100**
Median	67		51		66		51			
Range	29 - 407		10 -110		0 -106		14 - 405		0 - 0	
>84	4	16.7	6	17.1	11	24.4	9	5.4	**30**	**11.5**
Reasons for Exclusions										
died before treatment							5			
Mets	2				1		3			
co morbid	1						0			
wle only	2						1			
private							1			
patient refused							3			
patient lost	1									
BSC under gynae					1					

Table 13a: Median wait in days for 2nd stage treatment following diagnosis (Year on Year)

Median wait in days	Borders	D&G	Fife	Lothian
2013	67	51	66	51
2012	61	59	64	47
2011	65	48	58	48
2010	58	53	57	51
2009	55	n/a	67	56
2008	48	n/a	63	55

Note on Table 13: An analysis of outliers for 2013 shows where particular bottlenecks have occurred in the patient pathway from diagnostic biopsy though pathology turnaround, MDM discussion, onward referral to plastics (where appropriate) and completion of wide local excision. For details, see supplementary report.

The data demonstrates a high proportion of patient-induced postponements and delays to definitive treatment due to further investigation and inconclusive findings.

Three out of the four Borders outliers received their definitive treatment in-house.

Table 14: Sentinel lymph node biopsy (SLNB)

	Borders		D&G		Fife		Lothian		SCAN	
	n	% of Total	n	% of Total	n	% of Total	n	% of Total	n	% of Total
	30		45		47		181		303	
Patient Eligible for SLNB	16	53.3	29	64.4	33	70.2	82	45.3	160	52.3
	n16	% of eligible	29	% of eligible	33	% of eligible	82	% of eligible	160	% of eligible
SLNB done	3	18.8	4	13.8	8	24.2	36	43.9	51	31.9
+ve result	1	6.3	1	3.4	0	0.0	13	15.9	15	9.4

NB: total may also include patients who presented with lymph node metastases

Protocol of eligibility for consideration of SLNB: Breslow depth ≥1.0mm or Breslow depth <1.0mm with mitotic rate ≥1mm²

The role of SLNB is unclear. There is no Randomised Clinical Trial evidence to show that SLNB has any overall survival advantage. SLNB aids staging and provides some diagnostic information. SLNB is discussed with eligible patients.

Table 14a: Sentinel lymph node biopsy (Year on Year)

Year	eligible (% of total)	SLNB carried out (Total No)	SLNB carried out (% of eligible)	Positive SLNB (Total No)	Positive (% of carried out)
2013	52.3	51	31.9	15	29.4
2012	48.9	65	41.7	11	16.9
2011	53.9	92	56.1	15	16.3
2010	46.9	86	70.0	15	16.7
2009	48.8	91	66.0	15	16.5
2008	32.7	92	63.4	10	10.9
2007	50.2	77	57.0	21	27.3

Note: Years 2007, 2008, 2009 and 2010 exclude D&G patient data

Table 15: Lymph Node Dissection

	Borders		D&G		Fife		Lothian		SCAN	
	n30	%	n45	%	n47	%	n181	%	n303	%
Lymph node dissection	2	6.7	1	2.2	0	0.0	16	8.8	19	9.0
Positive lymph nodes	1	3.3	1	2.2	0	0.0	9	5.0	11	3.6

Current practice is for patients with a positive sentinel node to proceed to radical node dissection. Some patients may not have had previous SLNB. Treatment of clinically apparent regional lymph nodes is dependent on positive FNA or frozen paraffin sections of involved lymph node.

Table 15a: Lymph Node Dissection (Year on Year)

Lymph node dissection	SCAN	n Positive	% positive
2013	19	11	58.0
2012	16	5	31.3
2011	20	8	40.0
2010	17	4	23.5

Table 16: Multidisciplinary Meeting (MDM) for Melanoma patients

Patient discussed at MDM	Borders		D&G		Fife		Lothian		SCAN	
	n30	%	n45	%	n46	%	n177	%	n298	%
Discussed	30	100.0	41	91.1	46	100.0	176	99.4	293	98.3
Not discussed	0	0.0	4[1]	8.9	0	0.0	1[2]	0.6	5	1.7
Total	30	100.0	45	100.0	46	100.0	**177**	100.0	298	100.0

NB: 1 x Fife and 4 x Lothian patients had 2 simultaneous primaries

[1] 3 patients intitially managed by MaxFax, 1 patient missed, but referred and seen in Lothian

[2] 1 patient presented with brain metastases, with metastatic melanoma subsequently diagnosed from lung biopsy – went straight to oncology

Table 16a: Multidisciplinary Meeting (MDM) for Melanoma patients (Year on Year)

Patient discussed at MDM %	Borders	D&G	Fife	Lothian	SCAN
2013	100.0	91.1	100.0	99.4	98.3
2012	97.0	82.8	100.0	98.4	97.2
2011	100.0	95.7	100.0	96.6	97.4
2010	100.0	61.0	100.0	92.3	90.0
2009	100.0	n/a	100.0	96.6	97.5
2008	100.0	n/a	100.0	98.4	98.9

Table 17: Contact with Cancer Nurse Specialist (CNS) for Melanoma

Patient contact with CNS	Borders		D&G		Fife		Lothian		SCAN	
	n	%	n	%	n	%	n	%	n	%
Contact	11	36.7	16	35.6	17	37.0	158	87.3	203	61.4
No contact	19	63.3	29	64.4	29	63.0	23	12.7	100	38.3
Total	30	100.0	45	100.0	46[1]	100.0	181	100.0	303	100.0

[1] Fife duplicate, not counted twice

Table 17a: Contact with Cancer Nurse Specialist (CNS) for Melanoma (Year on Year)

Patient contact with CNS (%)	Borders	D&G	Fife*	Lothian	SCAN
2013	36.7	35.6	37.0	87.3	61.4
2012	60.6	17.2	61.5	80.7	67.4
2011	65.0	26.1	87.5	82.9	78.8
2010	82.1	n/a	64.6	90.6	86.9
2009	88.5	n/a	72.5	89.4	86.2
2008	95.7	n/a	68.1	88.9	84.3

*Fife: In addition to the regional CNS, Fife patients also have the opportunity to meet with specialist dermatology skin cancer link nurses based in Fife. These nurses link in with the regional CNS if there are any issues with which she may be able to help. It is therefore important to note that 95.7% of Fife patients were seen by a skin cancer link nurse, regional CNS or both.

Unfortunately, D&G and Borders are not able to replicate the Fife model described above as they do not have sufficient nursing resource. However all patients receiving treatments in Lothian have access to the CNS if this contact is sought.

Table 18: Five year Survival of Patients diagnosed in 2008 for SCAN (excl D&G)
(Clark Level ≥II or metastatic disease at presentation) n219

Breslow Depth		0-0.99	1-1.99	2-2.99	3-3.99	4+	Mets
Male		75n	19n	7n	5n	12n	4n
5 year survival: Alive	n	62	16	4	1	1	0
	%	**82.7**	**84.2**	**57.1**	**20.0**	**8.3**	**0.0**
5 year survival: Deceased	n	10	3	3	4	11	4
	%	13.3	15.8	42.9	80.0	91.7	100.0
Dead of melanoma	n	0	0	2	2	4	4
	%	0.0	0.0	28.6	40.0	33.3	100.0
Lost to Follow Up	n	3	0	0	0	0	0
	%	4.0	0.0	0.0	0.0	0.0	0.0
Female		106n	34n	9n	6n	9n	2n
5 year survival: Alive	n	97	29	6	4	3	1
	%	**97.5**	**85.3**	**66.6**	**66.6**	**33.3**	**50.0**
5 year survival: Deceased	n	8	4	3	2	6	1
	%	7.5	11.8	33.3	33.3	66.6	50.0
Dead of Melanoma	n	0	2	1	2	5	0
	%	0.0	5.9	11.1	33.3	55.6	0.0
Lost to Follow up	n	1	1	0	0	0	0
	%	0.9	2.9	0.0	0.0	0.0	0.0

Extract from SCAN Management Guidelines September 2012: *Follow-up*

There is no strong evidence to determine the exact pattern of follow-up. The following suggestion should be tailored to the individual patient:

Breslow <1mm, no ulceration, no mitoses: 3 - 6/12 months up to one year then discharge

Breslow <1mm, ulceration or ≥1 mitoses: 3/12 for three years, then 6/12 to 5 years

Breslow >1mm: 3/12 for three years, then 6/12 to five years

Stage IIIB, IIIC, resected stage IV: 3/12 for three years then 6/12 to five years, then 12/12 to 10 years

Stage IV unresectable: seen according to need

Table 19 QPI 1 Sample Table

QPI 1 Primary surgical biopsy		QPI Target	Borders	D&G	Fife	Lothian	SCAN
Number of patients with cutaneous melanoma whose diagnostic surgical biopsy was carried out by a skin cancer clinician	**N**		27	37	47	171	279
Number of patients with cutaneous melanoma undergoing diagnostic surgical biopsy	**D**		29	45	44	177	298
	%	90	93.1	82.2	93.6	96.6	93.6

Table 20 QPI 3 Sample Table

QPI 3 Multi-Disciplinary meeting (MDT)		QPI Target	Borders	D&G	Fife	Lothian	SCAN
Number of patients with cutaneous melanoma discussed at the MDT prior to definitive treatment	**N**		29	41	47	180	293
Number of patients with cutaneous melanoma (includes patients who present with metastatic disease)	**D**		29	45	47	181	298
	%	95	100.0	91.1	100.0	99.4.	98.3

Table 21 QPI 6 Sample Table

QPI 6 Wide Local Excisions		QPI Target	Borders	D&G	Fife	Lothian	SCAN
Number of patients with cutaneous melanoma undergoing surgical biopsy who receive wide local excisions	**N**		26	35	45	167	273
Number of patients with cutaneous melanoma undergoing surgical biopsy	**D**		27	45	46	171	290
Exclusions (died before treatment)			2			6	
1 x Fife, 1 x Borders, 4 x Lothian have patients with Simultaneous primaries.	%	95	96.3	77.8	97.8	97.7	94.1

Table 22 QPI 7 Sample Table

QPI 7 Time to Wide Local Excision		QPI Target	Borders	D&G	Fife	Lothian	SCAN
Number of patients with cutaneous melanoma who receive wide local excision within 84 days of diagnostic biopsy	**N**		21	29	34	154	229
Number of patients with cutaneous melanoma who receive wide local excision	**D**		26	35	45	167	273
	%	95	80.8	82.9	75.6	92.2	83.9

Melanoma Oncology 2013

During 2013, 41 new patients were seen in the medical oncology clinic and 20 in the clinical oncology clinic as well as approximately 260 follow-up appointments
The majority of patients seen in the medical oncology clinic had metastatic disease.
Patients in the clinical oncology clinic were primarily seen to discuss radiotherapy either in the adjuvant or palliative setting.

Clinical Trials in Melanoma in Edinburgh 2013

Adjuvant

No adjuvant trials were open in 2013.

Metastatic

1) CoBRIM
A phase III double blind placebo controlled study of vemurafenib versus vemurafenib plus GDC-0973 in previously untreated BRAF mutation positive patients with unresectable locally advanced or metastatic melanoma

2 patients were entered in 2013.

2) PACMEL
A randomized phase 2 study of paclitaxel with or without GSK1120212 or pazopanib in advanced wt BRAF melanoma.

1 patient was entered in 2013.

3) MK3475 – 006
A muilticenter randomized controlled three-arm phase III study to evaluate the safety and efficacy of two dosing schedules of MK-3475 compared to ipilimumab in patients with advanced melanoma.

6 patients were entered in 2013.

4) BRF115252
Dabrafenib for compassionate use in BRAF V600 mutation-positive metastatic melanoma

12 patients were entered in 2013.

Other Developments

Vemurafenib, a BRAF inhibitor, which is associated with improved survival compared to DTIC chemo in patients with previously untreated metastatic melanoma was approved for use in December 2013.

Ipilimumab, a CTLA4 antibody, associated with improved survival in patients with metastatic was also approved for use in NHS Scotland in 2013 for patients with previously treated metastatic melanoma.

ABBREVIATIONS

ACaDME	**A**cute **C**ancer **D**eaths and **M**ental Health: ISD data mart contains linked inpatient and daycase, mental health, cancer registration and death (GRO) records. It is updated on a monthly basis.
AJCC	American Joint Committee on Cancer
BGH	Borders General Hospital, Melrose
Bx	Biopsy
CM	Cutaneous Melanoma
CNS	Cancer Nurse Specialist
D&G	Dumfries and Galloway
FNA	Fine Needle Aspirate
GP	General Practitioner
ISD	Information Services Division, National Services Scotland
LMM	Lentigo Maligna Melanoma
MDM	Multidisciplinary Meeting
MDT	Multidisciplinary Team
Mets	Metastasis/Metastases
QA	Quality Assurance
SCAN	Southeast Scotland Cancer Network
SCR	Scottish Cancer Registry
SIGN	Scottish Intercollegiate Guidelines Network
SLNB	Sentinel Lymph Node Biopsy
SMG	Scottish Melanoma Group
SSMM	Superficial Spreading Malignant Melanoma
WLE	Wide local excision

Acral: relating to the extremities of peripheral body parts (fingers/palms/soles)

Adjuvant treatment: treatment that is given in addition to the primary, main or initial treatment

Anterior: nearer the front (of body)

Breslow Depth: prognostic factor in melanoma of the skin which describes how deeply tumour cells have invaded.

Desmoplastic: growth of fibrous or connective tissue

Desmoplastic melanoma: rare subtype of melanoma characterised by malignant spindle cells

Histogenetic Type: relating to formation of body tissue

Incidental finding: patient may be attending or referred to hospital for investigation or treatment of a condition unrelated to their cancer and a melanoma is diagnosed

Lentigo Maligna: a specific type of melanoma in situ that occurs around hair follicles on the sun-damaged skin of the head and neck

Lentigo Maligna Melanoma: melanoma evolving from Lentigo Maligna

Mitosis (pl. Mitoses): the process of cell division

Mitotic Rate: a measurement of how fast tumour cells are dividing.

Mucosal: relating to mucous membranes

Naevoid: resembling/in the form of a naevus/naevi

Nodular Melanoma: type of malignant, often fast-growing melanoma which typically presents as a raised bluish-black tumour

Pathological T stage: pathological staging of the tumour based on examined specimens of tissue

Polypoid: resembling/in the form of a polyp

Review patient: patient attending outpatient cancer clinic as part of follow-up for a previous melanoma

Spitzoid melanoma: melanoma with the features of a Spitz naevus (a rare melanocytic lesion)

Subungual: beneath a fingernail or toenail

Superficial spreading melanoma: most common form of cutaneous melanoma in Caucasians. Occurs most frequently from middle age onwards on sun-exposed skin. especially on the backs of males and lower limbs of females.

Supplementary Report

Patient wait for second treatment >84 Days

Fife

Patient	No of Days	Derm Cons	Dx to Path	Path to MDM	MDM to ref to Plastics	Ref to Seen By Plastics	Plastics to WLE	Cons	Hosp of WLE	Comments
1	85	SF	38	15	-11	22	21	OQ	QMH	specimen not thought to be malignant sent to Glasgow for analysis by locum. Ref to Plastics by GP
2	86	FS	8	9	6	19	44		SJH	Joint surgery with Max Fax
3	86	MM	8	17	3	30	28	AL	QMH	
4	86	MM	9	9	5	12	51	FH	NW	seen by Plastics in SAMH
5	92	SF	5	4	27	32	24	OQ	QMH	
6	93	MM	10	15	11	22	35	Lowrie	VHK	
7	94	MM	30	16	-4	29	23	SW	QMH	specimen not thought to be malignant sent to Glasgow for analysis by locum.
8	96	MM	20	10	-3	38	21	OQ	NW	Plastics OPA Perth RI 26/07/2013 as no appts in Fife till end Aug
9	98	MM	17	15	0	31	35	OQ	NW	
10	106	SA	14	17	4	27	44	OQ	QMH	
11	106	SF	30	7	11	29	29	SW	QMH	no reason documented for path delay

Lothian

Patient	No of Days	Derm Cons	Dx to Path	Path to MDM	MDM to ref to Plastics	Ref to Seen By Plastics	Plastics to WLE	Cons	Hosp of WLE	Comments
1	93	SAH	20	4	25	24	20	MB	WGH	patient-induced delay
2	93	VRD	23	8	0	7	55	MB	WGH	
3	94	MT(STJ)	8	10	0	35	41	MB	WGH	patient-induced delay
4	96	general practice	43	8	0	11	35	SAH	RIE/Lau	general practice ----> pathology lag
5	97	SAH	1	23	inapplicable	inapplicable	73	SAH	RIE/Lau	In House. Patient-induced delay.
6	99	VRD(STJ)	9	119	-46	73	17	CR	SJH	1st biopsy inconclusive. Further excision required for diagnosis/MDM
7	148	general practice	35	4	6	4	62	CR	SJH	further investigations preceded WLE
8	183	SAH	22	9	inapplicable	inapplicable	152	SAH	RIE/Lau	In House. patient-induced delays
9	286	LN	3	18	14	221	30	CR	SJH	long delay due to other Ca treatment. Now deceased.

Borders

Patient	No of Days	Derm Cons	Dx to Path	Path to MDM	MDM to ref to Plastics	Ref to Seen By Plastics	Plastics to WLE	Cons	Hosp of WLE	Comments
1	85	SL	16	7	1	52	9	PA/MB	WGH	transferred from STJ to WGH
2	91	SL	17	7	inapplicable	inapplicable	inapplicable	SL	BGH	In House WLE. Rescheduled from 28/01. clinician unavailable.
3	91	SL	9	14	inapplicable	inapplicable	inapplicable	SL	BGH	In House WLE. No other details documented.

4	104	SL	9	15	inapplicable	inapplicable	inapplicable	SL	BGH	In House WLE. Some delay due to Ophthalmology Treatment.