2 week skin cancer urgent referral pathway

Dr Stephen Hayes
Associate Specialist I Dermatology
University Hospital Southampton
UK melanoma mortality 1971-2008 -source cancer research UK
Survival depends on early diagnosis

Figure 3.4: Five-year survival by tumour thickness, patients diagnosed 1979-1998, by sex, Scotland

Survival %

Tumour thickness (mm)

<1.5 1.5-3.49 >3.5

Men Women

[Bar chart showing survival rates by sex and tumour thickness.]
Will education reduce skin cancer incidence?
HOLISTIC APPROACH TO DIAGNOSIS

• STOCK YOUR MIND WITH FACTS AND IMAGES
• History
• Inspect
• Palpate
• Dermoscopy
• Put it all together
What to refer urgently

- Suspected melanoma
- Suspected squamous cell cancer (SCC)
- Suspected other dangerous skin cancer (e.g. sarcoma, Merkel cell cancer, cutaneous deposit etc)
- Dangerous basal cell cancer (BCC) e.g. large neglected lesion close to the eye
What NOT to refer urgently

• Everything else!!!
How to refer urgently

• Fill in the form, including

• A decent description of the lesion, including measurements.
• Any cancer history,
• Medication, especially anticoagulants and immune suppression
If in doubt.....

• Make a routine referral
• Include accurate measurement and description
• Ask if the consultant reviewing the referral may wish to upgrade
• WE CAN UPGRADE A ROUTINE REFERRAL IF YOU GIVE US GOOD INFORMATION, BUT WE CANNOT DOWNGRADE A 2WW REFERRAL.
Melanoma

CT scan of 35 year old woman’s head

http://aletheastory.wordpress.com

Alethea Giorgiou passed away aged 35 on June 11th 2011. She blogged about her ‘melanoma journey’ to the end. I suggest learners spend a little time randomly Googling on melanoma to get a feel for what is out there in terms of peoples’ personal stories. Some of your patients will have seen frightening material.
Melanoma
Typical early superficial spreading melanoma
How not to miss melanoma

• New, changing mole in adult
• Different to other moles, ‘the ugly duckling’
• Multiple colours
• Irregular outline
• Asymmetry
• New firm growing nodule
• Beware the non- or hypo-pigmented melanoma
ABCD rule-good as far as it goes

<table>
<thead>
<tr>
<th>Normal Mole</th>
<th>Melanoma</th>
<th>Sign</th>
<th>Characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Normal Mole" /></td>
<td><img src="image2.png" alt="Melanoma" /></td>
<td>Assymetry</td>
<td>Half the mole does not match the other half</td>
</tr>
<tr>
<td><img src="image3.png" alt="Normal Mole" /></td>
<td><img src="image4.png" alt="Melanoma" /></td>
<td>Border</td>
<td>The border (edges) of the mole are ragged or irregular</td>
</tr>
<tr>
<td><img src="image5.png" alt="Normal Mole" /></td>
<td><img src="image6.png" alt="Melanoma" /></td>
<td>Color</td>
<td>The color of the mole varies throughout</td>
</tr>
<tr>
<td><img src="image7.png" alt="Normal Mole" /></td>
<td><img src="image8.png" alt="Melanoma" /></td>
<td>Diameter</td>
<td>The mole's diameter is larger than a pencil's eraser</td>
</tr>
</tbody>
</table>

*Photograph Used by Permission: National Cancer Institute*
Old photo shows dark mark

...wouldn’t listen to his wife and get it checked.

LISTEN TO THE WIFE!!!

5 years Later...
Ulcerated pigmented nodule on elderly white sun damaged skin - bad news.

• Male, 80 presented with blue/grey ulcerated nodular melanoma.

• Dead from brain, liver and lung metastases 6 weeks after this picture was taken
Squamous cell cancer

• Significantly more dangerous than BCC
• Faster growing
• Range of disease activity
  • Well differentiated
  • Moderately differentiated
  • Poorly differentiated
• Around 5% metastasise
SCCs outnumber BCCs on the ears
Squamous cell cancer (SCC) on badly sun damaged skin
Highly aggressive SCC - danger!
Squamous cell cancers
Back of hand-classic site
Beware the neglected cancer in elderly widows and widowers
New Firm Growing (NFG) lesion = red flag

- Cutaneous metastasis?
- Aggressive SCC?
- Amelanotic melanoma?
- Atypical fibroxanthoma?
- Merkel cell cancer?
- Sarcoma?

- THE PATHOLOGIST CAN DECIDE
Cutaneous metastasis from occult adenocarcinoma
Long delayed presentation, SCC already invading skull..
Assorted BCCs. Should these go on 2ww????
Old lady living alone - big surgically challenging BCC
Danger!
An ugly duckling on the back
Where’s the melanoma? Look carefully.
It’s not the obvious tumour...
This lesion, of which the patient was completely unaware as it was on his back, was also noted.
What not to refer on an urgent skin cancer pathway

• Most skin lesions are benign (we CANNOT remove benign skin lesions)

• Most actinic keratoses and Bowen’s disease can be managed in Primary Care

• Most BCCs should be referred non-urgently

• The GPSI service can treat small BCCs below the clavicle, ONLY.
Dermatofibroma pinch test
Bruise sent up on urgent skin cancer pathway
• Sent on urgent cancer pathway as ? SCC

• 5 year history
Bowen’s disease
= intraepidermal squamous neoplasia/
squamous cell carcinoma in situ
Bowen’s disease
Pyogenic granulomas—a grey area.
2 more pyogenic granulomas

These lesions are fast growing and bleed profusely. They should be removed for histology without delay as they are most unpleasant and also as the differential diagnosis is amelanotic melanoma.
Dermoscopy is invaluable

Nodular melanoma?
Dermoscopy is invaluable

Nodular melanoma?  No, it’s a harmless haemangioma.
Scary mole?
Dark but harmless naevus
Worrying lesion on old older, white sun damaged back?
Seborrhoeic keratosis
(but he needs a full skin check)
Seborrhoeic keratosis sent up on 2 week wait
dangerous because of being black
Which ugly duckling is the melanoma?
first ugly duckling
second ugly duckling
Spot the difference
Another ugly duckling on a man’s back
14 year old, slow change over years
Naevi on the foot are no more likely to be malignant than elsewhere.
Blood under nail - mind the gap
Mind the gap! Blood under the nail (again....)
Small naevi on feet are usually harmless
Blood clot sent up as ? melanoma
Trauma (talon noir)-short history, typical site
Summary: urgent skin cancer referral

- New, firm, growing, pink/red nodular lesion
- Especially in immune suppressed patients
- Suspected melanoma
- Suspected squamous cell cancers
- BCCs adjacent to eyes, other difficult anatomy
- Genetic disorder e.g. Gorlin’s syndrome, Xeroderma Pigmentosum
NOT reasons for urgent skin cancer referral

• Patient would like a mole check because girlfriend’s dad had a melanoma and would like to put his mind at rest
• Under 18, mole has grown a bit over last 2 years
• Black mole in black patient, or indeed small stable black mole in whites
• Actinic keratosis and Bowen’s disease (manage in Primary Care)
• Rashes (if necessary, phone the on call registrar for severe rash)
• Blood under toenail
• Used to have regular mole checks in Australia, USA (other country that has private/adequately funded dermatology care)
Top tips

• Do a refresher source, including self directed web based learning
• Beware new, firm, growing red lesions
• Ideally examine the whole skin
• Think about investing in dermoscopy skills
• Audit your referrals
• Expect to manage most actinic keratoses and Bowen’s disease in the community (as per NICE guidance)
• If in genuine doubt, DO refer
Dermatology education available

- If you would like me to present on dermatology (acne, eczema, skin cancer diagnosis, etc) I can come out to your practice by arrangement.
- Ideally, ask GPs and nurses from neighbouring practices
- No speaker fee required (modest voluntary donation to dermatology charity fund is acceptable if you like)
- Steve.hayes@uhs.nhs.uk
- This presentation is available as a free PDF download from my blog at www.dermoscopy.wordpress.com where I post case discussions and links to other sites.