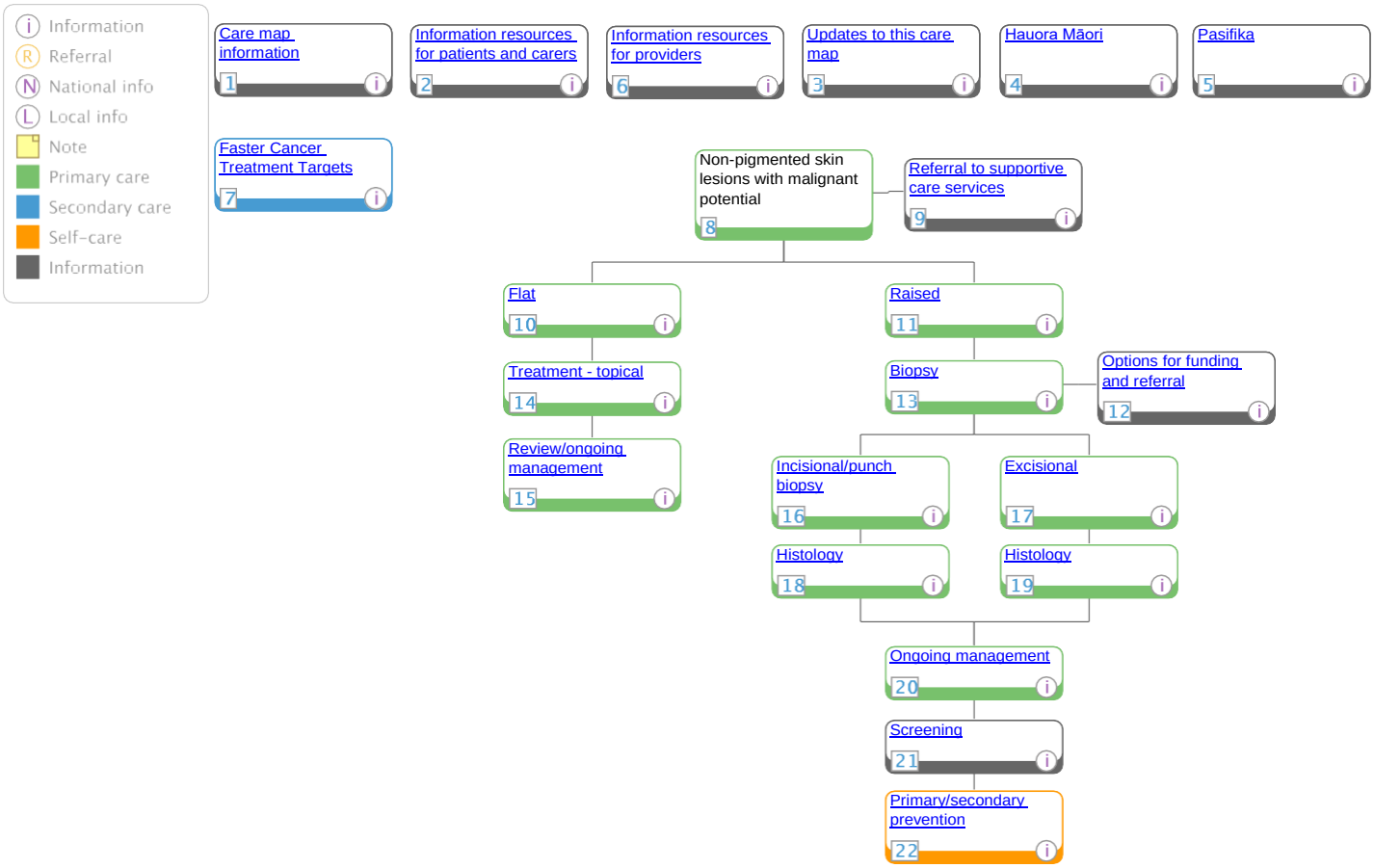
Skin Lesion - Management

Medicine > Dermatology > Skin Lesions



1. Care map information

In scope:

- Management of non-pigmented skin lesions with malignant potential

Out of scope:

- Management of skin lesions suspicious of melanoma

References:

See Provenance Certificate for full list of references.

2. Information resources for patients and carers

Resources:

- SCAN Your Skin handout (Skin Cancer College Australasia)
- Imiquimod (Aldara) patient information guide
- Fluorouracil (Efudix) patient information guide
- Cancer Society Patient Information Sheets on sun protection
- Cryotherapy Treatment of Skin Lesions (patient information)

Te Ara Whānau Ora Brochure

- Te Ara Whānau Ora Brochure

3. Updates to this care map

Date of publication: October 2017.

This care map has been developed in line with consideration to evidenced based guidelines.
For further information on contributors and references please see the care map's Provenance.

4. Hauora Māori

Māori are a diverse people and whilst there is no single Māori identity, it is vital practitioners offer culturally appropriate care when working with Māori Whānau. It is important for practitioners to have a baseline understanding of the issues surrounding Māori health.

This knowledge can be actualised by (not in any order of priority):

- acknowledging Te Whare Tapa Whā (Māori model of health) when working with Māori Whānau
- asking Māori clients if they would like their Whānau or significant others to be involved in assessment and treatment
- asking Māori clients about any particular cultural beliefs they or their Whānau have that might impact on assessment and treatment of the particular health issue (Cultural issues)
- consider the importance of whānaungatanga (making meaningful connections) with their Māori client / Whānau
- knowledge of Whānau Ora, Te Ara Whānau Ora and referring to Whānau Ora Navigators where appropriate
- having a historical overview of legislation that has impacted on Māori well-being

For further information:

- Hauora Māori

5. Pasifika

Pacific Cultural Guidelines (Central PHO) 6MB file

Our Pasifika community:

- is a diverse and dynamic population:
  - more than 22 nations represented in New Zealand
  - each with their own unique culture, language, history, and health status
  - share many similarities which we have shared with you here in order to help you work with Pasifika patients more effectively

The main Pacific nations in New Zealand are:

- Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau and Tuvalu

Acknowledging *The FonoFale Model (pasifika model of health)* when working with Pasifika peoples and families.

Acknowledging general pacific guidelines when working with Pasifika peoples and families:

- Cultural protocols and greetings
- Building relationships with your pasifika patients
- Involving family support, involving religion, during assessments and in the hospital
- Home visits
- Contact information

Pasifika Health Service - Better Health for Pasifika Communities:

- the Pasifika Health Service is a service provided free of charge for:
  - all Pasifika people living in Manawatu, Horowhenua, Tararua and Otaki who have long term conditions
  - all Pasifika mothers and children aged 0-5 years
- an appointment can be made by the patient, doctor or nurse
- the Pasifika Health Service contact details are:
  - Palmerston North Office - 06 354 9107
  - Horowhenua Office - 06 367 6433
- Better Health for Pasifika Communities brochure

Additional resources:

- Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2014-2018
- Primary care for pacific people: a pacific health systems approach
- Tupu Ola Moui: The Pacific Health Chart Book 2004
- Pacific Health resources
- Central PHO Pasifika Health Service

6. Information resources for providers

Resources:

- SCAN Your Skin consumer handout (Skin Cancer College Australasia)
- CHAOS and CLUES (a dermatoscopic algorithm for pigmented skin malignancy)
- Dermatoscopy in routine practice
- Prediction without Pigment (a decision algorithm for non-pigmented skin malignancy)
- How to use fluorouracil and imiquimod for non-melanoma skin cancer in a general practice setting
- Perioperative management of patients on oral anticoagulants

- Guidance on how to take good pictures for clinical use
- Skin Cancer College Australasia
- Liquid nitrogen/cryotherapy guidelines (DermNet NZ)

7. Faster Cancer Treatment Targets

Faster Cancer Treatment Targets

The Faster Cancer Treatment (FCT) health target builds on the significant improvements that have been made in the quality of cancer services over recent years. It provides a lens across the whole cancer pathway to ensure people have prompt access to excellent cancer services.

Faster cancer treatment health target:

- 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017. [3]

For more information:

- Faster Cancer Treatment programme

9. Referral to supportive care services

He Anga Whakaahuru - Supportive Care Framework [5]

Improving the quality of life for those with cancer, their family and whānau through support, rehabilitation and palliative care - the essential services required to meet a person's physical, social, cultural, emotional, nutritional, informational, psychological, spiritual and practical needs throughout their experience with cancer.

Further information on the Standards and Competencies

Support Services:

1. Primary care services referral :
   - anyone with a possible, probable or definite diagnosis of cancer and are enrolled with a PHO and/or is a resident in the PHO area

Māori Community Cancer Coordinators - community-based Māori cancer support services:

- Te Wakahuia (Palmerston North, Manawatu) Phone: 06 3573400
- Best Care Whakapai Hauora (Palmerston North) 06 3536385 Ext 773
- Te Rānanga o Raukawa (Otaki, Horowhenua) Phone: 06 3688679
- Te Kete Hauora (Tararua)Phone: 06 3746860
- referral form

2. Pae Ora Māori Health Service:
   - kaupapa Māori community and hospital based navigation service
   - referral form and contact details
3. Cancer Society:
   - for additional support services phone the cancer information nurses on the **Cancer Information Helpline 0800 226 237**
4. Central Region Cancer Services Directory:

The directory provides a list of cancer support services available across MidCentral, Whanganui and Hawke's Bay including:

- ethnic and cultural
- accommodation
- disability support
- government health services
- medication
- legal advice

5. Social Workers Oncology

- We can support you and your family/whānau as you come to terms with your diagnosis and the impact it may have in your day-to-day life, now and in the future
- for more information and contact details

6. Cancer Psychology Service (Massey): Te Ara Whatumanawa. We work with people and their whānau/family at all stages of the cancer journey, from diagnosis to treatment and beyond.

- free service
- 06 3505180
- referral form

7. Regional Cancer Treatment Service (RCTS):

Cancer treatment services are provided to patients in Taranaki, Whanganui, Tarawhiti, Hawkes Bay and MidCentral District Health Boards by the Regional Cancer Treatment Service (RCTS):

- for more information go to website

10. Flat

Flat lesions:

- actinic keratosis
- superficial basal cell carcinoma (BCC)
- squamous cell carcinoma (SCC) in situ
- BCC on the face can be flat - for example morpheic/ulcerative.

Amelanotic melanoma - dermoscopy of a pink flat potentially malignant lesion would most commonly be a superficial BCC

Dermoscopy should show the common features of superficial BCC on dermoscopy:

- short fine telangiectasia
- micro ulcerations
- pink/erythematous background

This can be confirmed at a quick glance.

If however one sees light pigment not appreciated with the naked eye, polymorphous vessels including dot vessels and polarising specific white lines one should consider **amelanotic/lightly pigmented melanoma** and do a full excision biopsy.

SCC in situ can be similar dermoscopy - key features are monomorphic, coiled vessels, scale, plus or minus light brown structure-less.

11. Raised

- raised lesions are not suitable for topical treatment and require excision
- basal cell carcinomas (BCCs) should not be treated with liquid nitrogen unless clinical diagnosis is superficial BCC or has been established from a punch biopsy
- consider punch biopsy for lesions of uncertain diagnosis or difficult surgical sites
- if confident squamous cell carcinoma (SCC) or BCC, arrange full excision
- if considering amelanotic nodular melanoma arrange URGENT full excision

12. Options for funding and referral

Funding options:

8. Private insurance
9. Self-fund
10. Hospital funding - for those unable to self-fund

MidCentral has a minor surgery contract with some of the local GPs.

Referral options:

- **Surgical clinic** – they will refer on to ENT/Plastics as appropriate
- **Private specialists** – dermatology, plastics, general surgery
- **GP with a Special Interest in Skin Cancer** – Kauri HealthCare

13. Biopsy

Surgical clearance margins

Basal cell carcinoma (BCC) <2cm well defined edge:

- 3mm surgical margin 85% tumour clearance
- 4-5mm surgical margin 95% tumour clearance
- larger tumours require **wider** margins
- consider MoH's surgery referral for:
  - high risk sites e.g. close to nose, eyes, lips
  - tumours >2cm
  - morpheic, infiltrative, micronodular, recurrent

Squamous cell carcinoma (SCC):

- 1-5% metastasize, so surgery is recommended with 4mm surgical margin if high risk SCC <1cm, and for all SCC >2cm
- radiotherapy if:
  - large
  - rapidly growing and surgery would be poorly tolerated
- as adjuvant therapy for positive surgical margins, consider MoH's surgery for:
  - all high risk SCC >2cm (2x risk recurrence; 3x metastatic risk)
  - site - ear, lip, scalp, eyelids, nose
  - non-exposed sites
  - SCC arising from scars, ulcers, injury
  - histology - depth, poor differentiation, perineural involvement

14. Treatment - topical

Provide advice regarding routine sun protection (daily broad spectrum 50+SPF sunscreen [AS/NZ 2604/ISO 24443 standard] to exposed areas every day, all year round, hats, wrap around [UV AS/NZ S1067.1:2016 standard] sunglasses, sun-protective clothing).

Actinic keratoses:

- **Cryotherapy** - double freeze-thaw cycle (no defined duration but ensure whole lesion is frozen, allowed to thaw, and then repeat freeze)
  - Liquid nitrogen/cryotherapy guidelines (DermNet NZ)
- **Imiquimod** cream 3-5 times weekly nocte until redness or crusting or resolution is achieved up to 4 weeks, repeated for a further 4 weeks if needed
  - Imiquimod (Aldara) patient information guide
- **Efudix** (5-fluorouracil) cream - twice daily to lesion or for field of treatment for:
  - 2-4 weeks face
  - 4-6 weeks distal limbs
  - Fluorouracil (Efudix) patient information guide

Squamous cell carcinoma (SCC) in situ:

- **Cryotherapy** - 30 sec single episode of double-freeze thaw cycle or 2 freeze-thaw cycle (no defined duration but ensure whole lesion is frozen, allowed to thaw, and then repeat freeze)
- **Efudix** (5-fluorouracil) cream twice daily for 4-6 weeks, repeating if required. Either remove scaling pre-treatment or apply cream under occlusion. Removing scale can be done with a light freeze with liquid nitrogen, curettage or salicylic acid 6% in cetomacrogol cream

Superficial basal cell carcinoma (BCC):

- **Imiquimod** 5% cream - applied nocte 5 days per week for 6-12 weeks (Imiquimod is topical treatment of choice)
- **Efudix** (topical fluorouracil) - applied twice a day for 3-6 weeks
- **Cryotherapy -** requires significant double freeze-thaw treatment which results in permanent white scar (best to avoid cryotherapy distal to knees)

Lentigo maligna:

- surgical excision with 5mm margin, treatment of choice
- topical therapies - imiquimod cream once-twice daily continuously until very weepy then continuing for 10-12 weeks (whilst continually inflamed)

Resources:

- How to use fluorouracil and imiquimod for non-melanoma skin cancer (BPAC)
- Cryotherapy Treatment of Skin Lesions (patient information)

15. Review/ongoing management

Can review response at 3 weeks to adjust treatment duration - at this time:

- assess for treatment response
- encourage toleration of side effects as appropriate
- decide how long treatment courses should be

Essential to review at 4-6 weeks after end of treatment to decide:

- if resolved
- if needs repeat treatment cycle or
- needs biopsy/excision

If not resolved, consider repeat treatment if confident of clinical diagnosis
If uncertain, consult a colleague, perform a biopsy or refer to hospital

Resources:

- How to use fluorouracil and imiquimod for non-melanoma skin cancer (BPAC)

16. Incisional/punch biopsy

Incisional/punch biopsy:

- punch biopsy only for diagnostic uncertainty
- minimum 3 mm punch biopsy
- do not need to include normal skin
- these often do not need stitching
- dressing with foban ointment tds works well
- 4 mm usually stitch

- 6-8 mm biopsies are available
- can use an 8 mm punch biopsy to excise a 4-5 mm lesion as long as care is taken to excise all of the lesion
- suggest marking an 8 mm circle with a marking pen prior to local anaesthetic insertion
- check the edges of the lesion with a dermoscope
- a figure of 6 pulley stitch can be used or 2 single interrupted stitches
- do not need to stop aspirin - for information see Perioperative management of patients on oral anticoagulants

17. Excisional

Excisional:

- if confident basal/squamous cell carcinoma and on a body site where readily achievable e.g. back/leg, excise with a 4 mm margin although a lesser margin may be acceptable
- attempt similar on face/hands - on these sites, the deep margin may be shallower
- use a dermoscope to map the lateral margins
- orientate the lesion with a suture placed in specimen e.g. superior
- do not need to stop aspirin - for information see Perioperative management of patients on oral anticoagulants

Important to ensure a healthy deep margin often going down to the deep fascia which has the added benefit of ease of closure

18. Histology

Proceed to wider excision with margins as recommended in 'Excisional' box.
For funding and referral options go to 'Options for funding and referral' box.

19. Histology

- confirm fully excised
- consider referral for adjuvant radiotherapy - see 'Biopsy' box for guidance
- if incomplete, re-excise or refer to a colleague/hospital

20. Ongoing management

Ongoing management:

- High risk - recommend yearly full skin checks (see SCAN Your Skin handout)
- Lower risk - consider yearly full skin checks to detect new skin cancers – see 'Screening' box
- When reviewing, examine the scar site and nodal basin-local lymph nodes. For melanoma, examine all lymph nodes,
- Educate on early detection (see SCAN Your Skin handout):
  - **S**caly/sore
  - **C**hanging
  - **A**bnormal
  - **N**ew
  - also:
    - amelanotic/lightly pigmented melanoma
    - nodular melanoma
    - acral/nail bed melanoma
    - and non-sun exposed melanoma.
- Holistic sun protection measures - see 'Primary/secondary prevention' box

21. Screening

Population screening for melanoma has not been shown to reduce mortality from melanoma so the Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealanddoes not recommend routine screening for the general population. This is an area of ongoing international research and the above position may change. The current position is similar to prostate cancer. Inform patients of benefits and risks and they can make an informed choice to be screened or not. Risks include anxiety, cost and possibly unnecessary procedures. Benefits include possible early detection with better outcomes and skin cancers that are easier to treat.

Risk assessment and prognostication are regularly used in medicine to guide management decisions. It is generally believed that screening of high-risk people by total skin examination for early detection is more feasible, cheaper, has fewer false positive screens and lower patient anxiety (Williams et al 2011) compared to population screening. Risk prediction can be complex.

Dependent on level of risk, this may be just a heightened index of suspicion from both doctor and patient or, for example, include annual total body photography or referral for regular skin examinations by a physician trained and competent in skin surveillance. To calculate this probability, one could use the 10 point questionnaire in the SCAN Your Skin handout (which has been used to take a history) or alternatively BPAC has developed a risk predictor model 2016 (launch BPAC icon in MedTech - see 'skin/melanoma risk assessment').

22. Primary/secondary prevention

Sun hygiene:

- daily broad spectrum SPF 50+ sunscreen to exposed areas all year round
- hats, sun protective clothing
- avoid peak of day - UV index
- Cancer Society Patient Information Sheets on sun protection

Vit D:

- will get adequate through sunscreen, 3 mins pd in summer and 25 mins pd in winter to produce enough daily Vit D
  - research studies from NIWA scientists in 2014 reveal that persons of darker skin type do not need much more sun exposure to generate sufficient Vit D from the sun, than paler skin types
- consider supplements and food sources:
  - food sources containing Vitamin D include:
    - oily fish (e.g. tuna, salmon, mackerel)
    - liver
    - lamb
    - eggs

Sunbed:

- avoid completely

Diet:

- rich in fruit and vegetables

Skin Lesion

Provenance Certificate

Overview | Editorial methodology | References | Contributors | Disclaimers

Overview

This document describes the provenance of MidCentral District Health Board's **Skin Lesion** pathway.

This localised pathway was last updated in **October 2017.**

One feature of the "Better, Sooner, More Convenient" (BSMC) Business Case, accepted by the Ministry of Health in 2010, was the development of 33 collaborative clinical pathways (CCP).

The purpose of implementing the CCP Programme in our DHB is to:

- Help meet the Better Sooner More Convenient Business Case aspirational targets, particularly the following:
    - Reduce presentations to the Emergency Department (ED) by 30%
    - Reduce avoidable hospital admissions to Medical Wards and Assessment Treatment and Rehabilitation for over-65-year-olds by 20%
    - Reduce poly-pharmacy in the over-65-year-olds by 10%
- Implement a tool to assist in planning and development of health services across the district, using evidence-based clinical pathways.
- Provide front line clinicians and other key stakeholders with a rapidly accessible check of best practice;
- Enhance partnership processes between primary and secondary health care services across the DHB.

To cite this pathway, use the following format:

Map of Medicine. Medicine. MidCentral District View. Palmerston North: Map of Medicine; 2014 (Issue 1).

Editorial methodology

This care map was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of medicine editorial methodology. It has been checked by individuals with front-line clinical experience (see Contributors section of this document).

Map of Medicine pathways are constantly updated in response to new evidence. Continuous evidence searching means that pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the pathways through the quarterly publication cycle.

References

This care map has been developed according to the Map of Medicine editorial methodology. The content of this care map is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. This localised version of the evidence-based, practice-informed care map has been peer-reviewed by stakeholder groups and the CCP Programme Clinical Lead.

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Contributors

MidCentral DHB's Collaborative Clinical Pathway editors and facilitators worked with clinical stakeholders such as front-line clinicians and pharmacists to gather practice-based knowledge for its care maps.

The following individuals have contributed to this care map:

- Dr Adrian Macquet, GP, Kauri HealthCare (Primary Care Clinical Lead)
- Mr Chris Daynes, General Surgeon, MDHB (Secondary Care Clinical Lead)
- Dr Louise Reiche, Dermatologist
- Dr Paul Cooper, Medical Director & Clinical Director Acute Care, Central PHO
- Liz Elliott, Clinical Advisor Health of Older People, MidCentral DHB (Editor)

Disclaimers

Clinical Board Central PHO, MidCentral DHB

It is not the function of the Clinical Board Central PHO, MidCentral DHB to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.