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Rodney Surgical Centre
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15:15 - 15:30 The GP's Role in Skin Cancer

The GP's Role in Skin Cancer

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The next 5-10 years

- New expensive drug treatments will shift the health economics
- Screening for melanoma? By who? For who?
  - Science of dermoscopy, technology, incidence, concensus
- GPs will play an important role

Criteria for screening for a disease

- The condition should be an important health problem
- There should be a recognisable latent or early symptomatic stage
- Proof that screening works

- There should be an accepted treatment for patients with recognised disease
- There should be a suitable test or examination that has a high level of accuracy and is acceptable to the population
- Facilities for diagnosis and treatment should be available

GP management of Skin Cancers

- Simply put, there are only three possible diagnoses for a skin lesion: clearly malignant, clearly benign and too close to call
- If you are 100% sure that the lesion is a skin cancer then arrange for it to be removed. Each GP knows the limits of their surgical skill and should refer as necessary
- If you are certain that the lesion is benign, reassure your patient
- BUT……

If you are only 99% sure that the lesion is benign, a definitive diagnosis is still required

Options include diagnostic punch biopsy (not for melanocytic lesions), excisional biopsy or referral

For GPs the number of lesions needed to be excised for every skin cancer removed is approximately 20 for melanoma and three for NMSCs

Three useful rules of thumb

- If the history and examination are discordant, assume the worst
- If a lesion has been previously biopsied and found to be benign, but you are still concerned, biopsy it again
- If the patient leaves the room but you are still concerned about a lesion you did not biopsy, call them back

Interpreting pathology reports

- 3 options: clearly malignant, clearly benign, and too close to call.

- If it is clearly benign or clearly malignant the report is generally succinct

- If the lesion is too close to call the report will often be wordy, ambiguous, have a number of caveats and leave you confused. Call the pathologist to discuss the report. If unsure re final diagnosis assume the worst and excise or refer

Early diagnosis

- The earlier a skin cancer is diagnosed the better the mortality and morbidity
- The larger/deeper a lesion is the more disfiguring/problematic the surgery will be and the higher the death rate
- Dermoscopy improves specificity and sensitivity

Dermatoscopy

- Proven to improve benign : malignant ratio
- Very useful for margins
- Excellent affordable software for storage and sharing of images
- Computor aided diagnosis

Practical Pointers

- Well defined NMSC without high risk features
  4mm margin (5% recurrence at 5 years)

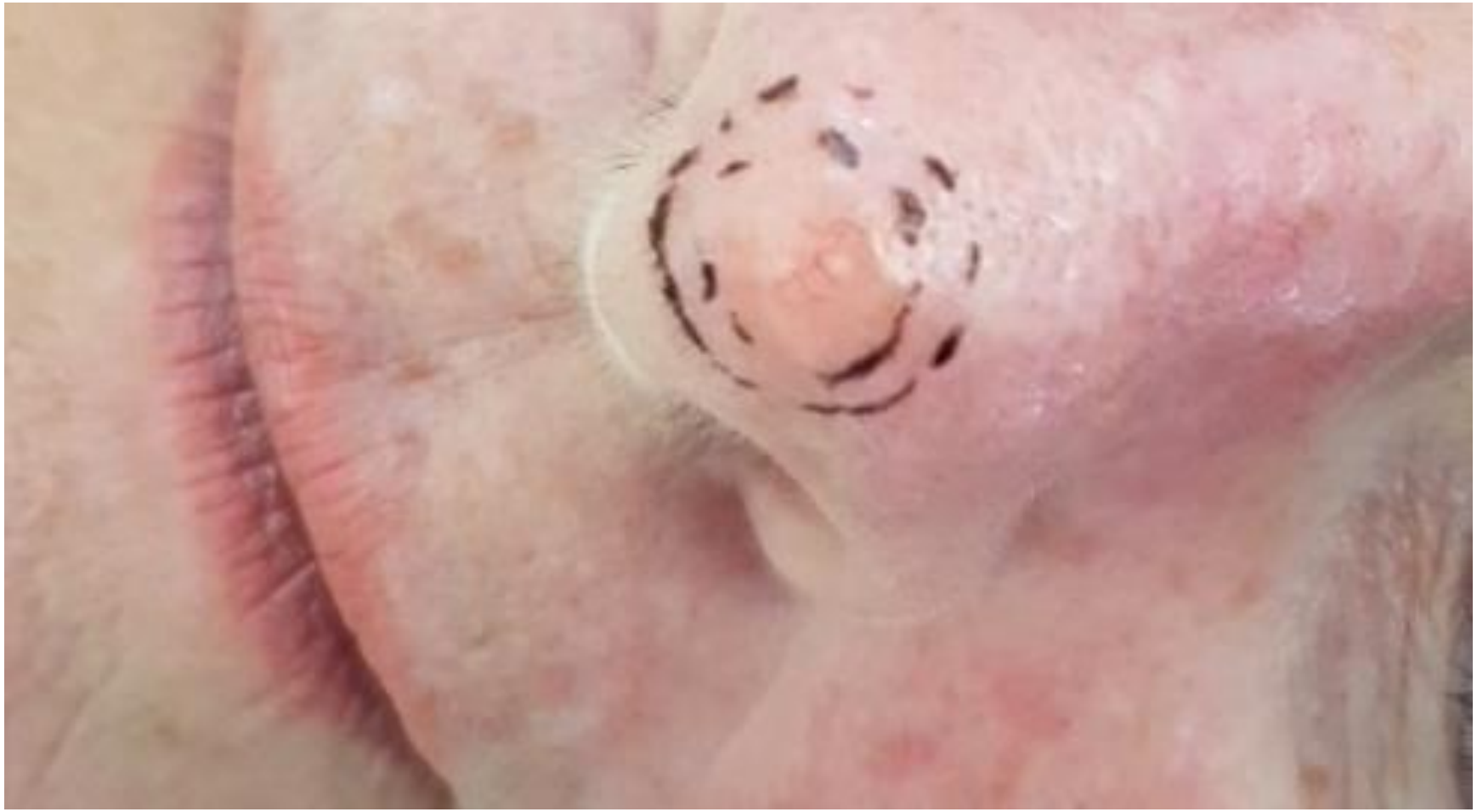
- Suspected melanoma 2mm margins

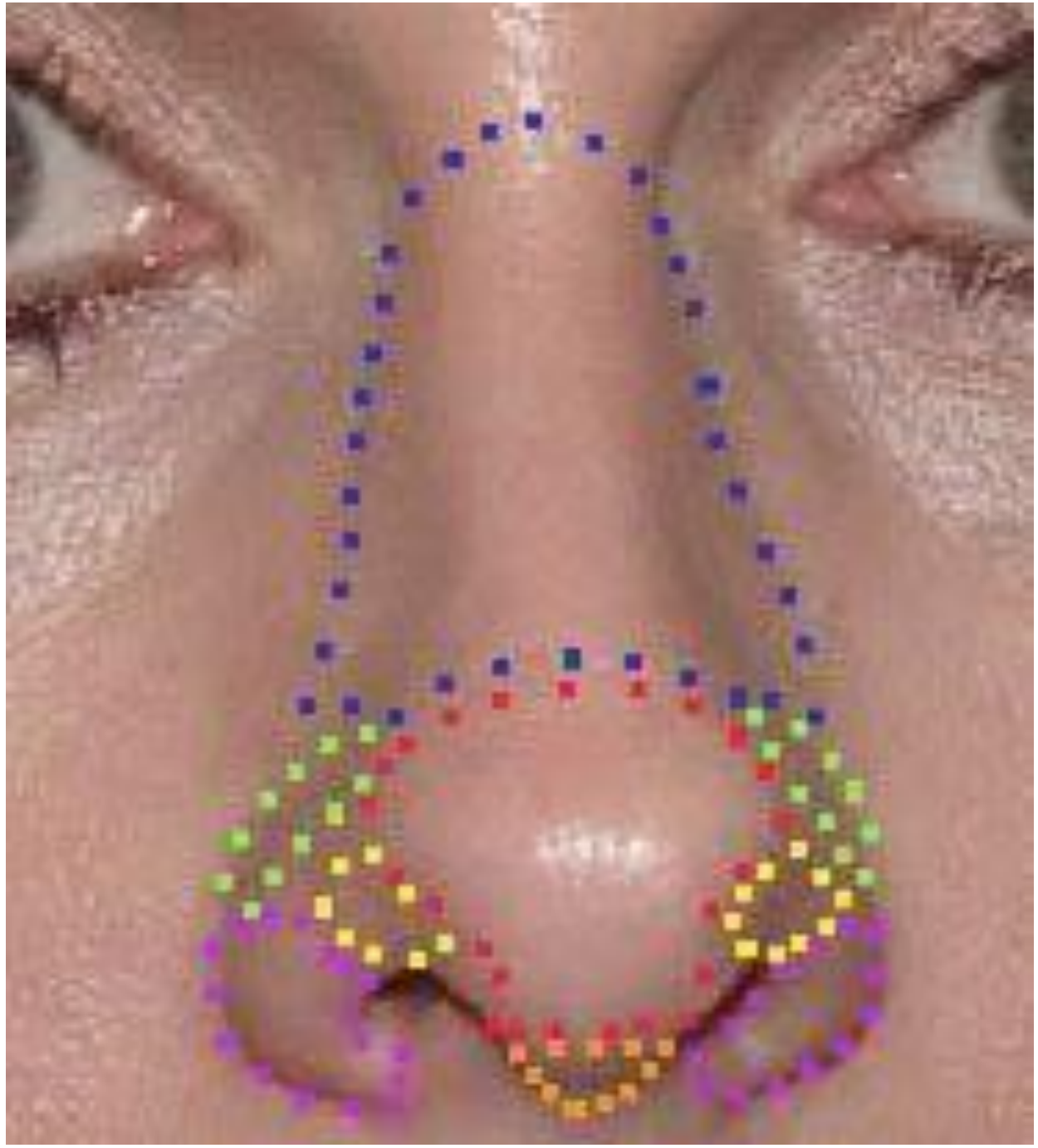
Consider referring if;

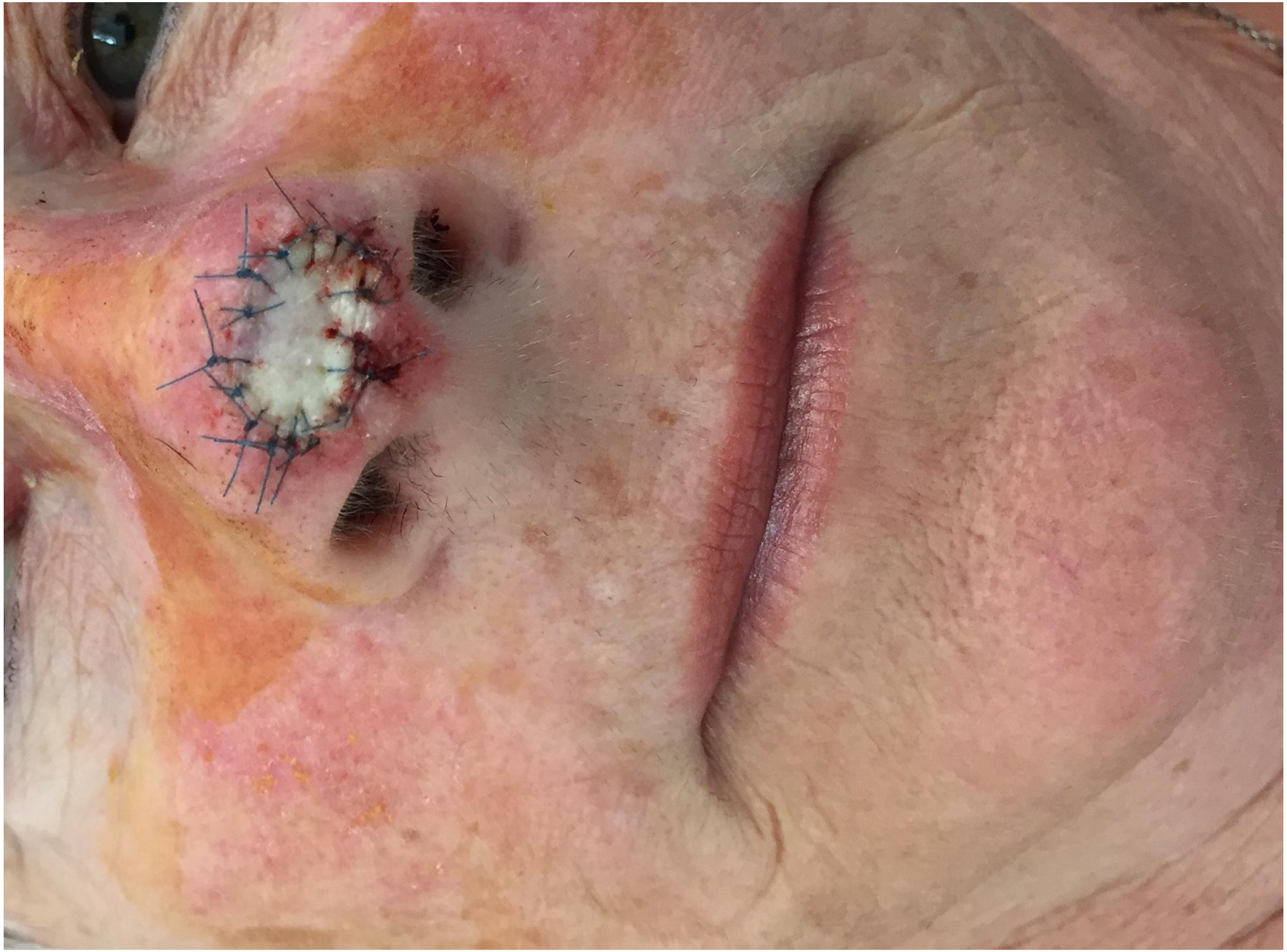
- Difficult location (face, below knee, hands) or poorly defined

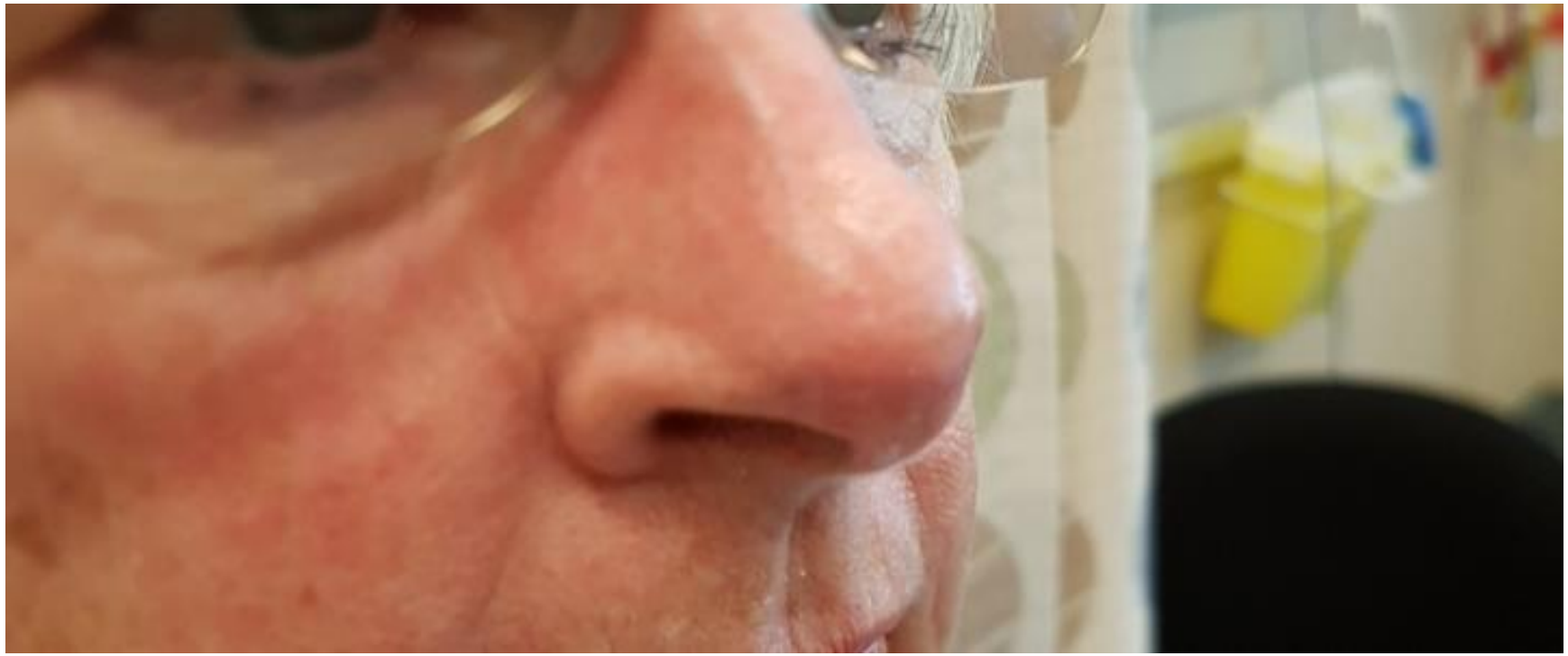
- High risk lesion: location (scalp, nose, ears, eyelids and lips), is >2cm diameter

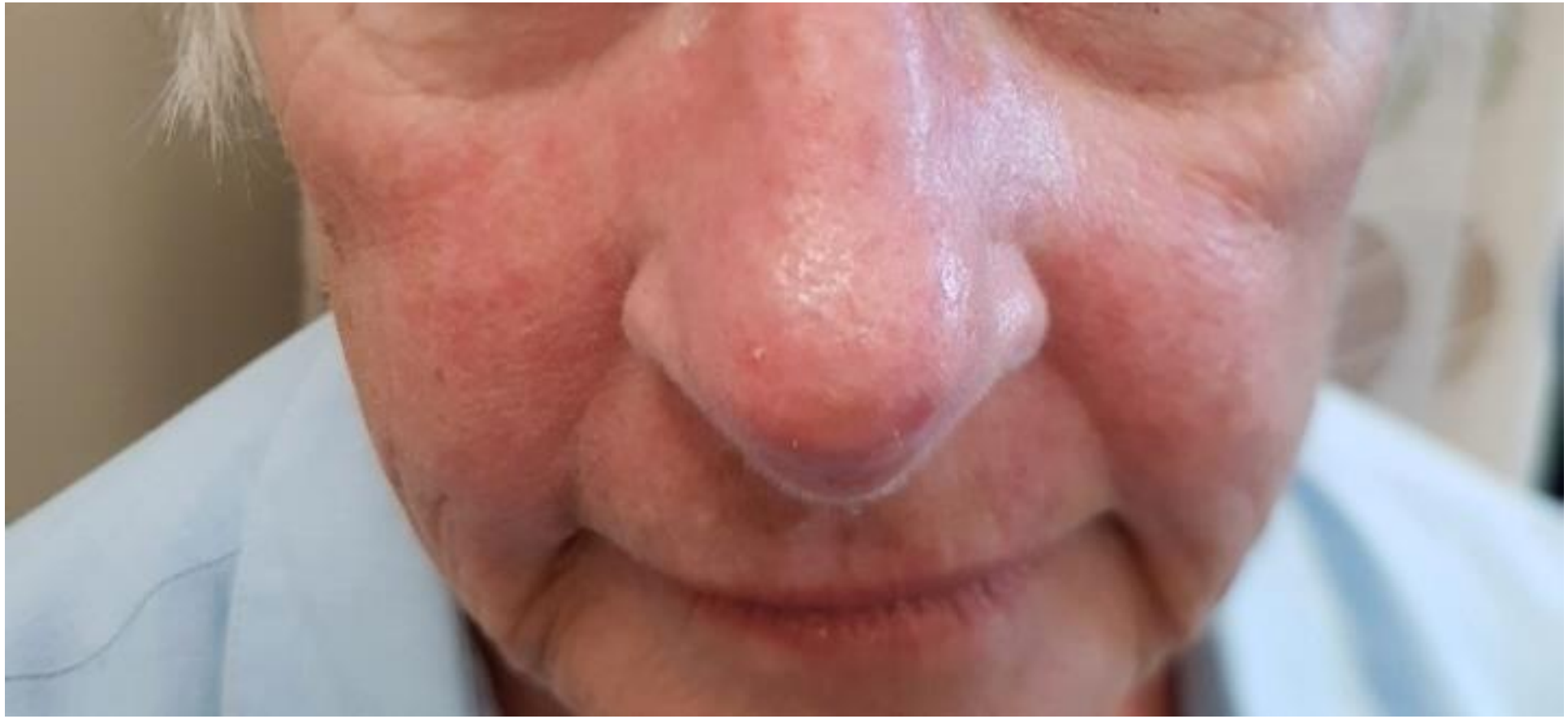
- Perineurial invasion refer for RT (47% local recurrence, and 35% local nodal involvement)

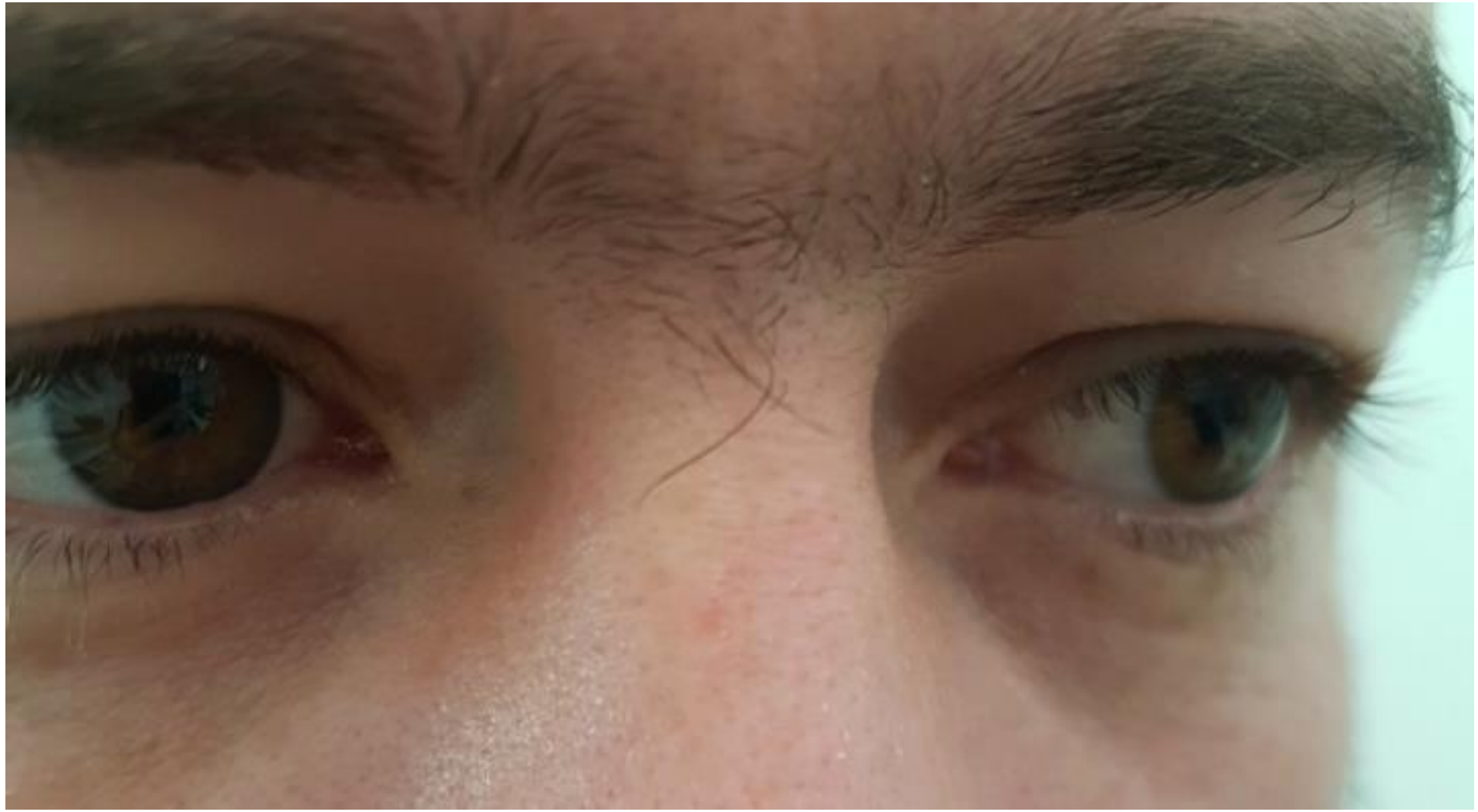


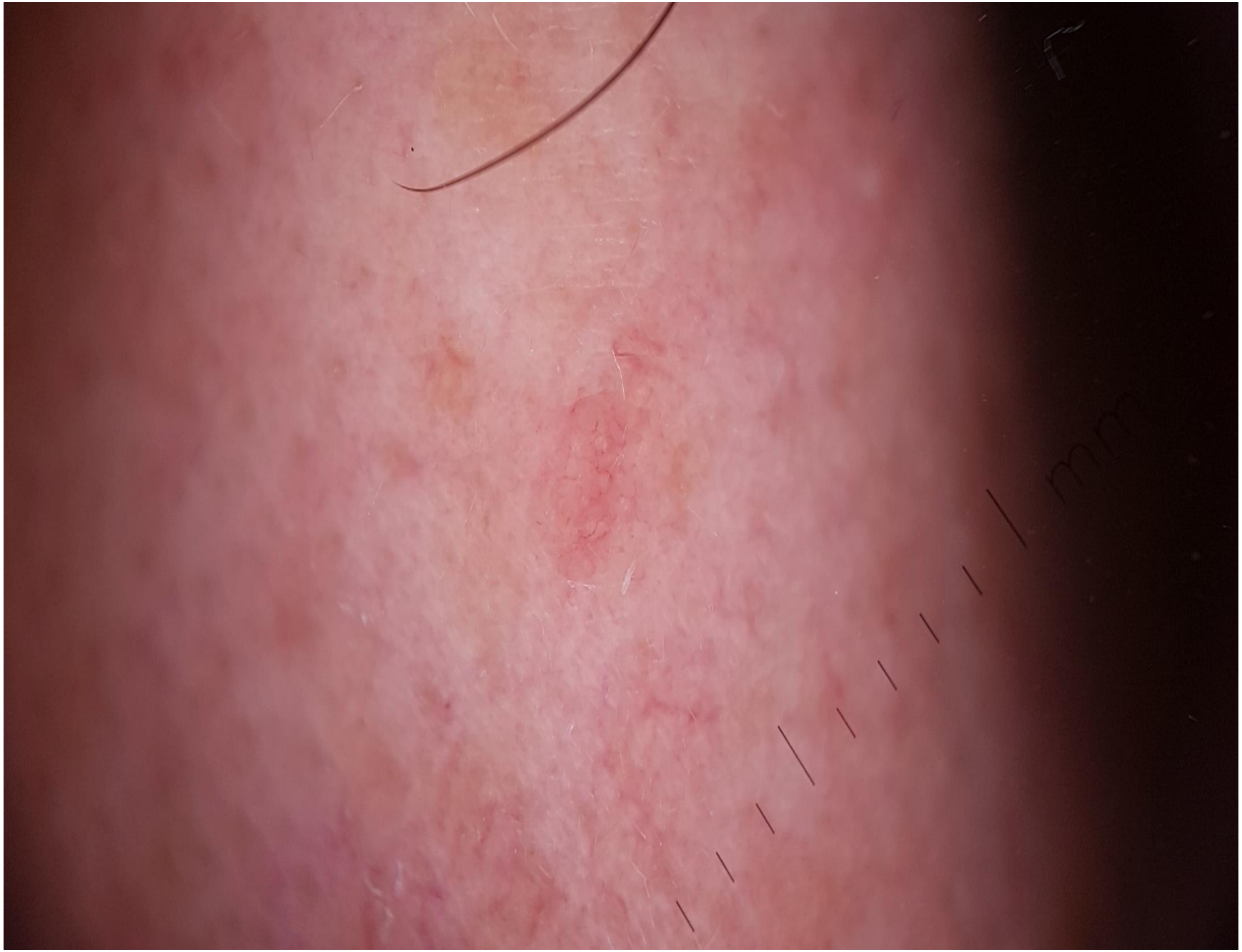












Summary

- GPs role will grow ++
- Be sure or refer
- To be sure more often….get a dermoscope and start learning
- Learn simple surgical skills (covers 90% of situations)

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