West Yorkshire & Harrogate Cancer Alliance

Guidelines for the Management of Skin Cancers

Version 4.2

October 2017
### Document Control

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<td>Author(s)</td>
<td>West Yorkshire &amp; Harrogate Skin Cancer MDT Leads</td>
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<tr>
<td>Owner</td>
<td>West Yorkshire &amp; Harrogate Cancer Alliance</td>
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#### Version Control

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<td>March 2015</td>
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<td>October 2017</td>
<td>Full review and Update</td>
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<td>4.1</td>
<td>April 2019</td>
<td>Leeds Specialist Skin Pathway &amp; Regional Specialist Skin Referral Pathway added</td>
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<td>4.2</td>
<td>June 2019</td>
<td>Update to 1.3.2. Local MDT Teams</td>
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### Contributors to current version

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<tr>
<th>Contributor</th>
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<th>Section/Contribution</th>
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<tr>
<td>Walayat Hussain</td>
<td></td>
<td>Full review and Update</td>
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<td>Sub Regional Palliative &amp; EOLC Group</td>
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<td>Trust Lead Skin Cancer Nurses</td>
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<td>Review and update of the following sections: Distribution of clinics for immunocompromised patients with skin cancer Arrangements for skin cancer in specific anatomical sites</td>
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### Contributors to previous version

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<tr>
<th>Contributor</th>
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<tbody>
<tr>
<td>Howard Peach</td>
<td></td>
<td>Melanoma Section – Page 21</td>
</tr>
<tr>
<td>Graeme Stable</td>
<td></td>
<td>Non Melanoma Section – Page 33</td>
</tr>
<tr>
<td>Will Merchant</td>
<td></td>
<td>Pathology Section 6 – Page 38 (v2.1 Aug 2010)</td>
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## ii Information Reader Box

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<tr>
<td>Author(s)</td>
<td>West Yorkshire &amp; Harrogate Cancer Alliance Skin Cancer MDT Leads</td>
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<tr>
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<td>Sign-off Date</td>
<td>October 2017</td>
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<td>Published</td>
<td>November 2017</td>
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<td>Next Review Date</td>
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<td>Proposed Target Audience for Consultation / Final Guideline</td>
<td>WY&amp;H CA Skin Cancer MDT Teams (including York)</td>
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<td>WY&amp;H CA Lead Nurses (including York)</td>
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<td>Proposed Circulation List for Final Statement</td>
<td>All WY&amp;H Cancer Alliance guidelines will be made available electronically on the website. No hard copies will be supplied.</td>
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<tr>
<td>Contact details</td>
<td>West Yorkshire &amp; Harrogate Cancer Alliance NHS Wakefield CCG</td>
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<tr>
<td></td>
<td>White Rose House</td>
</tr>
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<td></td>
<td>West Parade</td>
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<td>Wakefield</td>
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*Valid at date of publication (October 2017)*
Introduction

1.1 National Guidance for Skin Cancer

The National Institute for Clinical Excellence (NICE) ‘Guidance on Cancer Services - Improving Outcomes in People with Skin Tumours including Melanoma - The Manual 2006, lists the following key recommendations:

The main recommendations made in the IOG document are:

- Cancer networks should establish two levels of multidisciplinary Teams – local hospital skin cancer multidisciplinary teams (LSMDTs) and specialist skin cancer multidisciplinary teams (SSMDTs). All health professionals who knowingly treat patients with any type of skin cancer should be members of one of these teams, whether they work in the community or in the hospital setting.

- People with precancerous skin lesions should be either treated entirely by their GP or referred for diagnosis, treatment and follow-up to doctors working in the community who are members of the LSMDT/SSMDT. If there is any doubt about the diagnosis, people with precancerous lesions should be referred directly to their local hospital skin cancer specialist, normally a dermatologist, who is a member of the LSMDT/SSMDT. Where appropriate, follow-up of these patients may be undertaken by their own GP.

- Patients with low-risk basal cell carcinomas (BCCs) should be diagnosed, treated and followed up by doctors working in the community as part of the LSMDT/SSMDT (usually a GP with a special interest in dermatology [GPwSI]), or a local hospital skin cancer specialist, normally a dermatologist, who is a member of the LSMDT/SSMDT and to whom they have been directly referred. Where there is doubt about the lesion being low or high grade, the patient should be referred directly to the LSMDT/SSMDT.

- All patients with a suspicious pigmented skin lesion, with a skin lesion that may be a high-risk BCC, a Squamous Cell Carcinoma (SCC) or a Malignant Melanoma (MM), or where the diagnosis is uncertain, should be referred to a doctor trained in the specialist diagnosis of skin malignancy, normally a dermatologist, who is a member of either an LSMDT or an SSMDT.

- Cancer networks should ensure, through the skin cancer network site-specific group, that LSMDTs and SSMDTs work to network-wide agreed protocols for:
  - referral
  - review of patient care by the multidisciplinary team (MDT)
  - management and audit of services for precancerous lesions and skin cancer services.

- They should also ensure provision of ongoing education for all healthcare professionals about this very common group of tumours.
• The follow-up of patients after treatment should be jointly agreed between patient and doctor. After appropriate instruction, patients with low-risk disease will normally practice self-examination but follow-up may be offered in a community setting where appropriate. Patients with a high risk of recurrence of their skin cancer or of new primary cancers should normally be followed up in hospital but should still be instructed in self-examination and provided with written and photographic information.

• All patients and carers should have access to high-quality information, in an appropriate style and format, about their condition and its management and about access to relevant support services.

• Skin cancer network site-specific groups should follow protocols covering the management of high-risk groups or those with special needs such as transplant patients, those with genetic predisposition to skin cancer, patients with rare skin tumours (including cutaneous lymphoma), and children and young people.

• Data collection on skin cancer including cancer registration should be improved to adequately describe the epidemiology and service implications of the increasing incidence of skin cancer. This should be facilitated by new developments in information technology to enable more accurate and timely provision of this information.

• Commissioners of cancer services should create an infrastructure for well-conducted research to take place in order to contribute to the skin cancer evidence base in epidemiology, treatment and management.

1.2 Purpose and Scope of these Guidelines

The purpose of this document is to set out agreed clinical guidelines for the investigation and management of Skin Cancers which are based on NICE Improving Outcome Guidance for People with Skin Tumours including Malignant Melanoma.

The document describes the investigation and management of skin cancers for malignant melanoma, squamous cell carcinoma, basal cell carcinoma and rare skin including lymphoma.

The document also describes the roles of the local care teams, specialist teams and Supranetwork teams including referral pathways. The Specialist Melanoma MDT and Specialist Non Melanoma MDT are based in Leeds. A monthly Supranetwork T-Cell Lymphoma MDT has also been developed based in Leeds. All cases of nodular mycosis fungoides (stage 2B or over) should be referred to the MDT for discussion and consideration of TSEBT. Patients referred from outside of the WY&H Cancer Alliance will be discussed with colleagues by video conference. The Supranetwork T-cell Lymphoma MDT covers WY& Harrogate, SY North Derbyshire Bassetlaw and Humber Coast & Vale Cancer Alliances.
These guidelines were written by members of the former YCN Skin Cancer Site Specific Group and will be reviewed at least every three years or when new guidance is available.

1.3 Skin Cancers in West Yorkshire & Harrogate Cancer Alliance

The West Yorkshire & Harrogate Cancer Alliance (WY&H CA) has a resident population of approximately 2.6 million and there are 11 Clinical Commissioning Groups and 6 Acute Hospital Trusts within the Network. The Cancer Centre is based at Leeds Teaching Hospitals NHS Trust

1.3.1 Network Teams

The composition of local, specialist and Supranetwork skin cancer teams is as follows:

1.3.2 Local MDT Teams

Calderdale & Huddersfield NHS Foundation Trust                      MDT Lead  Dr C Hutchinson
Harrogate & District Foundation Trust                                MDT Lead  Dr B Walker
Bradford Teaching Hospitals NHS Trust                               MDT Lead  Dr A Wright
Mid Yorkshire Hospitals NHS Trust                                   MDT Lead  Dr D Fairhurst
York Teaching Hospitals NHS Foundation Trust                        MDT Lead  Dr A Muinonen-Martin
                                                                   Mr N Brown
                                                                   (from 17.7.2019)

*Please note that the York Teaching Hospitals NHS Foundation Trust is now part of the Humber Coast and Vale Cancer Alliance. However, patients from the York Local Skin MDT are referred into the Leeds Specialist MDTs.

1.3.3 Specialist Teams

Leeds Teaching Hospitals NHS Trust (Melanoma) MDT Lead  Mr H Peach
Leeds Teaching Hospitals NHD Trust (Non Melanoma) MDT Lead  Dr G Stables

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<thead>
<tr>
<th>Hospital Trust</th>
<th>Local/Specialist MDT Team</th>
<th>MDT Lead</th>
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<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>Leeds (St James’s University Hospital) Melanoma Specialist MDT</td>
<td>Mr H Peach</td>
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<td></td>
<td>Leeds (LGI) Non Melanoma Specialist MDT</td>
<td>Dr W Hussain</td>
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Supranetwork Skin Lymphoma MDT
Supranetwork Skin Lymphoma MDT (based at Leeds) MDT Lead is Dr P Laws

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<td>NHS Trust</td>
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1.4 Referral Guidelines between Teams

The Yorkshire Cancer Network has:

- 5 Local Multidisciplinary Skin Cancer Teams who cover the secondary care of patients who are classed as care levels 1, 2, 3 and 4
- 2 Specialist Multidisciplinary Skin Cancer Teams who cover patients who are classed as levels 5
- Supranetwork Skin Lymphoma MDT established. This MDT will cover patients who are classed as level 6

Referral guidelines between LMDTs and the two SMDTs (Melanoma and Non-Melanoma based in Leeds) have been agreed in line with the following listed in the IOG for People with Skin Tumours including Melanoma,

Patients discussed at the LSMDT are as follows:-

- All patients with SCCs or high-risk BCCs that involve the excision margins or are recurrent
- All patients with MM – primary, recurrent and metastatic
- Patients suitable for Mohs’ surgery
- Patients with skin lesions of uncertain but possible malignant nature
- Cases for nodal dissection including sentinel node biopsy (SNB)
- Immunocompromised patients with skin cancers and patients who have Gorlin’s syndrome or other genetic conditions in which predisposition occurs
- Patients with rare skin cancers (including lymphoma)
- Patients for whom there is a discrepancy between the clinical diagnosis and histopathology report

The following patients are to be referred to the SSMDTs at Leeds Teaching Hospitals;

- Patients with high-risk SCCs that pose difficulty in management
- Patients with MM managed by other site specialist teams Gynaecological, mucosal and head and neck (excluding ocular)
• Patients with newly diagnosed melanoma stage 1B or higher who are eligible for sentinel node biopsy (SNB)
• Patients with MM stage 1 or above who are eligible for clinical trials that have been approved at cancer network level
• Patients with multiple MM
• Children younger than 19 years with MM
• Any patient with metastatic MM or SCC diagnosed at presentation or on follow-up
• Patients with giant congenital naevi where there is suspicion of malignant transformation
• Patients with BCCs that are metastatic
• Patients with malignant skin lesions of uncertain pathological diagnosis,
• Patients with rare skin cancers, including lymphoma and sarcoma

• For periodic review, patients developing skin cancers who are immunocompromised, have Gorlin's syndrome or other genetic predisposition syndromes
• Patients needing nodal dissection including sentinel lymph node biopsy (SNB) – these patients should be seen and referred by the LSMDT
• Patients who may benefit from radiotherapy, if not available at the LSMDT
• Patients who may be eligible for entry into clinical trials
• Patients who require adjuvant treatment (where this is shown to be beneficial)

1.5 Patient flows between West Yorkshire Cancer Alliance and the Humber Coast & Vale Cancer Alliance

York Hospitals NHS Trust’s relationship with the Scarborough General Hospital MDT

Please note that since 1 July 2012 Scarborough and Bridlington Hospitals were managed by York Teaching Hospital NHS Foundation Trust.

Scarborough & North East Yorkshire Healthcare NHS Trust provides local and diagnostic skin cancer services for the population of Scarborough, Whitby & Ryedale. Due to geography & patient choice, patients from North Yorkshire and York and East Riding of Yorkshire can flow into services based within two Cancer Alliances.

A Local Skin MDT at Scarborough was established in April 2010. Patients from Scarborough are seen in an outreach service by Dermatologists from York Hospitals NHS Trust. The patients are then discussed at the MDT, which is held fortnightly via video conferencing between Scarborough General Hospital & York Hospitals NHS Trust. Patients requiring onward referral to a specialist MDT are referred to Hull, Leeds or York depending on the type of cancer and anatomical site.
1.6 Skin Cancer Clinical Pathways

The former YCN Skin Cancer NSSG developed and reviewed the following pathways for the diagnosis and management of skin cancer and individual localities are working towards achieving these pathways. The pathways include the elements of the YCN Supportive Care Pathway developed in line with the NICE Supportive and Palliative Care Improving Outcomes Guidance:

- Non-Melanoma Network Pathway
- Melanoma Network Pathway
- Organ transplant patient (OTP) with Suspected Skin Cancer Pathway for Adults. This pathway refers to renal, liver or cardiac organ transplants.
- Referral to Teenagers and Young Adult Cancer Service (TYAS) Skin Cancer Network Pathway
- Former YCN, HYCCN and NTCN Supranetwork Skin Lymphoma Referral Pathway

1.7 Patient Information

Clinical teams offer all newly diagnosed cancer patients information specific to their site, treatment and relevant to their individual need. Patients can also access NHS choices for an information prescription and clinical teams will offer help to do this, if required.

1.8 Locality Skin Cancer CNS to Leeds Melanoma CNS Pathway

A locality Skin Cancer CNS to Leeds Melanoma CNS pathway was developed by the former YCN Skin Cancer Nurses, in order to aid co-ordination of the care of patients between the cancer units and the cancer centre. Please see pathway overleaf.
Diagnosis of Malignant Melanoma

Patient managed locally

Less than 1mm Stage 1A

1mm or thicker

Less than 1mm Stage 1B to be discussed with SMDT

Following diagnosis patient seen by locality Skin Cancer CNS or contacted by phone/letter.

Offer patient Sentinel Node Biopsy information and the Leeds Trust ‘Melanoma Team who we are’ leaflet

Following patient contact/discussion local Skin CNS to contact Leeds Melanoma CNS with any relevant information e.g. if holistic assessment has been carried out and what patient information has been given

To send Melanoma CNS a copy of the holistic assessment if already carried out

Local CNS stays the key worker until Sentinel Node Biopsy (SNB) results known. This is with support from the Leeds Melanoma CNS

Positive SNB

Patient with stage 3 and 4 plus other appropriate patients e.g. patients in adjuvant clinical trials will be followed up in Leeds

Decision about follow up will be written on the Leeds Specialist MDT form and available on PPM

Following MDT meeting Leeds Melanoma CNS to contact the local Skin Cancer CNS and confirm that the patient will continue follow up at Leeds.

Leeds Melanoma CNS will become the key worker with support from the local skin CNS in line with the local supportive and palliative care pathway

Negative SNB

Patient discussed in the Melanoma MDT and a decision about where the follow up will be taken.

Decision about follow up will be written on the Leeds Specialist MDT Form and available on PPM

Following MDT meeting Leeds Melanoma CNS to contact the local Skin CNS and discuss the MDT decision with timescales about when patient should be followed up locally

Local Skin CNS to stay the key worker with support from Leeds Melanoma CNS, in line with the local supportive and palliative care pathway

WY&H Cancer Alliance Skin Cancer CNS to Leeds Melanoma CNS Pathway

Agreed and Updated October 2013 (Reviewed May 2017)

Less than 1mm Stage 1B to be discussed with SMDT

Valid at date of publication (October 2017)
1.9 Supranetwork Skin Lymphoma MDT

Background
Within the NICE Improving Outcome for People with Malignant Melanoma is a recommendation to have a Supranetwork Multi-Disciplinary Team for Skin Lymphoma that Specialist Commissioning Groups should designate. Skin Lymphomas are rare and complex in diagnosis because of the service overlap with haematology. There are approximately 300 new cases of cutaneous lymphoma annually in the UK.

Background to Supranetwork Skin Lymphoma MDT

A monthly Supranetwork Skin Lymphoma MDT has been developed based in Leeds. The MDT will discuss as requested any patients with lymphoma localised to the skin. All patients with cutaneous T cell lymphoma (stage 2B or over) should be referred to the MDT to allow discussion of treatment options, including TSEBT. Patients referred from outside of the Cancer Alliance will be discussed with colleagues by video conference. The Supranetwork Skin Lymphoma MDT covers the former YCN, North Trent Cancer Network and Humber and Yorkshire Coast Cancer Network.

The aim of the Supranetwork MDT is:

- To review patients with lymphoma localised to the skin
- To provide help with diagnosis in patients where this is difficult including histopathology review
- Apply uniform treatment strategies across the networks in compliance with agreed network guidance
- Collect information on management of patients across the networks
- Ensure patients receive treatment as near to home as possible
- Document diagnosis and stage for patients
- Encourage entry of patients in to trials where necessary
- Provide advice on implementation of new therapies

Supranetwork Skin Lymphoma MDT Operating Policy

The Supranetwork Skin Lymphoma MDT commenced on 3rd March 2010 and takes place on the second Wednesday of each month in Leeds. The Supranetwork Skin Lymphoma Multidisciplinary Team has an Operating Policy, which outline's the referral pathway and the MDT's membership.

The Skin Lymphoma MDY Operating Policy is available on line from the West Yorkshire & Harrogate Cancer Alliance

Supranetwork Skin Lymphoma Clinical Pathway

A referral to Supranetwork Skin Lymphoma Clinical Pathway between the former YCN, HYCCN and NTCN pathway was agreed by all 3 Network Boards and is included in the Leeds Skin Lymphoma MDT Operating Policy.
1.10 Referral for photopheresis

All cases of erythrodermic cutaneous T-cell lymphoma, stages 3 and 4, having both skin involvement and the same circulating clonal T-cells will be discussed at the MDT meeting, where a decision is made to seek an opinion for consideration of treatment by photopheresis to the Supranetwork MDT. Individual cases will then be discussed with a clinician from the photopheresis department at Rotherham prior to referral.

1.11 Referral for Total Skin Electron Beam Therapy (TSEBT)

Patients with mycosis fungoides (stages 1b, 2a, 3 or 4) may be appropriate for TSEBT. Most cases of 1b and 2a will have failed skin directed therapies prior to consideration of TSEBT. It is anticipated that most relevant patients appropriate for TSEBT will have already been referred in to the skin lymphoma service. Where this is not the case the patient should be referred to Dr D Gilson, Bexley wing, St James' Hospital and reviewed in Supranetwork MDT.
1.12 Distribution of clinics for immunocompromised patients with skin cancer

Currently in the Yorkshire Cancer Network there are no dedicated immunocompromised clinics held for patients with skin cancer but there are dedicated slots for such patients in MDT skin cancer clinics - as shown in the table below:

Table updated October 2017

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<th>Frequency of Clinic</th>
<th>Location of Out-Patient Clinic (hospital site)</th>
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<td>Derm Skin Cancer Cons.2</td>
<td>2</td>
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<td>St Luke’s</td>
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<td>(combined skin cancer clinic)</td>
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<tr>
<td>Calderdale &amp; Huddersfield</td>
<td>Yes</td>
<td>Dr N Tyrogalas Thursday CRH</td>
<td>1 clinic slot per consultant per week</td>
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Any Airedale skin cancer patient with an organ transplant is diagnosed and followed up in the Bradford dedicated immunocompromised patient slots at St Luke’s Hospital (as below)

In addition, the NSSG have agreed a Network Pathway for Organ Transplant Patients (OTP) with Suspected Skin Cancer for Adults Network pathway. The lead for this pathway is Dr G Stables. The pathway refers to renal, liver or cardiac organ transplants.
1. **Arrangements for skin cancer in specific anatomical sites**

**Updated October 2017**

The LSMDTs and SMDTs within West Yorkshire & Harrogate Cancer Alliance have the following referral arrangements in place.

- **Patients with head and neck skin cancer (08-1A-212)**

Below are the named MDTs for specified clinical situations and part of the patient pathway agreed by the Skin Cancer MDT Leeds

Patients referred to the skin MDT with:
- oral and nasal mucosal melanoma
- ocular mucosal melanomas
- periocular skin cancers
- other head and neck skin cancer

<table>
<thead>
<tr>
<th>Trust</th>
<th>Referral Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Trust</td>
<td>Refer to the skin cancer MDT at Bradford.</td>
</tr>
<tr>
<td>Bradford Teaching Hospitals</td>
<td>Discuss in the Skin Cancer MDT. Refer to Head and Neck SSMDT Bradford in accordance with stage of disease.</td>
</tr>
<tr>
<td>Calderdale &amp; Huddersfield</td>
<td>Refer onto MDT at Bradford – skin cancers are discussed at CHFT - for specialist opinion refer onto the Leeds &amp; Mid Yorkshire MDT</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals NHS Trust</td>
<td>Refer to Head and Neck MDT - Mid Yorks holds joint MDT meeting with Leeds.</td>
</tr>
<tr>
<td>Leeds Non Melanoma</td>
<td>Refer to Head &amp; Neck MDT (Lead - Mr T K Ong) if required.</td>
</tr>
<tr>
<td>Leeds Melanoma</td>
<td>Refer to Head &amp; Neck MDT (Lead - Mr T K Ong) if required.</td>
</tr>
<tr>
<td>Harrogate and District NHS Trust</td>
<td>Discuss at HDFT Skin MDT with Mr Holt and refer on to the York Head &amp; Neck MDT.</td>
</tr>
<tr>
<td>York Hospitals NHS Foundation Trust</td>
<td>Discuss in the Skin Cancer MDT. Refer to Head &amp; Neck MDT accordance with stage of disease (Lead - Mr A Coatesworth). All melanomas for specialist opinion refer to Leeds, Hull or Middlesborough SMDT depending on address and patient preference.</td>
</tr>
</tbody>
</table>

Pathology confirmed

**Local/Specialist Skin MDT**

Harrogate, Mid Yorkshire, Calderdale, Bradford, York, Leeds

Discuss patient and refer to Specialist Head & Neck MDT.

**Specialist Head and Neck MDT**

Leeds & Mid Yorkshire, Bradford, York for discussion and management plan

MDT Lead (Leeds & Mid Yorkshire) Mr T K Ong
DT Lead (Bradford) Mr C Bem DT Lead (York) Mr A Coatesworth

Any MM>1mm refer to Leeds Specialist Melanoma MDT for MDT discussion, in parallel with referral to Head & Neck Specialist MDT
- **Patients with anal and peri-anal skin cancer (08-1A-213j)**

Below are the named MDTs for specified clinical situations and part of the patient pathway agreed by the Skin Cancer MDT Leads

For patients with anal and peri-anal cancer

<table>
<thead>
<tr>
<th>Trust/ Foundation Trust</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Trust</td>
<td>Refer to the Leeds cancer centre via the colorectal MDT at Airedale.</td>
</tr>
<tr>
<td>Bradford Teaching Hospitals NHS Foundation Trust</td>
<td>Discuss at Skin Cancer MDT. Refer to Colorectal MDT Bradford. Anal cancers are referred to Leeds Cancer Centre.</td>
</tr>
<tr>
<td>Calderdale &amp; Huddersfield NHS Foundation Trust</td>
<td>Discuss at colorectal MDT at CHFT – for specialist opinion refer onto Leeds</td>
</tr>
<tr>
<td>Mid Yorkshire Hospital NHS Trust</td>
<td>Refer to the Colorectal/lower GI MDT (Mr M Rodgers). Anal cancers are referred on to Leeds.</td>
</tr>
<tr>
<td>Leeds Non Melanoma</td>
<td>Refer to Colorectal MDT Lead (Mr Rick Saunders) - LGI</td>
</tr>
<tr>
<td>Leeds Melanoma</td>
<td>Refer to Colorectal MDT Lead (Mr Rick Saunders) - LGI</td>
</tr>
<tr>
<td>Harrogate and District NHS Foundation Trust</td>
<td>Discuss at GI MDT at HDTF – Lead Mr Leinhardt. Anal cancers then referred to Leeds Cancer Centre.</td>
</tr>
<tr>
<td>York Hospitals NHS Foundation Trust</td>
<td>Discussed at the colorectal or skin MDT. Anal cancers are referred to the Leeds Cancer Centre. In Scarborough discussed at the colorectal MDT meeting and referred to the specialist MDT in Hull (Lead Dr Dhadda).</td>
</tr>
</tbody>
</table>

Pathology confirmed. Primary discussion may be undertaken by Colorectal Surgeon, depending on patient symptoms when referred.

- **Colorectal MDT** Harrogate, Mid Yoraks, Calderdale, Bradford, York, Leeds, Airedale
  
  Discuss patient and refer to Leeds Colorectal MDT for specialist opinion on anal cancers. If skin cancer is melanoma >1mm referral also made to Specialist Melanoma MDT.

- **Local/Specialist Skin MDT** Harrogate, Mid Yoraks, Calderdale, Bradford, York, Leeds
  
  Discuss patient and refer to Local Colorectal MDT (except Leeds who refer directly to Leeds Colorectal MDT)

- **Leeds Colorectal MDT** (Anal patients discussed at end section of the MDT)
  
  For discussion and management plan (MDT Lead – Mr R Saunders)

If the skin cancer is a malignant melanoma >1mm refer to Leeds Specialist Melanoma MDT for MDT discussion regarding any adjuvant treatment etc., in parallel with referral to Colorectal MDT for patient management plan.
- Patients with skin cancer of external female genitalia (08-1A-214j)

Below are the named MDTs for specified clinical situations and part of the patient pathway agreed by the Skin Cancer MDT Leads

For patients with cancer of the external female genitalia, including mucosal melanoma

<table>
<thead>
<tr>
<th>Airedale NHS Trust</th>
<th>Refer to the Leeds cancer centre via the Airedale gynaecology MDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford Teaching Hospitals NHS Foundation Trust</td>
<td>Discuss skin MDT, refer to Leeds cancer centre via the Bradford gynaecology MDT.</td>
</tr>
<tr>
<td>Calderdale &amp; Huddersfield NHS Foundation Trust</td>
<td>Discuss at obs &amp; gyne MDT at CHFT – for specialist opinion refer onto Leeds</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals NHS Trust</td>
<td>Discuss at Mid Yorks MDT. Refer to the Gynaecology MDT (Mr Sharma)</td>
</tr>
<tr>
<td>Leeds Non Melanoma</td>
<td>Refer to Gynaecology MDT Lead (Dr Tim Perren) - SJUH</td>
</tr>
<tr>
<td>Leeds Melanoma</td>
<td>Refer to Gynaecology MDT Lead (Dr Tim Perren) - SJUH</td>
</tr>
<tr>
<td>Harrogate and District NHS Foundation Trust</td>
<td>Refer to Gynaecology MDT at HDFT – Lead Miss T Jackson</td>
</tr>
<tr>
<td>York Hospitals NHS Foundation Trust</td>
<td>Patients discussed at the Gynae or skin MDT as appropriate and referred for specialist opinion Refer to Mr W Hunter at York, or Mrs. Ramaswamy at Scarborough / Hull as appropriate.</td>
</tr>
</tbody>
</table>

Pathology confirmed

Local/Specialist Skin MDT
Harrogate, Mid Yorks, Calderdale, Bradford, York, Leeds
Discuss patient and refer to Local Gynaecology MDT (except Leeds who refer directly to Leeds Gynaecology MDT)

Any MM>1mm refer to Leeds Specialist Melanoma MDT for MDT discussion, in parallel with referral to Gynaecology MDT

Local Gynaecology MDT
Harrogate, Mid Yorks, Calderdale, Bradford, York, Airedale
Discuss patient and refer to Leeds Gynaecological Specialist MDT as per Cancer Alliance guidelines (All vulva cancers to Leeds)

Leeds Cancer Centre Gynaecological Oncology Specialist MDT
For discussion and management plan MDT Lead – Mr T Perren
- Patients with skin cancer of external male genitalia (08-1A-215j)

Below are the named MDTs for specified clinical situations and part of the patient pathway agreed by the Skin Cancer MDT Leads

For patients with cancer of the external male genitalia, including mucosal melanoma

<table>
<thead>
<tr>
<th>Trust</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Trust</td>
<td>Refer to the Airedale urological MDT and penile cancers are then sent to the Leeds cancer centre – Mr I Eardley</td>
</tr>
<tr>
<td>Bradford Teaching Hospitals NHS Trust</td>
<td>Discuss at skin MDT; refer to Urology Specialist MDT at Bradford. Penile cases refer to penile MDT (Mr Eardley) – St James</td>
</tr>
<tr>
<td>Calderdale &amp; Huddersfield NHS Trust</td>
<td>Discuss at urology MDT at CHFT – then refer onto Bradford for specialist opinion. Leeds for chemotherapy and radiotherapy</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals NHS Trust</td>
<td>Discuss at Mid Yorks Skin MDT. Refer to the urology MDT (Mr Weston) then to Mr I Eardley - SJUH</td>
</tr>
<tr>
<td>Leeds Non Melanoma</td>
<td>Refer to Penile MDT Lead (Mr Ian Eardley) - SJUH</td>
</tr>
<tr>
<td>Leeds Melanoma</td>
<td>Refer to Penile MDT Lead (Mr Ian Eardley) - SJUH</td>
</tr>
<tr>
<td>Harrogate and District NHS Trust</td>
<td>Refer to SJUH penile MDT – Lead Mr Ian Eardley</td>
</tr>
<tr>
<td>York Hospitals NHS Foundation Trust</td>
<td>Discussed at skin or urology MDT as appropriate. Refer penile cases to SJUH penile MDT – Lead Mr Ian Eardley Department</td>
</tr>
</tbody>
</table>

Pathology confirmed

Local / Specialist Skin MDT
Harrogate, Mid Yorks, Calderdale, Bradford, York, Leeds
Discuss patient and refer to Local Urology MDT or directly to Leeds

Any MM>1mm refer to Leeds Specialist Melanoma MDT for MDT discussion, in parallel with referral to Urology MDT

Local / Specialist Urology MDT
Harrogate, Mid Yorks, Calderdale, Bradford, York, Leeds, Airedale
Discuss patient and refer to Leeds Supranetwork Penile SMDT for specialist opinion if penile cancer

Leeds Supranetwork Penile Specialist MDT
For discussion and management
(Lead Mr I Eardley)

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V 4.1
Valid at date of publication (October 2017)
- Patients with lymphoma involving the skin (08-1A-216j)

Below are the named MDTs and the clinical indications for referral agreed by the Skin Cancer MDT Leads

For patients with systemic/nodal lymphomas presenting in the skin, or primary cutaneous lymphoma

<table>
<thead>
<tr>
<th>Trust/MDT Name</th>
<th>Referral Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale NHS Trust</td>
<td>Refer to the Bradford and Airedale Haematology MDT (Dr D Gilson is a core member) and then to the Leeds Cancer Centre Specialist Lymphoma MDT for opinion.</td>
</tr>
<tr>
<td>Bradford Teaching Hospitals NHS Foundation Trust</td>
<td>Discuss at skin MDT. Refer to the Bradford and Airedale Haematology MDT (Dr Gilson is a core member) and then to the Leeds Cancer Centre Specialist Lymphoma MDT for an opinion.</td>
</tr>
<tr>
<td>Calderdale &amp; Huddersfield NHS Foundation Trust</td>
<td>Referred directly to the Leeds Cancer Centre Specialist Lymphoma MDT for opinion (CHFT haematology are core members of this MDT).</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals NHS Trust</td>
<td>Discuss at Mid Yorks Skin MDT. Refer to the Leeds Cancer Centre Specialist Lymphoma MDT for opinion.</td>
</tr>
<tr>
<td>Leeds Non Melanoma</td>
<td>Refer to the Leeds Cancer Centre Specialist Lymphoma MDT</td>
</tr>
<tr>
<td>Leeds Melanoma</td>
<td>Refer to the Leeds Cancer Centre Specialist Lymphoma MDT</td>
</tr>
<tr>
<td>Harrogate and District NHS Foundation Trust</td>
<td>Refer to HDFT skin cancer MDT and on to the Leeds Cancer Centre Specialist Lymphoma MDT for opinion.</td>
</tr>
<tr>
<td>York Hospitals NHS Foundation Trust</td>
<td>Refer to the Leeds Cancer Centre Specialist Lymphoma MDT.</td>
</tr>
</tbody>
</table>

Pathology confirmed

Local/Specialist Skin MDT
Harrogate, Mid Yorks, Calderdale, Bradford, York, Leeds
Discuss patient and refer to Local Haematology MDT or directly to Leeds. (For mycosis fungoides stage 2B or over refer to Supranetwork Skin Lymphoma MDT)

Local/Specialist Haematology MDT
Mid Yorks, Bradford, York, Airedale, Harrogate
Discuss patient and refer to Leeds Haematology MDT for specialist opinion

Leeds Specialist Haematology Lymphoma MDT
For discussion and management
(Lead Dr P Laws)
All cases of mycosis fungoides (stage 2B or over) to be referred to the Supranetwork Skin Lymphoma MDT.

Supranetwork Skin Lymphoma MDT
Leeds
The MDT takes place on the second Wednesday of every month at Leeds (St James's hospital)
(Lead for Supranetwork Skin Lymphoma MDT is Dr P Laws)

Any MM>1mm refer to Leeds Specialist Melanoma MDT for MDT discussion, in parallel with referral to Haematology MDT
• Patients with sarcoma involving the skin (08-1A-217j)

Below are the named MDTs for specified clinical situations and parts of the patient pathway agreed by the Skin Cancer MDT Leads

For patients with sarcomas involving the skin

<table>
<thead>
<tr>
<th>Airedale NHS Trust</th>
<th>Refer to the Leeds sarcoma MDT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford Teaching Hospitals NHS Foundation Trust</td>
<td>Discuss at Skin Cancer MDT. Refer to the Leeds Sarcoma MDT (Lead Mr K Horgan). Head and Neck Skin Sarcomas refer in parallel to Bradford Head &amp; Neck MDT (Lead Mr C Bem)</td>
</tr>
<tr>
<td>Calderdale &amp; Huddersfield NHS Foundation Trust</td>
<td>Refer to the Leeds Sarcoma MDT (Lead Mr K Horgan). Head and Neck Skin Sarcomas refer in parallel to Bradford Head &amp; Neck MDT (Lead Mr D Sutton)</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals NHS Trust</td>
<td>Refer to Leeds Sarcoma MDT (Mr K Horgan). Head and Neck Skin Sarcomas refer in parallel to joint Leeds and Mid Yorkshire Head and Neck MDT (Mr T K Ong).</td>
</tr>
<tr>
<td>Leeds Non Melanoma</td>
<td>Refer to Sarcoma MDT Leeds (Mr Horgan) – LGI. Head and Neck Skin Sarcomas refer in parallel to joint Leeds and Mid Yorkshire Head and Neck MDT (Mr T K Ong)</td>
</tr>
<tr>
<td>Leeds Melanoma</td>
<td>Refer to Sarcoma MDT Lead (Mr K Horgan) - LGI</td>
</tr>
<tr>
<td>Harrogate and District NHS Foundation Trust</td>
<td>Refer directly to the Leeds Sarcoma MDT – Lead Mr K Horgan. Head and Neck Skin Sarcomas refer in parallel to York Head &amp; Neck MDT (Lead Mr P Whittfield)</td>
</tr>
<tr>
<td>York Hospitals NHS Foundation Trust</td>
<td>Refer directly to the Leeds Sarcoma MDT Mr K. Horgan). Neck MDT (Lead Mr A Coatesworth)</td>
</tr>
</tbody>
</table>

Pathology confirmed

Local/Specialist Skin MDT Harrogate, Mid Yorks, Calderdale, Bradford, York, Leeds

Discuss patient and refer to the Leeds Sarcoma SMDT

Leeds Sarcoma SMDT

For discussion and management (MDT Lead – Mr K Horgan)

(soft tissue sarcoma of the head & neck surgery undertaken by core member of the Bradford, York or Leeds & Mid Yorks H&N MDT teams)
3. Referral Guidelines to the Leeds Specialist MDT (Melanoma Unit)

3.1 Introduction

Referral guidelines were established by the Network in 1996 as part of the Network Melanoma Guideline. The agreed referral pathways were developed on the basis of the availability of expertise and entry criteria for adjuvant trials at that time.

These guidelines need to be reviewed in light of the IOG and the UK guidelines for the management of cutaneous melanoma. The IOG recommendations require each network to have a robust and transparent patient pathway for referral and management of each individual patient, which addresses their specific issues and requirements. These guidelines aim to address the responsibilities of the Leeds Specialist Melanoma MDT to achieve these national standards.

3.2 Primary Melanoma Referrals

Melanocytic lesions which are of clinical concern should be removed with a narrow margin excision biopsy within the LSMDT.

The following patients need to be referred by the Local Skin Multidisciplinary Team (LSMDT) to the Specialist Melanoma MDT (SSMDT) in Leeds.

Patients with melanomas Stage Ib or higher are eligible for Sentinel Node Biopsy (SNB) and therefore may be eligible for adjuvant trials.

STAGE 1B or higher : Melanoma < 1mm plus mitosis or ulceration

Melanoma >1mm in vertical growth phase should be offered SNB

• Patients with melanoma Stage IIB may be eligible for adjuvant trials even without an SNB.

STAGE IIB Melanoma 2.01 - 4.0mm + ulceration

Melanoma >4mm without ulceration

• Other melanoma patients should be referred to the SSMDT as described in the IOG. These referrals will normally be made to Dr Angana Mitra at SJUH and should include those patients with:-

a. early onset melanoma (under 19 years),

b. melanomas arising in susceptible individuals (such as those with giant congenital pigmented naevi, or familial melanoma)

c. multiple primaries or familial melanomas

d. melanoma managed by other site specific teams e.g. H&N, gynae
e. metastatic disease at presentation or on follow up

f. skin lesions of unknown malignant potential

The referral for all primary melanomas requiring review at the SSMDT should be faxed through under the 2-week review rule to Lisa Varley, MDT coordinator (Fax: 0113 2067758) and a hard copy sent. All referrals should be accompanied by copies of the relevant histology reports, and imaging, as appropriate. For each patient, their pathology and imaging will be discussed at the weekly MDT meeting, and a copy of the outcome of these discussions will be sent to the referring clinician, the GP and the local MDT clinical lead. If appropriate they will be offered an outpatient appointment in Leeds. This is a multidisciplinary clinic where patients will be able to see clinician who is relevant to their condition to discuss:

- Melanoma, lifestyle and prognosis (if not already done by the referring physician)
- Surgery
- Current Clinical trials
- Adjuvant Therapy

Patients can be provided with a summary of their clinic visit, if requested. A faxed formatted summary will be sent to the patient’s GP and the referring doctor within 24 hours of first appointment at the SSMDT and where recurrent disease is diagnosed.

3.3 Sentinel Node Biopsy

Patients who fulfill the IOG guidelines and who could be considered for entry into an approved clinical trial (based upon a positive SNBx) will be counseled about SNBx in Leeds. Those patients who elect to proceed to SNBx will have their SNBx and WLE carried out in Leeds. If their SNBx is positive then their completion LND will also be performed in Leeds. The level of LND following a positive SNBx will be as per Appendix A.

3.4 Clinical Nodal Recurrence

All patients who develop a clinically suspicious node should be referred urgently to the Leeds SSMDT for investigation and treatment. FNA can be performed locally but open biopsy of any suspicious area should only be undertaken in Leeds. On review we will arrange:-

- Confirmation of metastasis (usually by fine needle aspiration cytology)
- Staging by CT scan. Normally this will take place in Leeds but staging scans could be arranged locally as per the network guidelines (Appendix B).
- Lymph node dissection
- Subsequent counseling about adjuvant therapy and options for clinical trials
• Testing for current genetic mutations, associated with melanoma, as a marker for current adjuvant therapies

• Subsequent clinical review in clinic

3.5 Other loco-regional disease

All patients who develop locally recurrent or in-transit disease, should be referred urgently to Leeds, including any relevant imaging, Such patients will normally require

• Confirmation of metastasis

• Staging by CT / MRI scan - Normally this will take place in Leeds but staging scans could be arranged locally according to the network guidelines (Appendix B) where this is more convenient for the patient.

• PET-CT scan if appropriate

• Surgery
  
  Usually local excision

  Local ablation including electrochemotherapy

  Isolated limb infusion where necessary to palliate extensive disease

  Radiotherapy

  Neo-adjuvant chemotherapy prior to resection

  • Subsequent counseling about adjuvant clinical trials

**Isolated Limb Infusion (ILI)** is available at the SSMDT. The indications for an ILI are:

• Recurrent local disease not amenable to surgical resection.

• Frequency of recurrence such that recurrent surgical resections are inappropriate

• Multiple areas of recurrence where surgery would be extensive

• Surgical resection would result in significant morbidity.

Some patients may require an Isolated Limb PERFUSION (ILP) which is different to an ILI. All patients should be referred to Leeds where an assessment of the required treatment will be made and if an ILP is felt necessary a referral on to the Royal Marsden Hospital will be made by Leeds.
3.6 Site Specific Disease (melanomas arising on the head and neck, vulva or, penis)

Patients with melanoma in ‘rare’ sites such as on the vulva, who fill the usual criteria for referral to the Leeds Melanoma SSMDT, should be referred simultaneously to the melanoma and the site specific SSMDT’s. In many cases surgical resection will be performed by the site specific team and not by the melanoma team. Histology and imaging will be reviewed by the melanoma SSMDT, before agreeing the appropriate treatment needed with the site specific team. This should ensure that patients eligible for trials are identified early with preparations for their enrollment initiated at the same time as surgery is arranged.

Patients with Head & Neck nodal recurrent melanoma will be managed by the Head & Neck MDTs in Leeds, York or Bradford and the SMMDT. Referral to the appropriate H&N MDT for surgical planning, should occur at the same time as referring the patient to the SMMDT. The SMMDT will undertake a pathology review, including genetic phenotype, discuss suitability for a clinical trial and if appropriate an outpatient follow up made. Ongoing surveillance will remain under the MDT most appropriate for the anatomical site of the primary. It is more common for patients with recurrent melanoma of the head and neck to be offered adjuvant radiotherapy A similar arrangement will be expected of other site-specific areas e.g. gynaecology. Patients should be warned that they may get an appointment to one of the Melanoma clinic in addition to the site specific team.

Follow up will be decided on an individual case according to clinical priorities.

3.7 Stage IV Melanoma

Patients with suspected or established stage IV melanoma should be referred to the medical oncologists at the SSMDT.

3.8 Radiotherapy

The role of radiotherapy for melanoma patients is limited, however guidelines for referring patients within the Leeds area have previously been established (Appendix C). Patients who are not under the care of a site specific team and fulfill the guideline recommendations for consideration of radiotherapy, are referred to the SMMDT. This will be after the histopathology is available in the case of therapeutic lymph node dissections where prompt referral will be necessary to ensure that patients are seen within an appropriate therapeutic timescale.

3.9 Histopathology,

All patients referred to the SMMDT will have their pathology double reported. The Leeds SMMDT co-ordinator Lisa Varley will request from the pathology department of the hospital where the tissue was removed for the relevant slides to be released. The Leeds SMMDT will review all primary and wide local excisions as well as any recurrent lesions. Documentation of the review will be sent to the referring consultant. Should there be an alteration in the histopathology assessment the SMMDT pathologist will write directly to the original pathologist, to discuss the change, as currently happens.
Biopsy of Pigmented Lesions

Pigmented lesions should not have an incisional biopsy (iB). Suspicious lesions should have a narrow margin excisional biopsy, orientated longitudinally along the limb and closed directly. If this is not possible, then either the wound is left open to heal secondarily or the patient referred urgently to Leeds, where they will be seen and appropriate excision planned. In a few exceptional situations an incisional biopsy may be appropriate, specifically large lesions where the diagnosis is uncertain and only where the result may change your management. E.g. if the pathology of any incisional biopsy was to come back as benign but the lesion would still be viewed as suspicious then an excisional biopsy should be performed from the outset. There are several clinical issues with biopsying pigmented lesions:-

1. A lesion may be mitotically inactive on the iB, however review of the whole specimen may reveal mitotic figures. It is now unclear whether the mitoses are true or as a response to the recent iB. For thin melanomas ≤1mm this will upstage them from 1a to 1b, with all the clinical consequences associated with this.

2. An iB may suggest a thin melanoma ≤1mm and a wide local excision (WLE) is carried out. However review of the entire lesion could reveal elements which are thicker than 1mm. The patient may now require a further WLE if the initial WLE is now deemed inadequate. Of greater significance however is that they may not now be able to have a sentinel node biopsy (SNB) as the accuracy of SNB is highest when the lymphoscintigraphy and following patent blue dye injection is within 5mm of the primary site.
3.10 Appendix A - Guidelines for Lymph Node Dissection (LND)

1. Positive Sentinel Node Biopsy (Microscopic disease)
   i. Axilla - Levels I, II & III
   ii. Groin - Deep (Ilio-inguinal) dissection if
      a. Pelvic node seen on lymphoscinintigraphy which was not retrieved at SNBx
      b. Multiple positive sentinel nodes superficially in groin
      c. Lymphatics seen bypassing nodes superficially and entering pelvis directly
         - Superficial Groin Dissection, generally will be required but specifically
           whenever a, b, c above do not apply.

   iii. Neck – selective neck dissection, to include parotid if involved. Levels dependent upon site of sentinel
        node but generally II-V

   i. Palpable Nodes (Macroscopic disease)
      a. Axilla - Levels I, II, III
      b. Groin - Deep (Ilio-inguinal) dissection
      c. Neck – level I-V, including any involved structures
3.11 Appendix B – Local Guidelines: Imaging Patients with Malignant Melanoma

3.11.1 Introduction

The vast majority of patients presenting with a melanocytic lesion are treated with surgical excision and do not require imaging. Patients with stage IIIA or higher melanoma will require a staging CT.

Leeds Cancer Network Imaging guidelines are based on the Royal College of Radiologists published guidelines 2006 (1) and written following discussion with the members of the melanoma MDT. They will be subject to further review after publication of the National Treatment guidelines in 2010 and at all relevant intervals subsequently.

3.11.2 Staging of Malignant Melanoma

There are 2 ways to stage malignant melanoma. These first is the TNM system and second method is described by the American Joint Committee on Cancer (AJCC 2010). The AJCC staging system incorporates serum LDH and is more detailed and therefore our preferred method of staging. Neither staging system takes into account the site of the primary melanoma or the sex of the patient which are significant predictors of prognosis. The AJCC staging system is detailed in Appendix 1.

3.11.3 What is the role of imaging?

1. To detect all sites of disease at presentation (staging investigation)
2. To assess response to treatment
3. To detect recurrence of disease

3.11.4 Which patients should be imaged?

<table>
<thead>
<tr>
<th>Stage</th>
<th>Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>No imaging</td>
</tr>
<tr>
<td>II</td>
<td>No imaging</td>
</tr>
<tr>
<td>III a</td>
<td>No imaging (unless H&amp;N primary)</td>
</tr>
<tr>
<td>b,c</td>
<td></td>
</tr>
<tr>
<td>1st site</td>
<td></td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>Head, Neck, Chest, Abdo,Pelvis</td>
</tr>
</tbody>
</table>

CT
Upper limb | Chest, Abdo, Pelvis- (Neck, Pelvis if clinically indicated)  
Torso | Head, Neck, Chest, Abdo, Pelvis  
Lower Limb | Chest, Abdo, Pelvis  
Trial Patients | Trial protocol - may need funded contrast CT brain, MRI or PET-CT

Stage IV

• Head, Neck, Chest, Abdo and Pelvis  
• Follow up scan as clinically indicated

3.11.5 What CT parameters should be used?

- Oral administration of 1L iodinated contrast medium  
- 100-150 ml of intravenous iodinated contrast injected at 3-4 ml/sec  
- MDCT commenced at 20-25 seconds for the chest and 70-80 seconds for the abdomen  
- Slice thickness no greater than 2.5mm and reformatted at no more than 5mm for viewing

3.11.6 What is the role for PET – CT?

No routine use although this is likely to change within the next few years as both more evidence arises and local availability is offered to patients  
PET – CT maybe advised after MDT discussion  
Might be of value to the both patient and surgeon where major surgery (e.g. amputation) is being considered  
Not useful in detecting brain disease as normal physiological uptake occurs

3.11.7 What is the role of MRI?

No routine use  
Brain MRI, contrasting PET – CT (normal physiological uptake by brain of radioactive tracer), is useful in detecting disease in patients suspected clinically to have brain metastases  
Brain MRI maybe required as part of a funded trial  
Can be used to define site of complex soft tissue disease at either presentation or following recurrence when surgery is being considered  
To characterise typically sub-cm liver lesions detected at CT

3.11.8 What is the role of Ultrasound?

- No value in routine staging of patients  
- Guidance for FNA of lesions suspicious of recurrence  
- May be of value in problem solving
3.11.9 What is the role of the bone scan?

- Investigating bony pain in conjunction with plain X-rays

3.11.10 Imaging to consider

- Interval CXR to assess response to treatment in patients with pulmonary metastases
- MRI, CT, on a case by case basis to problem solve
- PETCT – when upstaging a patient would make planned extensive surgery unnecessary

3.11.11 References

1. Recommendations for Cross-Sectional Imaging in Cancer Management, (Issue 2) 2006. The Royal College of Radiologists

<table>
<thead>
<tr>
<th>Classification</th>
<th>Thickness (mm)</th>
<th>Ulceration Status/Mitoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tis</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
| T1             | ≤ 1.00         | a: Without ulceration and mitosis < 1/mm²  
b: With ulceration or mitoses ≥ 1/mm² |
| T2             | 1.01-2.00      | a: Without ulceration     
b: With ulceration                        |
| T3             | 2.01-4.00      | a: Without ulceration     
b: With ulceration                        |
| T4             | > 4.00         | a: Without ulceration     
b: With ulceration                        |

<table>
<thead>
<tr>
<th>N</th>
<th>No. of Metastatic Nodes</th>
<th>Nodal Metastatic Burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>N0</td>
<td>0</td>
<td>NA</td>
</tr>
</tbody>
</table>
| N1              | 1                       | a: Micrometastasis*     
b: Macrometastasis†       |
| N2              | 2-3                     | a: Micrometastasis*     
b: Macrometastasis†       |
| N3              | 4+ metastatic nodes, or matted nodes, or in transit metastases/satellites with metastatic nodes |

<table>
<thead>
<tr>
<th>M</th>
<th>Site</th>
<th>Serum LDH</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0</td>
<td>No distant metastases</td>
<td>NA</td>
</tr>
<tr>
<td>M1a</td>
<td>Distant skin, subcutaneous, or nodal metastases</td>
<td>Normal</td>
</tr>
<tr>
<td>M1b</td>
<td>Lung metastases</td>
<td>Normal</td>
</tr>
<tr>
<td>M1c</td>
<td>All other visceral metastases</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Any distant metastasis</td>
<td>Elevated</td>
</tr>
</tbody>
</table>

Abbreviations: NA, not applicable; LDH, lactate dehydrogenase.  
*Micrometastases are diagnosed after sentinel lymph node biopsy. 
†Macrometastases are defined as clinically detectable nodal metastases confirmed pathologically.
**Table 2. Anatomic Stage Groupings for Cutaneous Melanoma**

<table>
<thead>
<tr>
<th>Clinical Staging*</th>
<th>Pathologic Staging</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>N</td>
</tr>
<tr>
<td>0</td>
<td>T1s</td>
</tr>
<tr>
<td>IA</td>
<td>T1a</td>
</tr>
<tr>
<td>IB</td>
<td>T1b</td>
</tr>
<tr>
<td>II</td>
<td>T2a</td>
</tr>
<tr>
<td>IA</td>
<td>T2b</td>
</tr>
<tr>
<td>IIB</td>
<td>T3a</td>
</tr>
<tr>
<td>II</td>
<td>T3a</td>
</tr>
<tr>
<td>IIC</td>
<td>T3b</td>
</tr>
<tr>
<td>III</td>
<td>AnyT</td>
</tr>
<tr>
<td>IV</td>
<td>AnyT</td>
</tr>
</tbody>
</table>

*Clinical staging includes microstaging of the primary melanoma and clinical/radiologic evaluation for metastases. By convention, it should be used after complete excision of the primary melanoma with clinical assessment for regional and distant metastases.

Pathologic staging includes microstaging of the primary melanoma and pathologic information about the regional lymph nodes after partial (i.e., sentinel node biopsy) or complete lymphadenectomy. Pathologic stage 0 or stage IA patients are the exception; they do not require pathologic evaluation of their lymph nodes.
3.12 Appendix C Radiotherapy guidelines

Leeds Teaching Hospital
Specialist Skin Cancer Multidisciplinary Team
Radiotherapy Guidelines for Melanoma

Introduction

Radiotherapy is not commonly used to treat patients with melanoma, due to a lack of robust clinical data to support treatment. Historically melanoma is considered radio-resistant although specific indications are now recognised. Review of the available evidence based literature suggests that radiotherapy is indicated for patients with melanoma at some point in their disease in 23% of cases, however utilisation rates suggest only 1% of melanoma patients receive radiotherapy in clinical practice (1). These guidelines have been produced as a reference for clinicians to identify those patients in whom radiotherapy should to be considered.

Primary Treatment

Local recurrence can occur in ≤5% of patients following a wide local excision of a primary melanoma. Histological features of ulceration, primary >4mm Breslow, presence of satellites or head & neck location increases this rate to ≤ 15% or higher if several high risk features are evident. Desmoplastic melanomas displaying neurotropic invasion have a local recurrence rate ≤50%. Surgical wide or wider local excision is not always possible without significant cosmetic or functional consequences. Radiotherapy should be considered for the following clinical situations:-

Lentigo Maligna - extensive lesions need consideration of Imiquimod (Aldara) or Primary Radiotherapy (provided by the Skin Clinical Oncology Team). Malignant transformation within a LM should be excised with a 1cm margin with the residual lesion treated as above.

Primary Melanoma

• Head and neck region

  >4mm

  Desmoplastic melanoma with neurotropism

• Residual microscopic or macroscopic disease where re-excision is not possible
Recurrent Disease

Therapeutic lymph node dissection is used to treat the approximately 20% of melanoma patient develop regional nodal disease. Recurrence following a TLND is ~15% although certain nodal features are associated with higher rate of relapse; Extra-capsular spread (31-63%); >4 lymph nodes involved (22-63%); Lymph node >3cm (42-80%); Cervical node location (33-50%). The adjuvant use of radiotherapy following a TLND is controversial due to the perceived radioresistance of melanoma and the increased risk of lymphoedema when radiotherapy is combined with surgical nodal resection. Several studies have shown improved loco-regional control (84-88%) with TLND and adjuvant radiotherapy compared to reported loco-regional control rates of 50-70% with surgery alone. The role of radiotherapy as primary treatment to a regional nodal basin, following a positive sentinel node biopsy is still under review. Adjuvant radiotherapy following a TLND should be considered for the following clinical situations:-

• Head & Neck
  >3 nodes involved
  Extra-capsular spread
  Lymph node > 3cm
  Recurrent disease

• Axilla / Groin
  > 4 nodes involved
  Extra-capsular spread
  Lymph node >3cm
  Recurrent disease

• Local Recurrence
  Nodule >2cm consider enrolling into Reovirus study – refer to Leeds MDT
Palliative Treatment

Radiotherapy has a defined role in the palliative treatment for recurrent melanoma in the brain, bone, lymph node lung and soft tissues. CNS metastatic disease occurs in nearly 50% of patients with advanced melanoma and in 15-20% of this group is the first site of recurrence. The goal of whole brain radiotherapy (WBRT) is local disease control, stabilisation / improvement of neurological function and survival. Spinal cord compression can be treated by corticosteroids and either surgical decompression, radiotherapy or both modalities. Whenever possible solitary lesions should be surgically excised and with or without adjuvant radiotherapy. If surgical resection is not achievable then radiotherapy is required for the following clinical situations:-

d.CNS

Brain

Solitary brain metastasis, surgical resection/stereotactic radiosurgery where possible with post-operative WBRT

multiple metastases disease

after surgery Spinal Cord

Compression

Surgical decompression plus radiotherapy or Primary Radiotherapy

•Soft Tissues surgical resection when possible

Unresectable soft tissue recurrence

Micro / macroscopic margins following surgical resection

Recurrent nodal disease following previous TLND.
References

Clinical Practical Guidelines 'The management of cutaneous melanoma' National Health and Medical Research Council - Australia Cancer Network 1999


Estimation of an Optimal Radiotherapy Utilisation Rate for Melanoma Delaney G., Barton M., Jacob S. Cancer 100(6):1293-1301 2004

European School of Oncology START State of the Art Oncology in Europe:- Melanoma treatment guidelines www.startoncology.net


6th World Congress on Melanoma, Vancouver, September 2005

3.13 Appendix D  Clinical Trial guidelines

Leeds Cancer Centre Melanoma Clinical Trial Portfolio

All patients referred to the SMMDT will be considered for any relevant study and appropriate screening investigations initiated prior to discussion and possible enrollment.
4 Referral Guidelines to the Specialist Non-Melanoma Skin Cancer MDT

Updated by G Stables 2013

The Specialist Non-Melanoma Skin Cancer MDT meets weekly at Chapel Allerton Hospital, Leeds. The SSMDT will provide a treatment plan for the LSMDT to allow local treatment if possible.

Core members

Dr Walayat Hussain, Consultant Dermatologist, Mohs Surgeon and SSMDT Lead
Dr Graeme Stables, Consultant Dermatologist and Mohs Surgeon
Mr Chris Fenn, Consultant Plastic Surgeon
Mr Howard Peach, Consultant Plastic Surgeon
Dr Fiona Roberts, Consultant Clinical Oncologist/Radiotherapist
Drs Will Merchant (Lead Dermatopathologist), Andrew Boon, Sara Edward, Radhika Ramnath, Consultant Dermatopathologists
Ruth Johnson, MDT Coordinator
Jenny Fallon, Skin Cancer Specialist Nurse

Contact details

Dr Walayat Hussain, The Leeds Centre for Dermatology, Chapel Allerton Hospital,
Leeds LS7 4RB
Secretary: Kate Moore 0113 392 4367
Fax 0113 392 4358
email walayat.hussain@nhs.net

Ruth Johnson: The Leeds Centre for Dermatology, Chapel Allerton Hospital,
Leeds LS7 4RB
Telephone 0113 392 4377
Fax 0113 392 4281
Email ruth.johnson@leedsth.nhs.uk

Referral requirements:

- referral letter including diagnosis, size, site, previous treatments, relevant PMH and medications.
- copies of relevant pathology reports.
- diagrams/photographs of site and previous surgery.
- faxed or hard copies to Dr Walayat Hussain copied to Ruth Johnson, MDT Coordinator.
  Check that referral has arrived.
Exclusions

- patients with head and neck cancer invading into bone or metastatic to cervical lymph nodes should be referred directly to the local or regional Head and Neck Cancer MDT.
- patients with cutaneous sarcoma should be referred directly to the Regional Sarcoma MDT in Leeds.

Referral criteria

- Diagnosis is uncertain but may be malignant: clinical and histopathology opinion from the SSMDT
- BCCs and SCCs where best treatment modality unclear: Mohs micrographic surgery (see Appendix 1), plastic/reconstructive surgery or radiotherapy.
- Radiotherapy and adjuvant radiotherapy (see Appendix 2).
- Stage 3 SCC and metastatic SCC (if head and neck SCC invading into bone or metastatic to cervical nodes refer directly to local or regional Head and Neck MDT)
- Mohs micrographic surgery requiring general anaesthesia & plastic/reconstructive surgery to repair the Mohs defect (see Appendix 1).
- Skin Cancer in genetically predisposed patients including Gorlin’s Syndrome where MDT review and Mohs surgery may be of benefit
- Rare cancers (see Appendix 3).
- Any cases for approved trial entry

Appendix 1 - Mohs Micrographic Surgery Clinical Guidelines

Referral pathway

- Where Mohs micrographic surgery is a possible treatment modality the patient will be seen in the Specialist Non-Melanoma Skin Cancer MDT Clinic for multidisciplinary assessment.
- Where the decision to have Mohs micrographic surgery has been made locally or in the LSMDT, the patient should be referred directly to Dr Hussain, Dr Stables or Dr Rahim who will personally see the patient in a Mohs assessment clinic or via the MDT clinic.
- Periocular tumours are seen initially by Dr Hussain/Stables/Rahim and then may be referred to Prof Bernie Chang, Consultant Oculoplastic Surgeon.
- If the patient may require specialist plastic surgical reconstruction the patient will be seen in the Specialist Non-Melanoma Skin Cancer MDT Clinic.
- All patients who are assessed as requiring Mohs resection and reconstruction will be discussed, by the Specialist Non-Melanoma Skin Cancer MDT, prior to any treatment.

Referral requirements

- The diagnostic biopsy: a punch biopsy may give more information about the tumour subtype; a shave or scoop biopsy if possible may prevent creating scar deep in the skin which may obscure the deep tumour margin.
- Patients must be fit, mobile and have the stamina to travel to Leeds to undergo possibly repeated local anaesthetic surgery on one day. Patients may be reconstructed on a separate day, at a separate hospital by another reconstructive surgeon e.g. Plastic Surgeon, Oculoplastic Surgeon, Maxillofacial Surgeon.
- Letter of referral, pathology reports, diagrams/photos of site and previous surgery.
**Indications for Mohs micrographic surgery**

- Recurrent tumours
- Incompletely excised tumours
- Primary tumours:
  - BCC: infiltrative, micronodular, sclerosing, morphoeic
  - Indistinct clinical margins
- Tumours arising in previously irradiated skin
- Gorlin’s syndrome
- Locations requiring maximal tissue sparing
  - Periocular
  - Columella
  - Nasal tip, alar rim
  - Lips
  - Auricular
- Tumours treatable by Mohs micrographic surgery (this list is not exhaustive)
  - BCC
  - SCC
  - Microcystic adnexal carcinoma
  - Sebaceous carcinoma
  - Mucinous carcinoma

**4.1 Appendix 2 - Radiotherapy Treatment of Non-Melanoma Skin Cancers**

Radiotherapy can be a very effective treatment for selected non-melanoma skin cancers. In general histological confirmation of diagnosis (usually by shave or punch biopsy) should be undertaken prior to treatment. Treatment generally involves multiple visits on a daily basis (usually between five and fifteen) and patients need to be co-operative and able to lie still, usually supine. Following radiotherapy there is a significant skin reaction which can last for up to six weeks and therefore the patients need to be able to care for these areas, though District Nurses can be arranged if dressings are needed.

Indications for treatment are best considered in terms of basal cell carcinomas (BCC) and squamous cell carcinomas (SCC).

**Basal Cell Carcinomas**

- Surgical excision should be considered the gold standard treatment for most basal cell carcinomas. However, for patients over the age of sixty, radiotherapy may represent an excellent alternative. In selected series cure rates of 90% and over are reported.

- It can be particularly useful when surgical excision would leave a poor cosmetic result or if the patient would have problems undergoing excision.

- Radiotherapy can be particularly useful for lesions of the temple, forehead, nose, ear and scalp

- Areas to avoid for radiotherapy include the upper eyelid and the lower leg and areas which have previously undergone radiotherapy
• Radiotherapy should generally be avoided in patients with Xeroderma Pigmentosa and Basal Cell Naevus Syndrome

• For an elderly patient where surgical excision would require a general anaesthetic, it may be preferable to consider radiotherapy as an alternative.

• For older patients the results from radical radiotherapy are similar to those from surgical excision and patients can often be offered a choice of these modalities.

**Adjuvant radiotherapy for incompletely excised BCCs**

Radiotherapy can be considered as an alternative to further surgery for patients who have undergone incomplete excision of basal cell carcinomas, particularly if further excision would result in a poor cosmetic result.

**Squamous Cell Carcinoma**

The gold standard treatment for squamous cell carcinomas remains surgical excision. However, for elderly patients where this would be traumatic or the cosmetic result would be poor, radical radiotherapy can represent a good alternative.

**Adjuvant radiotherapy for SCCs**

Following incomplete excision of squamous cell carcinomas, if further excision is not deemed possible adjuvant radiotherapy may represent a reasonable alternative.

**Nodal irradiation**

Following nodal dissection for metastatic squamous cell carcinoma, if residual disease is thought likely to be present, adjuvant radiotherapy can be considered.

Appendix 3 – Rare Skin Tumours

Rare Skin Tumours (NICE IOG Skin Tumours February 2006, P128-9)

**Epidermal and appendage tumours:**

• Apocrine carcinoma
• Hidradenocarcinoma
• Eccrine porocarcinoma
• Sebaceous carcinoma
• Tumours associated with Muir–Torre syndrome
• Eccrine epithelioma (syringoid carcinoma)
• Microcystic adnexal carcinoma
• Primary adenoid cystic carcinoma
• Primary mucopidermoid carcinoma
• Primary mucinous carcinoma
• Digital papillary adenocarcinoma
• Malignant cylindroma
• Malignant spiradenoma (spiradenocarcinoma)
• Malignant pilar tumour
• Malignant pilomatrixoma
• Neuroendocrine carcinoma (Merkel cell tumour/trabecular carcinoma)

**Dermal and subcutaneous tumours:**

• Atypical fibroxanthoma (AFX) (superficial malignant fibrous histiocytoma)
• Haemangioendothelioma
• malignant Schwannoma)
5 Imaging Guidelines

Updated 2013

At the former YCN Skin Cancer Group meeting that took place on Tuesday 29th January 2013, members agreed that for patients with squamous cell carcinomas and melanoma they will refer to national British Association of Dermatologist (BAD) guidelines for advice on what imaging they will perform.

Guidelines available from The British Association of Dermatologists [http://www.bad.org.uk](http://www.bad.org.uk)

However, the following should also be taken into account:

Melanoma

**NICE: Melanoma Assessment and Management Guideline (NG14)** Published in July 2015 have specific imaging guidance on melanoma imaging. The NICE guidelines are available from the following link

[https://www.nice.org.uk/guidance/ng14](https://www.nice.org.uk/guidance/ng14)

Non Melanoma

Rapidly evolving technology in imaging sometimes makes choosing the most appropriate imaging procedure for an individual patient difficult. MRI and lymphoscintigraphy have proven valuable in local disease characterisation and regional lymph node involvement, while PET/CT is proving the most diagnostically accurate procedure for assessment of distant metastatic disease. The clinician must take into account both the stage and type of cutaneous malignancy in deciding which imaging technique to employ, or indeed whether imaging is required at all.
6 Pathology Guidelines

6.1 Introduction

These guidelines for the examination and reporting of skin cancer specimens are supplementary to the following national guidance:

- Minimum dataset for skin cancer histopathology reports issued by the Royal College of Pathologists
- National melanoma guidance

All skin cancer patients will be selected for review as per the national and local guidelines. There should be a nominated Lead skin pathologist for the service but all pathologists reporting skin cancer specimens should have the opportunity to contribute to the skin cancer MDT, participate in a relevant EQA scheme and in local audit (including an assessment of consistency where more than one pathologist participates in service provision).

If there is a significant discrepancy with the clinical findings the pathological material should be reviewed, if possible by a second pathologist with an interest in skin cancer.

Specimens should be reported to an agreed timeframe so as to allow appropriate clinical decision making at a planned MDT meeting.

6.2 Specimen Types

6.2.1 Diagnostic

- Incisional biopsies
- Excisional biopsies
- Punch biopsies

6.2.2 Therapeutic

- Excision biopsies
- Lymph node dissections
- Sentinel node biopsies
6.3 Specimen examination

Each pathology service should establish a defined protocol for each type of diagnostic and therapeutic skin specimen type received by the laboratory, taking into account the above guidance. The protocols should be regularly reviewed and updated by the Lead skin pathologist, in consultation with other pathologists who participate in service delivery.

The protocols should include a code for specimen orientation as agreed with the local skin surgical team.

Skin tissue should only be removed and stored for the purposes of research if it is surplus to the requirements of the diagnostic process. Appropriate patient consent and ethical approval should be obtained.

6.4 Minimum dataset for reporting

6.4.1 Diagnostic specimens

**Punch and incisional biopsies**
Tumour type plus those data items from the list below which can be reasonably and accurately adduced

**Excision biopsies**
These are often intended to be both diagnostic and therapeutic, so the complete dataset should be provided, as detailed below

6.5 Therapeutic excision specimens

**For Basal Cell Carcinoma**

Specimen type
Site
Tumour diameter
Tumour subtype
High risk factors:
  - High risk site: lip, ear, periorcular, nose, nasolabial
  - High risk size: >2 cm
  - High risk sub-type: Morphoeic/Infiltrative, Micronodular, Superficial, Atypical Squamous Component

Perineural spread
Lateral margin* Deep margin*
* For low risk tumours margins may be reported as
  - clear (≥1mm),
  - borderline (<1mm) or
  - involved

* For high risk tumours, margins should be measured to the nearest 0.5mm and the distance to margin quoted.

For Squamous cell carcinoma

Specimen type
Tumour type
Tumour grade Site
Tumour diameter
High risk factors:
  - High risk site: lip, ear, perineum, sole of foot
  - High risk size: > 2 cm
  - High grade: Poorly differentiated
  - High risk thickness: ≥ 4mm
  - Subcutaneous fat involvement
  - High risk sub-type: spindle cell/acantholytic
Lateral margin*
Deep margin*

* For low risk tumours margins may be reported as
  - clear (≥1mm),
  - borderline (<1mm) or
  - involved

* For high risk tumours, margins should be measured to the nearest 0.5mm and the distance to margin quoted.

For Malignant Melanoma

Specimen type
Site
Tumour diameter
Histological Subtype
Breslow thickness Growth
Phase Mitotic Count
Ulceration Regression
Host lymphocytic response (tumour infiltrating lymphocytes)
Angiolymphatic invasion
Perineural invasion
Microsatellites
Distance to lateral margin
Distance to deep margin

The dataset items should be reported in a proforma either within, or separate from or instead of the free text part of the pathology report. Departments and MDTs should work towards recording and storing the dataset items as individually categorised items in a relational database, so as to
allow electronic retrieval and to facilitate the use of pathology data in clinical audit, service planning and monitoring, research and quality assurance.

Laboratories should use an agreed diagnostic coding system (e.g. SNOMED). All malignancies must be reported to the Northern and Yorkshire Cancer Registry, in accordance with the service level agreement with their host Trust.

### 6.6 Grading And Staging Conventions

#### 6.7.1 Tumour grading

**Basal cell carcinoma**

No grade

**Squamous cell carcinoma**

Well, moderate and poor

**Melanoma**

N/A

#### 6.7.2 Tumour staging

TNM classification of malignant tumours (6th edition)

For melanoma: Clark level, growth phase and Breslow thickness

### 6.8 Use of ancillary laboratory techniques

All laboratories providing a Pathology service in the network must have at least conditional laboratory (e.g. CPA) accreditation and ensure participation an appropriate external quality assurance programme which demonstrates satisfactory laboratory performance.

Immunohistochemical procedures which may be of value include the following:

<table>
<thead>
<tr>
<th>Diagnostic scenario</th>
<th>Immunohistochemical markers</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamoid BCC v. Squamous cell carcinoma</td>
<td>Bcl-2, BerEP4</td>
<td></td>
</tr>
<tr>
<td>BCC v. Skin Adnexal carcinoma</td>
<td>EMA, CEA, CD117(adenoid cystic ca)</td>
<td></td>
</tr>
</tbody>
</table>
6.9 Audit

All pathologists reporting skin cancer specimens should participate in a relevant EQA scheme and in local audit (including an assessment of consistency where more than one pathologist participates in service provision). Audit may take the form of:

- review of compliance with specimen examination and reporting procedures
- completeness of datasets
- systematic logging of diagnostic agreement/disagreement during review of cases for MDTMs
- review of diagnostic consistency between pathologists using data from cases
- in EQA circulations or blind circulations.

The results of the audit process should be discussed with all pathologists who participate in service delivery and used to inform the development of reporting protocols.

6.10 Referral for review or specialist opinion

6.10.1 Referral for treatment

All patients referred for treatment at a hospital within the Yorkshire Cancer Network following diagnosis elsewhere must be reviewed and discussed at the treating hospital’s multidisciplinary team meeting (MDTM).
The complete diagnostic pathology report must be available at the MDTM, and where appropriate, the histological/cytological material should be reviewed prior to the meeting. This is particularly important if there is a significant discrepancy with the clinical findings.

Pathological material should be requested at least 5 working days before and received at least 3 days before the relevant MDTM to allow sufficient time for review.

A formal report should be issued by the reviewing pathologist to the responsible clinician at the treating hospital. The results of the review should be sent to the original pathologist, either by copy of the review report or by letter.

Where patients have been referred for oncology treatment, requests for specialist biomarker studies will be co-ordinated between the treating oncology service, their local pathology service and the referring hospital's pathology service, as appropriate. The oncology service must agree a mechanism for requesting tests and the relevant pathological material with their local pathology service. Requests for pathological material should be made in good time to ensure that results are available at the MDTM where the patient is to be discussed.

6.10.2 Referral for specialist opinion and named histopathologist for cutaneous lymphoma

The named Histopathologist for the Network, to whom all new presumed cases of cutaneous lymphoma, should be referred for a second histology opinion is detailed below:

Dr B. Mathew
Consultant Histopathologist
Department of Histopathology
Bexley Wing
St James’s University Hospital
Leeds

Dr Mathew will provide dermatopathology support for the Supranetwork Skin Lymphoma MDT (with Dr J Goodlad, Consultant Histopathologist as cover). Dr Mathew is the named Histopathologist for the Network. Dr John Goodlad, Consultant Histopathologist, Haematological Malignancy Diagnostic Service (HMDS), Bexley Wing, St James's University Hospital will provide support from HMDS.

All suspected skin lymphoproliferative lesions or lymphomas should be referred to the Haematological Malignancy Diagnostic Service for phenotypic analysis and confirmation of diagnosis. All cases will be double reported within HMDS by Dr Goodlad [or member of his team] and Dr Mathew.

Other cases do not need systematic central review nor referral out with the Network, unless the patient is being referred for treatment externally or by the Cancer Centre, when cases should be referred to the Lead Pathologist of the appropriate MDT and dealt with according to their specialist MDT guidelines.

Cases referred for individual specialist or second opinion will be dealt with by the individual pathologist and a report issued by them. Where relevant, tissue blocks should be made available to allow any further investigations that are deemed appropriate. The result of the review should be communicated to the referring pathologist by letter and also by fax/telephone as appropriate.
6.11 References

3. Guidelines on inter-departmental dispatch of samples from patients sent to another hospital or centre for assessment and/or treatment. The Royal College of Pathologists (2004)
4. WHO classification of Skin Cancer
7 Palliative & End of Life Care

This section has been reviewed and updated in May 2017

7.1 Definitions

Palliative care is part of supportive care. It embraces many elements of supportive care.

Palliative & End of life care is care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last year(s) of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

The Department of Health (2008) definition of end of life care states that it includes:

- Adults with advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, COPD, stroke, chronic neurological conditions, dementia);
- Care given in all settings (e.g. home, acute hospital, ambulance, residential/nursing care home, hospice, community hospital, prison);
- Care given in the last year(s) of life
- Patients, carers and family members (including bereavement care).

End of Life Strategy, Department of Health 2008
National Council for Palliative Care Services 2006

7.2 Who Provides Palliative / End of Life Care?

Palliative / end of life care is provided by two distinct categories of health and social care professionals:

- All health care and social care professionals providing the day-to-day care to patients and carers in any care setting
- Those who specialize in palliative care (consultants in palliative medicine and clinical nurse specialists in palliative care, for example) who care for palliative care patients who have complex needs

Those providing day-to-day care should be able to:

- Assess the care needs of each patient and their families across the domains of physical, psychological, social spiritual and information needs
- Meet those needs within the limits of their knowledge, skills, competence in palliative care
- Know when to seek advice from or refer to specialist palliative care services

Training and education in the skills required for palliative / end of life care should be available to and undertaken by all health and social care professionals.
The national strategy *Ambitions for Palliative and End of Life Care 2015-2020* sets out the vision to improve end of life care through partnership and collaborative action between organisations at local level throughout England.

More information can be found at: [http://endoflifecareambitions.org.uk/](http://endoflifecareambitions.org.uk/)

For more information about local improvements, frameworks, tools to support best practice please contact your local End of Life Care Lead or Specialist Palliative Care Team.

One aspect of care is to discuss with individuals, if they wish, their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future. This is the process of Advance Care Planning (ACP).

An ACP discussion might include:
- the individual’s concerns and wishes,
- their important values or personal goals for care,
- their understanding about their illness and prognosis,
- their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these.

Such discussions can also inform shared decision-making regarding treatments with palliative intent. Local arrangements for recording this information for each individual patient will differ. Many services are developing/have developed Electronic Palliative Care Co-ordination Systems (EPaCCS) where by this information can be shared across professionals and settings (e.g. on SystmOne). Contact your local specialist palliative care team for more information.

### 7.3 Specialist Palliative Care

Is provided by specialist multidisciplinary palliative care teams in services or units whose core specialty is palliative care (for example hospices, community or hospital palliative care teams). The specialist teams should include palliative medicine consultants and palliative care nurse specialists together with a range of expertise provided by physiotherapists, occupational therapists, dieticians, pharmacists, social workers and those able to give spiritual and psychological support.

Eligibility for referral to specialist palliative care services is based on patient need not diagnosis. The agreed criteria for referral are as follows:

1. The patient has active, progressive and usually advanced disease for which the prognosis is limited (although it may be several years) and the focus of care is quality of life.

2. The patient has unresolved complex needs that cannot be met by the caring team, for example:
   - Uncontrolled or complicated symptoms (e.g. symptoms not adequately controlled within 48 hours by the referring team, or sooner if causing overwhelming distress).
   - Complex psychological/emotional difficulties.
   - Complex social or family issues.
   - Difficult decision making about appropriate future care.
Patients fulfilling these criteria should be referred to and assessed by a member of the specialist palliative care team.

The subsequent care package will be dependent on this assessment and should be made in agreement with the patient, carer(s) and referring team. It is not appropriate for specialist palliative care services to be committed to patients by professionals outside these services. Equally, specialist services should ensure that the assessment process is accessible and responsive to patients in need.

The level of specialist palliative care support required may fluctuate. Shared care of patients between the specialist palliative care professionals and the referring team (for hospital patients) or the primary care team (for patients at home / care home) is usually appropriate. Timely and effective communication is essential in these situations. For these patients advice from specialist palliative care services on a 24 hour basis should be available in all care settings. Sometimes the specialist palliative care consultant and team may take the lead role in patient care, usually in a specialist in-patient unit (hospice) or designated specialist palliative care beds.

Referral systems for specialist palliative care services vary in different areas. They should be clear to all local referring consultants and primary care teams.

7.4 Further Information

Contact the local Specialist Palliative Care Teams for further information

7.5 Directory of Specialist Palliative Care Services across West Yorkshire & Harrogate

The Directory has been checked and updated in May 2017

Bradford, Airedale, Wharfedale and Craven
Bradford Teaching Hospitals NHS Foundation Trust
Airedale NHS Foundation Trust
NHS Bradford, Airedale, Wharfedale and Craven
Website: www.palliativecare.bradford.nhs.uk

<table>
<thead>
<tr>
<th>Airedale General Hospital Palliative Care Team</th>
<th>Tel</th>
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<tr>
<td></td>
<td>01535 292184</td>
<td>01535 295016</td>
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<tr>
<td>Sue Ryder Care – Manorlands Hospice (Oxenhope)</td>
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<tr>
<td></td>
<td>01535 642308</td>
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<tr>
<td>Bradford Teaching Hospitals Palliative Care Team</td>
<td>Fax</td>
<td>01535 642902</td>
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<tr>
<td>Tel</td>
<td>01274 364035</td>
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<tr>
<td>Fax</td>
<td>01274 366851</td>
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<tr>
<td>Bradford Community Palliative Care Team</td>
<td>Tel</td>
<td>01274 323511</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>01274 215660</td>
</tr>
<tr>
<td>Marie Cure Hospice (Bradford)</td>
<td>Tel</td>
<td>01274 337000</td>
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<tr>
<td></td>
<td>Fax</td>
<td>01274 337095</td>
</tr>
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<td>Out of Hours Advice via on-call Palliative Medicine Consultant via Marie Curie Hospice / Manorlands Hospice</td>
<td>Tel</td>
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**Calderdale and Huddersfield**
Calderdale & Huddersfield NHS Foundation Trust
NHS Calderdale
NHS Kirklees

<table>
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<tr>
<th>Calderdale Royal Hospital &amp; Huddersfield Royal Infirmary Palliative Care Team</th>
<th>Tel</th>
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<tr>
<td>Calderdale Community Palliative Care Team</td>
<td>Tel</td>
<td>01422 310874</td>
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<td>01422 378425</td>
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<tr>
<td>Overgate Hospice</td>
<td>Tel</td>
<td>01422 379151</td>
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<tr>
<td></td>
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<td>01422 384210</td>
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<tr>
<td>Kirkwood Hospice and Community Palliative Care Team</td>
<td>Tel</td>
<td>01484 557906</td>
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<td>01484 557918</td>
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<td>Out of Hours Advice via Hospices</td>
<td>Tel</td>
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**Harrogate and District**
Harrogate NHS Foundation Trust
NHS North Yorkshire and York
Website: [https://www.hdft.nhs.uk/services/palliative-care/](https://www.hdft.nhs.uk/services/palliative-care/)

<table>
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<tr>
<th>Harrogate Hospital and Community Palliative Care Team</th>
<th>Tel</th>
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<tr>
<td>Fax</td>
<td>01423 555763</td>
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<tr>
<td>St Michael’s Hospice</td>
<td>Tel 01423 872658</td>
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<td></td>
<td>Fax 01423 815454</td>
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<tr>
<td>Out of Hours Advice via Hospice</td>
<td>Tel 01423 879687</td>
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**Leeds**

**Leeds Palliative Care**

Website: [www.leedspalliativecare.co.uk](http://www.leedspalliativecare.co.uk)

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<thead>
<tr>
<th>Leeds Teaching Hospitals NHS Trust Specialist Palliative Care Team</th>
<th>Tel 0113 2064563</th>
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<tr>
<td></td>
<td>Fax 0113 2064863</td>
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<tr>
<td>Sue Ryder Care - Wheatfields Hospice and Community Palliative Care Team (West Leeds)</td>
<td>Tel 0113 2787249</td>
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<td>Fax 0113 2302778</td>
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<tr>
<td>St Gemma’s Hospice and Community Palliative Care Team (East Leeds)</td>
<td>Tel 0113 2185500</td>
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<tr>
<td></td>
<td>Fax 0113 2185524</td>
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<tr>
<td>Out of Hours Advice via SJUH Switchboard</td>
<td>Tel 0113 2433144</td>
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**Mid Yorkshire**

Mid Yorkshire Hospitals NHS Trust
NHS Wakefield District
Kirklees PCT
Website: [https://www.midyorks.nhs.uk/palliative-care1](https://www.midyorks.nhs.uk/palliative-care1)

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<th>Dewsbury Hospital and Community Palliative Care Team</th>
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<tr>
<td></td>
<td>Fax 01924 543883</td>
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<tr>
<td>Dewsbury Day Support and Drop-in (Rosewood Centre)</td>
<td>Tel 01924 512039</td>
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<tr>
<td>Mid Yorkshire Hospitals NHS Trust Palliative Care Team</td>
<td>Tel 01924 543801</td>
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<tr>
<td>Pontefract Community Palliative Care Team (Prince of Wales Hospice)</td>
<td>Tel 01977 781456</td>
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<tr>
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<td>Fax 01977 796209</td>
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<td>Prince of Wales Hospice (Pontefract)</td>
<td>Tel 01977 708 868</td>
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<td>Fax 01977 600097</td>
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<td>Wakefield Hospice</td>
<td>Tel 01924 331400</td>
</tr>
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<td></td>
<td>Fax 01924 362769</td>
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<td>Out of Hours Advice via Pinderfields Hospital Switchboard</td>
<td>Tel 01924 541000</td>
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York Hospitals NHS Foundation Trust  
NHS North Yorkshire and York

[https://www.yorkhospitals.nhs.uk/our_services/az_of_services/palliative_care/](https://www.yorkhospitals.nhs.uk/our_services/az_of_services/palliative_care/)

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<th>Service</th>
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<tr>
<td>York Hospital Palliative Care Team</td>
<td>01904 725835</td>
<td>01904 726440</td>
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<td>Community Palliative Care Team</td>
<td>01904 724476</td>
<td>01904 777049</td>
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<td>St Leonard’s Hospice</td>
<td>01904 708553</td>
<td>01904 704337</td>
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8. Appendix - Leeds Specialist Skin Pathway

Leeds Specialist Skin Pathway 23rd May 2018

The Leeds Teaching Hospitals NHS Trust

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Valid at date of publication (October 2017)
8.1 Appendix - Regional Specialist Skin Referral Pathway

Regional Specialist Skin Referral Pathway

The Leeds Teaching Hospitals NHS Trust

Refer from in-
Leeds Unit

Refer from local skin unit

Case discussed at MDT Histopathology meeting; decision made regarding definitive treatment

Written correspondence to referring decision with advice. Patient to be seen back at referring unit

Definitive treatment in Radiotherapy

Definitive treatment in Dermatology

Treat in Radiotherapy

Referral to other MDT

Treat in Dermatology including MOHs

Patient decision for no treatment despite MDT advice – ONG number given if changes mind

Treat in plastic

Agreed May 2018. Review May 2021. Reviewed by Dr Hussain