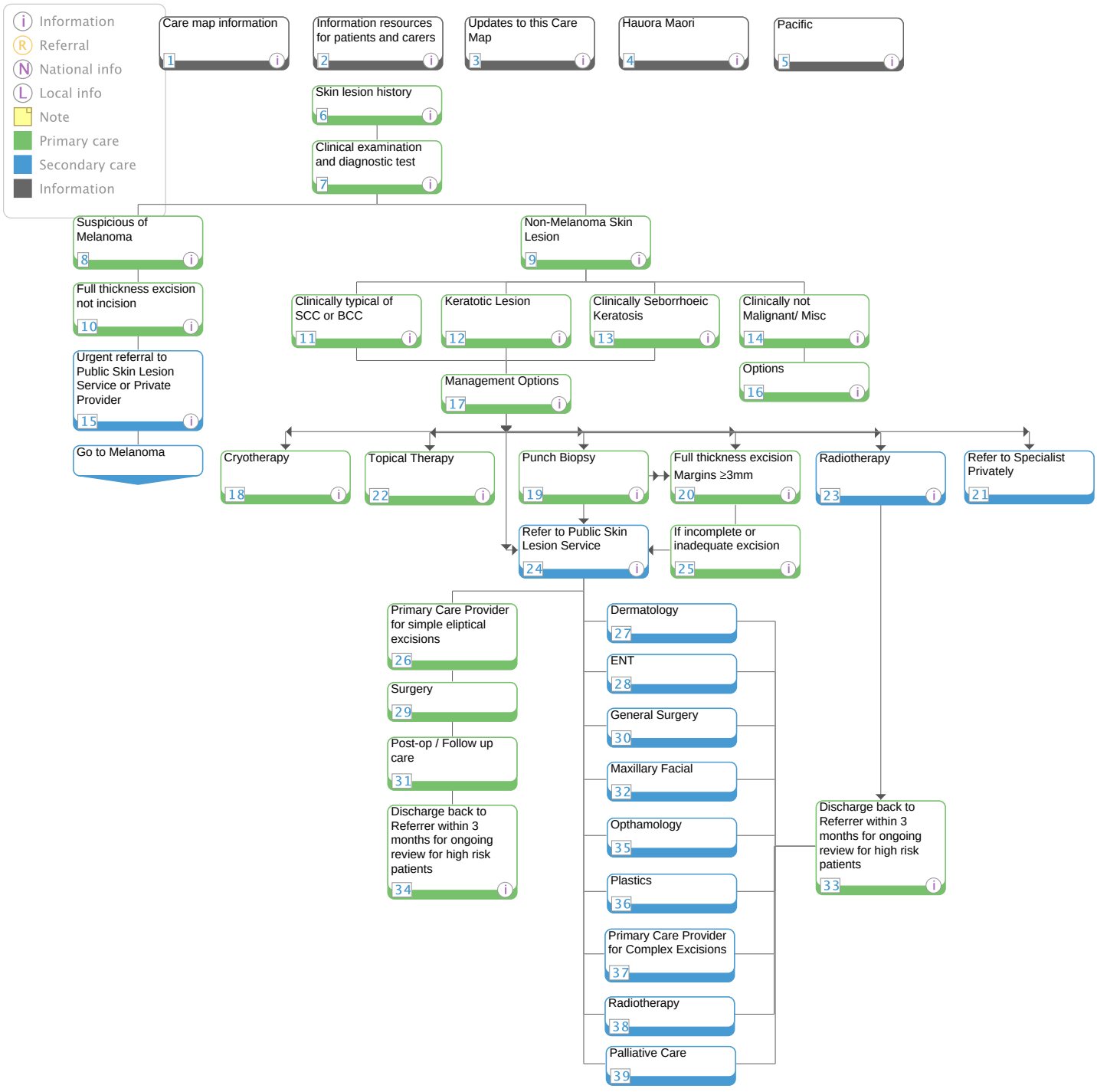
Skin Lesion

Medicine > Dermatology > Skin Lesions



Published: 18-Feb-2016 Valid until: 30-Jun-2019 Printed on: 17-Sep-2018

This care map was published by Hawkes Bay District. A printed version of this document is not controlled so may not be up-to-date with the latest clinical information.

Skin Lesion

1 Care map information

Quick info:

Clinical Guidelines for triage

Clincal assessment within 2 weeks of referral being received:

- immuno compromised

Clinical assessment within 2 - 6 weeks, and treatment as appropriate:

- SCC
- BCC on nose, eyelids, lips, ears
- other rapidly growing tumours

Clinical assessment within 3 months and treatment as appropriate:

- BCC elsewhere

References:

See Provenance Certificate for full list of references.

2 Information resources for patients and carers

Quick info:

Melanoma guide from Cancer Society
NZGG (2008) Pamphlet on melanoma
Health Pathways (Nov 2010) Sun smart behaviour leaflet
Health Pathways (Nov 2010) Looking after your skin surgery wound
Advanced cancer
Cancer in the family
Eating well during cancer treatment
Emotions and cancer
Understanding grief
Hawkes Bay Hospital Patient Information Leaflets
Health Navigator
Multi-professional Guidelines for the Management of the Patient with Primary Cutaneous Squamous Cell Carcinoma
Link to Dermnet

3 Updates to this Care Map

Quick info:

Date of publication: September 2014.
Updated: January 2015
Next update due: January 2016
This care map has been developed in line with consideration to evidenced based guidelines.
For further information on contributors and references please see the care map's Provenance.
NB: This information appears on each page of this care map.

4 Hauora Maori

Quick info:

Maori are a diverse people and whilst there is no single Maori identity, it is vital practitioners offer culturally appropriate care when working with Maori whanau. It is important for practitioners to have a baseline understanding of the issues surrounding Maori health. This knowledge can be actualised by (not in any order of priority):

- clinicians acknowledging Te Whare Tapa Wha (Maori model of health) when working with Maori whanau
- asking Maori clients if they would like their whanau or significant others to be involved in assessment and treatment
- asking Maori clients about any particular cultural beliefs they or their whanau have that might impact on assessment and treatment of the particular health issues
- consider the importance of introductions and mihimihi ('whanaungatanga') - a process that enables the exchange of information to support interaction and meaningful connections. This means taking a little time to ask where this person is from or where they have significant connections to. This information is reciprocated; i.e. the health professional also shares where they are from
- knowledge of the Hawke's Bay health sector's strategies and initiatives for improving Maori health and wellbeing
- having a historical overview of legislation that has impacted on Maori well-being

Training is available through the Hawke's Bay DHB to assist you to better understand Maori culture and to better engage with Maori patients. Contact the coordinator (education@hbdhb.govt.nz) to request details of the next courses.

For more information on the regional and national Maori Health Strategies go to:

Mai Maori Health Strategy 2014-2019- Full file or Summary diagramme

He Korowai Oranga: Maori Health Strategy - sets the Government's overarching framework to achieving the best health outcomes for Maori.

Hawke's Bay District Health Board contracts Maori Providers to deliver some screening, and mobile nursing services. A referral to one of these providers may assist Maori patients to feel more comfortable about receiving these services.

Central Hawke's Bay

- Central Health - http://www.centralhealth.co.nz/

Hastings

- Te Taiwhenua o Heretaunga - http://www.ttoh.iwi.nz/
- Kahungunu Health Services (Choices) - http://www.choices.maori.nz/

Napier

- Te Kupenga Hauora - http://www.tkh.org.nz/

Wairoa

- Kahungunu Executive - http://www.familyservices.govt.nz/directory/viewprovider.htm?id=5352&back=searchprovideralphabetical.htm?letter=K&providerId

5 Pacific

Quick info:

Pacific people value their culture, language, families, education and their health and wellbeing. Many Pacific families have a religious affiliation to a local church group.

The Pacific people are a diverse and dynamic population:

- more than 22 nations represented in New Zealand
- each with their own unique culture, language, history, and health status
- share many similarities which we have shared with you here in order to help you work with Pasific patients more effectively
- for many families language, cost and access to care are barriers

Pacific ethnic groups in Hawke's Bay include Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau, Kiribati and Tuvalu. Samoan and Cook Island groups are the largest and make up 2/3rds of the total Pacific population. There is a growing trend of inter-ethnic relationships and New Zealand born Pacific populations.

Acknowledge The FonoFale Model (Pasific model of health) when working with Pasific peoples and families.

General guidelines when working with Pasific peoples and families (information developed by Central PHO, Manawatu):

- Cultural protocols and greetings
- Building relationships with your Pasific patients
- Involving family support and religion during assessments and in the hospital
- Home visits

Hawke's Bay-based resources

- HBDHB interpreting service 06 8788 109 ext 5805 (no charge for hospital patients; charges apply for community-based translations)
- Tim Hutchins- Pacific Navigation Services LTD 027 9719199
- Services to assist Pacific peoples to access healthcare (SIA)
- Improving the Health of Pacific People in Hawke's Bay – Pacific Health Action Plan

Ministry of Health resources:

- Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2014-2018
- Primary care for Pacific people: a Pacific and health systems approach
- Health education resources in Pacific languages (links to a webpage where you can download resources)

6 Skin lesion history

Quick info:

- **ABCDE**
  - **A**symmetry
  - **B**order - irregularity or smudging of pigment over the border
  - **C**olour variation - several different colours or increased depth of pigment within the lesion
  - **D**iameter - any pigmented lesion with size > 1 cm or any mole that is growing
  - **E**volving - Increasing size
  - Any bleeding or crusting (if not clinically a seborrhoeic keratosis)
- ethnicity
- skin type
- previous treatment to this lesion

Risk factors:

- **IMMUNOSUPPRESSION**
  - prednisone/steroid therapy
  - methotrexate
  - renal failure
  - chemotherapy
  - hydroxyurea
- acute episodes of intense sunburn rather than cumulative effects
- blue eyes/skin pigment type/childhood freckling
- cumulative UV radiation eg. use of sunbeds
- place of residence
- age
- smoking
- family history
- previous skin malignancies
- childhood exposure to UV radiation

Markers of sun damage:

- freckles (ephilides)
- solar lentigines
- actinic or solar keratoses

7 Clinical examination and diagnostic test

Quick info:

- ABCDE

What is involved in an examination:

- exposure of the patient
- good lighting
- magnification
- photography with labels and measurements
- dermoscopy for suspicious lesions

Dermoscopy

Clinical Examination (augmented by dermoscopy) is considered the preferred method for examination of skin lesions:

- dermoscopy should be performed by trained professionals
- a detailed dermoscopy algorithm needs to be documented
- 3-point checklist or
- Chaos and Clues

Physical examination

- location of skin cancer/s
- skin type
- >100 normal moles
- atypical moles
- essential to document (PHOTOGRAPH and record):
  - evidence of solar damage
  - location of solar damage e.g. freckles, lentigines, actinic keratoses, elastosis
  - number of naevi e.g. >20 on arms, over 100 on whole body
  - evidence of previous skin cancer removal, scarring and treatment

Link to dermnet.org.nz
NZGG (2008) Melanoma: A Guide to Diagnosis - images and descriptions

8 Suspicious of Melanoma

Quick info:

NOTE: Do not do a punch, shave, or incisional biopsy for a suspected melanoma, it needs to be fully excised.

Most melanoma present with an initial flat phase.
Nodular melanoma and Amelanotic melanoma are commonly misdiagnosed.

9 Non-Melanoma Skin Lesion

Quick info:

Follow Chaos and Clues or Dermnet

Published: 18-Feb-2016 Valid until: 30-Jun-2019 Printed on: 17-Sep-2018

10 Full thickness excision not incision

Quick info:

NOTE: Do not do a punch, shave, or incisional biopsy for a suspected melanoma, it needs to be fully excised.
Please take a photograph prior to excision including labels and measurements.

If you are concerned that a lesion is a melanoma, it is acceptable for you to perform a full excision biopsy in primary care:

- make sure you include a minimum of a 2mm margin (preferably 4mm) around the edges including depth and that the incision plane is perpendicular to the skin surface down to subcutaneous fat (i.e. not angling in towards the lesion)
- lesion on a limb should be excised along Langers Lines if possible
- when a melanoma is proven by histology, then a wider excision may need to be performed. This can be very difficult if the original excision is transversely on a limb
- always perform an oblique excision on the limbs for this reason

If this is positive the wider excision should be undertaken by a credentialed surgeon.

11 Clinically typical of SCC or BCC

Quick info:

Squamous Cell Carcinoma (SCC)

Kerato-acanthoma

Basal Cell Carcinoma (BCC)

12 Keratotic Lesion

Quick info:

Keratotic Lesions

13 Clinically Seborrhoeic Keratosis

Quick info:

Seborrhoeic keratoses

14 Clinically not Malignant/ Misc

Quick info:

Miscellaneous include:

- Non-healing ulcers
- Chondrodermatitis nodularis helicis on ears
- Pyogenic granuloma
- Epidermoid cysts
  - Sebaceous cysts and
  - Pilar (tricholemmal) cysts
- Dermatofibroma
- Milia
- Lipoma (subcutaneous, soft, static growth, painless)
- Benign papilloma/ wart
- Benign naevus/ mole (and NOT dysplastic naevus syndrome)

Published: 18-Feb-2016 Valid until: 30-Jun-2019 Printed on: 17-Sep-2018

- Tattoos

Monitor in primary care.

These can usually be diagnosed clinically and do not generally require excision to exclude malignancy.
If in doubt, consider asking a colleague for an opinion before performing an excision.
If congenital melanocytic naevi, record measurements of the lesion and check for any suspicious changes over time.

15 Urgent referral to Public Skin Lesion Service or Private Provider

Quick info:
Complete the referral via PMS using:

- skin lesion referral form (MedTech outbox document/ My Practice form)
- for electronic referrals, use the Dermatology form
- attach photos with labels and measurements
  - where on body lesion is located
  - dermoscopic photo

16 Options

Quick info:
Non-healing ulcers

- If small, excision biopsy
- If large, full thickness biopsy of the margin.

Chondrodermatitis nodularis helicis

- Specialist assistance for excision

Pyogenic granuloma

- Excision or biopsy then cautery with care to destroy the feeding blood vessel

Epidermoid cysts

- **Sebaceous cysts and**
- **Pilar (tricholemmal) cysts**

Treat conservatively if asymptomatic. Options include triamcinolone 20mg injected subcutaneously around lesion.
OR
excise completely

Dermatofibroma
Treat conservatively.
Provide reassurance. Excise if patient wishes.

Milia
Treat conservatively.
OR
(rarely) incise and express intact if patient insists.

For the following:

- **Lipoma (subcutaneous, soft, static growth, painless)**

- **Benign papilloma/ wart**
- **Benign naevus/ mole (and NOT dysplastic naevus syndrome)**
- **Tattoo**

If the lesion is non-symptomatic, and the patient has no aesthetic concerns, reassure the patient, no treatment is necessary.

If the lesion is symptomatic and/or the patient has aesthetic concerns, a lesion can be excised by a general practitioner if:

- it can be excised
- the patient is happy for the lesion to be excised in general practice.

17 Management Options

Quick info:

Two photographs to be taken of lesion:

- location of lesion
- close up view of actual lesion

Photograph needs a measuring strip and to be labelled with patient ID.

18 Cryotherapy

Quick info:

Dermnet

This is ideal for superficial lesions ONLY.
Should never be used for pigmented skin lesions.
Follow up in 4-8 weeks to check efficacy of treatment.
Use fine flow tube nozzle from BOC gases (Brymill Cryogun).

19 Punch Biopsy

Quick info:

THESE ARE NOT TO BE USED ON PIGMENTED SKIN LESIONS

A punch biopsy may be helpful in the following:

- a rash
- to confirm the diagnosis of a clinically suspicious non-pigmented skin tumour

Clinical history, including details of any treatment is essential.

Punch biopsies in 3 mm - 6 mm diameter sizes are available.

Consider closing wound with a single stitch for haemostasis and cosmesis.

20 Full thickness excision Margins ≥3mm

Quick info:

Any excision specimen needs to be accurately marked and oriented for pathologist.

Perineural invasion can mean incomplete excision and, therefore, require wider/deeper excision.

Published: 18-Feb-2016 Valid until: 30-Jun-2019 Printed on: 17-Sep-2018

Requires careful follow-up to confirm recurrence does not occur.

22 Topical Therapy

Quick info:

Aldara

- Aldara patient advice guide
- link to special authority form
- Aldara is contraindicated on the mucous membranes

Efudix

- Medsafe Efudix (Fluorouracil) datasheet
- DermNet NZ Efudix Information

23 Radiotherapy

Quick info:

Essential Referral Criteria:

- **must** be biopsy proven invasive bcc or scc carcinoma (not superficial or insitu as these can be treated with aldara or efudix) **and**
- surgery **must** have been considered as the primary modality but the patient prefers radiotherapy **and**
- not invading deep structures such as cartilage or bone **and**
- no previous radiotherapy to that site

Additional Referral Criteria:

- multiple close lesions that would require massive excision
- in an anatomically difficult site e.g. on the face

24 Refer to Public Skin Lesion Service

Quick info:

Complete the referral via PMS using:

- skin lesion referral form (MedTech outbox document/ My Practice form)
- for electronic referrals, use the dermatology form
- attach **photos** with labels and measurements
  - where on body lesion is located
  - dermoscopic photos

Referrals are triaged to either:

- primary care provider
- secondary care provider
- tertiary care provider

This service is run by a Dermatologist who has administration support and an IT system that can select the quickest and most appropriate pathway for the definitive management of the problem.

Please provide a list of co-morbidities and medications.

The vast majority of these patients are initially seen and treated under local anaesthetic as outpatients.

Subsequent reconstruction under general anaesthetic may be arranged by the specialty.

Published: 18-Feb-2016 Valid until: 30-Jun-2019 Printed on: 17-Sep-2018

25 If incomplete or inadequate excision

Quick info:

Consider wider excision in primary care, or refer to Public Skin Lesion Service.

33 Discharge back to Referrer within 3 months for ongoing review for high risk patients

Quick info:

Discharge back to Referrer within 3 months with a discharge letter advising of appropriate review plan.

Seventy five percent of local recurrences and metastases are detected within 2 years and 95% within 5 years. It would therefore seem reasonable for the patient who has had a high-risk SCC to be kept under close medical observation for recurrent disease for at least 2 and up to 5 years. Guidelines (published 2009; update in progress 2014)

34 Discharge back to Referrer within 3 months for ongoing review for high risk patients

Quick info:

Discharge back to Referrer within 3 months with a discharge letter advising of appropriate review plan.

Seventy five percent of local recurrences and metastases are detected within 2 years and 95% within 5 years. It would therefore seem reasonable for the patient who has had a high-risk SCC to be kept under close medical observation for recurrent disease for at least 2 and up to 5 years. Guidelines (published 2009; update in progress 2014)

Published: 18-Feb-2016 Valid until: 30-Jun-2019 Printed on: 17-Sep-2018

Skin Lesion Provenance Certificate

Overview

This document describes the provenance of Hawke's Bay's District Health Board's Skin Lesion Pathway. It was developed in November 2013 and first published in September 2014. A review of the Pathway is due in January 2016.

The Collaborative Clinical Pathways programme is one initiative stemming from the *Transform and Sustain* agenda. The main aims of CCP are to:

- → Identify opportunities to improve how health and disability care is planned and delivered within the district to improve patient access to a wider range of health services that are both closer to home and reduce avoidable hospital admissions.
- → Provide health professionals throughout the Hawke's Bay district with best practice, evidence-based clinical pathways that are available at the point of care.

Outcomes we expect to achieve include faster access to definitive care, improved health equity and outcomes, better value from publically-funded resources, and better patient experience through clear expectations, improved access and greater health literacy. These outcomes are clearly aligned to the NZ healthcare *Triple Aim* and *Better, Sooner, More Convenient* policy directions.

Editorial methodology

This Pathway was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of Medicine editorial methodology. It was developed by individuals with front-line clinical experience (see Contributors section of this document) and has undergone consultation to gain feedback and input from the wider clinical community.

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

An update to this Pathway is scheduled for 12 months after first publication. However, feedback is welcomed at any time, with important updates added at the earliest opportunity within the Map of Medicine publishing schedule (the third Friday of each month).

References

This Pathway has been developed according to the Map of Medicine editorial methodology. Its content is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. Feedback on this Pathway was received from stakeholders during a consultation process.

Contributors

The following individuals contributed to this care map:

- Andrew Dowley, Otolaryngologist
- Hugh Findlay, Urgent Care Physician/Dermatosurgeon
- Hannes Meyer, General Practitioner
- Anne Carr, Registered Nurse, Surgical Outpatients
- Robyn Madden, Registered Nurse, Surgical Outpatients
- Helen Le Quesne, Practice Nurse, Taradale Medical
- Sonya Harwood, CPO Coordinator, Health Hawke's Bay
- Gary Duncan, Plastic Surgeon

Map editing and facilitation

- Shirley-Anne Gardner (MidCentral DHB) (Pathway facilitator)
- Alaina Glue (Central PHO) (Pathway editor)
- Penny Pere, Clinical Development & Improvement Manager, HBDHB
- Rebecca Kay, Portfolio Manager Hospital Services, HBDHB

Disclaimers

Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay

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