National Institute for Health and Care Excellence

Suspected cancer

Stakeholders' Comments – Draft Guideline

NOTE:

NICE is unable to accept comments from non-registered organisations or individuals. If you wish your comments to be considered but are not a registered stakeholder, please register via the NICE website or contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.

Please fill in both the 'stakeholder organisation' and 'name of commentator' fields below in order for your comments to be considered.

Stakeholder Organisation:	**British Association of Dermatologists (BAD)**
Name of commentator:	**BAD Clinical Services Skin Cancer sub-committee BAD Therapy and Guidelines sub-committee British Society for Dermatological Surgery**

Order number *(For internal use only)*	Document Indicate if you are referring to the **Full** version **NICE** version or the **Appendices**	Page Number Indicate **number** or **'general'** if your comment relates to the whole document	Line Number Indicate **number** or **'general'** if your comment relates to the whole document	Comments Please insert each new comment in a new row. Please do not paste other tables into this table, as your comments could get lost – type directly into this table.
Example	Full	16	45	Our comments are as follows ……
Proformas that are not correctly submitted as detailed in the example above may be returned to you.				
1	Full and NICE	General		We are concerned that there appears to be no dermatological representation on the GDG to provide greater insight into the impact of the recommendations in the guideline.
2	Full and NICE	General		We are also concerned of the seemingly lack of understanding by the GDG of the Skin IOG and referral pathways for skin cancer already in place which are part of local cancer networks.
3	Full and NICE	1	3	We question the need to include *"in children, young people and adults"* in the title and suggest "*in patients of all ages*".
4	NICE	3	3	We believe this is a gross underestimation – it is very likely that there are that many BCCs alone.
5	NICE	3	23-27	What about common local pathways requiring primary care CT pre-2ww referrals?
6	Full	29	10	Safety netting: The recommendations suggest either a planned review in an agreed time frame OR patient initiated review. However on page 30 paragraph 4, it states *"that 'safety-netting' would need to involve planned review of the person with symptoms."* Here it seems to state it has to be a planned review with an additional

				patient initiated review if required. The wordings in these 2 sections seem to be contradictory.
7	NICE	37	9	Symptomatic breast referrals are all under 2ww?
8	NICE	37	29	There may be local supra-network referral pathways not primarily to local urology unit.
9	NICE	37	39	We do not concur, as this broad definition would include all balanitis xerotica obliterans and Zoon's balanitis.
10	NICE	38	8	The impact of the statement will overload 2ww pathways already overstretched, causing significant breaches for trust departments and is also at odds with the Skin IOG. All high-risk BCCs need to be referred directly to the LSMDT under an 18-week wait referral. The referral should be flagged up for rapid access under this pathway, not a 2ww, with the appropriate patients' medical history and skin lesion information. LSMDT core members will review these cases and upgrade the patients accordingly onto designated clinic lists.
11	NICE	38	20	We suggest replacement of the word "consider" with "refer" as it is a requirement to refer as 2ww for suspicious lesions in line with the Skin IOG.
12	NICE	77	16	As above.
13	NICE	77	19	As above.
14	NICE	78	5	We believe this is incorrect – the GDG needs to refer to both the 2006 Skin IOG and the 2010 update.
15	NICE	81	23	We do not know how sensible this is - rather refer as 2ww as this could result in a prolonged pathway.
16	Full	203	4	We know that GPs are likely to refer many more suspicious lesions – use of the term 'diagnose' is a poor choice and the % 5-year survival rate is inappropriate and showcases poor understanding of the cancer.
17	Full	203	7	We feel there is a missed opportunity to raise red-flag lesions - and for example, recommend including PGs into pathways. Nodular melanomas as are not rare - should this be amelanotic melanoma?
18	Full	203	22	We feel there is a need to differentiate between routine and suspicious pigmented lesions. There is also the need to highlight that not all melanomas are pigmented, and urgent referral is required for new or changing red nodules or ulcerated lesions. Patients with previous history of melanoma should be referred directly to a LSMDT/SSMDT to ensure that they get on the appropriate pathway.
19	Full	204	1	We believe there is a wealth of information out there; the GDG should use data from several rather than predominantly a single article.
20	Full	208	1	We think that a more generic and less specific (product-related) section would be better. Discuss digital dermoscopy, mole-mappping systems, etc. There is a lot of information provided but resulting in weak results and recommendations. Once again there is a broader range of information available and other studies that should be included.
21	Full	208	3-41	We have read this section on cost-effectiveness analysis of MoleMate several times and are still not clear what the final conclusion from the analysis is. The first five paragraphs seem to be in favour while the last is not. We think the final conclusion should be made clearer. We suspect the conclusion was that it was not cost-effective as it doesn't figure in the final recommendation.
				The data on MoleMate adds nothing to the conclusions of the paper by Fiona Walters published in the BMJ in 2012. That showed clearly that MoleMate added no value to

				clinical examination. We don't understand how these very clear conclusions can be changed by the GDG. Moreover, the results for MoleMate alone, i.e. without structured clinical examination as used in the study, do not give confidence that it would have high positive predictive value for melanoma. This may well be the mode of use in primary care should it be more widely used. Therefore its use cannot be supported on the evidence available, and indeed it may increase risk of misdiagnosis.
				The use of MoleMate is outside of cancer pathways requirements and its use has escalated increases in referrals under 2ww. Unfortunately, the legal implications for making wrong diagnoses at times by primary and intermediate grade clinicians impact on skin cancer pathways. Currently, conversion rates for 2ww referrals are between 5-20%; the additional increase from MoleMate referrals will have a significant impact on already over-stretched staffing resources and diverts consultant time away from patients with acute inflammatory skin disease.
22	Full	211	End of the page	Clinical suspicion (aided by using 7PCL) is most important - dermoscopy is not a routine GP tool and training in skin lesion recognition and management would be required (see GPwSI Training programme).
23	Full	212	"Trade-Off"	We do not understand the first sentence; weak conclusion after so much time spent on the Wilson paper.
24	Full	216	18	Include keratoacanthomas and uncertain lesions here to include other high-risk, non-melanoma skin cancers.
				"Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of squamous cell carcinoma." It is better to make a recommendation based on clinical experience on specific symptoms to trigger a referral, rather than just based on "suspicion". The guidelines have no practical value if it just says "consider a referral when you suspect a BCC/SCC". That is common sense and a given that a GP will refer when they suspect BCC/SCC and it does not require guidelines to say that.
25	Full	217	Signs and symptoms	We suggest the GDG includes rapid expansion, painful lesion in sun-damaged/exposed skin in susceptible patients, plus, some classic keratinous/crateriform.
26	Full	218	13.3 general	We have seen reports from our membership of a sustained increase in referrals for 2ww consultations for the past 10 years. In one example, this summer the increase was 30% and the volume of referrals has thus far been sustained; their 'winter dip' is yet to transpire. Seeing these patients within 2 weeks has caused a knock-on effect such that low-risk BCCs are struggling to be fitted in within the 18-week pathway and even putting significant pressure on ensuring that the SCCs and melanoma re-excisions are performed in a timely fashion.
				We do understand the rationale for getting the highest risk BCCs seen urgently - those growing rapidly and on the eyelid for instance - but, our concern is that the guidance is not robust enough, and all head-and-neck BCCs plus biopsy proven infiltrative BCCs and incompletely excised BCCs will end up filling the 2ww clinic too. This would most likely break the system, without much benefit for what is, on the whole, not a life-threatening tumour. It is a requirement of the Skin IOG and NHS England peer-review measures to ensure that

				high-risk BCCs are referred to LSMDT/SSMDT core members within the host hospital to ensure appropriate diagnosis and that the procedure is carried out in the correct setting.
				The recommendation that suggests some BCCs should be seen via the 2ww route is both illogical and unsustainable. There is no evidence to support that BCCs should be seen in a 2ww clinic. Since BCCs are extremely common, a change in referral pathway for these would have a detrimental effect on patients with a probable melanoma or SCC. Dermatologists would no longer be able to prioritise if all of those patients came through the same route.
				In line with the national trend, it is proving a major struggle to cope with the demand of the existing 2ww referrals for SCCs and melanomas. If BCCs are added to these cases it will be impossible to cope with this demand given our already struggling services. There is already a mechanism for clinicians to upgrade patients under the 2ww pathway for treatment.
27	Full	218	Other Considerations	We disagree - there has to be a lower threshold and higher suspicion in these patients. Perhaps describe immunosuppression (acquired/drug-induced (including past use)/haematopoietic).
28	Full	220	16 blue area	*"Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of a basal cell carcinoma if there is concern that a delay may have an unfavourable impact, because of factors such as lesion site or size. [new 2015]."* We think the impact of this recommendation has been underestimated. Although, the number of BCCs referred would probably not change significantly, the proportion referred for appointment within 2 weeks would significantly increase causing strain on departments already struggling with the 2-week referrals. We agree the BCCs on high-risk sites need to be seen earlier than "routine", but how earlier is debatable. We do not think 2-week referrals are practical or necessary. Also, size should not be a criterion for an urgent referral. The importance of size decreases after site has been taken into account, e.g. a 1 cm BCC on the nose needs earlier attention than a 3 cm BCC on the back.
29	Full	220	16 blue area – alternative	*"Consider routine referral for people if they have a skin lesion that raises the suspicion of a basal cell carcinoma"* We disagree - who will make this decision? There should be locally agreed pathways for this which are part of the cancer network. Making it a national recommendation will cause havoc and is outside the Skin IOG.
30	Full	222	1st Paragraph	We suggest "histology" instead of "excision" as it excludes biopsy and alternative treatments.
31	Full	222	2nd Paragraph	Again, we think the guideline needs to refer to both the 2006 Skin OPG and the 2010 update.
32	Full	222	Last Paragraph before references	We disagree - this will change dramatically with the 2ww recommendation and will require additional resources with costs.
33	Full and NICE	General		**General comments on how the draft guideline is at odds with the Skin IOG** 1. We know of no data which support the idea that we can discriminate between BCCs requiring 2ww (if any) and those seen according to current pathways.

				And how are primary care specialists to make this distinction? 2. Dermoscopy is only part of the diagnostic process for melanoma, and one whose use is subject to the same error as other visual diagnostic procedures. The clinical history is a critical determinant of melanoma diagnosis, sometimes the only determinant, as is clinical examination. Emphasising dermoscopy as a sole basis for referral presupposes that it is more powerful than the history and examination findings combined. This is not the case, and in our view this advice is potentially dangerous. 3. There is no advice about the referral of patients with enlarging red nodules, a not infrequent and often-missed presentation of melanoma, SCC, and rare skin cancers such as Merkel cell carcinoma. All of these are potentially lethal. Primary care awareness for this group needs to be increased.
				The time spent on MoleMate seems disproportionate, confusing and seemingly comes to no clear conclusion. Concentration on the value of appropriate use of dermoscopy (better/shorter term than 'dermatoscopy') with appropriate training/education would be preferred (it almost feels that someone has an interest in promoting the use of sialoscopy/MoleMate). The additional emphasis on opthalmoscopy is also disproportionate; ocular melanomas are rare (on a par with intranasal/vulval/anal so why no mention of other techniques of special area examination). Routine referral for BCC versus 2/52-week inclusion if unfavourable impact on outcome, will lead to over-saturation of shortage 2/52 slots by BCCs as there will be a failure to discriminate. It would be better to suggest that BCCs should all be referred on a soon basis and those with perceived high risk on a very soon or urgent basis with justification on an individual basis rather than a mandatory 2/52 wait.
				14-1C-111j Skin Measure Patient Pathways for Primary Care/ Community Services and MDTs 'that GPs should refer suspected cases of skin cancer requiring treatment, including BCCs, to the contact point of the relevant named MDTs in the network configurations, or for cases of low-risk BCC, there is the option of referral to the contact point of a relevant GP-based service'.
				14-1D-101j Provision of Clinics for Immunocompromised Patients with Skin Cancer Please note referral requirements for immunocompromised patients in line with the Skin IOG and skin measure require: There should be a regular clinic in one of the hospitals of the locality which should: • be identified on the hospital outpatient department clinic list or timetable as a clinic for immunocompromised patients with skin cancer; • have bookable numbered clinic slots identified for the immunocompromised patients; • have a dermatologist core member of a named MDT with direct patient care sessions for the clinic in their job plans; • have a nurse specialist member of a MDT with the

				clinic specified as part of their work plan or job description.
				Referral pathways need to reflect the clinical criteria and models of practitioners working within the levels of care defined in the 'skin measures' since 2008. Descriptions of the models and types of BCC which make up these lists are classified from the point of view of peer-review and referral for treatment specified in clinical terms, here since *initial* decisions in primary care, regarding referral for treatment need to be made before histology is available.
				The Skin IOG, either explicitly or by implication, effectively specifies six levels of care, differing in the degree of specialisation and service consolidation needed. The personnel foreseen as offering these levels range from any GP, through specifically authorised and trained community practitioners, local and specialist MDTs to supra-network MDTs. All this is incorporated into the network referral guidelines and network infrastructure for skin cancer, set out in the measures. Therefore, the cancer referral guideline must triangulate and comply with the Skin IOG, and any update made outside of these requirements need to be removed from this consultation. This draft and update of the cancer referral guidance does not reflect the necessary guidance and referral pathways which have been implemented since its inception in 2005. It is with some urgency that we must insist the GDG reviews the necessary documentation and references to these requirements laid out in the Skin IOG and skin measures 2014.

Please add extra rows as needed.

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Closing date: 9th January 2015

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion or the Institute the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.