British Association of Dermatologists

Undergraduate Elective Prize/Project Grant Report

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Pictures
Top: Concord Hospital Education Centre
Middle: The Three Sisters, Blue Mountains
Bottom: Sydney Harbour

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Introduction

I recently completed my 7-week elective at the Department of Dermatology, Concord Repatriation General Hospital (CRGH), Sydney. Due to a combination of ozone depletion, an outdoors lifestyle and previous lack of knowledge about the dangers of the sun, Australia has one of the highest rates of skin cancer in the world. Similar to the UK, Australia also has a public funded healthcare system: Medicare. The aim of my elective was to explore how the Australian healthcare system manages this large burden of skin cancer disease, and also to experience dermatology in an alternative setting.

Comparing and contrasting Australia and the UK

Considering the prevalence of skin cancer in Australia, I was particularly interested in learning about the way they approach diagnosing and treating the disease. Patients who are referred with suspicious lesions by their GP are triaged by the registrar, and offered an appointment slot according to clinic availability and also suspected diagnosis. For squamous cell carcinomas (SCCs), the typical wait time can be as long as two months. This is quite different to the UK where a patient with a suspected SCC would be seen under the cancer pathway within two weeks. This made me appreciate the expedited wait times which I had previously taken for granted here in the UK, and also helped me grasp the extent of the strain that the Australian dermatology services are under.

I completed a six-month audit of the department's suspected skin cancer biopsy list and compared the results to a similar audit I had completed in the UK. At CRGH, 76.2% of lesions were malignant, 14.1% were benign and 9.7% were pre-malignant. The data I collected in the UK showed that 31.2% of biopsies were reported as malignant. Comparing the two results, it is unclear why there is a noticeable difference in the percentage of histologically confirmed malignancies. Possible reasons to take into consideration include the differing incidence rate of skin cancers, appropriateness of referrals from primary care, and patient and clinician preferences towards management. I am looking forward to presenting my audit findings later this year, and continuing my participation in the project to further investigate and strive to improve UK skin cancer pathway services.

Since the UK and Australia both have public healthcare systems, I was interested in comparing the funding process for expensive treatments such as biologics. In the UK, applications are made to local Clinical Commissioning Groups, which can sometimes be an arduous process.

Meanwhile in Australia, all applications are made centrally through the government-led universal Pharmaceutical Benefits Scheme (PBS). One key difference is that dupilumab, an anti-IL-4 and anti-IL-13, is not currently funded by the PBS. Knowing that dupilumab is approved by NICE and available in the UK for the treatment of severe eczema, it was difficult to see patients suffering with extreme symptoms, yet not being able to be offered any further treatment. Biologics for psoriasis are available in both countries although the criteria to qualify for treatment is different. In Australia, patients are eligible after failure of only 2 treatments (out of phototherapy, methotrexate, ciclosporin and acitretin), although the PASI cut off score was higher than the UK criteria at >15.

Overall, it was interesting to gain insight into how Australian and UK dermatology services differ. I enjoyed the opportunity to reflect on how even between countries of similar development stage and method of healthcare funding, availability of treatments and waiting times can vary greatly.

Clinical Experience

A highlight of my elective was attending the department's 'Monthly Meeting.' These meetings were structured similarly to OSCE exams and were well attended by dermatology trainees all over Sydney. Consultants brought in interesting patients for attendees to take a history and examine. Each registrar would be allocated one particular case to present in the discussion part of the meeting. After seeing all the patients, attendees proceed to the seminar room and summarise their allocated case findings to the consultants. They were then asked 'viva' style questions and to report the histopathology of the patient's skin biopsy slides. These meetings struck me as a great way to teach trainees and increase their exposure to rarer conditions, while also being beneficial to the consultants as they often received advice from colleagues regarding difficult cases. At these meetings and also during clinics, I saw a variety of rarer diseases including Sweets syndrome, dissecting cellulitis, morphea, and even a patient with suspected xeroderma pigmentosum. My knowledge of dermatology grew immensely over the course of my elective, and I found the diversity of dermatological pathologies very intellectually stimulating.

Australian attitudes to the sun

Walking through supermarkets and even surf shops, it was clear that sun protection was a priority to the Australian consumer population. Public health awareness campaigns such as the

‘Slip Slap Slop’ campaign and ‘Sun Sound’ on beaches could be seen around the city to remind the public to protect their skin. Young Australians who grew up surrounded by these initiatives reported practicing sun safety measures every day, suggesting that these campaigns are having the desired effect. It was also encouraging to learn that since research has shown a link between tanning bed use and melanoma, commercial use of tanning beds has been made illegal across Australia. Perhaps it will not be long before the UK follows suit.

‘Sun Sound’ poster on a beach in New South Wales

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