Greater Manchester &
Cheshire Cancer Network

Skin Cancer Clinical Sub-Group

Clinical Guidelines Document

(11-1C-107j, 11-1C-108j, 11-1C-109j)

Including:
Arrangements for skin cancer in specific anatomical sites
(11-1A-211j – 11-1A-216j)

Date agreed: 18 June 2012
Date for Review: June 2013

CONTENTS

Agreed Network Clinical Guidelines
Peer Review Measure 11-1C-107j

The following guidelines have been adopted by the GMCCN Skin NSSG:

1. Guidelines for the management of basal cell carcinoma. British Association of Dermatologists, 2008

2. Multiprofessional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma. British Association of Dermatologists, 2009

3. Revised UK guidelines for the management of cutaneous melanoma. British Association of Dermatologists, 2010

4. Joint British Association of Dermatologists and UK Cutaneous Lymphoma Group guidelines for the management of primary cutaneous T-cell lymphomas, 2006

Internet links to these documents can be found below:

http://www.bad.org.uk/site/622/default.aspx

The NSSG will review the above guidelines at least annually or as and when new guidance is published.

Network Imaging Guidelines for Patients with Skin Cancer (March 2012)
Peer Review Measure 11-1C-108j

MALIGNANT MELANOMA

Summary of imaging modalities:
All imaging modalities currently still have low sensitivity and specificity for melanoma metastases (1). The mainstay of initial staging is computed tomography (CT). This should be performed as helical / multi-detector CT of thorax, abdomen and pelvis with oral and i.v. contrast. (For details on technical parameters, see appendix).
Patients who are suitable for radical therapy should be considered for PET-CT as indicated below (2-4). Sentinel node biopsy is more sensitive for the detection of regional lymph node involvement than PET-CT (5, 6).
Patients undergoing clinical trials may have more intense imaging protocols, e.g. brain scan at baseline.

1. Chest x-ray
   - Associated chest symptoms
   - Follow-up of high-risk patients / known lung metastases

2. Ultrasound
   - Not for staging purposes unless unable to perform CT
   - Assessment of abdominal symptoms or deranged liver function tests
   - Follow-up of high-risk patients

3. Staging CT
   - Exclusion of metastases
   - All patients for systemic therapy or radical surgery / lymphadenectomy.

4. ^{18}FDG PET-CT
   - Prior to radical surgery / lymphadenectomy, if CT negative
   - Confirmation of solitary site metastasis, if resection considered

5. Magnetic resonance (MR) scanning

Not routinely indicated. Consider for
- Characterisation of equivocal liver lesions
- Exclusion of brain metastases as an alternative to CT
- Exclusion of meningeal disease

Biopsy of nodal enlargement (US guidance desirable)
- FNA if cytology service available (immediate microscopy for confirmation of cellularity recommended)
- Core biopsy if nodes large enough

Sentinel node scintigraphy

- As per guidelines on Sentinel Node Biopsy in the British Association of Dermatologists revised UK guidelines for the management of cutaneous melanoma 2010 (7):

- SLNB should be considered in Stage Ib melanoma and upwards in a specialist skin MDT (Stage Ib = <1mm Breslow thickness with ulceration or mitoses ≥ 1 / mm^2 or 1.01 – 2 mm Breslow thickness with no ulceration)

	SN –ve	SN +ve	Observation only	Therapeutic lymphadenopathy
5yr melanoma specific survival rate	90 %	72 %	87 %	52 %
5yr disease free survival rate	83 %	53 %	73 %	

Morton, Thompson et al 2006 N Engl J Med 2006;355:1307-17.

Initial imaging by pathological tumour stage (AJCC) – as per revised BAD guidelines (7)
Stage I, II & IIIA
- Imaging not routinely indicated, to evaluate specific signs or symptoms only.
- Chest x-ray or CT for suspected metastases, according to symptoms.
- PET-CT and MRI only by discussion within the context of the MDT

Stage IIIB and above
- CT thorax, abdomen and pelvis and consider head.
- Consider PET-CT if metastatectomy planned, to exclude disease elsewhere.
- MR for equivocal CT / organ-specific assessment (e.g. liver, brain)

Follow-up imaging
Stage I, II & IIIA
- Routine imaging not indicated

Stage IIIB and above
Patient on observation:
- As dictated by symptoms
- CT surveillance if considered appropriate by SSMDT

Patients on clinical trial:
- As per trial protocol

Nodal recurrence
- Staging CT +/- PET-CT if treatment appropriate (as above)

Distant metastatic disease
- CT if impact on management

NON-MELANOMA SKIN CANCER

Squamous Cell Carcinoma and Basal Cell Carcinoma
Baseline investigations including CXR as clinically indicated.
If clinical or pathological suspicion of advanced local disease consider MR or CT for assessment of local invasion (MR best for assessment of perineural invasion and CT best for bone infiltration).
Distant staging if clinically indicated: CT of chest and abdo +/- pelvis to including loco-regional nodes (e.g. neck).

Consider PET-CT in:
- Advanced disease suitable for radical treatment, if negative CT
- Equivocal nodal disease

Merkel Cell Tumour

Stage I & II

- Chest x-ray only. Discuss other imaging with radiologist at Skin MDT.
- Consider sentinel node biopsy for differentiation of stage I and stage II disease.
- Consider Somatostatin receptor scintigraphy (SRS) in cases of unexplained symtomatology if conventional cross-sectional imaging negative (8).

Stage III and above

- CT thorax, abdomen and pelvis.
- MR head if neurological symptoms.
- Consider Somatostatin receptor scintigraphy (SRS) in cases of unexplained symtomatology if conventional cross-sectional imaging negative.

Stage IV

- Consider Somatostatin receptor scintigraphy (SRS) for staging and planning of targeted peptide radiotherapy (8).

References

1. Veit-Haibach P, Vogt FM, Jablonka R, et al. Diagnostic accuracy of contrast-enhanced FDG-PET/CT in primary staging of cutaneous malignant melanoma. Eur J Nucl Med Mol Imaging. 2009;36(6):910-918.

2. Krug B, Crott R, Lonneux M, Baurain JF, Pirson AS, Vander Borght T. Role of PET in the initial staging of cutaneous malignant melanoma: systematic review. Radiology. 2008;249(3):836-844.

3. Pfannenberg C, Aschoff P, Schanz S, et al. Prospective comparison of 18F-fluorodeoxyglucose positron emission tomography/computed tomography and whole-body magnetic resonance imaging in staging of advanced malignant melanoma. Eur J Cancer. 2007;43(3):557-564.

4. Reinhardt MJ, Joe AY, Jaeger U, et al. Diagnostic performance of whole body dual modality 18F-FDG PET/CT imaging for N- and M-staging of malignant melanoma: experience with 250 consecutive patients. J Clin Oncol. 2006;24(7):1178-1187.

5. El-Maraghi RH, Kielar AZ. PET vs sentinel lymph node biopsy for staging melanoma: a patient intervention, comparison, outcome analysis. J Am Coll Radiol. 2008;5(8):924-931.

6. Aloia TA, Gershenwald JE, Andtbacka RH, et al. Utility of computed tomography and magnetic resonance imaging staging before completion lymphadenectomy in patients with sentinel lymph node-positive melanoma. J Clin Oncol. 2006;24(18):2858-2865.

7. J.R. Marsden, J.A. Newton-Bishop,* L. Burrows, et al. Revised U.K. guidelines for the management of cutaneous melanoma 2010. Br J Dermatol 2010;163:238–256.

8. Nguyen B.D, MD, Ann E. McCullough A.E. Imaging of Merkel Cell Carcinoma. RadioGraphics 2002; 22:367–376

NHS

Greater Manchester &
Cheshire Cancer Network

Agreed Network Pathology Guidelines
Peer Review Measure 11-1C-109j

Dr L A Jamieson, Consultant Dermatopathologist at Salford Royal Hospital is the Lead pathologist for the SSMDT. Dr L Motta, Consultant Dermatopathologist at Salford Royal Hospital is the deputy lead.

Dr P Shenjere and Dr D Nonaka, Consultant Histopathologists at the Christie Hospital are core members of the SSMDT

Dr A Norton is the Lead Pathologist in the network for cutaneous lymphomas.

Dr L Menasce and Dr P Shenjere, Consultant Histopathologists / Heamtopathologists at Christie Hospital NHS Trust, are core pathology members for the Supra Regional Cutaneous Lymphoma MDT

Dr L A Jamieson and Dr L Motta, Consultant Dermatopathologists at Salford Royal Hospital and core members of the Supra Regional Cutaneous Lymphoma MDT.

The Skin NSSG has adopted the Royal College of Pathologist's Guidelines for histological reporting of Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma and Lymphoma. Internet links to these documents can be found below:

http://www.rcpath.org/resources/pdf/skincancers2802.pdf
Basal Cell Carcinoma – page 5
Squamous Cell Carcinoma – page 11
Malignant Melanoma – page 17

Investigations and Indications
New Guidelines/ minimum data sets from the Royal College of Pathologists are awaiting a consultation period before approval. In the interim the Royal College of Pathologists has indicated that the AJCC Cancer Staging manual, 7th Edition, 2010, should be used for the staging of all melanoma and non-melanoma skin cancer. It is worth noting that this staging system differs from TNM 7th Edition and use of TNM 7th Edition is not recommended.

Failsafe
Double reporting of malignant melanoma and dysplastic naevi is recommended practice for all histopathology departments in the region. This is routine practice at SRFT where there are two consultant Dermatopathologists.
If double reporting is not possible or the case is problematic then the departments are encouraged to send the case for further assessment, preferably via the SSMDT pathologists in order to expedite MDT discussion.
Rare skin cancers, for example adnexal carcinomas, should also be reviewed for discussion at the SSMDT.

Lymphoma
http://www.rcpath.org/resources/pdf/lymphomaminimumdatasetCORRECTED.pdf

The NSSG will review the above guidelines at least annually or as and when new guidance is published.

Skin Cancer MDT Guidelines for Head and Neck Skin Cancer
Peer Review Measure 11-1A-211j

Malignant Melanoma
All cutaneous malignant melanoma, including any arising in peri-ocular skin, should be discussed primarily at the Skin MDT. Level 4 cases should be discussed at the local skin MDT (LSMDT) and Level 5 cases should be discussed at the specialist skin MDT (SSMDT).
If excision of a melanoma is likely to encroach on a mucocutaneous junction (nasal, auricular canal, conjunctiva) then this should be discussed in the SSMDT but also with a member of the Head and Neck MDT.

Mucosal and Ocular Melanomas
These should be discussed primarily at the Head and Neck MDT with secondary discussion at the SSMDT, (for considerations including trial eligibility, general skin examination).

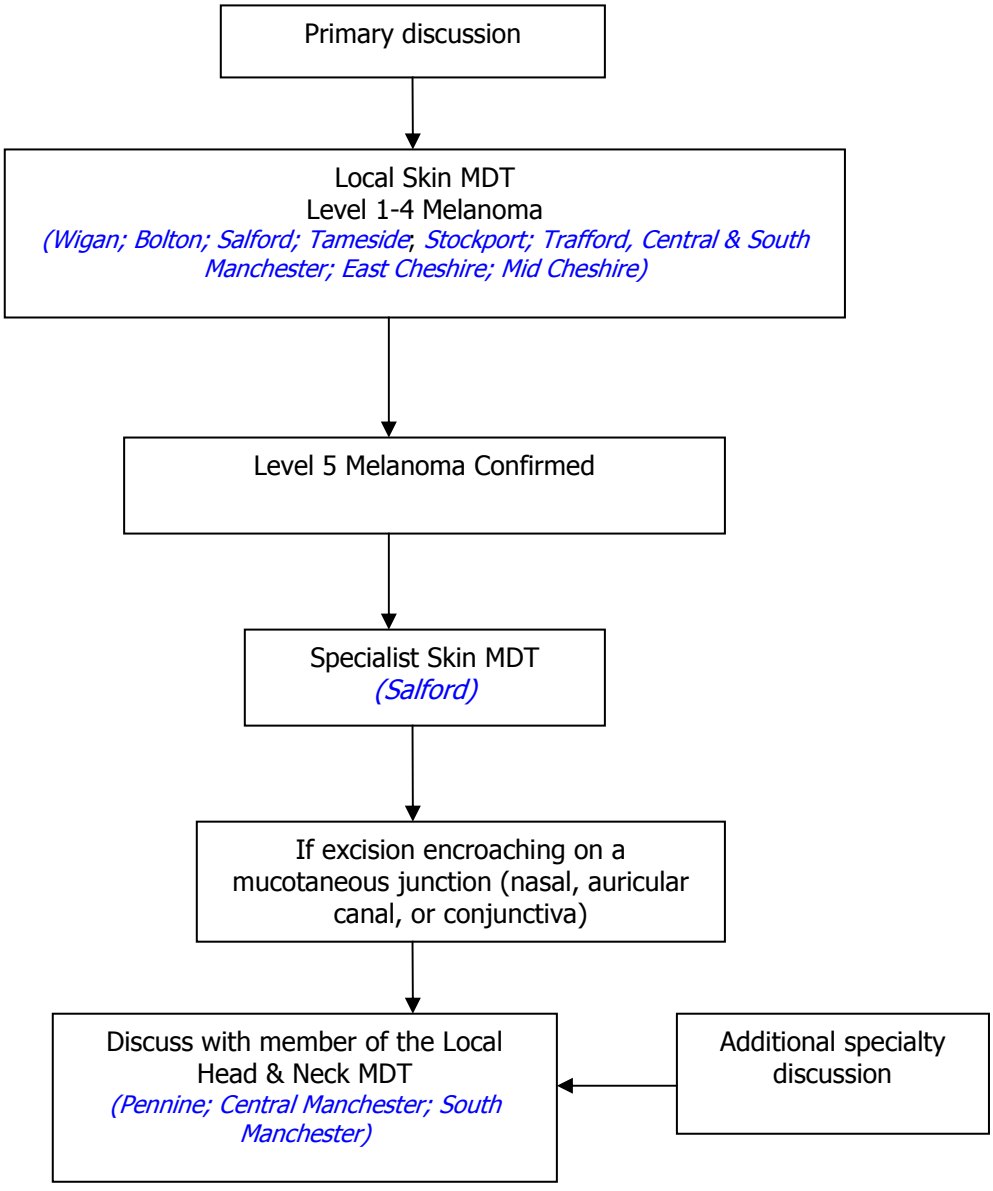
Squamous Carcinoma and Basal Cell Carcinoma
Peri-ocular basal cell, auricular and nasal carcinomas should be discussed at the LSMDT. When mucosal involvement or bony involvement is apparent this should be discussed at the Head and Neck MDT.
All level 3 and level 4 basal cell carcinomas and squamous cell carcinomas to be discussed at the LSMDT and all level 5 cases at the SSMDT.

Other Tumours (as per Appendix 1 p128/129 IOG NICE manual)
To be discussed at the specialist skin MDT

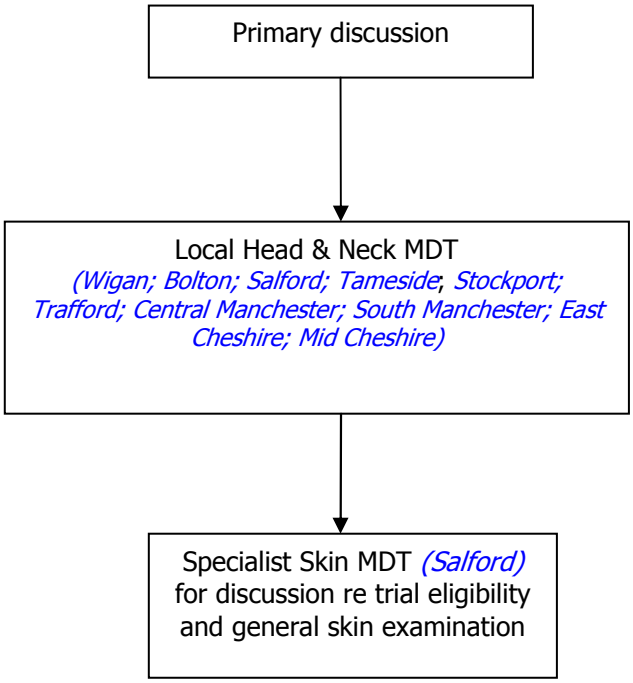
(Level 4/5 cases as per manual for skin services 2008 national peer review programme p23/24)

11-1A-211j Pathway for Head & Neck Skin Cancer

MELANOMA – Skin Cancer MDT

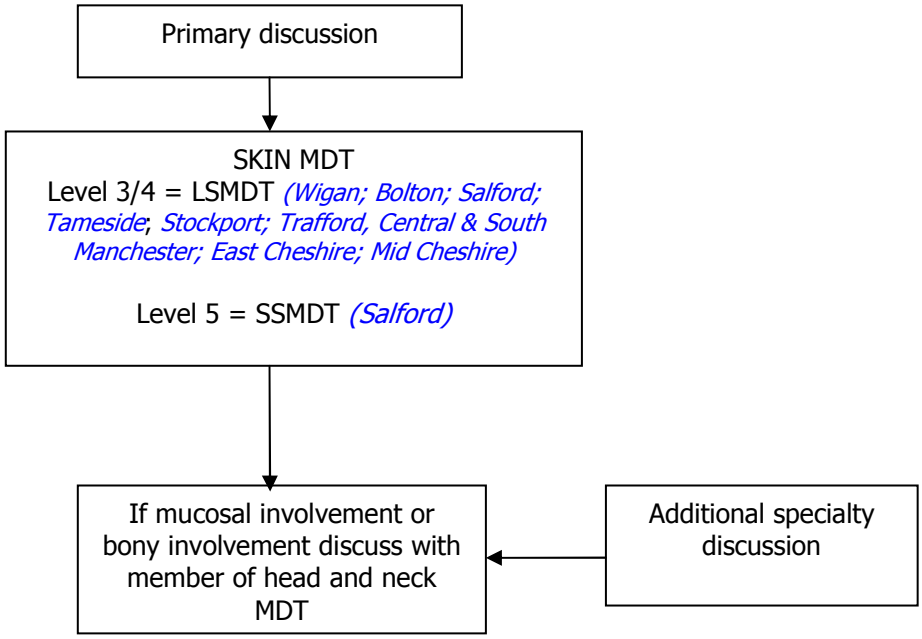


MUCOSAL AND OCULAR MELANOMA

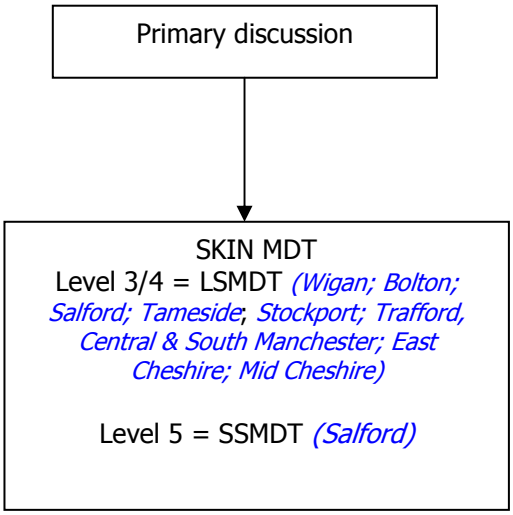


SQUAMOUS CARCINOMA AND BASAL CELL CARCINOMA

Peri-ocular, auricular and nasal carcinomas



SQUAMOUS CARCINOMA AND BASAL CELL CARCINOMA
Other sites carcinomas other than urological/gynaecological/colorectal



NB: Patients from Wigan Local Skin MDT are referred to the Specialist Skin MDT and plastic surgeons at Whiston Hospital, St Helens & Knowsley NHS Trust, part of the Mersey & Cheshire Cancer Network. GMCCN Patients may be referred to Mr Telfer, Mr Ghura, or Mr Madan, Consultant Mohs Surgeons based at Salford.

Peer Review Measure 11-1A-212j
Skin Cancer MDT Guidelines for Anal and Perianal cancer

The Skin Cancer MDT reviews and takes the lead in all skin cancer cases other than planned excision of a skin cancer involving the anal canal or anal margin; the latter defined as extending distal to the anal verge (the junction of the hair bearing skin) to a 5 cm circumferential area from it. This is compatible with and complimentary to the GMCCN Colorectal CSG guidelines which state: 'The Anal Cancer MDT at Christie Hospital reviews all network cases of anal margin and anal canal cancer.'

Specific Situations
Certain tumour types have additional guidelines:

MELANOMA
As for general tenet for any excision.
In addition, any melanoma arising in the anal canal or anal margin should be jointly discussed at the Anal Cancer MDT, Christie Hospital and the Skin MDTs, where issues including resectability, trial eligibility and general skin examination can be reviewed.

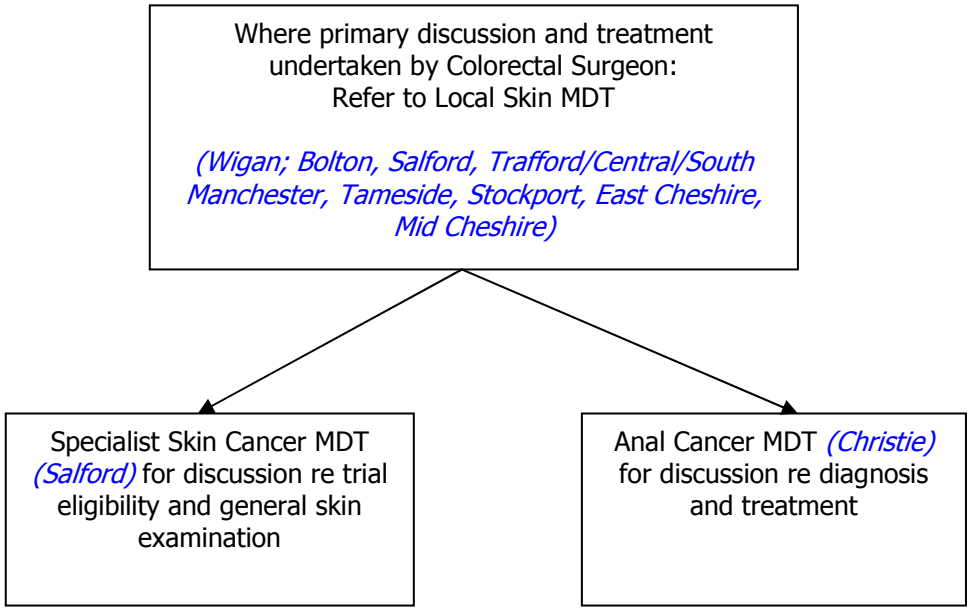
BOWENS DISEASE
As for general tenet for any excision.
For Bowen's disease encroaching on the perianal skin (but not the anal canal), considered treatable by non-surgical therapy (e.g. cryotherapy, efudix or aldara cream) may be treated by a member of the Skin MDT and discussed at the Skin MDT. However biopsy is mandatory to exclude other pathologies (Paget's disease, invasive neoplasia).

PERINANAL PAGET'S DISEASE
As for the general tenet for any excision.
If presenting to a member or the Skin MDT, treatment will be led by that person, with discussion principally at the Skin MDT. However collaboration with a colorectal MDT member is required to ensure no internal invasive cancer or Paget's involvement of anal canal.

11-1A-212j Pathway for Skin cancer of anal and perianal area

The Skin Cancer MDT reviews and takes the lead in all skin cancer cases other than planned excision of a skin cancer involving the anal canal or anal margin; the latter defined as extending distal to the anal verge (the junction of the hair bearing skin) to a 5 cm circumferential area from it. This is compatible with and complimentary to the GMCCN Colorectal CSG guidelines which state: 'The Anal Cancer MDT at Christie Hospital reviews all network cases of anal margin and anal canal cancer.'

MELANOMA



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Agreed Skin Cancer MDT Guidelines for Skin Cancer of External Female Genitalia
Peer Review Measure 11-1A-213j

SQUAMOUS CELL CARCINOMA
All SCCs should be discussed at the specialist gynaecological cancer MDT (Salford, Central Manchester or South Manchester).

MELANOMA
All melanomas involving the external female genitalia should be discussed at the specialist gynaecological cancer MDT (Salford, Central Manchester or South Manchester) as well as the specialist skin cancer and melanoma MDT at Salford.

BASAL CELL CARCINOMA
This should be discussed at the specialist gynaecological cancer MDT (Salford, Central Manchester or South Manchester) as well as the local skin cancer MDT.

SARCOMAS
These should be discussed at both the specialist gynaecological cancer MDT (Salford, Central Manchester or South Manchester) as well as the specialist sarcoma MDT at Christie.

11-1A-213j Pathway for Skin Cancer of External Female Genitalia

The skin cancer MDT reviews and takes the lead in all skin cancer cases where planned excision of a skin cancer will not encroach on the introital mucocutaneous junction. Melanoma has the following additional guidelines

MELANOMA

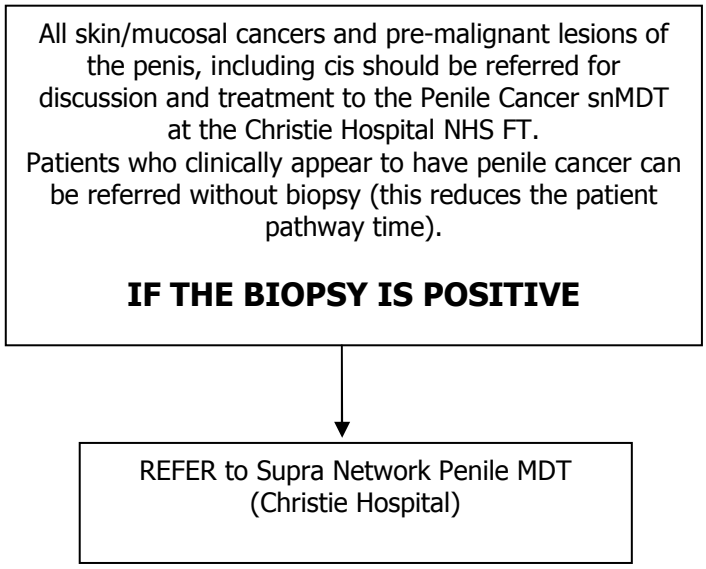
Level 4 & 5
All melanomas involving the external female genitalia should be discussed at the specialist gynaecological cancer MDT
(Salford, Central Manchester or South Manchester)
as well as the Specialist skin cancer and melanoma MDT
(Salford)

NB: Patients from Wigan Local Skin MDT are referred to the Specialist Skin MDT and plastic surgeons at Whiston Hospital, St Helens & Knowsley NHS Trust, part of the Mersey & Cheshire Cancer Network. GMCCN Patients may be referred to Mr Telfer, Mr Ghura, or Mr Madan, Consultant Mohs Surgeons based at Salford.

Agreed Skin Cancer MDT Guidelines and Pathway for External Male Genitalia
Peer Review Measure 11-1A-214j

The Supra Network Penile Cancer MDT reviews and takes the lead in all skin cancer cases of the penis, where there is planned excision of a skin cancer.

All tumour types have the following pathway:



NB: Patients from Wigan Local Skin MDT are referred to the Specialist Skin MDT and plastic surgeons at Whiston Hospital, St Helens & Knowsley NHS Trust, part of the Mersey & Cheshire Cancer Network. Patients may be referred to Mr Telfer, Mohs Surgeon at Salford.

Extended members of the Skin MDT will be:

Mr Vijay Sangar
Consultant Urological Surgeon & Chair of Penile Cancer Supra Network MDT (GMCCN, LCCN, MCCN)
Fax Number – 0161 446 3365

In cases of pre-malignant conditions other than CIS local referral may be appropriate.

If urgent opinions are required a referral without biopsy is suggested to avoid delays from biopsy to referral (which is the biggest delay in our pathways).

Agreed Skin Cancer MDT Guidelines for Skin Lymphoma
Peer Review Measure 11-1A-215j
Including
Supranetwork T-cell Lymphoma MDT for Total Surface Electron Beam Therapy (TSEBT)
Peer Review Measure 11-1A-208j

Mycosis fungoides (including Sezary syndrome)

Mycosis fungoides, stage IA, in addition to lymphomatoid papulosis can be discussed and managed by the Local Skin MDT (LSMDT). If the patient is not referred, the Supra-network T-cell lymphoma MDT (STLMDT) should still be notified so that the histological diagnosis can be confirmed, and that accurate figures of new diagnoses can be recorded.

Mycosis fungoides stage IB and above, must be discussed at the local Skin Cancer MDT and referred to the STLMDT as follows:

Referrals of Stage IB, IIA and III to be referred to: **Dr. Eileen Parry at Salford Royal Hospital**
(NB; Prognosis of stage III is greater than IIB (ISCL / EORTC updated guidelines, Blood 2008). Stage III patients are considered for photopheresis, which is managed by Dr Parry at Salford. Patients are referred on to Dr Cowan at Christie Hospital if further systemic treatment is needed)

Stage IIB and IV to be directed to: **Dr. Richard Cowan at the Christie Hospital**

For mycosis fungoides stage IIB and over AND cases patch/plaque stage 1B which are refractory to skin directed therapy can be considered for TSEB and other systemic therapy. Treatment options will include Total Surface Electron Beam Therapy (TSEBT), extracorporeal photopheresis (ECP), Bexarotene, radiotherapy, chemotherapy (oral / intravenous) and clinical trials.

TSEBT is performed at the **Christie Hospital** under Dr Cowan. Requests are made by/via the STLMDT.

ECP is used for erythrodermic CTCL stage III and IVA. Referrals should be initiated by the STLMDT. ECP is performed at Christie Hopsital (see measure 11-1A-208j)

Bexarotene is administered at Salford under Dr Parry and Christie under Dr. Cowan; requests are made by/via the STLMDT.

Radiotherapy, and oral / IV chemotherapy is administered at the Christie under Dr Cowan.

Referral should also be made to the local haemato-oncology MDT in the following circumstances:

- Where the Supranetwork MDT has requested that radiotherapy or chemotherapy or further / repeat investigation be administered at the local hospital as shared care.

- Where a patient is too ill to travel to Manchester.

Referrals to the STLMDT should include results of all relevant investigations including histology, immunophenotyping, and clonality studies in addition to blood tests and other staging investigations carried out.

NHS

Greater Manchester &
Cheshire Cancer Network

Referral for Extra Corporeal Photophoresis (ECP)
Peer Review Measure 11-1A-209j

The Greater Manchester & Cheshire Cancer Network Board, North West Specialist Commissioning Group, and the Skin Cancer Network Site Specific Group have agreed that:

Cases of erythrodermic cutaneous T-cell lymphoma, stages III & Iva, seen in the supra-network clinic and referred for ECP if considered appropriate

All referrals should come via the STLMDT from Salford or Christie, and should be discussed with the clinician in charge of the ECP facility.

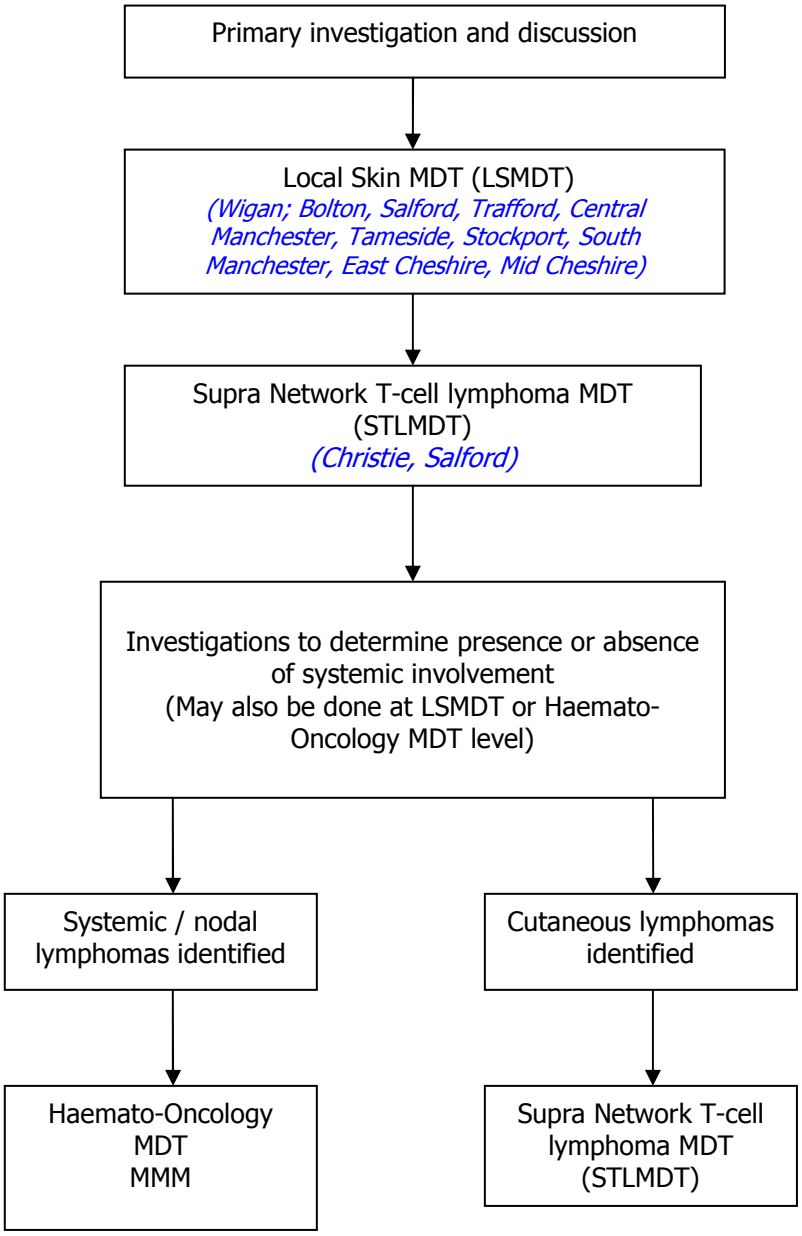
The named facility for extra corporeal photophoresis which the GMCCN will use is: **Christie Hospital**

The clinician in charge is: **Dr Therese Callaghan**

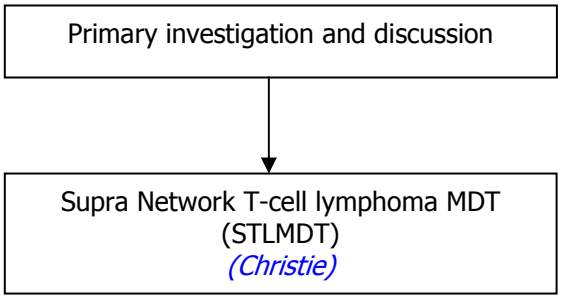
08-1A-215j Pathway for Skin Lymphomas

Cases of lymphoma presenting in the skin should be investigated locally and discussed at the local skin MDT and local Haemato-oncology MDT, in order to determine the presence or absence of systemic involvement.

LYMPHOMA

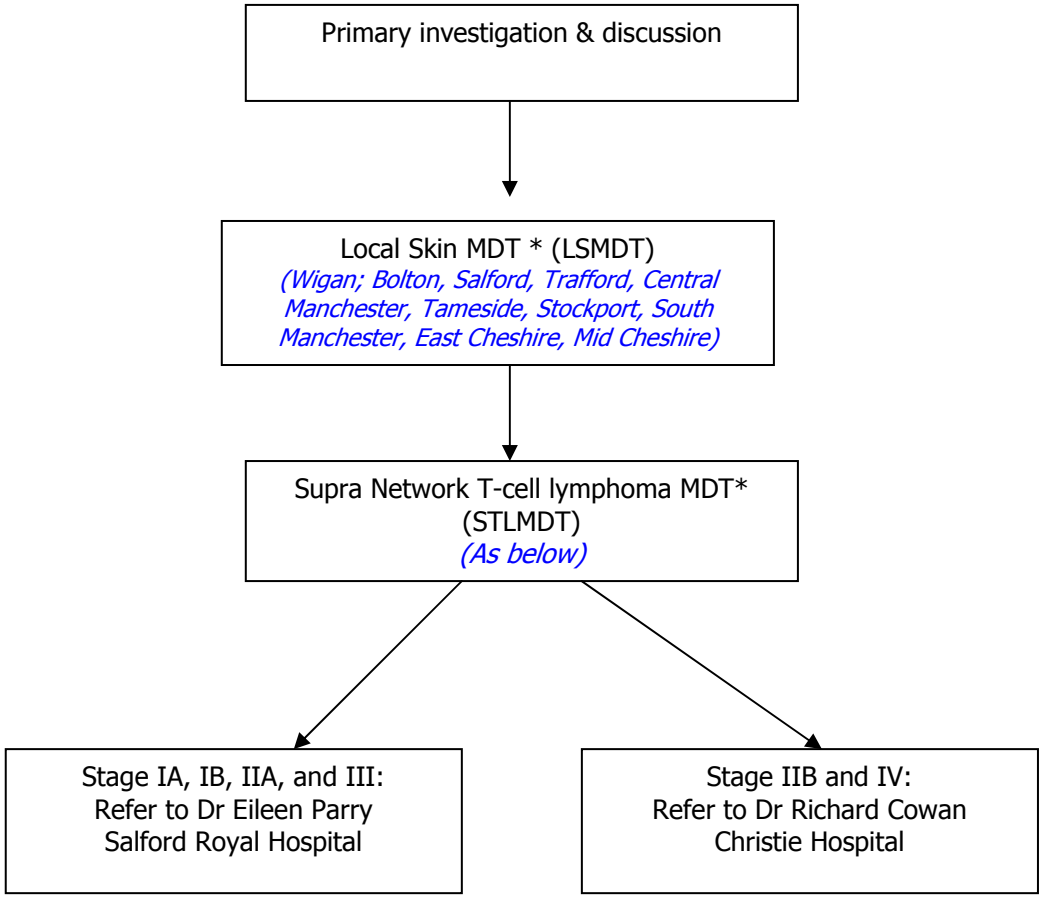


PRIMARY CUTANEOUS B CELL LYMPHOMA



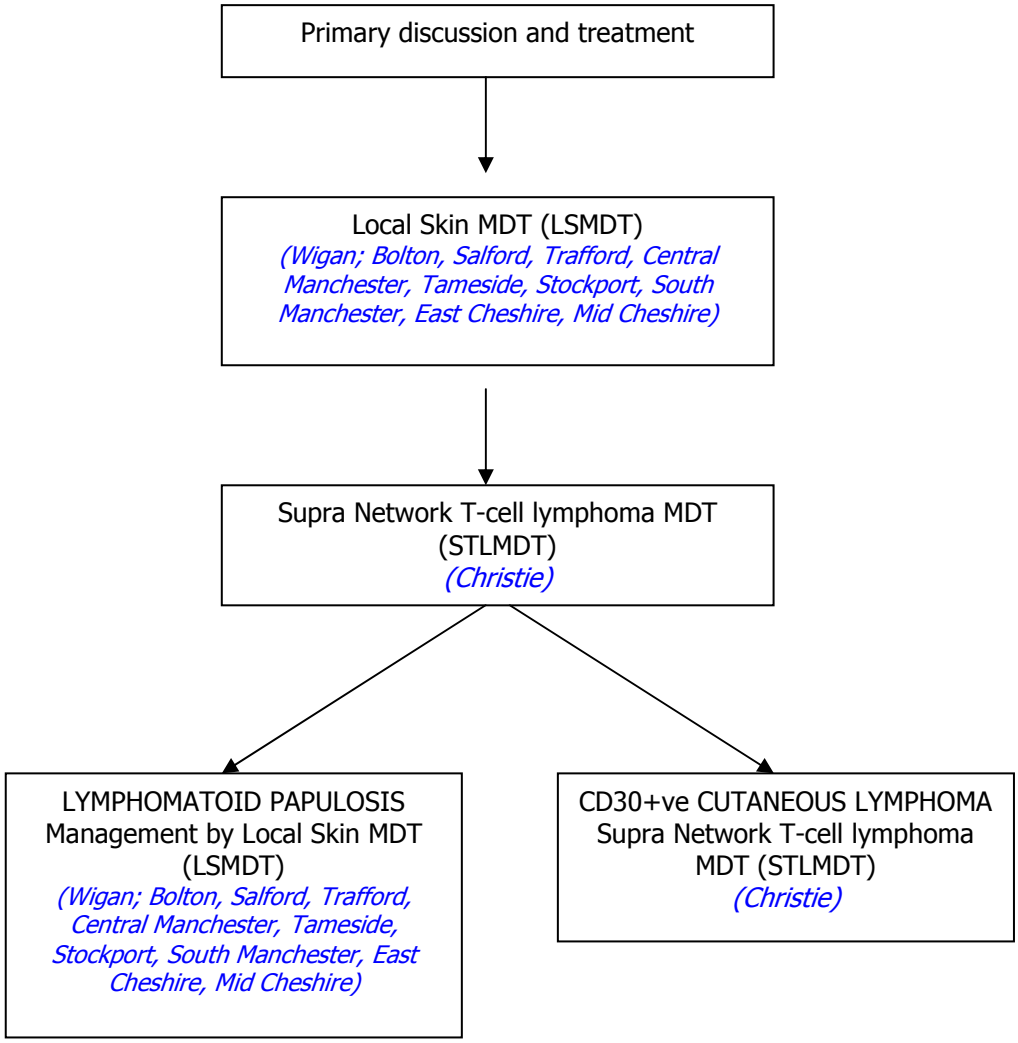
PRIMARY CUTANEOUS T CELL LYMPHOMA – MYCOSIS FUNGOIDES

Primary Cutaneous T cell lymphoma should be referred to the Supra-network T-cell Lymphoma MDT (STLMDT) as below:



* Refer to Haemato-Oncology MDT when STLMDT has requested radiotherapy / chemotherapy or further / repeat investigation to be administered locally as shared care or where patient is too ill to travel to Manchester

CUTANEOUS LYMPHOMAS – CD30+ve Spectrum



OTHER CUTANEOUS T CELL LYMPHOMAS

Review by Supra-network T-cell Lymphoma MDT

NB: Patients from Wigan Local Skin MDT are referred to the Specialist Skin MDT and plastic surgeons at Whiston Hospital, St Helens & Knowsley NHS Trust, part of the Mersey & Cheshire Cancer Network. GMCCN Patients may be referred to Mr Telfer, Mr Ghura, or Mr Madan , Consultant Mohs Surgeons based at Salford.

Agreed Skin Cancer MDT Guidelines for Sarcoma
Peer Review Measure 08-1A-216j

The Local Skin MDT or Specialist Skin MDT will refer all cases of incompletely excised or recurrent dermatofibrosarcoma protuberans and all cases of angiosarcoma, cutaneous leiomyosarcoma and any other cutaneous sarcomas to the Supraregional Sarcoma MDT for review.

- Core GMOSS members will arrange for review of patient at joint sarcoma clinic at Christie (alternate Tuesday mornings) and formal review at GMOSS MDT (Wednesday afternoons)
- In the majority of those cases needing further treatment this will be delivered by core GMOSS members
- Long term follow up will generally be within joint sarcoma clinic as per agreed guidelines

Summary of key recommendations:

- All suspected cutaneous sarcomas should be referred to Drs Shenjere and Nonaka at Christie for formal pathology review (EQA registered specialist sarcoma pathologist)
- Following review a report will be returned to the referring clinician with a suggestion that confirmed sarcomas should be referred to a core member of GMOSS at Christie to consider further treatment (Dr J Wylie, Consultant Clinical Oncologist or Mr Mowatt, Consultant Plastic Surgeon)

Contact :
Dr JP Wylie, Consultant Clinical Oncologist
Supraregional Sarcoma MDT Chair

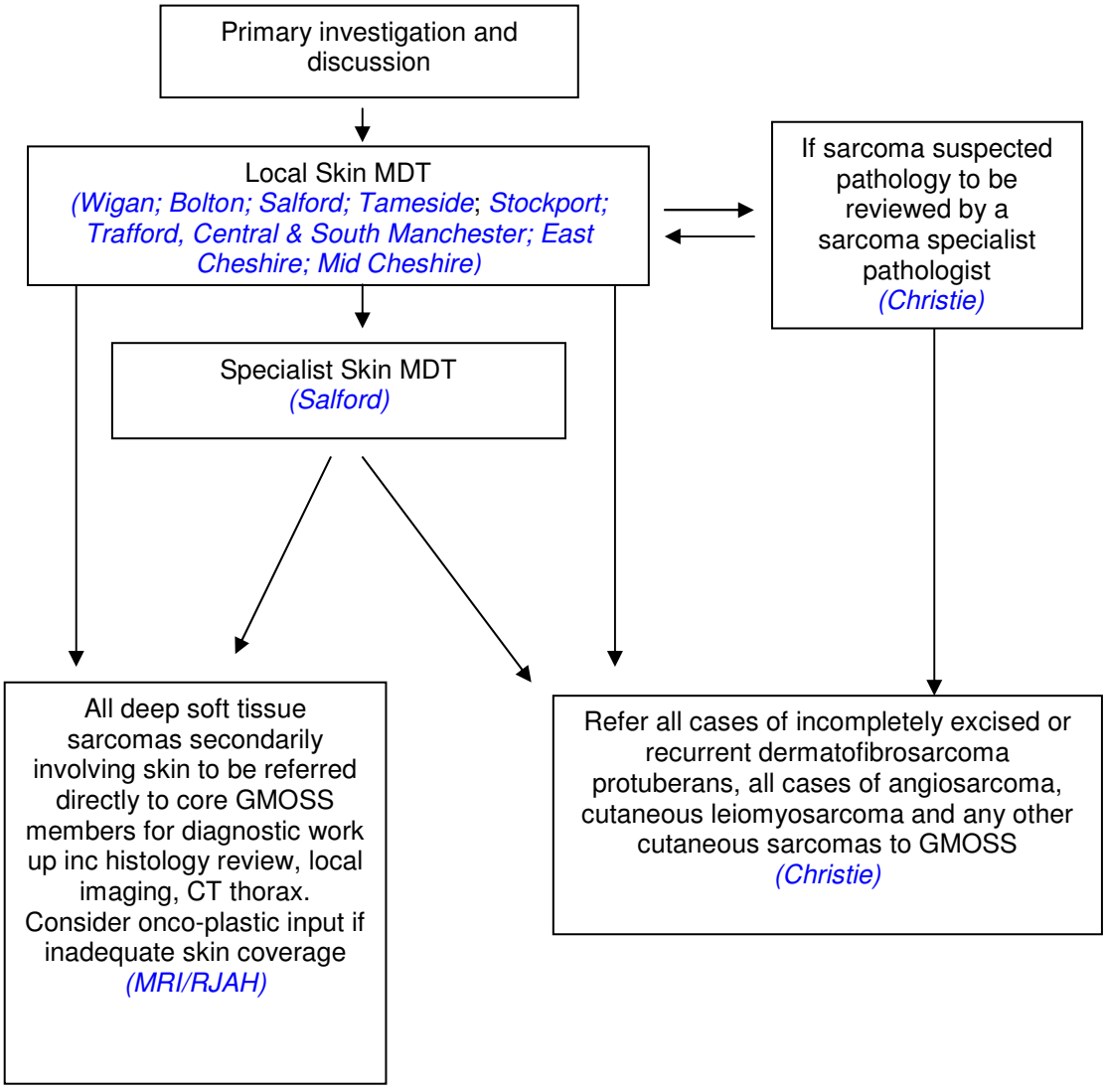
Preferred Contact

Sandy McAllister (Secretary)
Sandra.McAllister@christie.nhs.uk. Tel. 0161 446 8323, Fax 1061 446 3084

Alternative Contact

Rosie Tunstall (MDT co-ordinator)
Rosanne.Tunstall@christie.nhs.uk.Tel. 0161 918 7272, Fax 0161 918 7273

08-1A-216j Pathway for Sarcoma



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