

Basal Cell Carcinoma

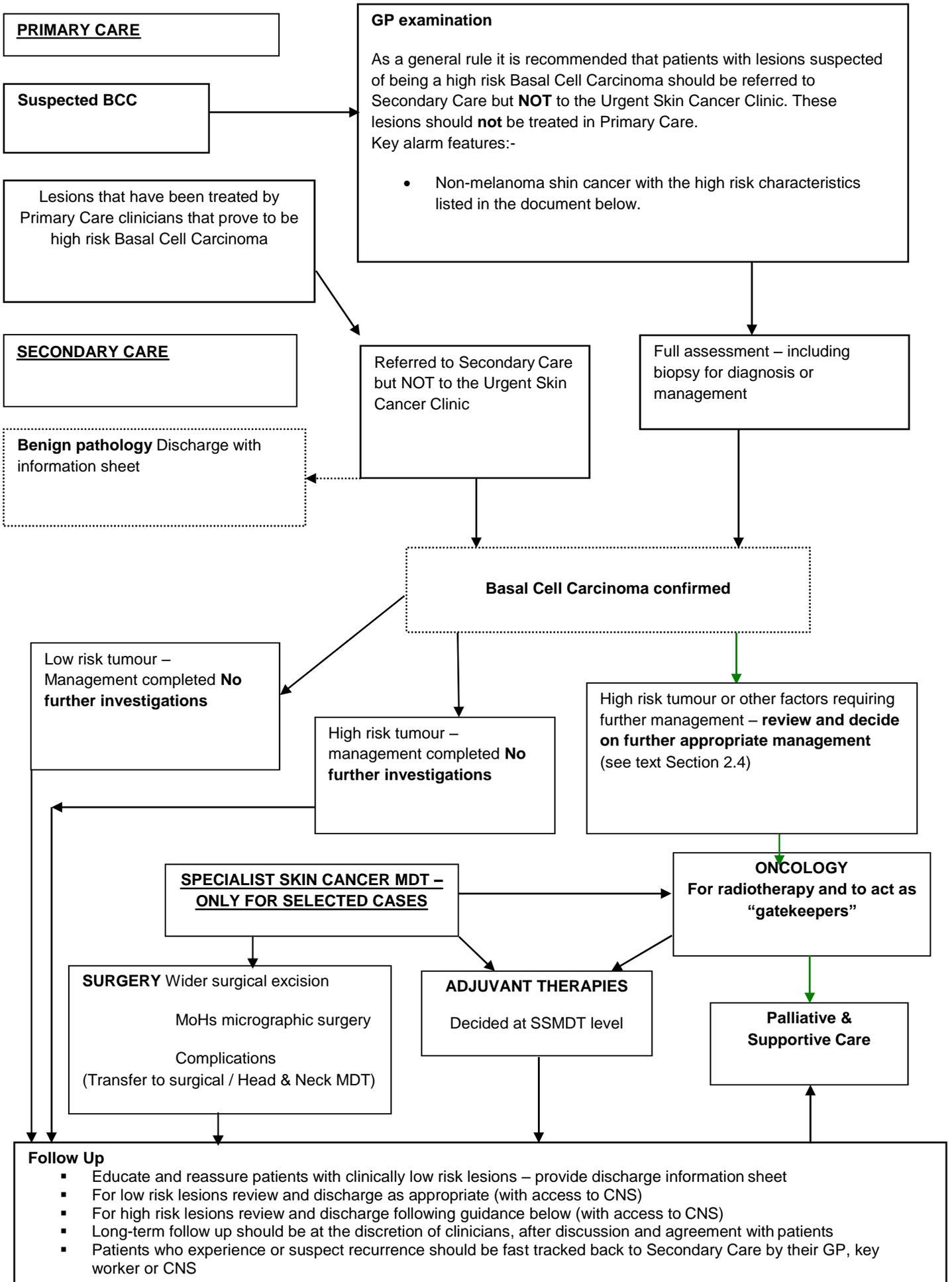
Pathway of Care

Publication date	December 2014
Expected review date	September 2016
Version number	4.0
Version status	Final

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1.0 Pathway Overview



2.0 Process and Terminology

2.1 Scope

This document sets out the pathway of care for patients with suspected/proven Basal Cell Carcinoma. It has been updated to ensure compliance with the 2006 NICE Improving Outcomes Guidance (IOG) for people with Skin Tumours including Melanoma (IOG), and the Peer Review Measures (2010). The IOG expects that the Kent & Medway Cancer Collaborative (KMCC) network provides three levels of care for patients with skin cancer.

These are:-

1. Primary Care
2. Local hospital skin cancer MDT (LSMDT)
3. Specialist skin cancer MDT (SSMDT)

Based on the population of Kent and Medway, the Skin Cancer Tumour Site Specific Group (TSSG) is proposing that there are two skin cancer MDTs in Kent and Medway that function at both Local and Specialist level, working to one set of protocols and policies agreed by the TSSG and its sub groups.

This document describes the process/care available at each level and is compliant with the 2006 IOG and the Peer Review Measures (2010).

2.2 Tumours

The scope of the pathway of care is confined to:-

High risk Basal Cell Carcinoma (BCC).

Definition:-

Primary cutaneous Basal Cell Carcinoma (BCC) is a common malignancy arising in the basal cells of the epidermis and its appendages. It is locally invasive and only very rarely has the potential to metastasize.

Clinical sub-types:-

- Nodulo-ulcerative
- Superficial
- Morphoeic
- Fibroepithelioma
- Pigmented

Certain tumoural characteristics are more likely to predict aggressive behaviour with extension or recurrence (and rarely potential to metastasize). (See *High Risk BSSs Section 4.1*).

Low risk BCCs may be managed by practitioners in Primary Care who are appropriately trained and are members of the LS/SSMDT. Management of high risk tumours should take place in Secondary Care.

2.3 Referral Guidelines and Processes

BCC usually presents as a slowly developing indurated area or nodular tumour that may ulcerate. The lesions can occasionally only be confidently differentiated from other non-melanoma and melanoma skin cancers on histology.

General practitioners are encouraged to refer patients with a suspected high risk BCC to Secondary Care for assessment and management.

Patients with suspected BCC should **NOT** be referred under National cancer 2-Week Wait rules (2-WW).

The BCC sub-group recommend that lesions identified as high risk Basal Cell Carcinoma should not be managed in Primary Care.

Lesions not thought to be BCC in origin and biopsied in Primary Care that prove to be high risk BCC should be referred non-urgently to Secondary Care. A copy of the histology report should be attached to the referral letter. If a photograph of the pre-biopsied lesion was taken, a copy should accompany the referral if possible.

2.4 High Risk BCCs

BCCs considered at high risk have a greater recurrence (and/or vary rarely metastasize) after treatment.

Histologic Sub-type

- *Morphoeic*
- *Infiltrative*
- *Micronodular*
- *Basosquamous*

Histologic Features:

- *Perineural invasion*
- *Invasion below dermis*

Sites

- *Nose and paranasal folds*
- *Periocular*
- *Ears*
- *Scalp and temples*
- *Lips*

Other Factors

- *Size > 20 mm*
- *Previously treated and recurrent disease*
- *Immunosuppressed patients*
- *Generic disorders (e.g. Gorlins/Basal Cell Naevus Syndrome)*

3.0 Secondary Care

Patients should be seen by a designated MDT member.

Patients will:-

- Undergo a thorough skin examination.
- Be reassured if the lesion is clinically benign.
- Have the lesion photographed if indicated.
- Have a biopsy taken or be booked for biopsy/removal as indicated.

Excision biopsy – ensuring an appropriate margin is preferred. incisional/punch/curette or shave biopsy of the lesion may also be performed as appropriate. The visit will be fully documented using the agreed pro-forma. The patient will receive appropriate information.

4.0 Cellular Pathology

It is expected that pathology departments will adhere to guidelines on specimen handling described in the Royal College of Pathology Minimum Data Set for Skin Cancer (RCP MDS).

All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC website:-
<http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

Patients with BCCs are not currently included in the DoH targets. Histology departments are not obliged to report on pigmented lesions within 2 weeks of biopsy unless doubt exists in the clinical diagnosis.

The Skin Cancer TSSG will monitor adherence to both the guidelines set out in the RCP MDS and targets through the process of regular audit.

5.0 Multi-disciplinary Teams (LS/SSMDT)

Selected patients with high risk BCCs should be discussed at multi-disciplinary meetings (MDMs). The MDT will comply with NICE Guidelines with regard to composition and function. These meetings will normally be held 2 weekly. Patients may be discussed at more than one MDM as they progress along their pathway of care.

The Skin Cancer MDT Co-ordinator will ensure that:-

- All appropriate new cases of Basal Cell Carcinoma are discussed at MDM.
 - Complex management cases
 - Incompletely excised
 - Patients requiring Mohs micrographic surgery
- MDT decisions are communicated to GP within 24 hours of the MDM.

- Data items described by the urgent skin cancer clinic pro-forma and RCP skin cancer pro-forma are accurately recorded.
- All patients are appropriately managed.
- MDM information is forwarded to the National Cancer Registration Service (NCRS).
- A documented initial or revised plan of care will be made at MDMs and filed in the patients notes.
- Cancer targets will be monitored and adhered to.

5.1 Data

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

Details of the Cancer Waiting Times dataset are available from:

<http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation>

Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable.

Details of the COSD are available from:

http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx

Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by the National Cancer Registration Service (NCRS).

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

Details of these datasets are available from:

<http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer>

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, SACT, diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

6.0 Treatment

6.1 Definitive Treatment of Primary or Recurrent Lesions

- Topical agents (imiquimod/5-fluorouracil)
- Cryotherapy/cryosurgery
- Photodynamic therapy (PDT)
- Radiotherapy
- Curettage and cautery
- Excision
- Mohs micrographic surgery
- Systemic therapies (rarely)
- Palliative and supportive care

Mohs micrographic surgery is appropriate for certain high risk tumours. This is a complex and time consuming technique. Departmental guidelines for referral should be followed.

7.0 Adjunctive and Complicated Disease Management

7.1 Adjuvant Treatment

The Skin Cancer TSSG will only support adjuvant therapies undertaken in the context of Specialist Skin Cancer MDTs. Oncologists will act as the “gate-keepers” for these therapies.

7.2 Metastatic and Nodal Disease (rare)

Metastatic BCC is an extremely rare but devastating complication of this cancer, with a poor survival outcome. Any patient with metastatic disease will be discussed with the MDT oncologists for further management.

Sentinel Node Biopsy (SNB) has no role in BCC management at present.

Only when surgical and/or other therapeutic options are being considered should staging investigations be arranged. These are defined in the KMCC Imaging Guidance document.

These may only be requested at the discretion of the MDT Oncologist/Surgeon and when the patient has accepted treatment.

(Please refer to the KMCC Imaging Guidance further information).

<http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/>

8.0 Children and Young People

Children and Young People (CYP) with Basal Cell Carcinomas will be treated in accordance with principles set out in the CPY IOG.

All children and Young People up to the age of 18 must be referred to the CYP Principle Treatment Centre, which for KMCC is based in the Royal Marsden Hospital.

All Young People between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre.

Referral to a CYP Principle Treatment Centre does not necessarily mean that treatment will be undertaken at that centre shared care management protocols may allow some treatments to be undertaken locally.

9.0 Oncology Provision

The Non-Surgical Oncological management of all patients with Basal Cell Carcinoma as defined by the Non-Surgical Oncology Sub Group (NOG) of the Skin Cancer TSSG is set out in the document “**The Oncological Treatment of Skin Cancer**”.

Note: This is located on the KMCC website:

<http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/dermatology-tssg/>

10.0 Supportive and Palliative Care

All patients with BCC will have access to appropriate specialist palliative care and support at every stage of the patient journey.

Open and frank discussions with patients should take place at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them.

Relatives and carers will need to be supported and given information. However, in accordance with the recommendations set out in other Improving Outcomes Guidance, relatives and carers should not be given information different to that given to the patient.

Frail and terminally ill patients with BCC should always be discussed with the specialist palliative care team.

Palliative care provision should be available for all patients who require it:-

- Hospital teams, including the Clinical Nurse Specialist for cancer patients.
- Primary Health Care Team to provide palliative care at home.
- General Practitioner should be informed within 24 hours of the diagnosis and treatment plan.

The management of symptoms, psychological, social and spiritual issues, the communication of the diagnosis and any associated problems, should be within the domain of all healthcare professionals.

Referral to specialist palliative care services should be considered when these issues have not been resolved and in particular for patients with:-

- Complex symptom management issues.

- Difficulties in adjusting to the diagnosis or disease progression.
- Psychological and family issues – such as communication problems within the family.
- Spiritual issues – such as challenging of belief system/faith/cultural values as a result of the cancer.

Consideration of specialist palliative care or support should be given throughout the patient pathway, particularly:-

- At the MDT discussion.
- When no active treatment is considered.
- After active treatment.
- At time of relapse.
- In the terminal stages of the disease.

11.0 Follow Up

Long term follow up of all patients after treatment of BCC is not necessary

Early detection and treatment improves outcomes of patients with recurrent or new primary disease. Studies suggest:-

- 82% of local recurrences occur within 5 years.
- 36% of patients develop new primary tumours.
- 20% of high risk patients (skin type and exposure) develop multiple new lesions.

Long term follow up may be appropriate in primary or secondary care or primarily led by patient self-examination.

- The key purpose of follow up is patient education.
- There is good evidence that well informed patients detect their own recurrence.
- Patients who do detect recurrence should be referred back to secondary care.
- Patients will have access to a clinical nurse specialist for support and advice.
- Patients will have access to appropriate information and should always be given relevant “discharge” information.

Patients with low risk lesions should be reviewed following appropriate treatment of the primary lesion for education and advice. Routine long term follow up of these patients is not required.

All other BCCs should be reviewed and may be discharged at an appropriate time following patient education and agreement. The follow up period should be.

Long term follow up should be undertaken at the discretion of clinicians and only after discussion and agreement with patients. Follow up could be nurse led.

When the MDT has agreed that adjuvant therapy is appropriate, follow up will be tailored to suit the needs of the patient.

The Skin Cancer TSSG will review this pathway of care annually or when new evidence becomes available, whichever is soonest. The Skin Cancer TSSG will also audit adherence to this pathway of care.

12.0 Personnel and Contact Information

A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: <http://kmcc.nhs.uk/tumour-sites/terms-of-reference/>

13.0 Glossary

Acronyms in common use throughout KMCC documentation:-

CNB	Cancer Network Board
CYP	Children and Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospital University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent and Canterbury Hospital, Canterbury (EKHUFT)
KCH	Kings College Hospital
KMCC	Kent & Medway Cancer Collaborative
KMCN	Kent and Medway Cancer Network
KMCRN	Kent and Medway Cancer Research Network
LSESN	London and South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone and Tunbridge Wells NHS Trust
NOG	Non- Surgical Oncology Group (<i>Permanent oncologist sub group of the TSSGs with specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs</i>).
PoC	Pathway of Care (<i>KMCC agreed disease site specific clinical guidelines</i>)
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of Life
RAT	Research and Trials Group (<i>Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda</i>).
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
QVH	Queen Victoria Foundation Trust Hospital, East Grinstead
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

14.0 Document Administration

Document Title	Basal Cell Carcinoma Pathway of Care
Principle author	Ashley Cooper
Co-author(s)	Caroline Tsatsaklas/Ian Vousden
Current version number	4.0
Current status	Final
Agreed as “fit for publication” by	December 2014
Original publication date	January 2008
Expected review date	November 2016

Enquiries:		
1] Jess Jenkins	01622 225103	jessicajenkins@nhs.net
2] Nick Rowell	01622 225 103	nrowell@nhs.net
3] Natalie Aluwalia	01634 335 127	natalie.aluwalia@nhs.net

Revision History			
Date of Revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
Jan 2008	0.1	Draft – development	K.Ayerst
April 2008	1.0	Published – agreed	Skin DOG
Feb 2009	2.0	Published – reviewed & agreed	Skin DOG
12/01/2012	2.1	Put into new format	C.Tsatsaklas
15/02/2012	2.2	A.Cooper changes incorporated and contact details updated	A.Cooper/C.Tsatsaklas
June 2012	2.3	Draft – updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	J.Bullass/C.Tsatsaklas
September 2012	3.0	FINAL – approved at Skin DOG 13/09/12 – agreed/published	A.Cooper/Skin DOG/ I.Vousden
August 2014	3.1	Draft - Removed text relating to DOGs, PCTs, KMCN – replaced with TSSGs, CCGs, Cancer Team, updated weblinks etc	C.Tsatsaklas
November 2014	3.2	Update to section 9.0 as directed by J.Jenkins	N.Aluwalia
December 2014	4.0	Published – ratified by O&Q Group	N.Aluwalia