Kent and Medway Cancer Collaborative

Squamous Cell Carcinoma

Pathway of Care

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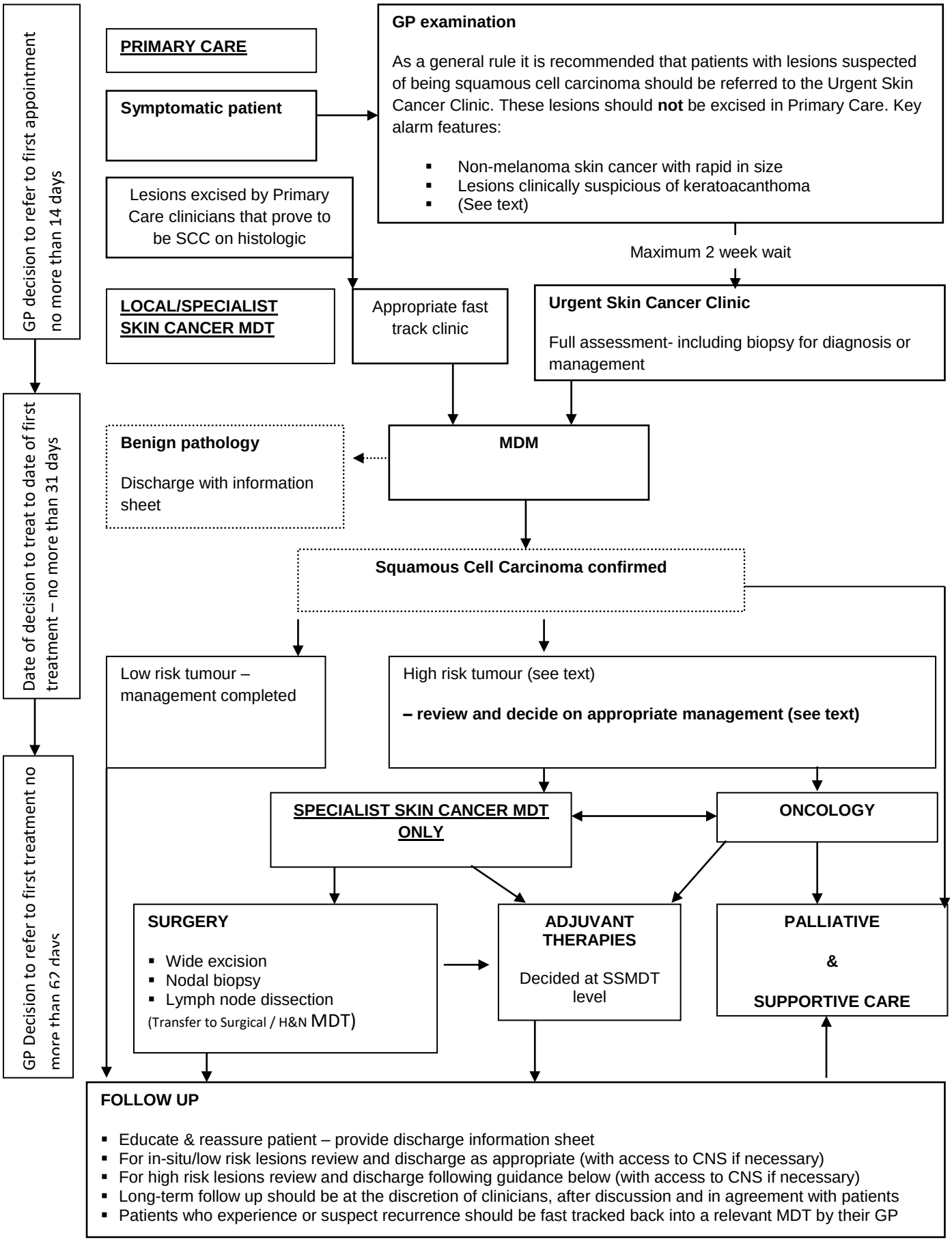
1.0 Pathway Overview



2.0 Process and Terminology

2.1 Scope

This document sets out the pathway of care (PoC) for patients with suspected/proven Squamous 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). The IOG expects that Kent & Medway provide 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 & Medway, the Skin Cancer Tumour Site Specific Group (TSSG) is proposing that there are two skin cancer Multidisciplinary teams (MDTs) in Kent & 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.

2.2 Tumours

The scope pathway of care is confined to:

- Primary cutaneous invasive squamous cell carcinoma (SCC) and keratoacanthomas (KAs)

Definition: Primary cutaneous squamous cell carcinoma (SCC) is a malignancy arising in the keratinising cells of the epidermis and its appendages. It is locally invasive and has the potential to metastasize (usually to regional lymphatics).

- Actinic keratoses
- Bowen's disease = SCC *in situ*
- Keratoacanthomas
- Invasive SCCs

2.3 Referral guidelines and process

SCC usually presents as a rapidly developing indurated area or nodular tumour that may be keratinizing, crusted or ulcerative. KAs frequently display a classical clinical picture and history but may only be confidently differentiated from other non-melanoma skin cancers on histology.

General practitioners are encouraged to refer patients with a suspected SCC as a matter of urgency.

Patients with suspected SCC should be referred under the National cancer 2-Week Wait rule (2-WW).

The SCC sub-group recommend that lesions thought to be invasive squamous cell carcinoma should not be biopsied in Primary Care.

Lesions not thought to be SCC in origin and biopsied in Primary Care that prove to be invasive SCC should be referred urgently under the 2-Week Wait Rule. A copy of the histology report should either be faxed with the referral or accompany the patient to the clinic appointment. If a photograph of the pre-biopsy lesion was taken, a copy should accompany the patient if possible. These patients will be discussed at the multi-disciplinary meeting (MDM) in the first instance.

2.4 High Risk SCCs

SCCs considered at high risk have a greater recurrence and/or metastatic rate after treatment.

Histologic features

- Depth of 4mm or greater (or Clark level 5)
- Poorly differentiated (Broder's 3 or 4)
- Perineural invasion

Sites (listed in increasing metastatic potential)

- Sun exposed sites (excluding lip and ear)
- Lip
- Ear
- Non-sun-exposed (e.g. perineum)
- Site of radiation or thermal injury, chronic ulcers, inflammation, sinuses or Bowen's disease

Other factors

- Size > 20 mm
- Previously treated and recurrent disease
- Immunosuppression

3.0 Local/Specialist Skin MDTs

Patients should be seen within 2 weeks of referral.

Patients will:

- Be reassured
- Undergo photography of lesion if appropriate
- Undergo thorough examination including assessment of loco-regional lymph node status
- Undergo excision biopsy (if necessary and not previously undertaken)

Excision biopsy - ensuring an appropriate margin is preferred. Incisional/punch/shave biopsy or curettage and cautery of the lesion may also be performed.

The visit will be fully documented using the agreed proforma. The patient will receive "discharge" 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://www.kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/

In order to comply with the DH 31 day (referral to diagnosis) target, histology departments are obliged to report on pigmented lesions within 2 weeks of biopsies taken at Urgent Skin Cancer Clinics.

The Skin Cancer TSSG will jointly monitor adherence to both the guidelines set out in the RCP MDS and the 31 day target through process of regular audit.

5.0 Multi-disciplinary meeting (MDM)

All patients with high risk SCCs should be discussed at MDMs.

These meetings will normally be held weekly.

Patients may be discussed at more than one MDM as they progress along their pathway of care.

5.1 LS/SSMDT

All patients should be discussed at multi-disciplinary meetings (MDMs).

The MDT will comply with NICE Guidelines with regard to composition and function.

These will normally be held weekly.

Patients may be discussed at more than one MDM as they progress along their pathway of care.

The Skin Cancer MDT co-ordinator role will be consistent with the job descriptions for other disease site MDT co-ordinators within Kent & Medway.

The MDT co-ordinator will ensure that:

- All new cases of high risk invasive squamous cell carcinoma are discussed at MDT.
- MDT decisions are communicated to GP urgently
- Data items described by the urgent skin cancer clinic proforma and RCP skin cancer proforma are accurately recorded
- All patients are appropriately managed
- MDT information is forwarded to the National Cancer Registration Service
- A documented initial or revised plan of care will be made at MDMs
- Population of InfoFlex dataset

5.2 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://www.datadictionary.nhs.uk/data_dictionary/messages/clinical_data_sets/data_sets/national_cancer_waiting_times_monitoring_data_set_fr.asp

  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 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

- No active management
- Topical agents (imiquimod/5-fluorouracil)
- Cryotherapy/cryosurgery
- Photodynamic therapy (PDT)
- Radiotherapy
- Curettage & cautery
- Excision
- Mohs micrographic surgery
- Systemic therapies
- Palliative and supportive care

7.0 Specialist Skin Cancer MDTs

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 adjuvant therapy.

7.2 Nodal Disease

Patients with nodal disease should undergo Fine Needle Aspiration (FNA) cytology or lymph node biopsy prior to carrying out formal block dissection.

Block dissection will only be undertaken in the context of the Specialist Skin Cancer MDT.

7.3 Staging investigations

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

Note: Imaging guidelines can be located in the KMCC agreed document located on the KMCC website on the following link: http://www.kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/

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

7.4 Sentinel Node Biopsy (SNB)

SNB has no role in SCC management at present.

The Skin Cancer TSSG will review this recommendation as evidence becomes available.

8.0 Children & Young People

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

All children and Young People up to the age of 18 must be referred to the CYP Principal Treatment Centre which for Kent & Medway is based at 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 Principal 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 Squamous Cell Carcinoma defined by the Non-Surgical Oncology Sub Group (NOG) of the Skin TSSG is set out in the document:

"The Oncological Treatment of Skin Cancer"

Note: *This is located on the KMCC website:-* http://www.kmcc.nhs.uk/tumour-sites/dermatology-tssg/

10.0 Supportive & Palliative Care

All patients with SCC 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 with patients 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 appropriate information. However, in accordance with the recommendations set out in other Improving Outcomes Guidance documents, relatives and carers should not be given information different to that given to the patient.

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

Palliative care provision should available for all patients:

- Hospital teams, including the Clinical Nurse Specialists for melanoma patients
- Primary Health Care Team would provide for 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 health care 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 the 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 Multidisciplinary Team Meeting
- When no active treatment is considered
- After active treatment
- At relapse
- In the terminal stages

11.0 Follow up

Early detection and treatment improves survival of patients with recurrent disease. 95% of local recurrences and metastatic disease are detected within 5 years. There is good evidence to support regular follow-up.

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 patients detect their own recurrence.
- Patients who do detect recurrence should be fast tracked back to the MDT.
- 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 in-situ/non-invasive and low risk lesions will be reviewed following appropriate treatment of the primary lesion for education and advice. Routine long term follow-up is not required.

All other SCCs should be reviewed and may be discharged at an appropriate time following patient education and agreement. The follow up period should be individualised and may be shorter than current protocols.

Long-term follow up is not mandatory and should be undertaken at the discretion of clinicians and only after discussion and in agreement with patients. Follow up, where required, could be nurse led.

When the MDT has agreed that where adjuvant therapy is appropriate, follow up will be "tailor-made" 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://www.kmcc.nhs.uk/tumour-sites/terms-of-reference/

13.0 Glossary

Acronyms in common usage throughout KMCC documentation:-

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

14.0 Document Administration

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June 2012	2.3	Draft – updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	C.Tsatsaklas
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