

# Optimal care pathway for people with basal cell carcinoma or squamous cell carcinoma

## Quick reference guide



Please note not all patients will follow every step of this pathway. The majority with BCC/SCC will not proceed beyond step 2.

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

### Step 1

#### Prevention and early detection

**Prevention:** Solar radiation is the major environmental cause of all skin cancers. People should be encouraged to use a combination of sun protection measures.

A randomised control trial suggests that prophylaxis with daily nicotinamide (vitamin B3) may help to reduce BCC/SCC by 26 per cent.

**Risk factors include:**

- outdoor occupations
- immunosuppression
- previous radiotherapy
- solarium use
- fair or red hair colour
- skin that burns and does not tan

- tendency to freckle
- a history of blistering sunburn
- a previous BCC/SCC
- family history
- increasing age
- past exposure to arsenic
- multiple solar keratoses.

Intensive ultraviolet (UV) exposure in childhood and adolescence is a causative factor for developing BCC, whereas SCC is caused by chronic UV exposure incurred over decades.

For a proportion of SCC, human papilloma virus (HPV) may act in concert with sun exposure.

**Early detection:**

Opportunistic identification of high-risk patients, with subsequent total body cutaneous examination.

Management of increased risk should include:

- education (self-examination, sun protection)
- a total skin check every six to 12 months.

### Step 2

#### Presentation, initial investigations and referral

**Signs and symptoms:**

**SCC:** The majority arise from solar keratoses. Induration, thickening or tenderness in the erythematous base of a scaling lesion.

**BCC:** A dome-shaped skin growth, pink scaly patch or pearly hard skin-coloured growth, a sore that will not heal or with visible blood vessels.

The following should be assessed by a primary care practitioner:

- any changing skin lesions, including new lesions or lesions that do not respond to treatment
- a rapidly growing skin lesion that remains unresolved after one month.

**General/primary practitioner investigations:**

Some lesions will be confidently diagnosed on clinical examination and history and others, particularly early lesions will require biopsy.

The following lesions should fall within the scope of a general practitioner with experience and confidence in surgical procedures. Well-defined primary lesions of:

- the trunk and extremities up to 15 mm; between 15 and 20 mm is a grey zone and they need referral depending on circumstances
- the face, forehead or scalp up to 10 mm.

Complete excision is the best approach for most within four weeks of the decision that it is necessary.

Dermoscopy by people who are adequately trained is useful in enhancing diagnosis of BCC.

**Referral: Most BCCs/SCCs do not require referral.**

For complicated BCC, consider referral for:

- incompletely excised lesions where surgical expertise is required for appropriate margins
- lesions involving the central face, ears, genitalia, digits, palm of hand or lower leg
- poorly defined lesions
- lesions fixed to underlying structures
- lesions lying adjacent to significant nerves
- trunk and extremities lesions > 20 mm
- cheek, forehead and scalp lesions > 10 mm.

For complicated SCC, consider referral for:

- SCC of the central face, scalp, lip and ear
- chronically immunosuppressed patients with multiple aggressive SCC
- locally recurrent and/or persistent SCC.

Healthcare providers should provide clear routes of rapid access to specialist evaluation.

Referral should incorporate appropriate documentation sent with the patient.

**Communication – lead clinician to:<sup>1</sup>**

- remind the patient about primary prevention measures for minimising their risk
- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

<sup>1</sup> Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

### Step 3

#### Diagnosis, staging and treatment planning

**Diagnosis:** Management may include: complete excision or re-excision with recommended margins; imaging (in some circumstances); a complete skin check.

**Staging:** Usually a biopsy is sufficient to diagnose a BCC/SCC.

In cases of SCC, clinically suspected lymph node metastases should be confirmed by fine needle aspiration cytology (under radiological or ultrasound guidance if required) if possible. Open surgical biopsy should be avoided.

Sentinel lymph node biopsy may be offered to patients as prognostic information and to assess the presence of lymph node metastasis +/- complete regional lymphadenectomy.

**Treatment planning:** Selected patients with advanced stage primary BCC/SCC, lymph node involvement and BCC/SCC in unusual sites are best managed by multidisciplinary teams in a specialist facility.

Research and clinical trials: Consider enrolment where available and appropriate.

#### Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

### Step 4

#### Treatment:

Establish intent of treatment:

- curative
- a good cosmetic and functional result

**Surgery** involves excision with an adequate margin of skin and subcutaneous fat. Margin-control surgery may be considered for some patients.

**Radiation treatment** should be reserved for the small minority of primary BCCs and SCCs that present particular problems for conventional surgery and for cases of persistent, recurrent or advanced BCC and SCC to improve control rates.

Other therapies for early-stage BCC/SCC when surgery is not suitable may include: curettage and electrocautery; acitretin; cryotherapy; photodynamic therapy; or imiquimod cream.

#### Communication – lead clinician to:

- discuss treatment options with the patient/carer including the intent of treatment as well as risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

For detailed information see <<http://www.cancer.org.au/content/pdf/HealthProfessionals/ClinicalGuidelines>>.

### Step 5

#### Care after initial treatment and recovery

All patients with a previous skin cancer are advised to undergo an annual skin examination for life.

Patients should be provided with information about preventing other cancers and educated on healthy lifestyle choices to improve general health and secondary prevention.

#### Communication – lead clinician to:

- explain the follow-up care plan to the patient/carer
- inform the patient/carer about secondary prevention and healthy living
- provide information about the signs and symptoms of recurrence.

### Step 6

#### Managing recurrent or metastatic disease

**Detection:** Patients should be advised to be alert for any new or changing skin lesion, cutaneous lump or persistent new symptom.

**Treatment:** Where possible, refer the patient to the original multidisciplinary team. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

**Palliative care:** Early referral can improve quality of life and, in some cases, survival. Referral should be based on need, not prognosis.

#### Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the patient/carer.

### Step 7

#### End-of-life care

**Palliative care:** Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

#### Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the patient/carer
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

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