Dermatology two week wait: are we referring appropriately?

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INTRODUCTION

This project aims to investigate the nature of GP referrals to secondary care via the dermatology two week wait (2ww) cancer pathway at a West Berkshire GP practice (~14200 patients). Local CCG data has recently highlighted a dramatic decline in the appropriateness of skin lesions being referred to secondary care which may partly be explained by community challenges such as time pressure in general practice and long waits for routine secondary care appointments. Referral rates have substantially increased, whilst conversion rates (the proportion of patients referred who are subsequently diagnosed with cancer) have decreased.

NICE GUIDELINES

Malignant Melanoma (MM):
Refer via 2ww if score 3 or more on weighted 7 point check list (table 1), dermatoscopy suggests MM or a pigmented/non pigmented lesion which is suspicious of a nodular melanoma.

Squamous Cell Carcinoma (SCC):
Consider 2ww in a lesion which raises a suspicion of SCC.

Basal Cell Carcinoma (BCC):
Routine referral. Exception: 2ww if concern that delay may have significant impact because of factors such as lesion site or size.

METHODS

The practice database was searched, spanning a 6 month period from 1/1/2015 to 30/6/15, to identify patients referred via the 2ww pathway. Referral letters were analysed, looking specifically at the content of the letter, the proposed diagnosis and the name of the referring GP. These were then compared to the outcome detailed in letters from secondary care.

RESULTS

In total, 75 patients were referred. The number of referrals made by individual GPs ranged from 1 to 23 (mean=5). 25% (19) were clinically felt by dermatology to be an SCC (6), were identified as a suspicious pigmented lesion (11) or were an appropriate 2ww BCC* (2), 9% (7) were clinically diagnosed as non-urgent BCCs, 50% (38) were benign (table 2), 9% (7) had no secondary care letter available for analysis and in 5% (4) of cases, the lesion had resolved. At final histological diagnosis, 5% (4) were SCC/MM/infiltrative BCC. Two cancers were picked up incidentally through a skin check (the referred lesion was benign).

A quarter of 2ww lesions referred by GPs over the 6 months were given a clinical diagnosis in secondary care of an SCC, a suspicious pigmented skin lesion or a 2ww BCC. GPs differ substantially in their threshold for referral, with referrals ranging from 1 to 23 per individual GP. This suggests that experience of dermatology and tolerance of risk/uncertainty substantially differs between GPs.

It is interesting that two histologically confirmed cancers were picked up incidentally through a secondary care skin check, despite the referred lesion being benign. This demonstrates the value of skin checks and raises the question whether checks should be performed by GPs in primary care consultations.

GPs could improve their recognition of non-urgent BCCs (9%) and seborrhic keratoses (most commonly referred benign lesion). Improvement is challenging, because unlike 2ww for other cancers, referral criteria rely broadly on physician knowledge and experience. The NICE referral criteria for a 2ww BCC are particularly difficult, because 'site and size' are vague criteria on which to base referral decisions. With an aim to improve referrals, the practice has now purchased two dermatoscopes, three partners have attended dermoscopy courses and an informal system of internal cross referral for skin lesions is in place. Introducing further educational sessions, opportunities for GPs to shadow 2ww clinics and a teleperm triage system could be additional ways to improve referrals.

The project is limited by its small sample size and that data collection was conducted at a single practice. Future research could expand the time frame over which referrals were analysed and include several practices with different patient demographics.

DISCUSSION AND CONCLUSIONS

Please contact hr7619@my.bristol.ac.uk for questions or further references. 30/08/2016.

REFERENCES

1. National Institute for Health and Clinical Excellence guideline (June 2015) Suspected Cancer: Recognition and Referral, Skin cancers 1.7. Available at: https://www.nice.org.uk/guidance/NG512/chapter/1-

Clinical diagnosis from Dermatology:

- Suspicious pigmented lesion: 15%
- SCC: 9%
- 2ww BCC: 8%
- Non 2ww BCC/benign: 3%
- Lesion resolved: 60%
- No letter: 5%

Benign naevus: 7
Actinic keratosis/Bowens: 6
Seborrhic keratoses: 13
Inflammatory skin condition: 1
Solar lentigo: 2
Ulcer: 1
Other (e.g. haemangioma/cyst/morphoea/viral wart/pigmentation in pregnancy): 8

Table 2: Breakdown of benign lesions

<table>
<thead>
<tr>
<th>Major Features (2 points each)</th>
<th>Minor Features (1 point each)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in size</td>
<td>Largest diameter 7mm or more</td>
</tr>
<tr>
<td>Irregular shape</td>
<td>Inflammation</td>
</tr>
<tr>
<td>Irregular colour</td>
<td>Oozing</td>
</tr>
<tr>
<td></td>
<td>Change in sensation</td>
</tr>
</tbody>
</table>

Table 1: Weighted 7 point check list for suspicious pigmented lesion

*Appropriate was defined as: an infiltrative facial BCC referred to plastics/for Mohs excision. These 2 lesions were referred by GPs as possible SCCs/MM, not as 2ww BCCs.