NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Pathway for the Treatment of Basal Cell Carcinoma in Primary Care

Definition

Basal Cell Carcinoma (BCC) is the most common form of skin cancer. It is a type of cancer that arises from the basal cells, small round cells found in the lower part (or base) of the epidermis, the outer layer of skin. Its main cause is long-term exposure to ultraviolet light, usually from the sun. Most tumours develop on exposed sites, chiefly the face and neck.

Relevant OPCS Codes:

C44.0 Skin of lip
C44.1 Skin of eyelid including canthus
C44.2 Skin of ear and external auricular canal
C44.3 Skin of other and unspecified parts of face
C44.4 Skin of scalp and neck
C44.5 Skin of trunk
C44.6 Skin of upper limb, including shoulder
C44.7 Skin of lower limb including hip
C44.8 Overlapping lesion of skin
C44.9 Malignant neoplasm of skin, unspecified

Policy

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. For patients that deviate from this pathway policy clinicians can apply for funding to the Exceptional Cases Panel - click here to access the funding request form.

Treatment, provided the diagnosis of BCC is confirmed may include:

- Monitoring
- Surgical excision
- Curettage and cautery/electrodessication
- Cryotherapy/cryosurgery
- Topical treatment (for example, imiquimod)
- Photodynamic therapy
- Mohs micrographic surgery
- Radiotherapy

For treatments where tissue is not obtained for histological confirmation (such as cryotherapy, PDT (Photodynamic Therapy), imiquimod or radiotherapy) it is expected that the histological diagnosis will have been confirmed before treatment.

Models of Care

NICE specifies the new clinical criteria for triage that should be used to identify those BCCs that should be managed by one of three different groups of healthcare professionals in primary care. The algorithms are shown on pages 3 and 4 of this policy[1].

- Low risk BCCs for DES/LES (Direct Enhanced Services/Local Enhanced Services) **(see Box 1, page 3)**. GPs performing skin surgery within the framework of the DES and LES under GMS or PMS.

- Model 1 practitioners which are Group 3 GPwSI (general practitioner with a special interest) in dermatology and skin surgery. This now considers a new GPwSI in skin lesions and skin surgery **(see Box 2, page 4)**.

- Model 2 practitioners. These are outreach community skin cancer services provided by Acute Trusts linked to the LSMDT (local hospital skin cancer multidisciplinary team) **(see Box 3, page 4**).

Only those low-risk BCCs in anatomical sites where excision is easy and in patients who do not have other associated risk factors should be managed by GPs with no special interest or training in skin cancer. The types of low-risk BCC that these GPs can excise and their requirement for accreditation by the CCG are outlined in Box 1. If the BCC does not meet the criteria, or there is any diagnostic doubt, following discussion with the patient, they should be referred to a member of the LSMDT.

The GP should have come through the training programme which has been set by the CCG working with the local dermatologists (adapted from page 28 of the NICE guidance).

There are a number of accredited GPwSI in dermatology and skin surgery. To increase the number of healthcare professionals in primary care who are able to manage suspected skin cancer, a new GPwSI in skin lesions and skin surgery is proposed with less onerous training and accreditation requirements than Group 3 GPwSI in dermatology and skin surgery. Model 1 practitioners are trained and accredited in the management and excision of low-risk BCCs in the community. They should manage an expanded range of low-risk BCCs, including some on the head and neck. As outlined in Box 2.

Their accreditation standards are shown on page 30 of the NICE guidance.

A Model 2 practitioner should be one of the following:

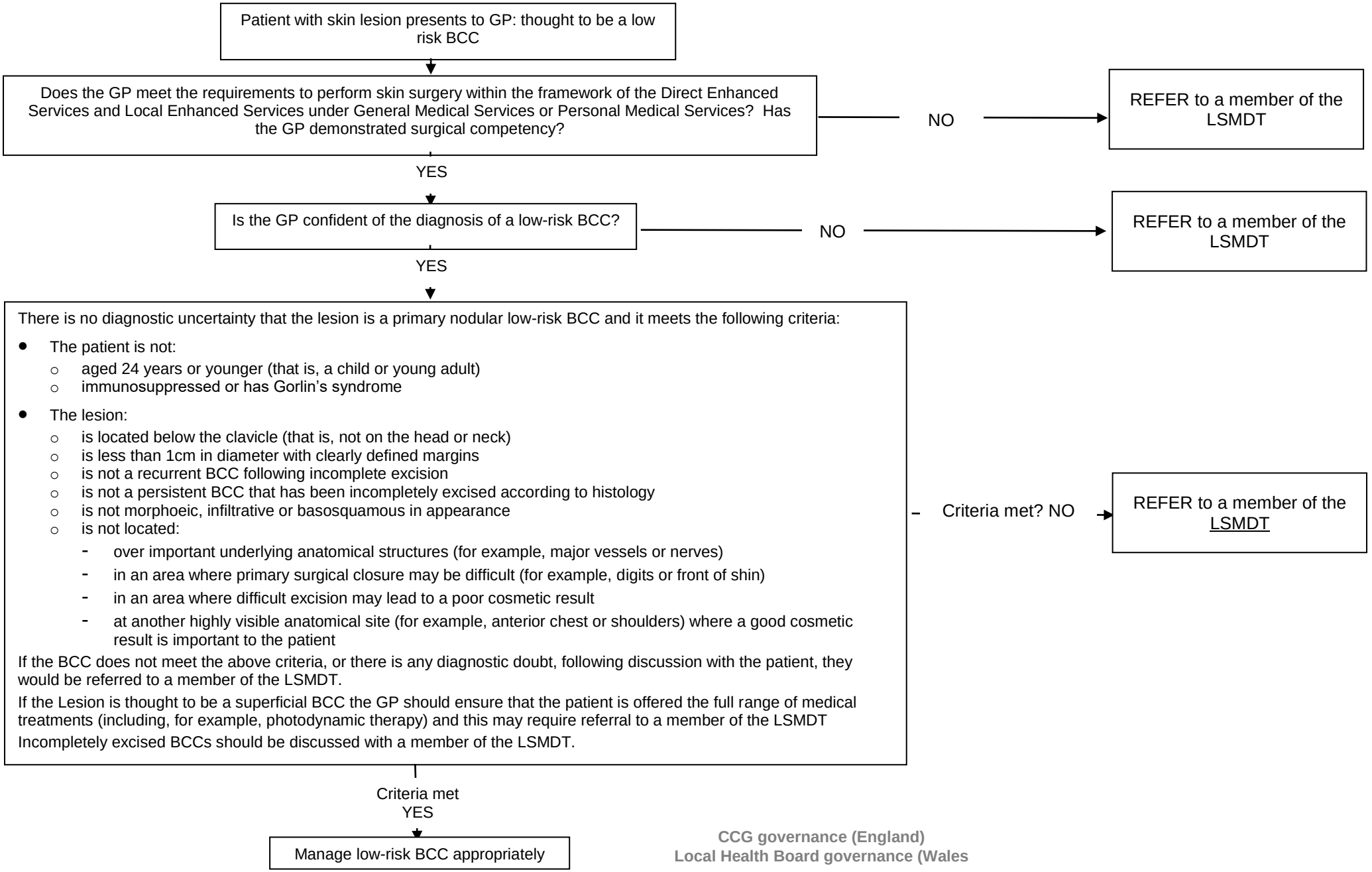
- a medical practitioner performing skin surgery in a community setting;
- a suitably trained specialist nurse. They can undertake surgery on both low and high risk BCCs as well as other types of skin cancer provided that they have demonstrated surgical competence and that surgery is performed after the lesions have been diagnosed by a member of the LSMDT and a management plan identified. Model 2 services sit within acute Trust or LHB (local health board) clinical governance frameworks.

The quality assurance required for histopathology is set out on page 33 and the requirements for data collection and audit are set out on page 34 of NICE guidance.

All healthcare professional providing these services must work to these agreed local clinical protocols for referral, treatment and follow-up.

The training sessions for those doing minor surgery covers the clinical presentations and histological variants of BCC (page 18 of NICE guidance).

Algorithms: Low-risk BCCs for DES/LES (box 1)



CCG governance (England)
Local Health Board governance (Wales

Model 1 Practitioners
(Box 2)

Patient referred to accredited Model 1 practitioner ('Group 3 GPSwSI in dermatology and skin surgery' or new 'GPSwSI in skin lesions and skin surgery') with a suspected low-risk BCC

Services should be commissioned from Model 1 practitioners for the management and excision of low-risk BCC where the definition of a low-risk BCC is made after excluding the following:

- **Patients who are:**
  - aged 24 years or under (that is, a child or young adult)
  - immunosuppressed or have Gorlin's syndrome
- **Lesions that:**
  - are on the nose and lips (including nasofacial sulci and nasolabial folds), or around the eyes (periorbital) or ears
  - are greater than 2cm in diameter below the clavicle or greater than 1cm in diameter above the clavicle unless they are superficial BCCs that can be managed non-surgically
  - are morphoeic, infiltrative or basosquamous in appearance
  - have poorly defined margins
  - are located
    - over important underlying anatomical structures (for example, major vessels or nerves)
    - in an area where primary surgical closure may be difficult (for example, digits or front of shin)
    - in an area where excision may lead to a poor cosmetic result

If any of the above exclusion criteria apply, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the LSMDT.

If the lesion is thought to be a superficial BCC the GP should ensure that the patient is offered the full range of medical treatments (including, for example, photodynamic therapy) and this may require referral to a member of the LSMDT.

Incompletely excised BCCs should be discussed with a member of the LSMDT.

Confirmed low-risk BCC

YES

Manage appropriately

CCG governance (England)
Local Health Board governance (Wales

Unable to confirm low-risk BCC

Is the 'Group 3 GPwSI in dermatology and skin surgery' also a **Model 2** practitioner?

NO → REFER to a member of the LSMDT

YES

Model 2 Practitioners
(Box 3)

Discuss patient's low-risk BCC with a core member of the LSMDT and agree management plan

Manage low-risk BCC appropriately

Acute Trust governance (England)
Local Health Board governance (Wales

Rationale

The importance of basal cell carcinoma (BCC) is underestimated, probably because it is rarely fatal. BCC is the commonest type of cancer in England and Wales with an average of 48,000 new cases registered each year in England between 2004 and 2006. The incidence of BCC in the South West region is 2.9 times higher than that of lung cancer and places a significant burden on NHS resources. Furthermore, the current number of registered cases is likely to be a significant underestimate of the true incidence of BCC, with modelling estimates indicating that the number of new cases per year is more likely to be between 55,000 and 60,000. This is partly because the Thames Cancer Registry, which covers all of London and much of the South East region, has until recently not been registering BCCs.

NICE identified that patients want their low-risk BCCs to be treated effectively the first time, with minimal risk of recurrence and the best cosmetic result possible.

NICE has recommended that low-risk basal cell carcinomas are managed in the community.

Evidence

A study that reported on trends in NMSC (new non-melanoma skin cancers) – this term includes BCC - in South Wales between 1988 and 1998 provides useful information on the likely UK incidence (*Holme et al 2000*). The following important points can be derived from this study:

- The number of patients presenting with NMSC (ie the incidence) increased from 174 to 265 per 100,000 population per annum between 1988 and 1998.
- There was a 66% increase in BCC and a 16% increase in Squamous Cell Carcinomas (SCC) over the ten year period.
- The overall ratio of incidence of BCC:SCC was 5:1, although this showed a variation with age, the ratio being 9:1 in 50-69 year olds and 2:1 in the over 85s.
- Incidence was particularly high in the elderly, with 1,364 per 100,000 population per annum in the over 85s and higher rates in men than women.
- The data described number of patients, not number of lesions, and excluded recurrent tumours, so these figures underestimate the clinical activity required to manage NMSC.
- Data capture was incomplete as some NMSC may have been treated using cryotherapy in General Practice settings.
- Extrapolation based on the 1998 data suggested the following number of new patients presenting with NMSC each year: 6,000 in Wales, 9,000 in Scotland and 100,000 in England.
- Whilst the authors felt the increased incidence of NMSC might be related to increase sun exposure, they commented that it might also have something to do with increased awareness as a result of health promotion initiatives.

Another, more recent study from Northern Ireland using data collected from the Northern Ireland Cancer Registry (NICR) has shown lower incidence rates of NMSC, with age-adjusted incidence rates for BCC of 104 and 71 per 100,000 population for males and females respectively in 2002 (*Hoey et al 2007*). As expected, SCC was less common, with age-adjusted incidence rates per 100,000 of 46 and 23 for males and females respectively in the same year. The authors reported a 62% increase in the number of skin cancer specimens (including melanoma) processed by histopathology laboratories in the 12 year period 1993 to 2004, and a 20% increase in the number of patients with skin cancer. Furthermore, it has been suggested that actual skin cancer workload is underestimated by about 30% by counting patients at first diagnosis of skin cancer only, rather than counting the number of tumors treated (*McLoone 2003, Lucke 1997*).

NICE concluded that retrospective studies, although flawed, do indicate a consistent trend of current practices and outcomes in favour of specialist care in the community setting. The controlled study by *George et al, (2008)* provides an important framework for further research which, along with more well-conducted studies using reliable audit data, should lead to more adequate reporting of the outcomes of excisional surgery in future.

References

1. NICE Guidance on cancer services: Improving outcomes for people with skin tumours including melanoma (update). http://www.nice.org.uk/nicemedia/live/10901/48878/48878.pdf
2. Blacks Medical Dictionary, 42nd edition, published 2010.

Glossary

Cautery:	The application of a hot instrument, an electrical current, a caustic substance or other substance to kill certain types of small tumours or seal-off blood vessels to stop bleeding.
Cryotherapy/Cryosurgery:	A procedure performed with an instrument that freezes and destroys abnormal tissue.
Curettage:	Removal of tissue with a curette, a spoon-shaped instrument with a sharp edge.
Dermatology:	The study of the skin.
Excision:	The act of surgically removing or 'cutting' out tissue from the body.
Histological:	Relating to the study of cells and tissue on the microscopic level.
Mohs micrographic surgery:	A surgical technique used to treat skin cancer. Individual layers of cancerous tissue are removed and examined under a microscope one at a time until all cancerous tissue has been removed.
Photodynamic Therapy:	Treatment with drugs that become active when exposed to light. These drugs kill cancer cells.
Radiotherapy:	Use of radiation, usually x-rays or gamma rays, to kill cancer cells and treat tumours.
Squamous cell carcinoma:	is cancer that begins in the squamous cells, which are thin, flat cells that look like fish scales under the microscope. Squamous cells are found in the tissue that forms the surface of the skin, the lining of hollow organs of the body, and the passages of the respiratory and digestive tracts. Squamous cell carcinomas may arise in any of these tissues.
Topical treatment:	Treatment with drugs in a lotion, ointment or cream applied to the skin.