SKIN CANCER NSSG

CLINICAL, PATHOLOGY, IMAGING AND ANATOMICAL GUIDELINES

2019

Version 7

Revised in this Version:

Review: **February 2021 or earlier if new guidance available**

INDEX

The NSSG has agreed to adopt the agreed to adopt the Melanoma Focus Guidelines and the NICE Guidelines on Management of Melanoma; where any difference exists between the two, the Melanoma Focus guidelines take precedence.

Guidelines for the management of Malignant Melanoma (2019)
https://melanomafocus.com/wp-content/uploads/2019/01/SNB-Consensus-Final-1.pdf
https://www.nice.org.uk/guidance/ng14
https://melanomafocus.com/activities/mucosal-guidelines/mucosal-melanoma-resources/

The NSSG has agreed to adopt the agreed to adopt the UK and British Association of Dermatologists Guidelines as the Network Clinical Guidelines for Basal Cell Carcinoma, Squamous Cell Carcinoma.

Guidelines for the management of basal cell carcinoma (2008)
http://www.bad.org.uk
doi:10.1111/j.1365-2133.2008.08666.x

Multi-professional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma 2009
http://www.bad.org.uk
https://onlinelibrary.wiley.com/doi/10.1046/j.0007-0963.2001.04615.x

The NSSG has agreed to adopt the agreed to adopt the British Association of Dermatologists and U.K. Cutaneous Lymphoma Group guidelines for the management of primary cutaneous lymphomas 2018; stage 1B and 2A Mycosis Fungoides are also sent for review to the SupraRegional Skin Lymphoma MDT.

British Association of Dermatologists and U.K. Cutaneous Lymphoma Group (CLG) guidelines for the management of primary cutaneous lymphomas 2018
http://www.bad.org.uk
doi: 10.1111/bjd.17240.

The NSSG is informed by NCCN guidelines on Merkel Cell Tumour, but does not currently employ sentinel node biopsy for this tumour group as this has not been proven to affect survival.
https://www.nccn.org/professionals/physician_gls/pdf/mcc.pdf

The NSSG is informed by NCCN guidelines on Dermatofibrosarcoma Protuberans
https://www.nccn.org/professionals/physician_gls/pdf/dfsp.pdf

The NSSG will review the above guidelines at least annually or as and when new guidance is published.

Pathology Guidelines

Dr Deepa Pandit, Consultant Histopathologist at Lancashire Teaching Hospitals Trust is Network Lead for Skin SSMDT, with Dr C Cardozo as Deputy. If cutaneous lymphoma is suspected, please see below for details. Double reporting is undertaken on all malignant melanomas and difficult melanocytic lesion. In case of difficult cases, second opinions are sought from Dr Patrick Shenjere at the Christie Hospital.

The Skin NSSG uses UICC and AJCC (8th edition 2017), and follows the Royal College of Pathology Guidelines for histological reporting of basal cell carcinoma, squamous cell carcinoma, malignant melanoma, merkel cell carcinoma, adnexal carcinomas, and lymphoma (2019).
Ref: https://www.rcpath.org/uploads/assets/26db5d67-e667-43aa-8b099514fe632984/dataset-for-the-histological-reporting-of-primary-cutaneous-adnexal-carcinomas-and-regional-lymph-nodes.pdf

https://www.rcpath.org/uploads/assets/53688094-791e-4aaa-82cec42c3cb65e35/dataset-for-histopathological-reporting-of-primary-cutaneous-basal-cell-carcinoma.pdf

https://www.rcpath.org/uploads/assets/fb177728-072d-4b8a-97ae94319eaac5fd/dataset-for-the-histological-reporting-of-primary-cutaneous-malignant-melanoma-and-regional-lymph-nodes.pdf

https://www.rcpath.org/uploads/assets/cd3d3fab-eab2-43e4-8d9fec9c5d55fd7a/dataset-for-the-histological-reporting-of-primary-cutaneous-merkel-cell-carcinoma-and-regional-lymph-nodes.pdf

https://www.rcpath.org/uploads/assets/9c1d8f71-5d3b-4508-8e6200f11e1f4a39/dataset-for-histopathological-reporting-of-primary-invasive-cutaneous-squamous-cell-carcinoma-and-regional-lymph-nodes.pdf

PATHOLOGY GUIDELINES FOR DIAGNOSIS AND ASSESSMENT OF SKIN CANCER

Gross:
Specimens should be described and cut up according to the above Royal College Minimum Datasets, (links above.)

Microscopy:
Reported according to Royal College Minimum datasets, see above.
This will include reporting of squamous cell carcinoma, basal cell carcinoma and melanoma.

All melanomas should reported by 2 Pathologists.

Synoptic reports can be used for all tumours and are preferable for melanoma (Appendix A).

TNM staging according to AJCC 8th edition should be included in reports.

Merkel cell carcinoma reported according to AJCC 8th edition.

Suggested immuno panels for skin tumours are given below (Appendix B).

Referral of cases to SSMDT

Histology from the peripheral hospitals, which is to be reviewed at the SSMDT, is requested by the Plastic Surgery Secretaries or by Skin MDT Coordinator. There is a standard format for request of this (Appendix C). If these cases do not arrive by the time of skin MDT, a reminder is sent by Skin MDT Co-ordinator.

Skin Lymphoma

If any skin lymphoma suspected, preliminary immunohistochemistry is carried out at RPH. Histology suspected as being primary cutaneous lymphomas and cases with diagnostic difficulty are sent to the Christie Hospital for final diagnosis.

APPENDIX A (Suggested Synoptic report for melanoma).

Pathological feature

Histological subtype

Ulceration (diameter in mm)
Breslow thickness
Clark level

Predominant cell type

Mitotic index (per sq mm)

Vascular or lymphatic invasion
Neurotropism

Tumour infiltrating lymphocytes (TIL)
Features of regression

Satellites
Associated naevus

Nearest lateral margin to in situ component
Nearest lateral margin to dermal invasive component
Distance from invasive tumour to nearest deep margin

Solar elastosis

If any areas of uncertainty this can be put as free text and prefaced with explanatory comments

Also in shave bx etc free text can be added eg estimated Breslows/Clarks.

APPENDIX B (IMMUNO PANELS):

MELANOMA

- S100 protein (stains all melanomas including desmoplastic melanomas)
- Melan A
- HMB45
- SOX10

LENTIGO MALIGNA & LENTIGO MALIGNA MELANOMA

- Melan A: useful to see extent of in-situ component
- S100 protein: invasive component may be desmoplastic & can be missed on H&E

SQUAMOUS CELL CARCINOMA V/S BCC

- Ber EP4: stains BCC
- EMA: stains SCC

SEBACEOUS TUMOURS

- EMA positive (mature sebocytes)
- CK 7 positive
- CEA negative
- Ber EP4 negative

ATYPICAL FIBROXANTHOMA (AFX)
Diagnosis of exclusion

At least 2 CK, 1 pancytokeratin and 1or 2 high molecular wt to rule out poorly differentiated SCC

- MNF 116
- CK5/6
- 34 beta e 12
- Ck14
- p63 (see Note below)

2 melanoma markers

- S100 protein
- Melan A

For leiomyosarcoma

- SMA
- Desmin

AFX

- CD10 +ve
- SMA can be focally positive

(Note: p63 + (favours SCC over AFX, but at least 1 CK should be +ve)
(Ref: Utility of p63 in the differential diagnosis of atypical fibroxanthoma and spindle cell squamous cell carcinoma. Gleason et al; J Cut Path: 2009: 36: 543–547)

MERKEL CELL CARCINOMA

- CD20 dot +ve
- Cam 5.2 dot +ve
- MNF 116 +
- TTF 1 usually negative; if +ve lung primary has to be excluded
- CK 7 negative
- CD56 +

POORLY DIFFERENTIATED EPITHELIOD TUMOUR

- Melanoma : S100 protein, Melan A
- Carcinoma : MNF 116, AE1/AE3 (at least 2 pan-cytokeratins; Cam 5.2 is negative in squamous carcinomas)
- Anaplastic large cell lymphoma : CD 45 (+ in only 50- 60% cases), CD30
- Epitheliod Angiosarcoma : CD31, Fli1

APPENDIX C

REQUEST FORM FOR HISTOLOGY CASES FOR SKIN MDT

NETWORK SKIN MDT MEETING

Date of meeting:……..

Please send the slides and/ or blocks and reports from the following cases to:

Dr. Deepa Pandit/ Dr Claribel Cardozo
Dept. of Pathology
Royal Preston Hospital
Sharoe Green Lane
Fulwood
Preston PR2 9HT.
Telephone No. 01772 523140
Email: deepa.pandit@lthtr.nhs.uk

PATIENT NAME	DOB	NHS NO	Specimen details	Histology Number (if known).

Imaging

Indications for PET-CT: guidance from The Royal College of Radiologists

J.Hill,A Scarsbrook,I.Lyburn,K.Bradley Ref No: BFCR(10)16

http://www.rcr.ac.uk/publications.aspx?PageID=310&PublicationID=334

The SSMDT utilises guidance RCR PETCT document in its imaging matrix.

PETCT imaging is determined in consultation with the attending consultant radiologist in the context of the SSMDT and follows indications prior to metastectomy and restaging of disease where indicated.

SKIN CANCER IN SPECIFIC ANATOMICAL SITES

2019

- **External Female Genitalia**
- **External Male Genitalia**
- **Anal and Perianal**
- **Head and Neck**
- **Lymphoma**
- **Sarcoma**

MDT Pathways for the above can be found in Appendix 1

Skin Cancer MDT Guidelines for Skin Cancer of External Female Genitalia

General Tenet

The Skin Cancer MDT reviews and takes the lead in all skin cancer (in-situ or invasive) cases except carcinoma of the vulva and (gynaecology oncologists) perineum(gynaecology oncologists MDT or Anal MDT) or penis which fall under the care of the supraregional Penile MDT.

Specific Situations

Certain tumour types have additional guidelines:

MELANOMA

As for general tenet for any excision.

In addition, any melanoma arising in the female genitalia, and dealt with by a gynaecological surgeon with principle discussion at the Gynaecological Cancer MDT, should also be discussed secondarily at the Skin MDT, where issues including trial eligibility and general skin examination can be reviewed.

EXTRAMMARY PAGET'S DISEASE

As for the general tenet for any excision.

In addition, any extramammary Paget's disease arising in the female genitalia, and dealt with by a gynaecological surgeon with principle discussion at the Gynaecological Cancer MDT, may also be discussed secondarily at the Skin MDT.

Skin Cancer MDT Guidelines for External Male Genitalia

Upon diagnosis ALL cases of penis cancer, including penile intraepithelial neoplasia, and pre-malignant/suspicious lesions should be recorded at the local MDT and referred immediately to the Supra-network MDT. This should include notes and histology. All local and specialist teams within the Networks (appendix C) may counsel patients regarding their primary treatment options. Definitive information will be provided following consultation with the SnMDT. This information should be relayed to the Primary Care Physician, referring Consultant and Patient.

Specific Situations

Certain tumour types have additional guidelines:

MELANOMA

As for general tenet for any excision.
In addition, any melanoma arising on penis, and dealt with by a urological surgeon with principle discussion at the Penile SnMDT, should also be discussed secondarily at the Skin MDT (or at the Skin MDT at the Christie) where issues including trial eligibility and general skin examination can be reviewed.

PAGET'S DISEASE CLOSE TO BUT NOT INVOLVING MALE GENITALIA (GROIN, SUPRAPUBIC)

As for the general tenet for any excision.

Outside of penis, but occurring in the vicinity, (groin, suprapubic, scrotum), Paget's disease presenting to a member or the Skin MDT, treatment will be led by that person, with discussion principally at the Skin MDT. However, if there is clinical suspicion of co-existent penile involvement, the Urology MDT should be involved, and any confirmation of penile involvement should result in referral to the Penile MDT. Perineal Paget's should prompt discussion with Colorectal MDT member.

Skin Cancer MDT Guidelines for Anal and Perianal cancer

General Tenet

The Skin Cancer MDT reviews and takes the lead in all skin cancer cases where planned excision of a skin cancer will not encroach on the anal canal mucosa. This is compatible with and complimentary to the L&SC Colorectal SMDT guidelines which state: 'The Colorectal MDT at LTHTR reviews all network cases of anal margin and anal canal cancer.'

Specific Situations

Certain tumour types have additional guidelines:

MELANOMA

As for general tenet for any excision.
In addition, any melanoma arising in the anal canal or anal margin, and dealt with by a colorectal surgeon with principle discussion at the Anal MDT, should also be discussed secondarily at the Skin MDT, where issues including trial eligibility and general skin examination can be reviewed.

BOWENS DISEASE

As for general tenet for any excision.
For Bowen's disease encroaching on the perianal skin (but not the anal canal), considered treatable by non-surgical therapy (e.g. cryotherapy, efudix or aldara cream) may be treated by a member of the Skin MDT and discussed at the Skin MDT. However, biopsy is mandatory to exclude other pathologies (Paget's disease, invasive neoplasia).

PERIANAL PAGET'S DISEASE

As for the general tenet for any excision.
Cases of perianal Paget's may present to Colorectal Surgeons or Dermatologists. Once a diagnosis of perianal Paget's is confirmed histologically, the Anal MDT will take the lead in investigation and treatment; Dermatology are happy if requested, to provide help with Metvix mapping or mapping punch biopsies, and Plastics would expect to be involved when extent of disease is been extensively beyond the anal verge.

Skin Cancer MDT Guidelines for Head and Neck Skin Cancer

Malignant Melanoma

All cutaneous malignant melanoma, including any arising in peri-ocular skin, should be discussed primarily at the Skin MDT.
If excision of a melanoma is likely to encroach on a mucocutaneous junction (nasal, auricular canal, conjunctiva) then this should be discussed in the Skin MDT but also with a member of the Head and Neck MDT.

Mucosal and ocular Melanomas

These should be discussed primarily at the Head and Neck MDT with secondary discussion at the Skin MDT, (for considerations including trial eligibility, general skin examination).

Squamous Carcinoma and Basal Cell Carcinoma

Peri-ocular basal cell and auricular basal carcinomas may be discussed primarily at the Skin Meeting or Head and Neck Meeting. Other basal cell carcinomas should be discussed primarily at the Skin Meeting.

Skin Cancer MDT Guidelines for Skin Lymphoma

Cases of lymphoma presenting in the skin should be investigated locally and discussed at the local Skin MDT (LSMDT) and local Haemato-Oncology MDT (HOLMDT), in order to determine presence of absence of systemic involvement. Investigations will usually comprise skin biopsy histology, immunoflourescence, and PCR clonality assay; blood tests (usually FBC, LFTs, U&Es, ESR, LDH, lymphocyte subset analysis, lymphocyte clonality, and for B lymphomas immunoglobulins, serum and urine electrophoresis; where appropriate HTLV1 serology; bone marrow aspirate and trephine, and CT chest, abdomen and pelvis.

Systemic/nodal lymphomas presenting in the skin remain under the management discretion of the HOLMDT.

Primary cutaneous B cell lymphoma may be treated locally by a member of the HOLMDT, but the Regional Skin Lymphoma Multidisciplinary Team (RSLMDT) should be notified.

Primary cutaneous T lymphoma should be referred to the Regional Skin Lymphoma Multidisciplinary Team (RSLMDT) as below:

Mycosis fungoides

Mycosis fungoides, stage 1b and above, should be discussed at the local Skin Cancer MDT and referred by the LSMDT to the RSLMDT as follows: Referrals of Stage 1b and 2a to be referred to Dr. Eileen Parry at Salford Royal Hospital. Stage 2b and above to be directed to Dr Richard Cowan, at the Christie Hospital.

Referral should also be made to the local Haemato-oncology meeting in the following circumstances:
Where the Regional MDT has requested that radiotherapy or chemotherapy or further/repeat investigation is administered at the local hospital as shared care.
Where a patient is too ill to travel to Manchester.

All referrals should include results of any immunophenotyping, clonality studies requested locally.

For mycosis fungoides of stage 2b and over, treatment options will include TSEBT, extracorporeal photopheresis, bexarotene (usually as part of the gemcitabine-bexarotene trial), other chemotherapy.

TSEBT is performed at the Christie Hospital requests are made by/via the RSLMDT.
Extracorporeal photopheresis is performed at the Manchester Blood Centre, Plymouth Grove, Manchester. M13 9LL. Referral of stage 3 and 4 cases to the Manchester Blood Centre; requests are made by/via the RSLMDT. Direct contact details for those who supervise extracorporeal photopheresis are: Hazel McAuley (Medical Secretary – all initial requests, as per the postal address at Plymouth Grove;
Email: hazel.macauley@nhsbt.nhs.uk) The supervising doctor is, until 1st August 2011, Dr., who visits Manchester from his base at Sheffield BTS.
From 1st August 2011, this will be Dr., who will visit Manchester from Liverpool BTS. Email: therese.callaghan@nhsbt.nhs.uk .
Bexarotene is administered at the Christie under Dr. Cowan and Dr. Parry; requests are made by/via the RSLMDT.

PUVA, radiotherapy, and other chemotherapy will usually be given at the local referring hospital.

Cutaneous lymphomas other than Mycosis fungoides

Lymphomatoid papulosis may be discussed at and managed by a member of the Skin MDT. Where any clinical doubt exists as to the diagnosis, this should be referred to the HOLMDT for work-up as for CD30+ve lymphoma.

CD30+ve lymphoma - this should be discussed at and managed by the HOLMDT
But the requests are made by/via the RSLMDT should be notified.

Other cutaneous T cell lymphomas

These should be reviewed by the RSLMDT.

L&SC Skin MDT Arrangements for Sarcoma

See current pathway (Page 28).
May be slightly modified soon to fit in with comprehensive network sarcoma guidelines

Rehabilitation Pathways for all Patient Pathways

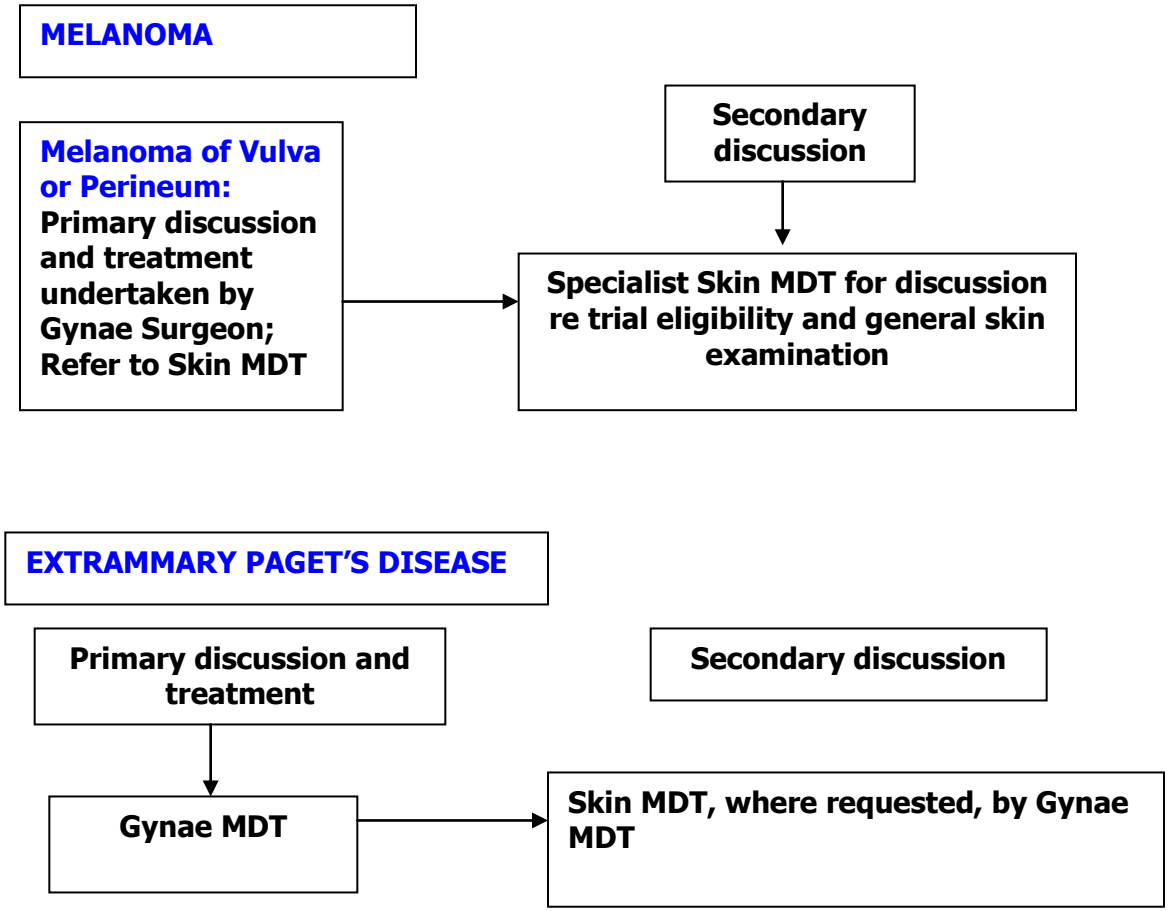
All patient pathways will refer to the NCAT rehabilitation pathways for the support of patients.

Rehabilitation Pathways

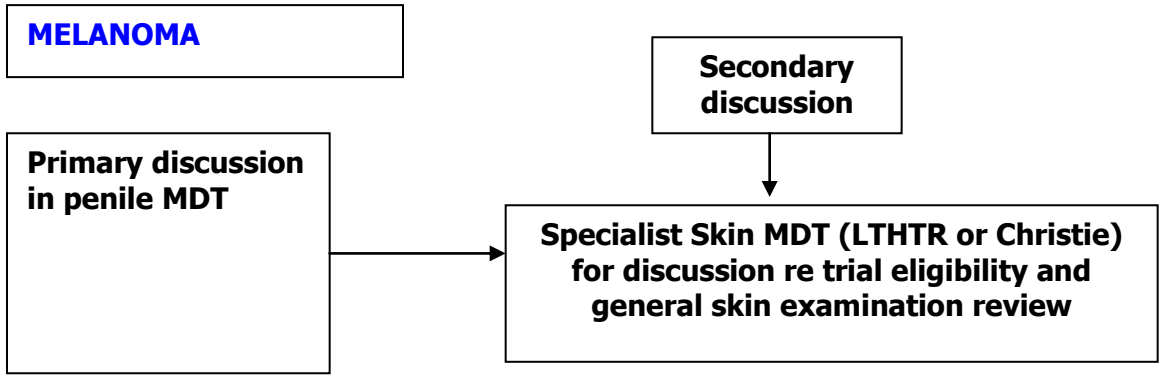
NCAT rehabilitation pathways for all stages of treatment:
http://webarchive.nationalarchives.gov.uk/20130513211237/http:/www.ncat.nhs.uk/our-work/living-beyond-cancer/cancer-rehabilitation#tab-bestpracticepathways - Diagnosis and care planning; Treatment; Recovery phase; Palliative care and End of Life

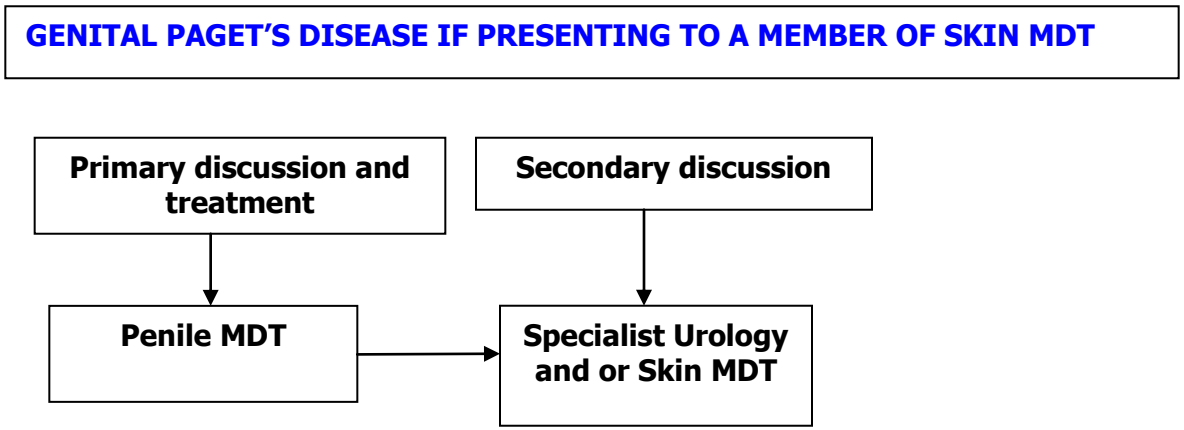
Skin Cancer MDT Pathway for Skin Cancer of External Female Genitalia

The Skin Cancer MDT reviews and takes the lead in all skin cancer cases where planned excision of a skin cancer will not encroach on the introital mucocutaneous junction. Certain tumour types have additional guidelines:



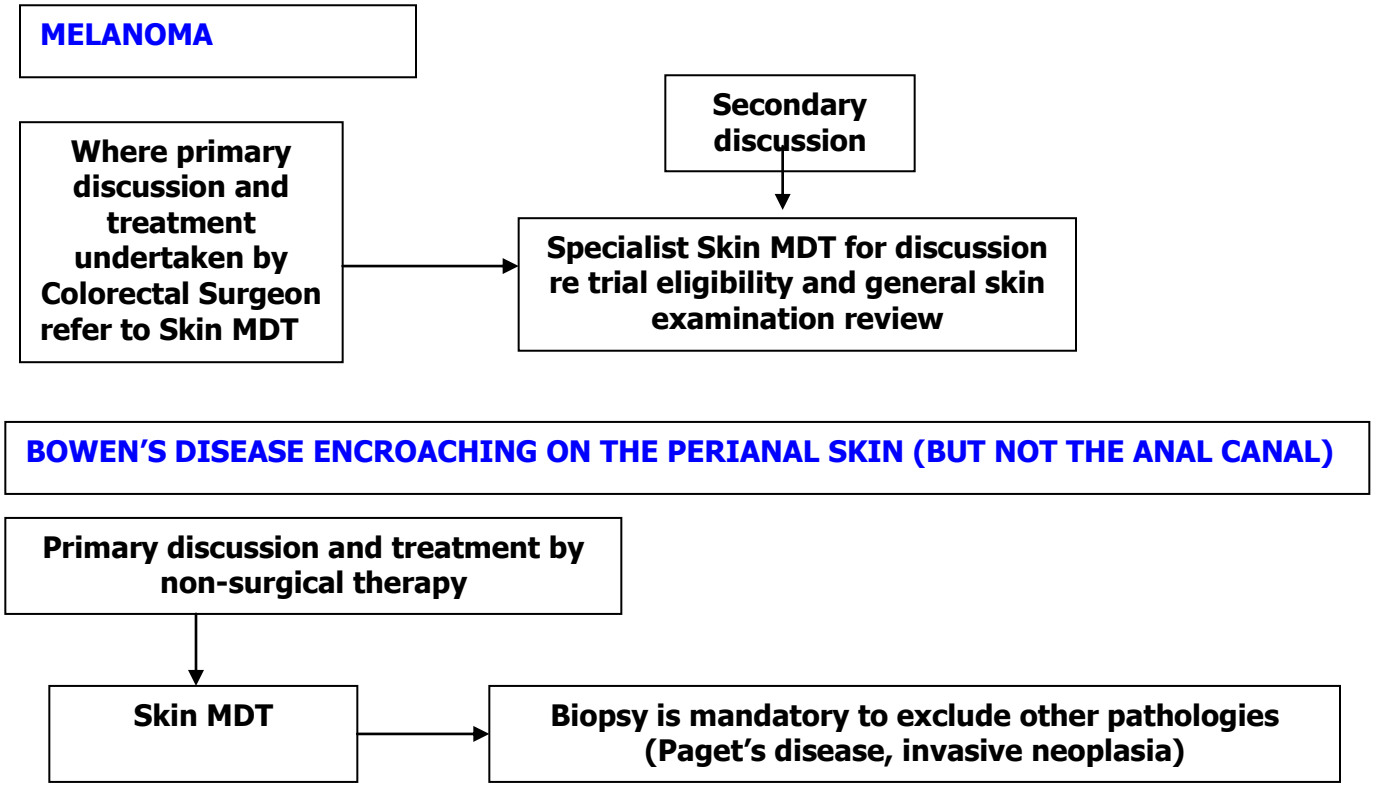
Skin Cancer MDT Pathway for Skin Cancer of External Male Genitalia



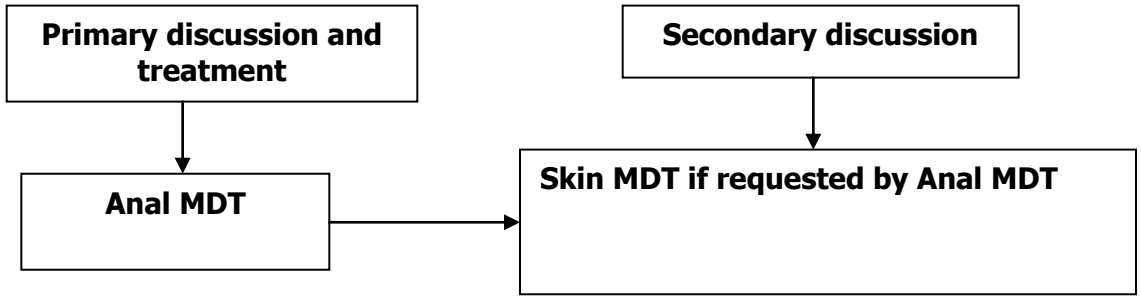


Skin Cancer MDT Pathway for Skin Cancer of <u>Anal and Perianal</u>

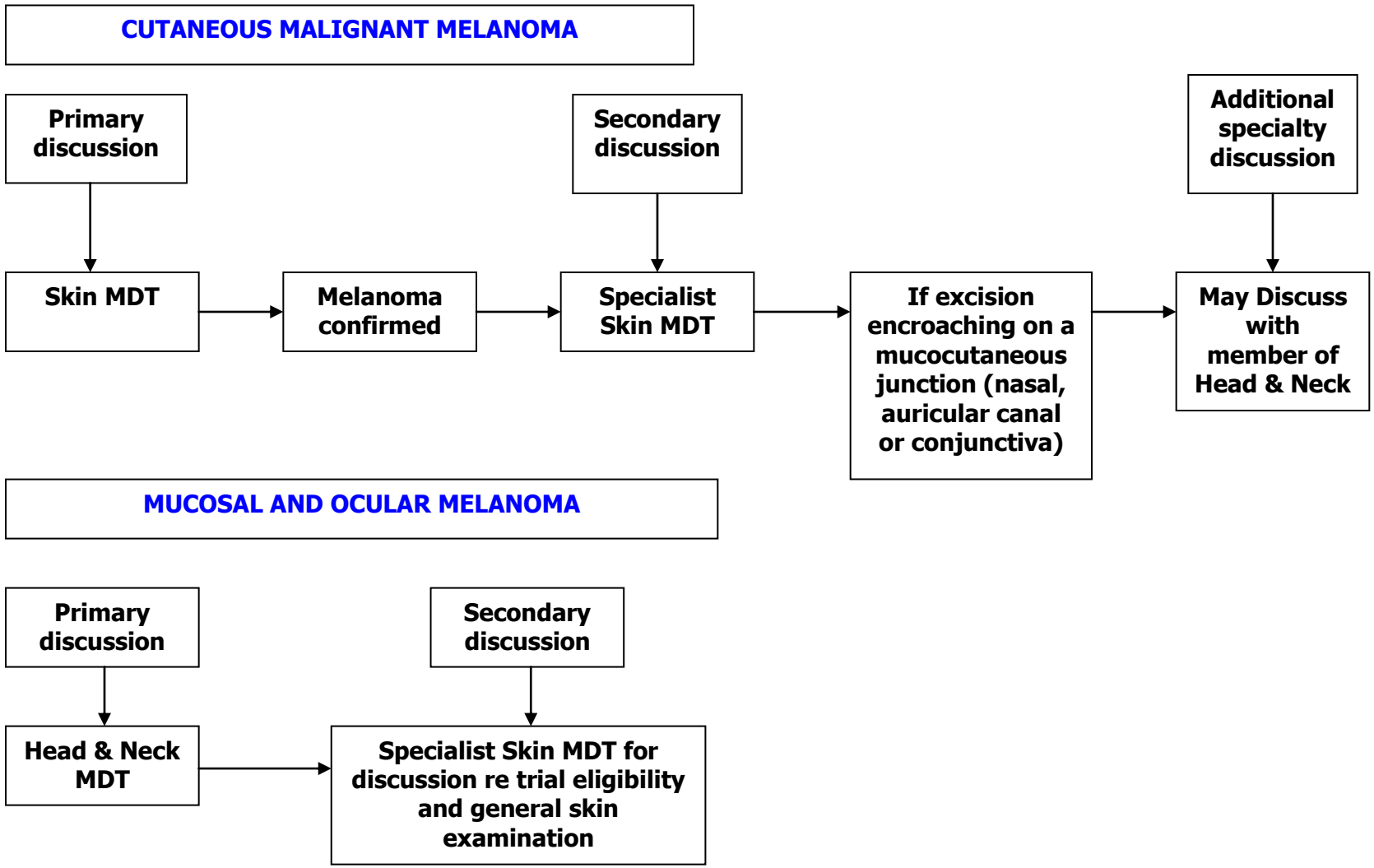
The Skin Cancer MDT reviews and takes the lead in all skin cancer cases where planned excision of a skin cancer will not encroach on the anal canal mucosa. This is compatible with and complimentary to the L&SC Colorectal SMDT guidelines which state: 'The Colorectal MDT at LTHTR reviews all network cases of anal margin and anal canal cancer.'

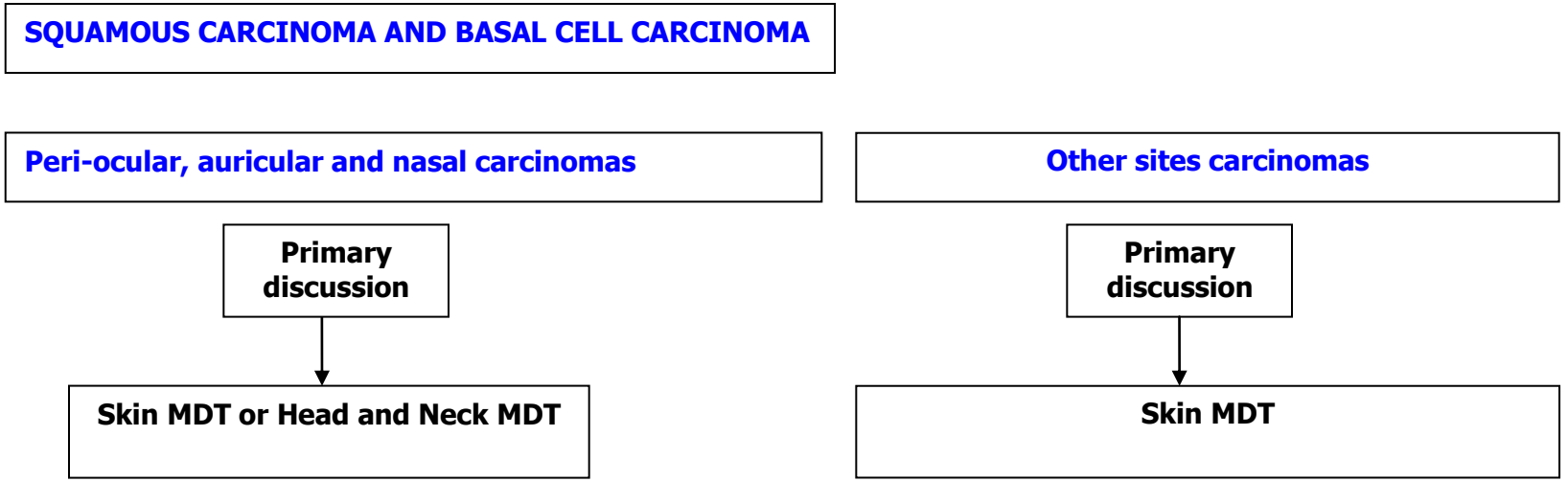


PERINANAL PAGET'S DISEASE IF PRESENTING TO A MEMBER OF SKIN MDT



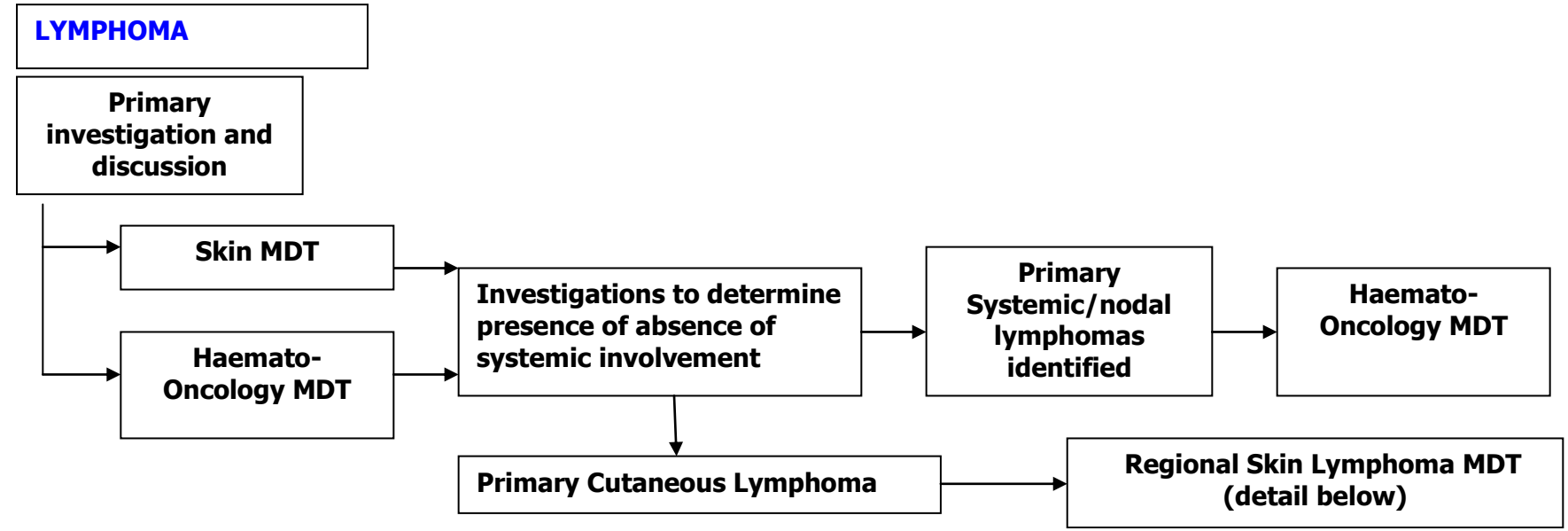
Skin Cancer MDT Pathway for Head and Neck Skin Cancer




SQUAMOUS CARCINOMA AND BASAL CELL CARCINOMA
Peri-ocular, auricular and nasal carcinomas
Primary discussion
Skin MDT or Head and Neck MDT
Other sites carcinomas
Primary discussion
Skin MDT

Skin Cancer MDT Pathway for Skin Lymphoma

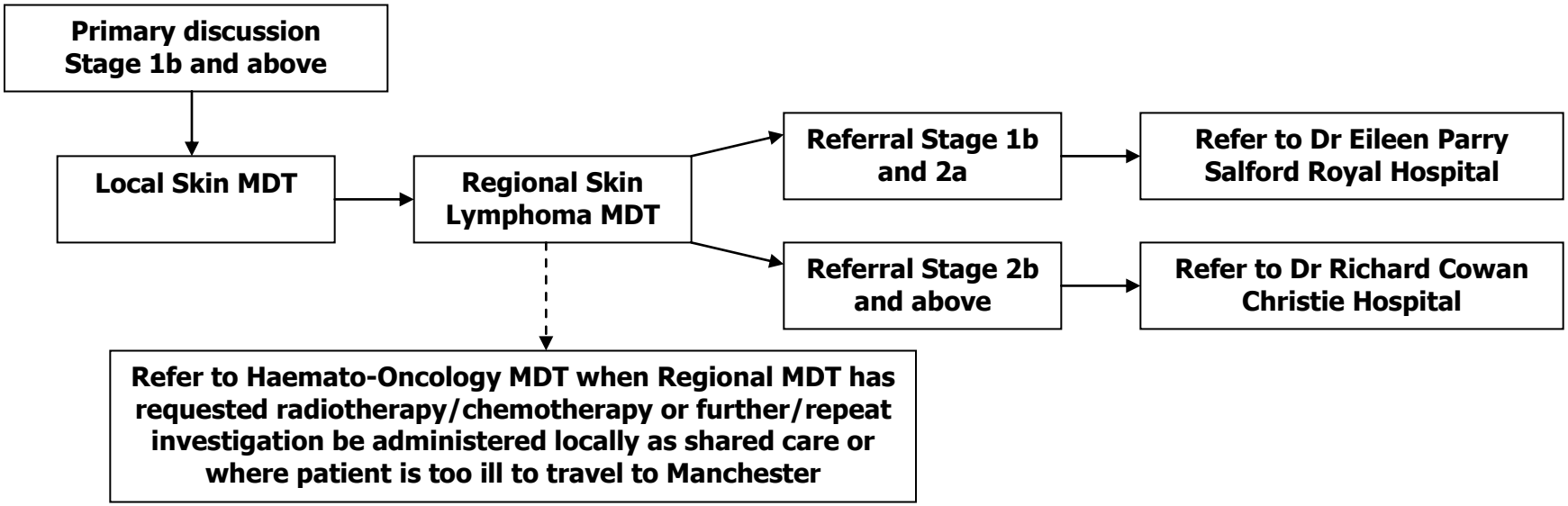
Cases of lymphoma presenting in the skin should be investigated locally and discussed at the local Skin MDT (LSMDT) and local Haemato-Oncology MDT (HOLMDT), in order to determine presence of absence of systemic involvement.



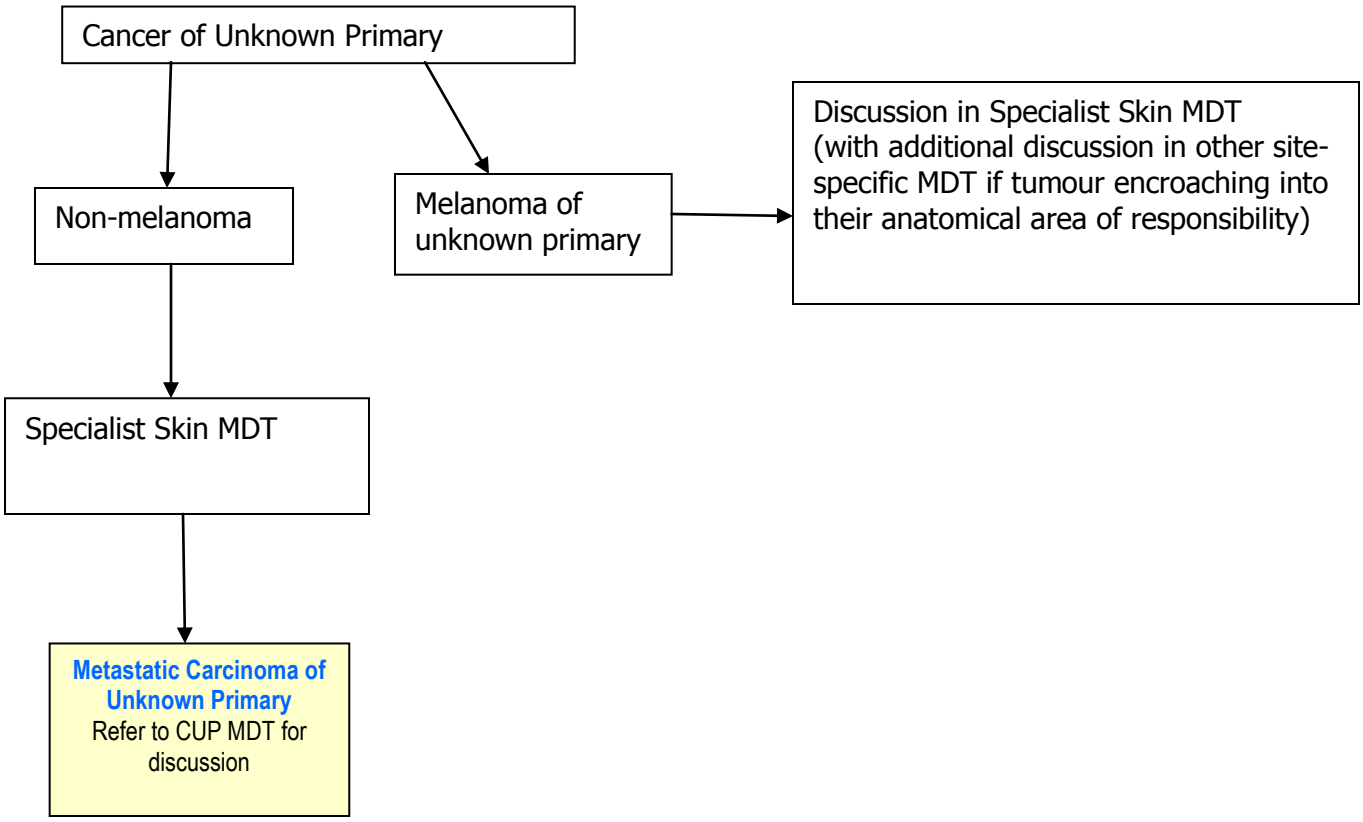
PRIMARY CUTANEOUS T CELL LYMPHOMA

Primary cutaneous T lymphoma should be referred to the Regional Skin Lymphoma Multidisciplinary Team (RSLMDT) as below:

MYCOSIS FUNGOIDES



Skin Cancer MDT Pathway for Cancer of Unknown Primary



L&SC Skin Sarcoma Pathway

Sarcomas involving skin may fall into two broad categories:

Group A

For Discussion in the Skin SMDT, in accordance with NICE guidelines -
Superficial sarcomas arising in dermis, usually not extending deeper than superficial fascia.
(Improving Outcomes for People with Skin Tumours including Melanoma 2006)

Dermatofibrosarcoma Protuberans (DFSP)
Kaposi's Sarcoma
Pleomorphic Dermal Sarcoma
Atypical Fibroxanthoma (AFX)
Dermal leiomyosarcoma
Angiosarcoma

In selected instances one of these entities may, at the discretion of Skin SMDT, be referred on to the Sarcoma Locality Group/Sarcoma Clinic (SC), Merseyside Sarcoma MDT

Unusually deep or serially recurrent examples of DFSP
Uncertainty of diagnosis e.g. AFX versus malignant fibrous histiocytoma

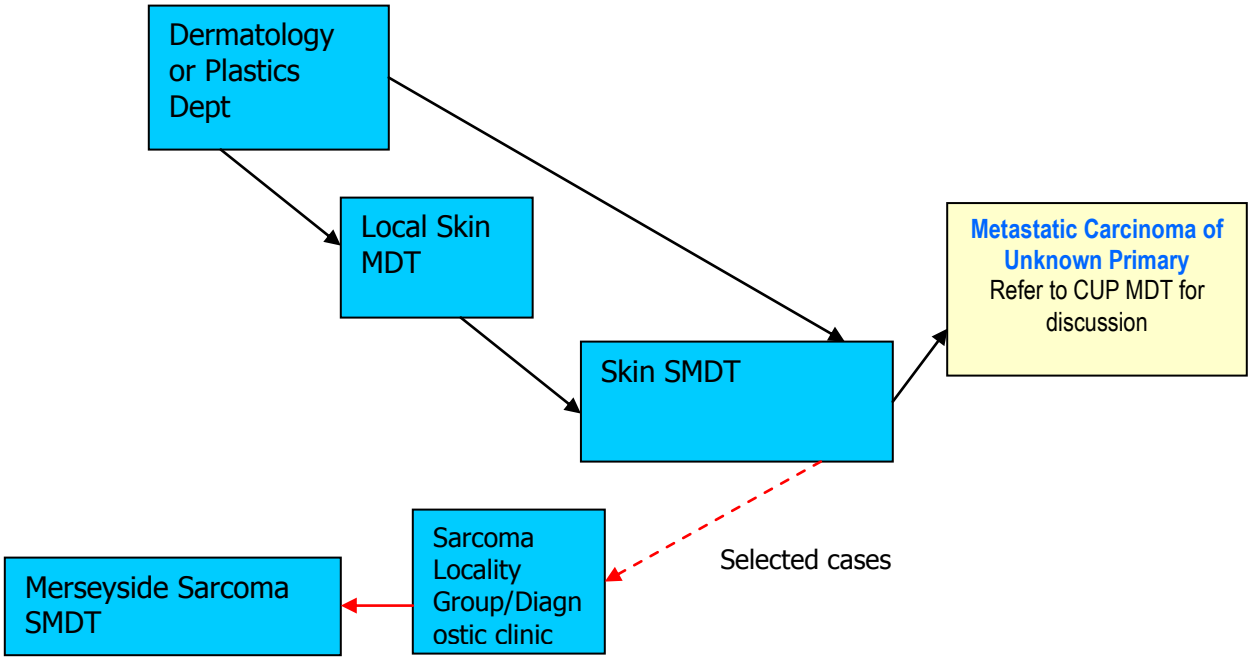
Group B

For discussion in the Sarcoma Locality Group/Sarcoma Clinic (SC) who will arrange case discussion at the Merseyside Sarcoma SMDT. Referral to the SC is either directly or via the Skin SMDT.

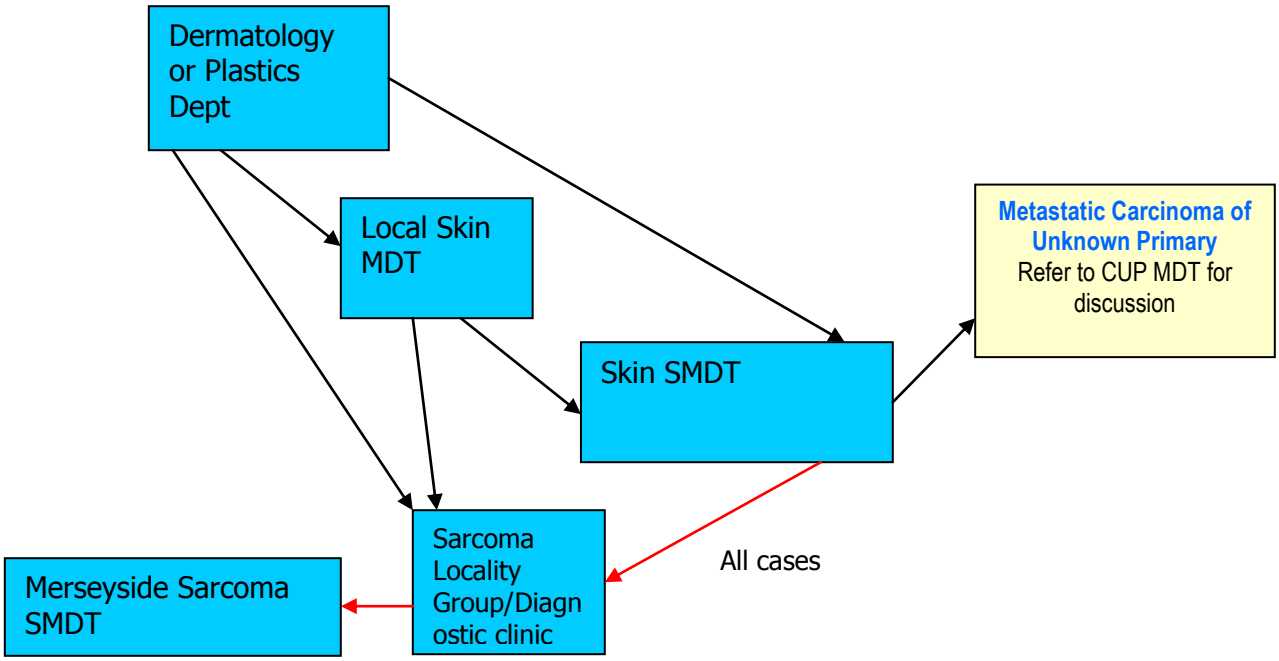
Any other soft tissue sarcoma that has extended into, or metastasised to skin
e.g
Malignant Fibrous Histiocytoma
Synovial Sarcoma
Fibrosarcoma
Leiomyosarcoma
Alveolar Soft Part Sarcoma
Clear Cell Sarcoma
Liposarcoma
Rhabdomyosarcoma
Neurofibrosarcoma/ Malignant Schwannoma
Ewing's sarcoma

See Pathways Below

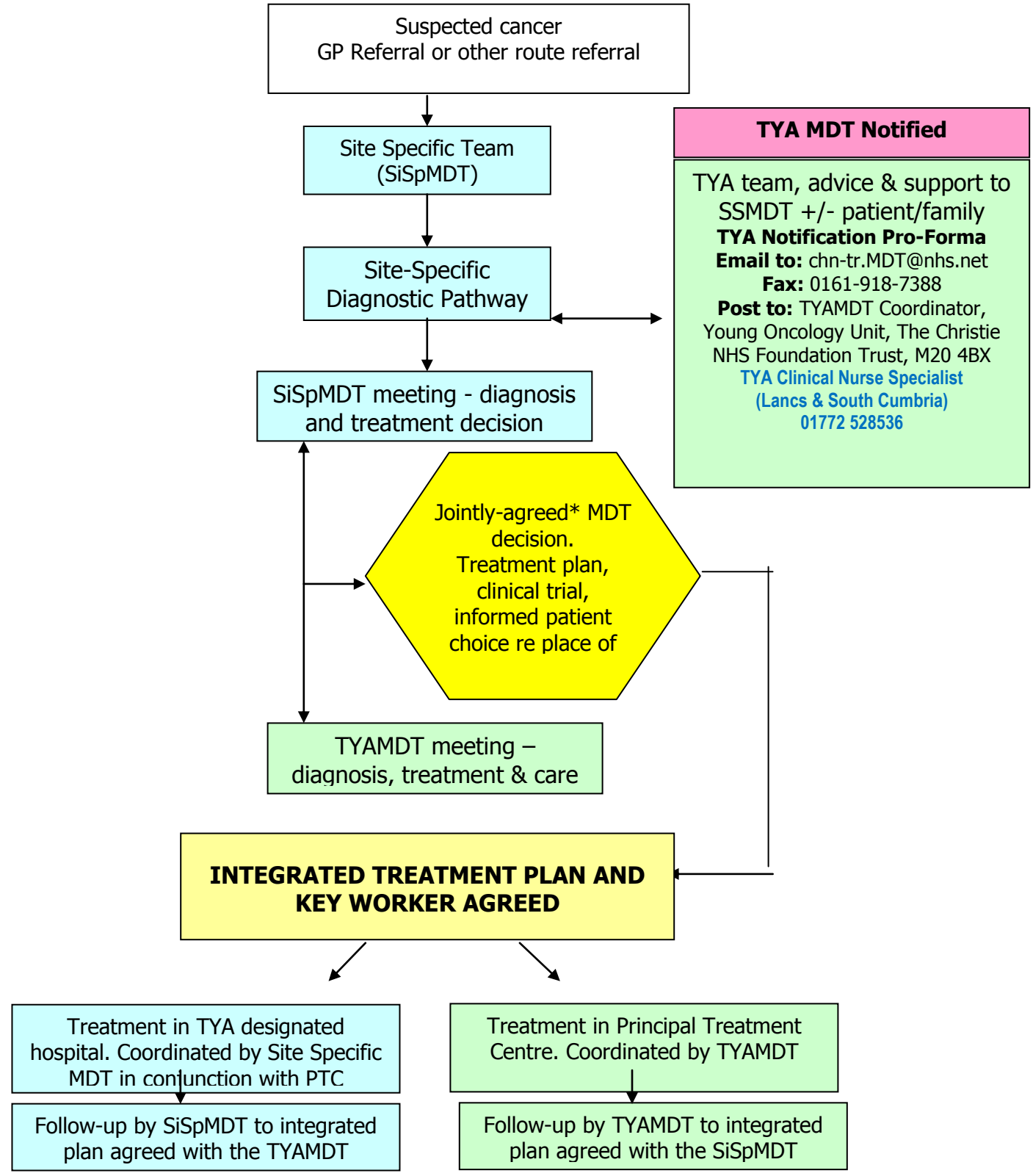
Group A Tumours



Group B Tumours CMD



TEENAGE AND YOUNG ADULT PATHWAY 19-24 YEARS
Designated TYA Hospitals



***NB** "Jointly agreed" refers to the MDT discussion. The patient will remain under the clinical care of the site specialist clinician until a formal referral for transfer of care to the TYA Unit Lead Clinician has been accepted.

3. Generic Pathway for 16 – 18yr olds

TEENAGE AND YOUNG ADULT PATHWAY 16-18 YEARS INCLUSIVE

TYA Designated and Non Designated Hospitals