Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Services

Meeting of the SWAG Network Skin Cancer Clinical Advisory Group (CAG)
Wednesday 2nd November 2022, 09:00-16:00
Engineers House, The Promenade, Clifton Down, Bristol BS8 3NB / Hybrid via MS Teams

Chair: Mr Ewan Wilson (EW)

	REPORT	ACTIONS
	(To be agreed at the next CAG Meeting)	

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

As there were no amendments for the report from the previous meeting, held on 9th February 2022, the report was accepted.

Actions from the Work Programme:

Medical Illustration Service at RUH: Stop clock audit of imaging workload in clinic time:

The audit was commenced pre-pandemic, but it had not been possible to progress further due to workload pressures. Team members are using personal devices to take images, which are then uploaded to the Cloud and immediately deleted from the device to comply with information governance.

Dermatoscopes are available to attach where needed. Taking the images does causes time pressures for the team, especially in the Consultant one stop clinics, and it would be ideal to have a Medical Illustration service.

NBT Consultants need to do the same when Medical Illustration is closed out of hours.

Any other business from virtual attendees:

RUH Consultant Pathologist A Basiouni shared concerns about the skin cancer pathology workforce. There is currently a huge backlog of work that will take some time to resolve, plus the number of new and complex cases continues to rise. With two Consultant Pathologists due to retire in the near future, it is predicted that the service will soon reach a critical situation; strategic developments are required to address this now.

Concerns were echoed by GRH Consultant Pathologist P Craig, with the situation already nearly at breaking point. The company which used to outsource some of the backlog can no longer provide any further help.

It has not been possible to recruit to two posts that have been vacant for over 9 months and another colleague is on permanent leave.

DRAFT

A significant problem has occurred in GRH, as a new laboratory system has proved to be not fit for purpose; the system was not tested before it went live. Previously, the work required to authorise slides took 10 minutes, but the new system has increased the process by an hour and reduced productivity.

A Royal College of Pathology meeting is scheduled to take place in the near future where the future of pathology services will be discussed. One solution may be to move pathologists outside the Trusts' management structures.

An experienced South West Pathology Lead has been appointed who will hopefully support digitisation and collaborative working which it is expected to take a number of years to resolve.

NBT Consultant Pathologist N Carson reports that Severn Laboratories are in a slightly better situation, being short of one WTE Consultant. The team is implementing digitisation which will be able to increase capacity in some of the other centres. It is hoped to increase trainee numbers, but service sustainability is challenged as there are problems finding the time to recruit and train sub-specialty staff. The aim is to increase educational training time for consultants so that in 5 to 10 years the team will have the appropriate number of trained specialists.

Problems with recruitment are caused when positive training environments are not in place.

Increased pressure on pathology turnaround time is expected in order to meet the 28 day Faster Diagnostic standard.

Pathology will have to prioritise those cases that are clinically urgent rather than urgent based on managerial performance targets.

The teams are doing everything possible to try and meet Cancer Waiting Time targets with existing resources.

Personalised Care and Support: Group Education Sessions:

Breast Cancer Teams in RUH have restarted the face to face Living Well events in collaboration with Macmillan, which have been paused since the COVID-19 pandemic. Patient feedback will be requested before considering again for skin.

UHBW have not restarted face to face sessions due to CNS workload pressures, but a range of videos has been produced to provide virtual advice and support and Holistic Needs Assessments continue to be provided.

Melanoma patients are given education about alert signs to look out for at every clinic appointment. This includes lymph node checks to assess how confident they feel and see if further support is required.

DRAFT

Somerset FT are following similar practices to UHBW and also see Squamous Cell Carcinomas (SCCs) for an education appointment. The assessing for confidence in lymph node checks undertaken by the UHBW team was considered helpful practice to share.

NBT are hoping to restart face to face group patient education events.

GRH have never held group education events and provide individual education health checks.

Pathology: Progress on implementation of standardised reporting:

The majority of centres are using the cancer standardised datasets for reporting histology, although this does not seem to be the case in the Taunton Laboratory.

When histology reports are exported, they can sometimes come across in a format that is difficult to read, with the text blocked together and the Minimum Data Set blended with the text.

Ideally, there would be an automated way of searching histology reports for use in service developments by applying programmes or algorithms, but this is not possible as the current software system is very outdated and needs improvements.

Action: To explore if there are IT solutions to optimise the histology report export process / search function. **N Carson**

Primary Care: Development of community skin cancer service:

At a meeting held with NHS England on Tuesday 1st November 2022, the increase in the number of Two Week Wait (2WW) referrals, which has more than doubled, was discussed.

It was emphasised that changes need to be made in the community setting if Skin Cancer Teams in Secondary Care are to meet CWT targets, but there is no quick fix; improvements will take a number of years, and the current aging sun damaged population will continue to drive up referral numbers.

To provide feedback on the quality of suspected cancer referrals to CCGs:

Attempts have been made to improve the quality of referrals pre-pandemic, with H Dunderdale forwarding examples of referrals that require further information to Commissioners to raise with GPs.

Cancer Alliance Lead for Primary Care and Community Settings, A Randle, is now undertaking a project to improve referrals as part of a 28 Day Pathway Mapping Project and is taking some actions to improve GP referrals from other cancer sites.

Potential future agenda item

DRAFT

A regional Cancer Network meeting will be held on Thursday 3rd November 2022 where this will be raised again, including the dermatology view that a way to triage referrals at the beginning of the pathway is required. When the system is overloaded, there needs to be a way to enable clinical prioritisation of high-risk cases; all cases need to be triaged using Teledermatology at the front of the pathway as well as looking for ways to manage GP referrals.

CAG Recommendation

Creation of a protocol for radiology stating that CNSs can order ultrasounds via ICE and creation of a referral protocol for the SSMDT, including biopsy guidance, for publication on the website:

In cases where a CNS identifies an abnormal lymph node in a CNS led follow up clinic, the following access to scans is available:

- SFT CNS team can order all scans
- RUH CNS team can order all scans except MRI; however, the reports go back to the patient's Consultant with no alert to the CNS team; this needs to be improved
- NBT CNS team do not have permission to order ultrasound, however they can order CT scans
- YDH CNS team can order ultrasound
- UHBW CNS team can order CT scans but not ultrasound; it is hoped that the protocol can be changed in the near future.

Equitable access to ordering ultrasound is recommended.

CAG Recommendation

Creation of a referral protocol for the SSMDT, including biopsy guidelines, for publication on the website:

It was hoped to create a digitised system for MDT referrals as had been developed for Bristol Neuro-Oncology Group (BNOG). However, there had been numerous complications with IT platforms that have yet to be resolved, although the referral form itself has been amended and made available.

Concerns have been raised about documentation of the Stage of disease to include microsatellites, as those high-risk Stage 2 and Stage 3 patients will need early referral to oncology for adjuvant treatment. The MDT also needs to clearly list Comorbidities and Performance Status to facilitate decision making, especially for the elderly and frail who may not want treatment.

Ideally the referring clinician who has met the patient should present the MDT discussion or delegate to another colleague. If this is not possible, the proforma should be completed with all relevant information.

Previous MDT discussions also need to be reviewed to avoid repeat discussions.

One possibility would be to arrange for referrers to dial in to the meeting at specific time slots.

DRAFT

Another possibility would be to create a system where cases are groups according to certain criteria, such as neoadjuvant, adjuvant, larger surgery etc. that require the more complex discussion, and those cases that can be progressed without full MDT discussion, such as SLNB, protocolised to standardised care.

It could be that a lot of the information required is actually recorded on Somerset Cancer Registry, but this is not visible during the meeting discussions.

Many of the Consultants that do complete the proforma with all of the relevant information find that this is not transferred on to the MDT list.

Skin CAG are asked to consider ways to optimise their MDT Meetings.

Action: MDT Reforms to be discussed at a future meeting **SSMDT**

Annual re-audit of BRAF mutation rates:

It is hoped that a re-audit will occur when time allows; this is expected to restart post-pandemic.

SFT team to share Talimogene laherparepvec (T-VEC) guidelines:

The updated guidelines are still be ratified by the local governance team and once approved, they will be shared.

Consultant Oncologist G Ratnayake provides the service with the CNS team. T-VEC is also available in Cheltenham, provided by Consultant Oncologist D Farrugia.

Patients would benefit from the choice of going to either centre to potentially reduce the burden of travel.

Due to a national shortage of aqueous cream, it has not been possible to treat some patients with Diphenylcyclopropenone, resulting in an increased number of patients referred to Cheltenham for T-VEC.

Action: Contact details to refer for T-VEC in SFT will be shared. **SFT Team**

2. Clinical Opinion on Network Issues

2.1 Regional Management of Benign Lesions

The Cancer Alliance asked that regional management of benign lesions was added to the agenda as practice differed across GRH and NBT.

In NBT, benign lesions are generally not removed unless a patient has successfully been through the appeals process.

It is not possible to include this on the Skin Cancer agenda due to the need to prioritise the cancer related issues on the agenda today; the CA is to refer to local skin service policies.

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2.2 The Welsh (Cardiff) Teledermatology Model

Please see the presentation uploaded on to the SWAG website

Presented by R Motley

R Motley, Consultant Dermatologist R Motley from the University of Cardiff Hospitals has introduced teledermatology for management of all skin lesions and rashes.

The system commenced in 2005 with emails and photographs from GPs. A year later a £50,000 grant was given to expand the service. All GPs were given digital cameras and training. In 2011 the service received a 'Best in the Nation' prize for this work.

By 2015, 70% of GP practices were using the system; 30% that were not engaged were not sending appropriate quality imaging and referring patients by an alternative route.

From 2016, it was decided that the only route of referrals should be via the teledermatology system.

Referrals are triaged by 2 Consultant Dermatologists and advice is received within a week.

Consultant Connect is now used to send the referrals, which is a very straightforward system where all relevant information can be viewed and then a response sent to the GP.

GPs are provided with a pamphlet with advice on how to take the images.

Patients are asked to sign a consent form which emphasises that, if their condition changes, they should seek an additional consultation to be reassessed.

Feedback is sent to GPs if the quality of images needs to be improved.

A dashboard of information on the referrals is available to view.

The system gives GPs rapid access to Consultant level expertise and avoids unnecessary appointments in Secondary Care.

Approximately 80% of suspected cancer referrals are downgraded.

99% of melanomas are diagnosed on screen and brought immediately to clinic, 50% of which were sent by the GP as non-urgent referrals that were then upgraded, helping to identify cancer earlier on.

Most routine cases take a couple of minutes to triage. When the service commenced, one session was allocated to 50 referrals. This has been adjusted to 40 referrals per session. British Association of Dermatologists recommend 25-30 referrals per session.

All patients diagnosed with melanoma are seen in person before scheduling for surgery, usually within the next week.

Cardiff do virtually no dermoscopy; a trial is going to be undertaken to see if this will enhance the service.

DRAFT

Any high-risk lesions are booked into the next clinic of the week. Basal Cell Carcinomas are on a long waiting list. It doesn't shorten waiting lists but enables clinical prioritisation.

Dermoscopy is recommended for less experienced Dermatologists and is recommended in NICE guidelines.

The time it takes to triage is also dependant on the quality of the platform.

The work can be undertaken remotely and flexibly.

It would be ideal if an archive of images of interesting teledermatology cases, including dermoscopy image, could be made available as a valuable training tool for Junior Medics, GPs and to help upskill the CNS team.

The result of the teledermatology assessment is fed back to the patient by the GP.

2.3 Cancer Alliance Skin Cancer Improvement Project

Please see the presentation uploaded on to the SWAG website

Presented by H Winter

Clinical Oncologist and SWAG Cancer Alliance Clinical Director, H Winter, thanked Skin CAG for participating in the Skin Cancer Pathway Improvement Project.

One of the priorities of the Cancer Alliance Workforce Strategy is to ensure that teachers, educators and supervision are appropriately valued.

Project Manager C Pointz-Wright, who is leading on the improvement project, has provided baseline information on current provision of teledermatology across the region.

In the Information on Provision of Teledermatology slide, SFT needs to be changed as this is provided by Consultant Dermatologist D de Berker, who processes in excess of 100 referrals per week.

The ideal package for GP education is being explored to enhance the quality of referrals, including ensuring that the right images are being provided.

In the Software slide, details on GRH software system need to be changed to Cinapsis rather than Consultant Connect.

In the Triage slide, Yeovil needs to be added to all tables and their teledermatology is triaged by the Consultant Dermatologists and Two Week Wait referrals are not currently triaged.

Details on the dermatology workforce, which were shared by the Integrated Health Boards (ICBs), were incomplete and will be double checked by the team.

Action: The ICB need to be informed that the information they have provided is inaccurate.	**C Pointz-Wright**
Action: Skin CAG will review the slides and send any corrections to H Dunderdale.	**Skin CAG**

DRAFT

Workforce shortages in administrative support staff need to be highlighted as well as shortages in the clinical team. This is currently a problem in YDH and it was noted that a lack of admin support can have a detrimental effect on the patient pathway.

A survey of CNS workloads in RUH showed that CNS teams spend 2-3 hours a day completing administrative tasks and this is part of the CA Workforce Strategy.

Administrative support for pathology needs to be provided and this needs to be looked at in every different stage of the pathway, in particular when work is outsourced and when service developments are implemented.

CAG Recommendation

Useful information on future events is included in the presentation.

For those interested in immunotherapy, South West Immunotherapy Group (SWIG) will be held on Wednesday 30th November 2022 at The Holiday Inn in Taunton and via MS Teams.

A monthly National Immuno-Oncology (IO) Education Forum is also held on the first Thursday of every month, 13:00-14:00.

CA has secured £30,000 from Health Education England (HEE) for CNS Clinical Examination training. Oxford Brookes can provide a ten-week training course for twelve nurses across the region. Six will start the course in January 2023. It is hoped that this will translate into measurable improvements in the service that can be provided.

Any other training needs can be flagged to H Winter.

The ability to transfer credits between educational institutions needs to be explored, as this is not always possible if a Masters has commenced at UWE for example.

Action: C Pointz-Wright to explore if credits from Oxford-Brookes can be transferred to a Masters commenced at UWE.

C Pointz-Wright

3. Patient Experience

3.1 National Cancer Patient Experience Survey (NCPES, 2021)

Please see presentation uploaded to the SWAG website

Presented by R Helps

The NCPES annual survey was sent to inpatients or day cases over a three-month period in 2021 and published in July 2022. The survey is designed to help monitor progress in cancer care and inform service quality improvements.

A total of 3,319 responses were received from across the SWAG CA which represents a 59% response rate; 103 responses were from skin cancer patients. The vast majority of responders were of white ethnicity, highlighting the need for further health inequality work to find out why this might be the case.

DRAFT

One barrier is that the survey is only available in English despite the fact that it is advertised in English, Polish and Arabic. This has been raised with the survey provider Picker.

Action: To look at the dropout rate of responses from ethnic minorities where English is their first language. **R Helps**

The overall rating of care across SWAG was 9/10, compared with the national average of 8.9. Questions relating to having a key point of contact and a plan of care reflect the positive work of the Clinical Nurse Specialists and Cancer Support Workers who complete Holistic Needs Assessments and provide personalised care and support.

For Skin Cancer Services, there were very few responses as the majority of patients are treated as outpatients so results are difficult to interpret. Sixteen out of the fifty-eight questions had higher positive results than the national average, with the rest of the questions very much in line, and six questions falling below; three of these related to hospital stays/ communications and could be related to restrictions caused by the COVID-19 pandemic. Two were related to activity in Primary Care (the ICB are working to improve this), and one was related to discussions about cancer research; many research trials were paused during the pandemic, and also not all patients would qualify for research.

The percentage of patients who were told they had cancer by their Consultant or CNS was not thought to be accurate and did not reflect the CNS workload. This was an example of one of the questions that could be misinterpreted.

It had not been possible to look at free text comments by cancer site, which is usually the most useful information. This will be addressed by Picker in the next iteration of the survey.

Details of the actions that each Trust is taking in response to the survey are within the presentation. Communication, shared care, and information on long term side effects are the common themes.

Skin CAG are to decide on any priorities for improvements and recognise areas of good practice.

3.2 Regional Patient Experience Surveys and Patient Education

Presented by the CNS Team

A regional patient experience survey was developed to capture quality information and inform service improvements as NCPES does not capture the majority of skin cancer patents. This has yet to progress in RUH due to workload pressures.

NBT now provide a survey for all patients via a QR code or online form at diagnosis and the end of treatment. This comprises 26 questions. The response rate needs to be improved but feedback is good. The main comment is about communication, with many administrators working from home, patients struggle to get phone calls and emails answered.

DRAFT

Somerset FT have a patient experience discussion group which convenes every two years, run by the Cancer Services team with the Skin team supplying names. Results are generally positive with the exception of travel to Bristol.

YDH have a dermatology survey but not a specific skin cancer survey. The team hope to develop this and will review the QR survey.

Action: NBT QR Survey will be shared with the CNS team **J Watson**

The free text comments that patients shared in a survey at the end of the RUH Education Events have been used to continuously adapt and improve the service.

First follow up would be a good point to give out patient experience surveys.

Patient education is available online via the UHBW website. The videos have been viewed mainly by UHBW and NBT patients, but the links could be given to patients in the other SWAG Trusts:

Bristol Royal Infirmary - What We Do | University Hospitals Bristol NHS Foundation Trust (uhbristol.nhs.uk)

4. Research

4.1 MelMar-T update

Presented by E Wilson

The MelMar-T pilot trial examined 1 versus 2 cm margins on wider excisions for patients with primary cutaneous melanoma eligible for SLNB. It is thought that 1cm may be sufficient and reduce the risks associated with skin grafts and flaps. Long term follow up will be recorded. The main international trial is now open and recruiting to time and target.

4.2 NIHR Clinical Research Network update

Please see presentation uploaded to the SWAG website

Presented by C Matthews and C Herbert

National recruitment to Skin Cancer Research was 3,164 in 2021/22 and 1,920 in 2022/23 to date. National and regional recruitment trends show a recovery post pandemic, with West of England recruitment now higher than in 2019/20.

Information on the 16 studies open and 1 in set up are available within the presentation.

DRAFT

Studies performing well:

- PROPHETIC
- MelMarT-II
- MITRE
- IMLYGIC®.

RELATIVITY-098 is an adjuvant study for Stage 3/4 resected melanoma looking at Nivolumab versus Nivolumab plus Relatlimab trial drug in 1:1 randomisation.

It has taken so long to open in the UK that it is near to closing as it has recruited well in other countries. BHOC has yet to recruit; CAG are asked to refer any eligible Stage 3 patients identified in the next few weeks.

A 6 month Associate Principal Investigator (PI) NIHR certified scheme is available to any clinicians interested in research who do not have this as part of their main job role. The role involves working alongside the PI of a study.

Results from the Participant in Research Experience Survey (PRES) for 2021/2, which had nearly 2,000 responses from 97 studies across 22 specialties, including cancer, were rated well; 93% indicated they would take part in research again. 93% also felt they had received all the information they needed. 92% felt researchers had valued their contribution. Comments included: research participation was easy and well organised, research staff were friendly and professional, and participants felt they were contributing to improve healthcare for others.

Recommendations include improving access to test results and contact details of the research team and access to parking and appointments out of working hours. The CRN will be looking at ways to address these issues.

Useful links and contact details for the Research Delivery Team are within the presentation.

Set-up is currently very slow and difficult in NBT and UHBW. MelMarT-II took an exceptionally long time, considering that the pilot was essentially the same trial.

The problems with RELATIVITY-098 had been national rather than regional, although there are problems with set-up in Bristol due to the impact of the pandemic on the trials unit.

Regional solutions to streamline set-up processes would be helpful.

Action: Lists of open studies will be shared with the MDTs. **C Matthews/H Dunderdale**

Discussions of research trials improve in MDT meetings when a research nurse attends.

DRAFT

4.3 Small Cell Carcinoma Research

Presented by P Craig

P Craig is a member of the RCP Dermatopathology subcommittee and Cellular Pathology Sub Advisory Committee and part of the test evaluation group for the cancer genomics test directory. Pathology workforce issues will be raised at an RCP meeting this afternoon.

It is an interesting time now that mass genomic testing is available and digital pathology and Artificial Intelligence projects are under development.

Collaborative work is underway to gather pathology data in a super-computer based in Warwick to look at biopsies. This will help develop AI algorithms over the next 6-7 years.

Academic pathology posts have been significantly reduced to the lowest number in the Western world.

Trusts have received £25,000 of central funding to support implementation of the National Genomics Test Directory, which is rapidly expanding. This will end next year, after which time, Trusts will be expected to provide the tests from existing funds. The additional workload that this involves for cellular pathology has not been taken into account; this has been calculated as requiring £200,000 per year for the GRH service; the lack of resources need to be flagged on Trust risk registers.

Future directions:

GRH are due to go digital along with the Bristol pathology network. SFT has been digital since 2016.

A paper published on rare cancers by the French Network may inform future service improvements.

A bioresource project is being set up which will require 60 high risk cutaneous SCC fresh frozen tumours of more than 2cm in diameter.

Some Health Research funded nursing staff would need to be involved.

A meeting between Gloucestershire, Bristol and RUH will establish how the teams can support the project. The main challenges will be identifying cases prior to resection to gain consent and providing adequate samples of fresh tissue.

Please contact paul.craig2@nhs.net for further information.

Action: P Craig to email E Wilson, N Carson, A Orlando and I Delikonstantinou at NBT and A Basiouni at RUH **P Craig**

DRAFT

5. Service Development

5.1 Artificial Intelligence Service Evaluation

Please see the presentation uploaded to the SWAG website

Presented by A Bray

The 12-month evaluation, funded by a NICE Innovation Grant, started in May 2022 and hopes to show if AI can support UHBW Dermatology Two Week Wait capacity by redirecting some of those referrals, and speed up cancer diagnosis. Additional months can be funded if necessary.

A lot of work has already been undertaken with Teledermatology and also withsetting up the local Medical Photography Hubs to get high quality images for patients closer to home.

The addition of AI, which involves using a smart phone app to upload a dermascopic image which is run through an MHRA Class 2 device accredited algorithm.

So far, 248 patients have been seen across 3 sites (BRI, South Bristol and Weston) and the image quality and online platform have been positively evaluated to date.

Some patients are sent straight to a face to face clinic by the booking team based on information on the two week wait referral forms.

Other exclusions are scars, tattoos, hair bearing areas and lesions that are bigger than the Dermatoscope, genitals and nails.

The AI then confirms if the lesion is suspicious, with a suggested diagnosis or benign. Benign cases then go through a safety net and are reviewed by a GMC registered Dermatologist employed by the company. If it is confirmed that the lesion is benign, the patient is sent a standard discharge letter. If there is any doubt, the patient is booked into a telephone clinic where management decisions, such as booking surgery or face to face clinic, can be made.

Approximately 50% are booked directly for surgery after the telephone appointment, 15% are classed as benign and discharged, and face to face two week wait clinic appointments were reduced. Very few patients are discharged once seen, as the AI has a very high sensitivity of 98.5%.

UHBW conversion rate to cancer is greater than the national average due to the high incidence of skin cancer locally. It will be interesting to see the conversion rate for the equivocal cases.

Outcomes will be reported next year when it will be determined if discharging 15% of 2WW referrals makes purchasing the AI a cost-effective investment. Without the safety net, this could increase to 30%.

It's application in Primary Care could also be explored.

DRAFT

Review of a static dermascopic image is different to a dynamic examination and may not pick up changes in the vessels.

Telephone versus face to face appointments saves a minimal amount of time for Consultants but saves a significant amount of time for patients.

Medical Photography Hubs are scattered across the region, saving patients hours of travel time.

6. Clinical Guidelines

6.1 AMBLor to identify low risk AJCC Stage I/II melanomas

The presentation is available on request

Presented by P Lovat

Professor P Lovat is Professor of Cellular Dermatology and Oncology Newcastle University and Chief Scientific Officer for AMLo Biosciences Ltd.

The new prognostic biomarker for early-stage melanoma is based on the expression of two proteins, AMBRA1 and Loricrin in the epidermis overlying primary non ulcerated AJCC stage I and II tumours.

An evaluation was undertaken which showed a significantly increased disease-free survival over 12 years for patients whose expression of AMBRA1 and loricrin was maintained compared to those where expression of both proteins was lost, notably with a negative predictive value of more than 98%.

Sub cohort multi variant analysis of 202 Stage IB tumours also showed the combined expression of these proteins as a stronger predictor of disease-free survival than Breslow depth.

The combined epidermal expression of AMBRA1 and Loricin is a prognostic biomarker with high sensitivity and specificity that is able to identify genuinely low risk subsets of AJCC Stage I and II non ulcerated melanomas.

As a simple based IHC biomarker that fits seamlessly into diagnostic pathways and provides improved personalised prognostic information, its inclusion into clinical diagnostic and management pathways may therefore aid the stratification of patients for reduced follow up /need for SLNB, enable significant healthcare savings as well as having the potential to improve patient anxiety.

6.2 Lynch Syndrome Service update

Presented by S John

Due to time pressures, a copy of the recorded presentation will be circulated to Skin CAG after the meeting today.

Action: H Dunderdale to circulate the Lynch Syndrome Service update to CAG members **H Dunderdale**

DRAFT

6.3 Lynch Syndrome / Muir-Torre Research Project

Please see the presentation uploaded on to the SWAG website

Presented by N Carson

Consultant Pathologist N Carson is commencing a project with G Dunnill and R Vincent to optimise management of sebaceous neoplasms, the use of MMR IHC and detection of lynch syndrome / Muir Torre patients; results will be fed back to Skin CAG at a future meeting.

Future agenda item

Lynch is the most common hereditary cancer syndrome affecting 1 in 300 of the population although 95% of patients are undiagnosed. It is cost effective to try and screen patients for LS and try to treat related cancer early on; these are mostly colorectal, endometrial and ovarian plus other less common cancers. It would be helpful if a comprehensive family history could be completed in Primary Care.

Muir-Torre Syndrome is a rare form of Lynch Syndrome, but in 50% of cases it is the herald tumour of the syndrome and will lead to other cancers. Any patient with more than one sebaceous neoplasm is eligible for genetic testing. The patient should also be asked for their past medical history and family history of cancer and at what age the cancer occurred, so that the Muir-Torre risk algorithm can be completed.

The project will involve review of all sebaceous neoplasm cases over the last seven years to find those that meet referral criteria for genetic assessment. The Lynch Syndrome CNS team will help contact those patients who have not had genetic testing to arrange for them to be referred, gathering any missing medical history in the process, in the hope that this will help these patients and their families. Many patients with Lynch Syndrome decide to have risk reducing surgery and need to plan their families carefully.

MMR IHC is not an effective test to rule out Muir-Torre and this does not need to be debated in the MDT.

MUTYH associated polyposis is an autosomal recessive cancer predisposition syndrome that also may increase the likelihood of sebaceous neoplasms and colorectal cancer which will also be considered.

Any help with the project would be appreciated: naomi.carson@nbt.nhs.uk

It could be possible for the CNS team to gather additional past medical history/family history in results clinics.

DRAFT

6.4 Melanoma: Assessment and Management (NICE)

Please see the presentation uploaded to the SWAG website

Presented by A Darvay

NICE guidance for the assessment and management of melanoma was updated in July 2022. The original document was over 200 pages long, and had now been reduced to 44 pages.

Advice on immunosuppressants has changed from 2015 (p 243) 'consider minimizing or avoiding immunosuppressants for people with melanoma' to 'For people on immunosuppressants and immunomodulators, seek advice from the patient's specialist team (2022, Page 9). CAG members should do a covering letter and copy the melanoma diagnosis letter to the patient's transplant team who will decide how to adjust treatment regimens.

NICE now suggest the following for BRAF as there is a reasonable risk of relapse, making it useful to have this information as early on as possible:

- Consider BRAF analysis Stage IIA and IIB
- Carry out BRAF analysis IIC-IV
- LSMDT arrange BRAF tests
- First test Immunohistochemistry (BRAF V600E)
- If IHC negative use a molecular test.

This is something that the team will work towards and is already requested in Stage IIA high risk patients in RUH.

Regarding Staging and SLNB, it is now advised not to offer imaging before SLNB unless nodes or distant metastases are suspected; this was already current practice.

The significant change is to consider SLNB for Breslow 0.8mm to 1.0mm with at least one of the following:

- Ulceration
- LVI
- Mitotic Index
- Discuss the option of delaying SLNB until after pregnancy
- Consider CT Staging for IIB
- Offer CT Staging IIC to IV
- Consider Staging with brain MRI if locally available and after discussion and agreement with the SSMDT.

NICE use of the word 'consider' is sometimes confusing but is interpreted here as, if a patent is Stage IIB, offer CT Staging.

DRAFT

Having a lower threshold for performing Brain MRI will be considered.

The guidance to consider a repeat staging scan before starting adjuvant treatment, unless imaging within the last 8 weeks is available, is particularly relevant at present due to current delays.

No changes have been made to management of Stages 0 to II, with the guidance to consider a clinical margin of at least 0.5 mm remaining the same, depending on anatomical site. It also states that if an excision doesn't achieve adequate histological margins, this should be discussed at SSMDT, but it is unclear why this couldn't be discussed by the local MDT and there is no mention of what an adequate histological margin may be.

It would be dependent on anatomical site, the size of the lesion and the patient preference and ultimately decided after MDT discussion.

Regarding a Wide Local Excision (WLE) NICE states 1cm for Stage 1 or 2cm for Stage 2 and the clinical margin should be around the histological biopsy scar and take into account the primary melanoma margin.

This depends on the anatomical site. It will be discussed further by the SSMDT.

For Stage III, the guidance is to not routinely offer completion lymph node dissection with Stage III disease and micro-metastatic nodal disease detected, unless there are factors that might make recurrent nodal disease difficult to manage:

- Melanoma of the head and neck
- Adjuvant treatment is contraindicated
- Regular follow up is not possible.

Centres are routinely following this guidance and sending patients straight to adjuvant treatment.

Patients may be offered completion if they have multiple positive nodes involved.

For In Transit Mets Stage III and IV where treatment with surgery is not feasible or for recurrent disease, there is the following range of treatments:

- Systemic tx
- ECP
- T-VEC (talimogene laherparepvec)
- ISI/P
- Radiotherapy
- Imiquimod.

The definition of In Transit is more than 2 cm away from the primary melanoma before it reaches the lymph node.

There is a 12 week window to start adjuvant pembro following SLNB.

Stage IIB will get a CT scan within 8 weeks prior to commencing systemic therapy because the first line treatment will be different to the adjuvant therapy if metastases are identified.

DRAFT

Action: To formally contact NBT Plastic Department to escalate the need to reduce SLNB waiting lists / increase theatre space so that Stage IIB patients can be managed appropriately. **A Darvay/H Dunderdale**

High Risk Stage II are to be immediately flagged to the Oncologists in the local MDT; a staging protocol will be made available.

A possible solution to avoid delays would be for these patients to be tracked by a navigator and an alert sent to say that a further wait will delay adjuvant treatment and track how many patients are being affected.

There has been an increased number of patients waiting for SLNB that have a repeat scan showing metastatic disease.

For Stage IV and Unresectable Stage III the SSMDT are to consider surgery or other ablative treatments in consultation with other site-specific MDTs; C02 laser ablation has been dropped in the 2022 guidance.

When looking at Stage IV and Unresectable Stage III Immunotherapy and targeted treatments, 'the committee noted the complexities and nuances in the treatment pathway' and made the following observations:

- Immuno is more effective than targeted (though higher toxicity)
- Nivolumab & Ipilimumab most clinically and cost effective
- Immuno monotherapy to decrease toxicity e.g. those with poor performance status, nivolumab or pembrolizumab similar clinical effectiveness so either should be offered

If Immunotherapy is unsuitable then targeted therapies based on BRAF status are an option in those with a high disease burden or rapidly progressive disease.

Targeted therapies include Encorafenib plus Binimetinib or Trametinib plus Dabrafenib . Both have similar clinical and cost effectiveness. If both these options are unsuitable then monotherapy with dabrafenib or vemurafenib should be offered. If not suitable then Dacarbazine and/or best supportive care should be offered.

For further information on adjuvant treatments, see NICE technological appraisals as documented in the presentation.

Follow up has also been reduced and further personalised as indicated in the presentation.

The addition of 'consider ultrasound of draining nodal basin(s) had been raised with radiology, but it was unlikely that there would be capacity to offer this at present.

NBT Radiology have been asked for a formal position on the guidance with the aim to work towards compliance in the future.

There is no scoring system for ultrasound assessment of lymph nodes at present.

In summary, use of CT, MRI and ultrasound will increase and CT-PET will decrease.

DRAFT

User Representative J Garret, who is currently on the follow up schedule of 4 check ups per year, is of the opinion that it would be preferable to have less check ups which were longer and more thorough. Initially, full body photographs were taken, but these have not been referred to in subsequent checks.

This will be taken on board when considering future surveillance protocols.

Patients need to be empowered to use these appointments to address any concerns.

Consultant Dermatologist A Bray will update the SWAG follow up flow chart which attempts to simplify interpretation of the NICE guidance.

The imaging that can be offered locally needs to be clarified.

Action: The flow chart will be extended over two sheets and sent to everyone to check that it works. **A Bray**

The caveat 'each organisation may adapt the guidance according to available resources' will be added.

7. Any Other Business

The guidelines on rare tumours will be revisited.

Date of next meeting: To be confirmed via Doodle Poll

-END-

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