

Recognising skin lesions: the traditional approach

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Recognising skin lesions: learning outcomes

- Help with making a correct diagnosis
- Ensuring appropriate management *whether or not the correct diagnosis is made*
- Understand how best to use the two week skin cancer referral pathway
- Alternatives to the two week wait pathway

Recognising skin lesions: why bother?

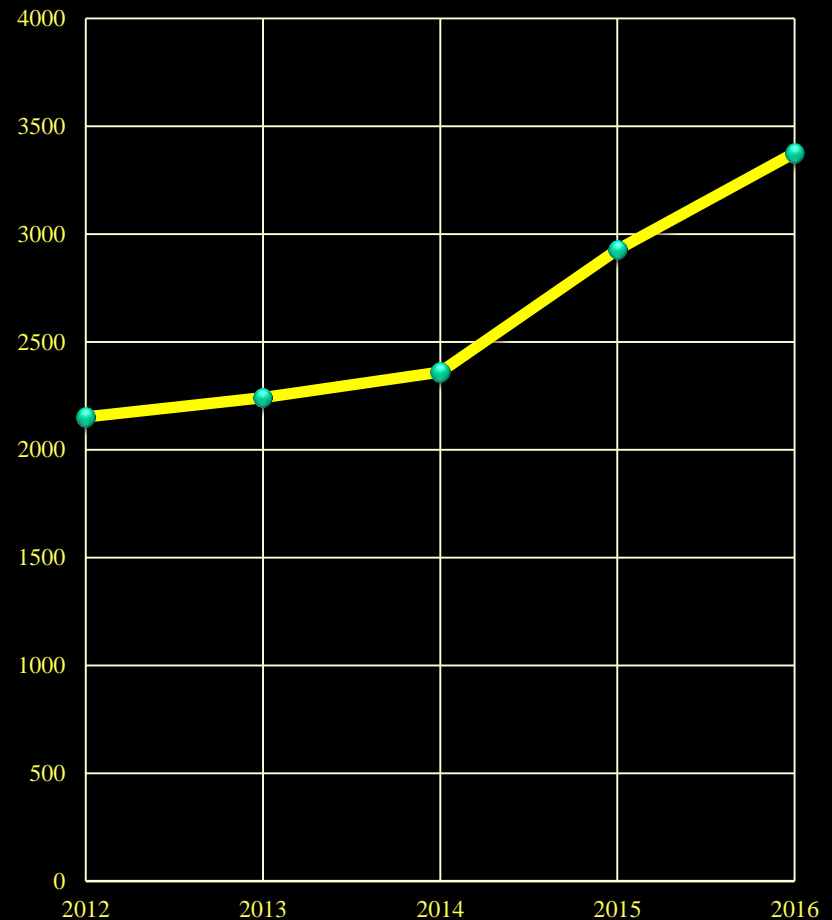
- Correct diagnosis = correct management
- Avoid unnecessary surgery
- Avoid 'non-relevant' 2 ww referrals
- Reduced anxiety for patients
- Reduced costs for commissioners

Referrals: two week wait pathway

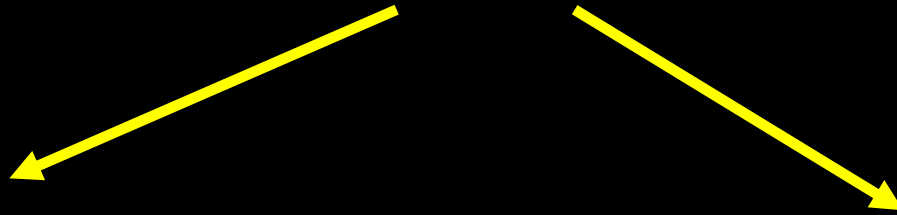
- Melanoma and squamous cell carcinoma, NOT basal cell carcinoma
- 2 ww conversion rates range from 4.6% to 13.2%
- Around 50% of all melanoma diagnosed by 2 ww
- 20-30% of Squamous cell carcinomas
- Large numbers of non-relevant lesions

Two week wait referrals: ULHT

- ULHT 57% rise in last 5 years
- Now a third of referral activity
- Negative impact on referrals for inflammatory diseases



Recognising skin lesions



Making a
diagnosis

Managing
uncertainty

Recognising skin lesions: making a diagnosis

- *History: general and dermatological*
- Examination

Making a diagnosis: general history

General:

- Age
- Skin type and sun exposure
- Family history
- General health

Making a diagnosis: dermatological history (1)

- Duration of lesion. Is it new?
- Congenital or acquired
- Solitary or multiple
- Any change?
- If change, over what timescale



Making a diagnosis: dermatological history (2)

- Crusting
- Bleeding
- Itching
- Pain
- Inflammatory, non-inflammatory
- No change



What is a mole?

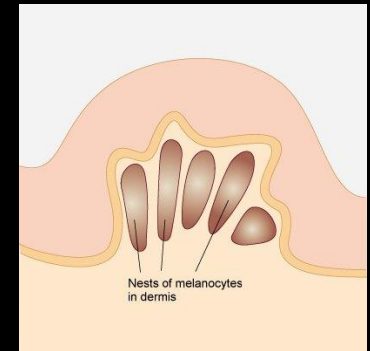
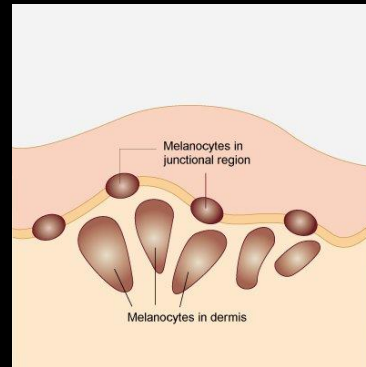
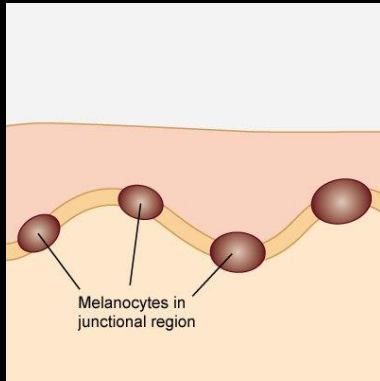


A brown animal that goes under the ground

Making a diagnosis: natural history of melanocytic naevi

- Appear in childhood, puberty and early adult life
- New melanocytic naevi rare after 30's
- Disappear in elderly

Melanocytic naevi



Junctional

Compound

Intradermal

Making a diagnosis: Dermatological history (3)

Pointers to skin malignancy:

- New and changing 'moles' (*not itching only*)
- Enlarging non-healing lesions
- History of sun exposure
- Previous history of skin cancer

Recognising skin lesions: making a diagnosis

- History: general and dermatological
- *Examination*

Making a diagnosis: Examination

DESCRIPTION
DESCRIPTION
DESCRIPITON

Making a diagnosis: Examination, site

- Lower legs
- Extremities (digits)
- Scalp
- Upper back, shoulders, trunk
- Face
- Backs of hands



Making a diagnosis: Examination, description

- Single or multiple
- Colour (red, brown, yellow, pink)
- Surface features, smooth non-keratotic, rough keratotic, pearly,
- Texture, soft, firm, bony hard, cystic
- Attachment to other structures

Single or multiple



Umbilicated



'Fried egg' sign

Colour



Surface features: smooth non-keratotic,
rough keratotic, pearly,



Texture: firm, hard, cystic, juicy



Making a diagnosis:

Examination, other descriptive terms

- Cyst = cavity lined with epithelium
- Nodule = dermal pathology
- Scar = healed dermal lesion
- Comedone = plugged sebaceous follicle
- Papule, plaque, umbilicated.....

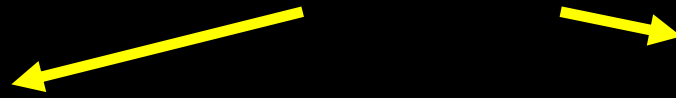
Making a diagnosis: Examination, description

A pearly nodulo-cystic lesion with overlying telangiectasia in a 70 yr old man on the face (likely to be a BCC)

A crusty pigmented lesion on the trunk of a 50 year old (likely to be a Seborrhoeic keratosis)

Making a diagnosis: Derivation of lesion

Is it epidermal or dermal?



Superficial,
crusty, scaly,
rough



Epidermal

Smooth surface,
usually elevated,
thickness similar
to diameter



Dermal



What structure is it derived from?

Derivation of common skin tumours

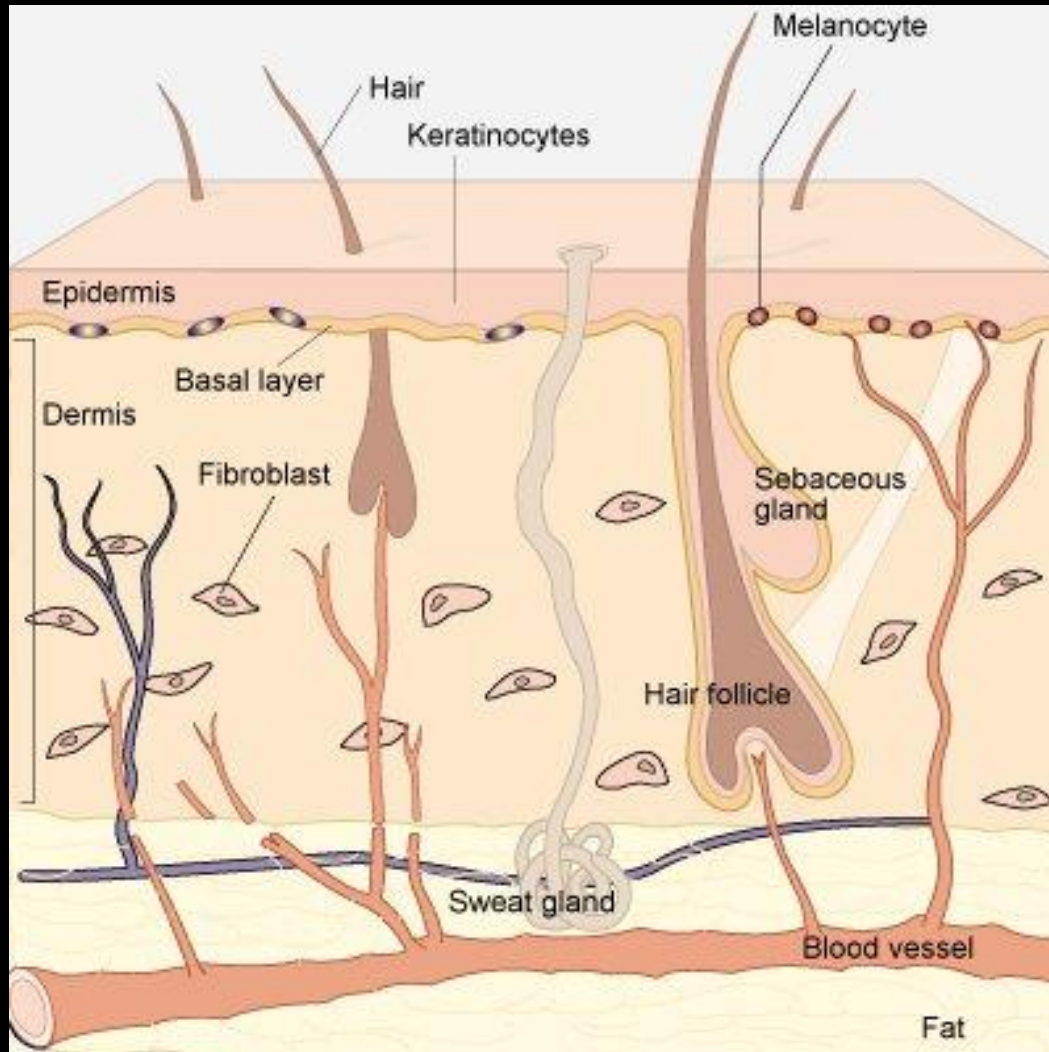
EPIDERMIS

Melanocytes	All types of melanocytic naevi and malignant melanoma
Keratinocytes	Seborrhoeic keratosis, solar keratosis, Bowen's disease, SCC

DERMIS

Hair follicles	Epidermoid cysts
Fibroblasts	Dermatofibroma
Blood vessels	Spider naevus, Campbell de Morgan spots, pyogenic granuloma

Derivation of common skin tumours



Epidermal lesions, keratinocytes: superficial, keratotic



Epidermal lesions, melanocytic: pigmented



Dermal lesions :



Cutaneous Horn


Clinical, not a
pathological
diagnosis

Causes:

- Viral wart
- Solar keratosis
- Squamous cell carcinoma

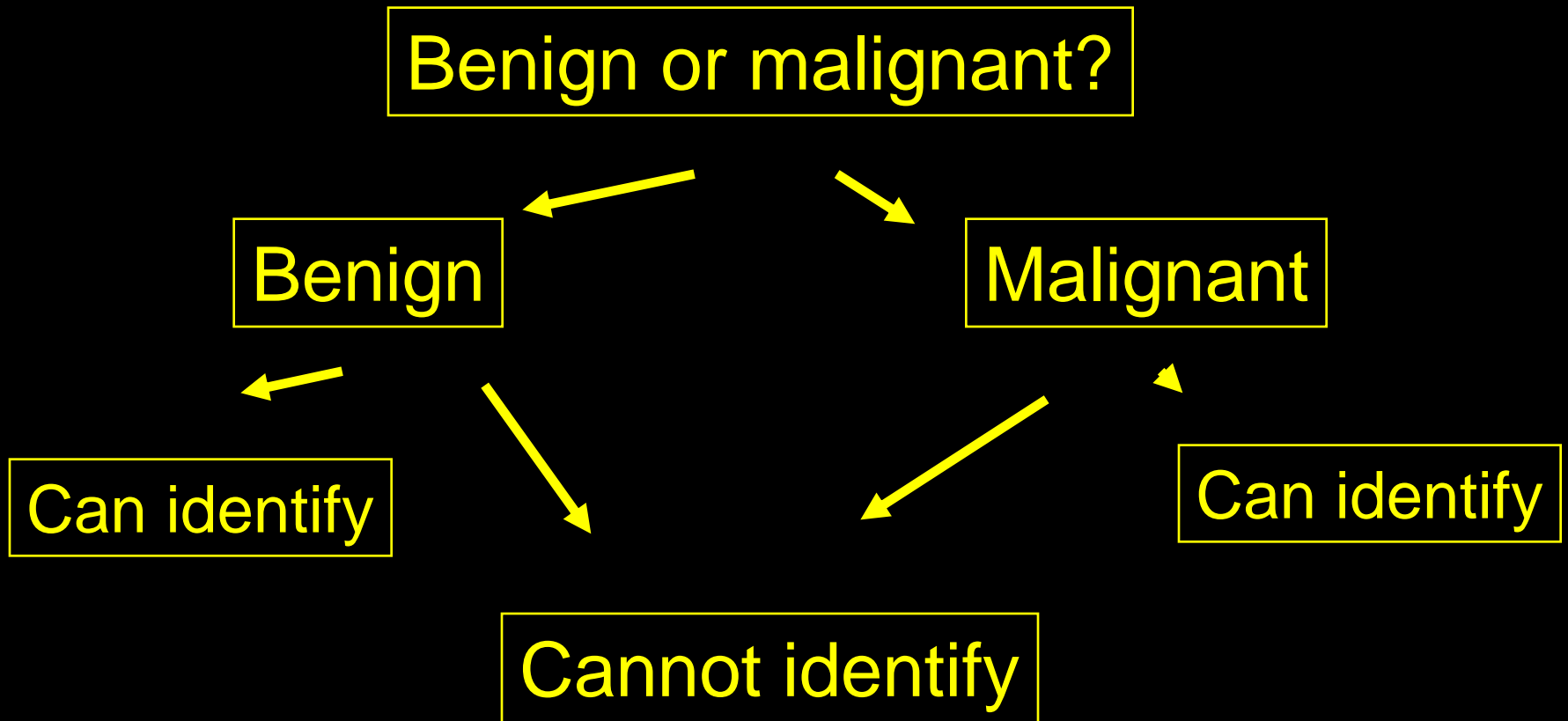


Making a diagnosis: probability

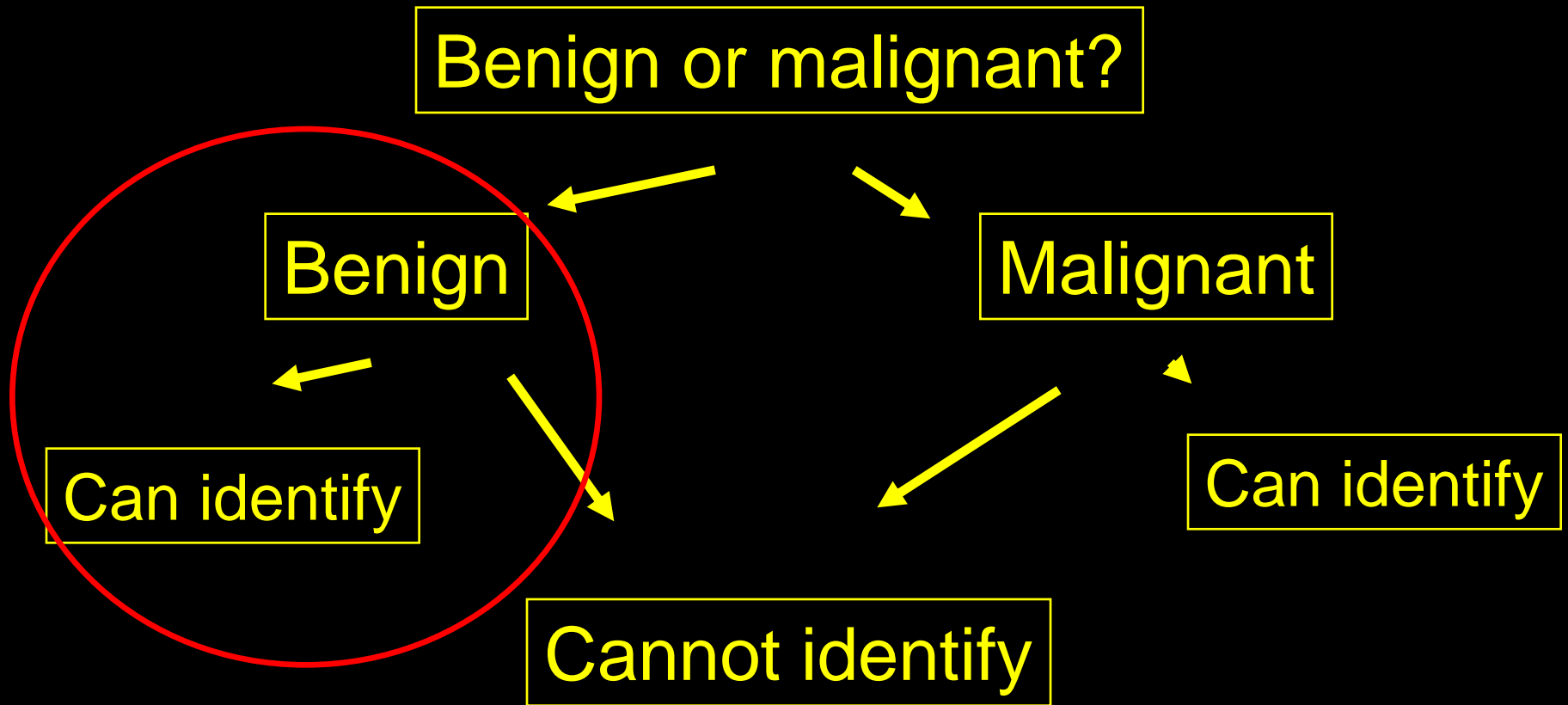


29%	Melanocytic naevus
24%	Seborrhoeic keratosis
16%	Epidermoid cyst
12%	Skin tag
5%	Dermatofibroma
2%	Malignant lesions
12%	Other, including pyogenic granuloma

Skin lesions: Managing uncertainty

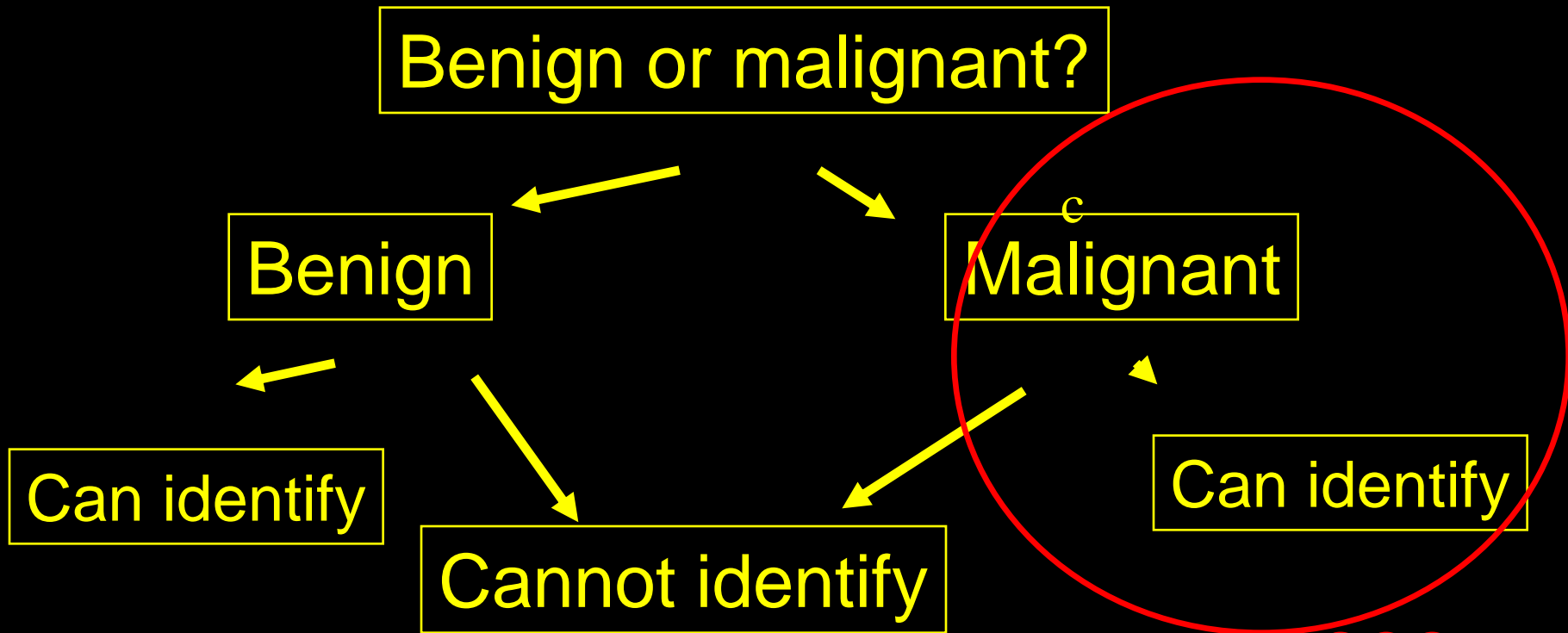


Skin lesions: Managing uncertainty



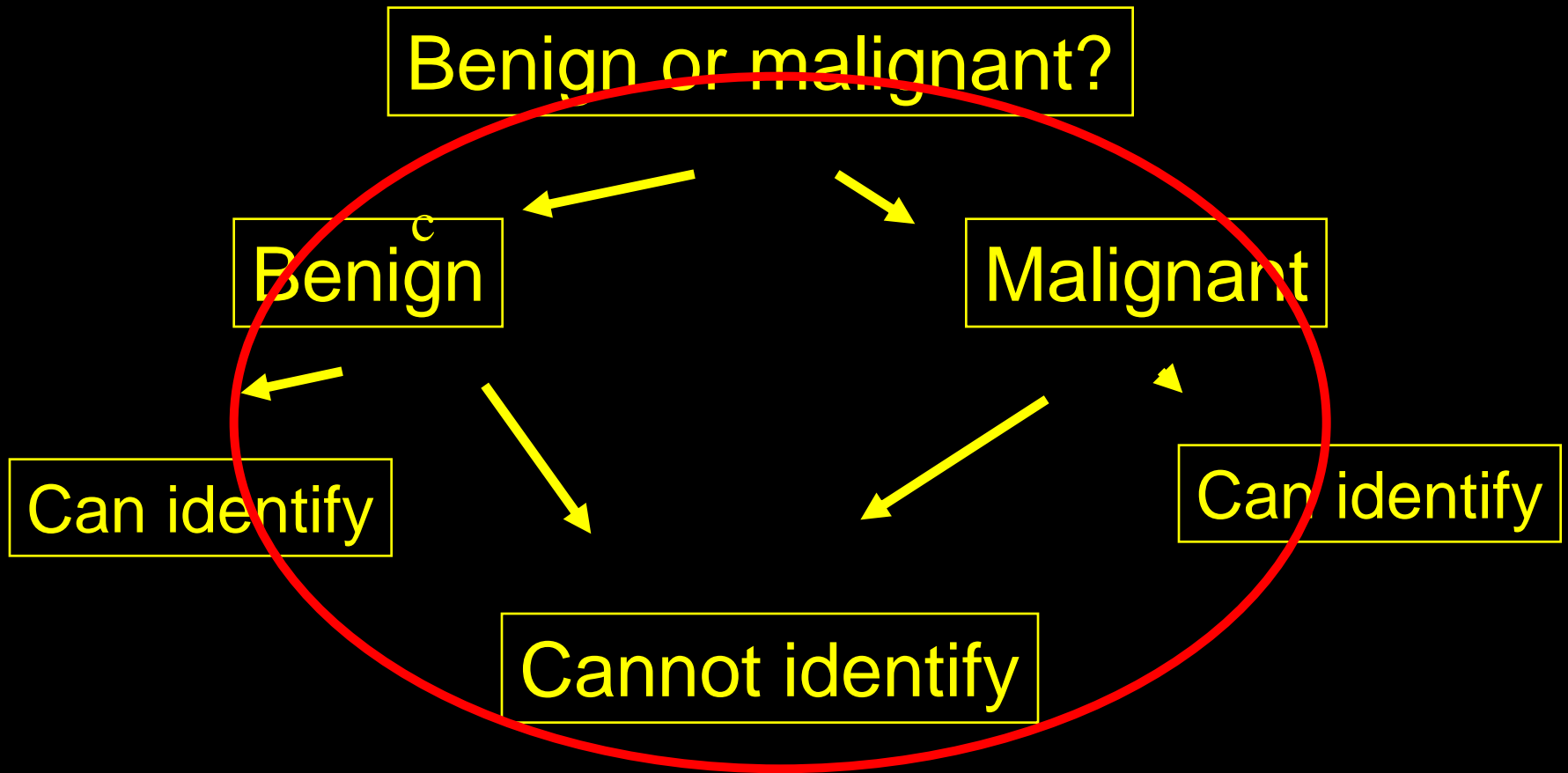
Low priority framework

Skin lesions: Managing uncertainty



Melanoma & SCC
2 week wait
NOT BCC (routine)

Skin lesions: Managing uncertainty



Managing uncertainty: cannot identify lesion. Basic principles

- Take good history, examine lesion
- Decide whether it is clinically benign or malignant
- Be prepared to use time as a diagnostic tool

Managing uncertainty: cannot identify lesion

Correct
Diagnosis



Correct
Management

No Diagnosis



Incorrect
Management

Avoid removing any lesion where you are uncertain
of the diagnosis

Example: seborrhoeic keratoses

Managing uncertainty: Cannot identify, clinically benign

- Stable and unchanging, reassure
- Smartphone image, tape measure
- Review after 6-12 weeks
- Advise patient to return if any change
- Consider tele-dermatology referral
- 'Spot clinic'

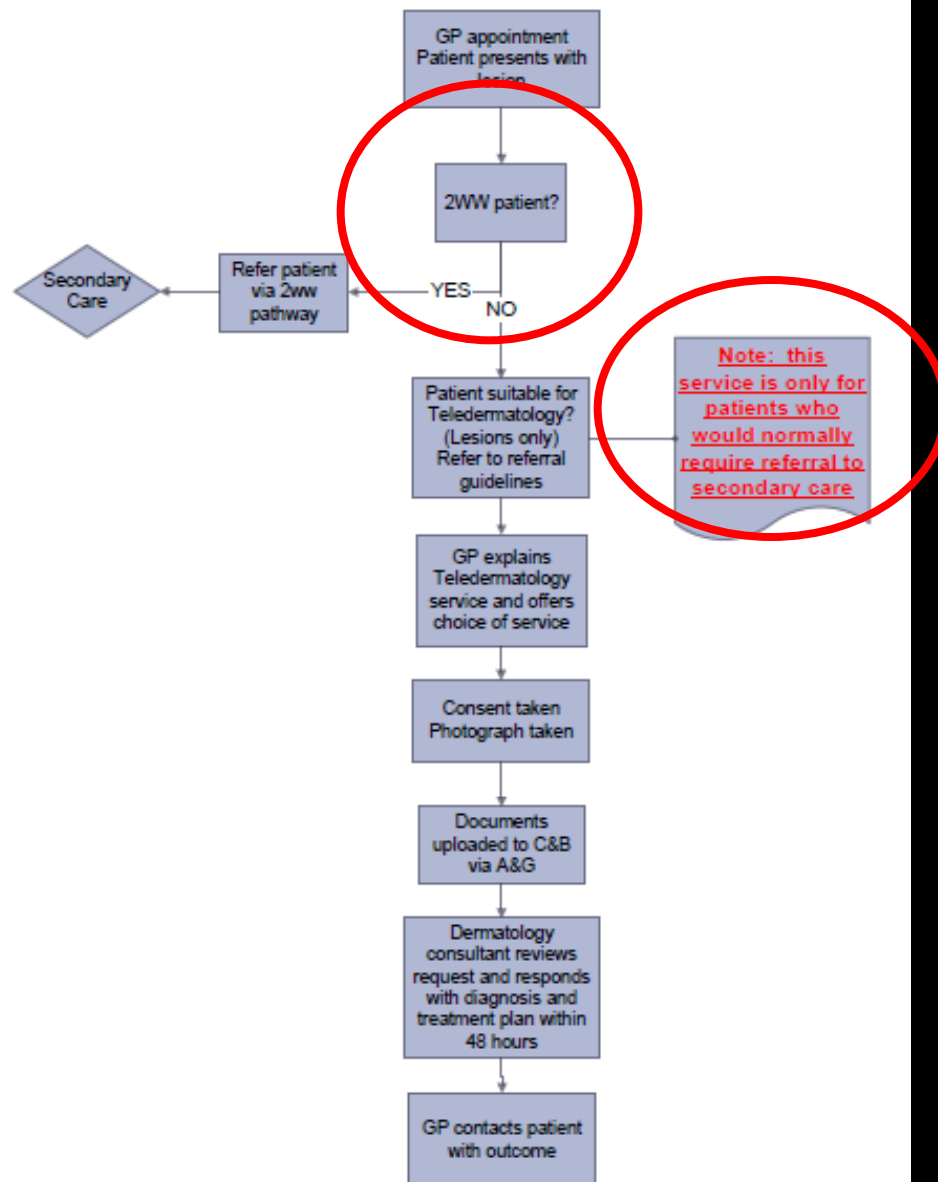


Experience of using Choose and Book Advice and Guidance Tele-dermatology for skin lesions in a district general hospital

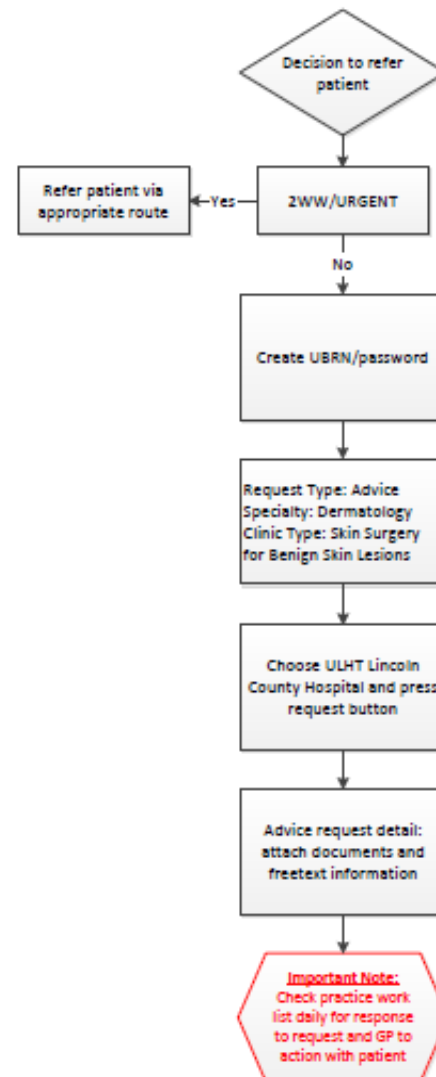
Julia K Schofield¹, Khalid Hussain¹, V Blankley², Melissa Hall²

¹United Lincolnshire Hospitals NHS Trust, ²Lincolnshire West Clinical Commissioning Group

CHOOSE & BOOK TELEDERMATOLOGY PATHWAY



TELEDERMATOLOGY C&B ADVICE AND GUIDANCE BOOKING PROCESS



Advice Response - 0002 6617 3160

Advice Request Details

Please find attached photos. Pt has a mole upper back which has started to itch recently. I would be grateful for your advice.
Yours sincerely,

Advice Request Attachments

File Name	File Description	Added By	Date/Time Added
[redacted]	-	SMITH, Debra (Mrs) (Referring Clinician Admin)	16-Jun-2015 17:58
[redacted]	-	SMITH, Debra (Mrs) (Referring Clinician Admin)	16-Jun-2015 17:57
[redacted]	-	SMITH, Debra (Mrs) (Referring Clinician Admin)	16-Jun-2015 17:57
[redacted]	-	SMITH, Debra (Mrs) (Referring Clinician Admin)	16-Jun-2015 17:57

Advice Response Details

From the history and images provided this looks to be a benign melanocytic lesion. Itching on its own is not usually a symptom of malignant change, so provided the mole is stable and not changing there is no cause for concern. I suggest watchful waiting and self monitoring. If there is any change in size, shape or colour over a three month period please refer as a 2 week wait. Julia

Advice Response Attachments

Add Attachment

File Name	File Description	Remove
None Found		

Cancel Submit

Release Info

0123
 0123
 Lincolnshire West
 Clinical Commissioning Group

Consent form for the use of digital images with referral for people with skin conditions

Statement of the patient

I confirm that I: CHLOETTE SIEVRIGHT 415188
55, LINDSAY CLAYDON LINDSAY

- Have had the process of teledermatology explained to me and I have had the opportunity to ask questions about the procedure
- Understand that I have the right to withdraw or withhold my consent at any time without this affecting my right to future care
- Am aware that teledermatology is not always a substitute for seeing a hospital consultant and that there may be a difference between the diagnostic accuracy of a face-to-face consultation and a teledermatology referral
- Understand that the images will be securely stored

I consent to use of the recordings (please tick all boxes that apply):

1. For medical records only

2. To teach appropriate professional staff

3. To inform and educate other patients and new families, to who the images are relevant

4. For clinical research and audit

5. In publications and electronic publication as long as I am not identifiable in the image. If images are potentially identifiable I will be contacted for specific consent before publication.

Signature: [Signature] Date: 15/6/2015

Name: _____

Relationship to patient if signed on behalf of patient: _____

Statement of healthcare professional

I have discussed the teledermatology service with the patient and provided them with the opportunity to ask any questions.

Signature: [Signature] Date: 15/6/15

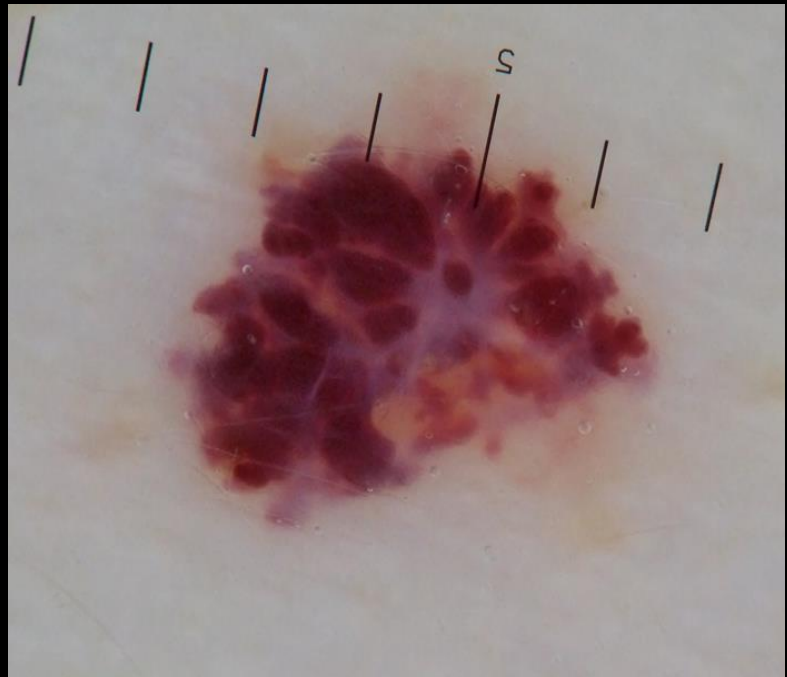
Name: LUCY HINDOCHA

Photographer

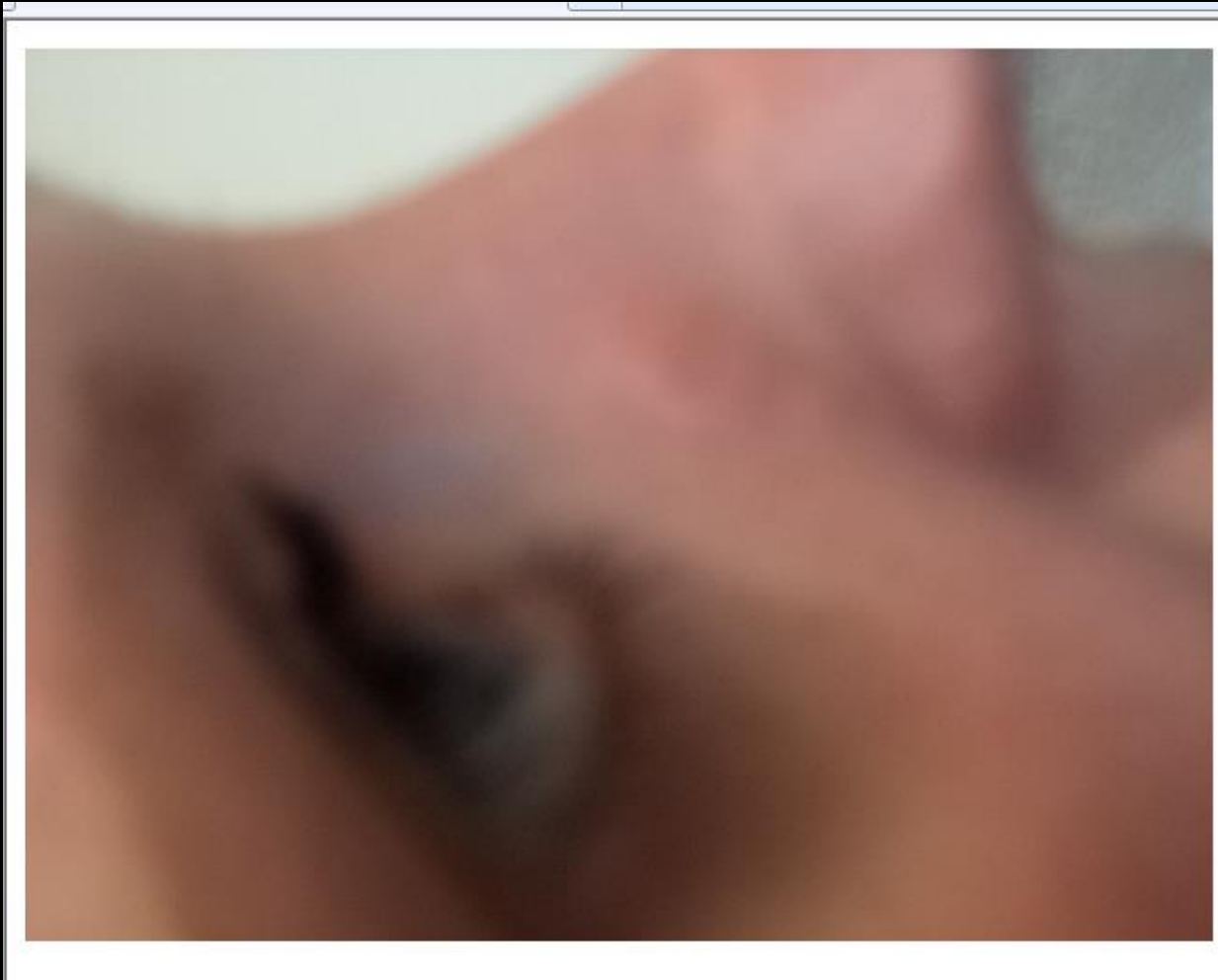
Signature: [Signature] Date: 15/6/15

Name: LUCY HINDOCHA

Teledermatology Consent Form v2 May 2014



Poor images



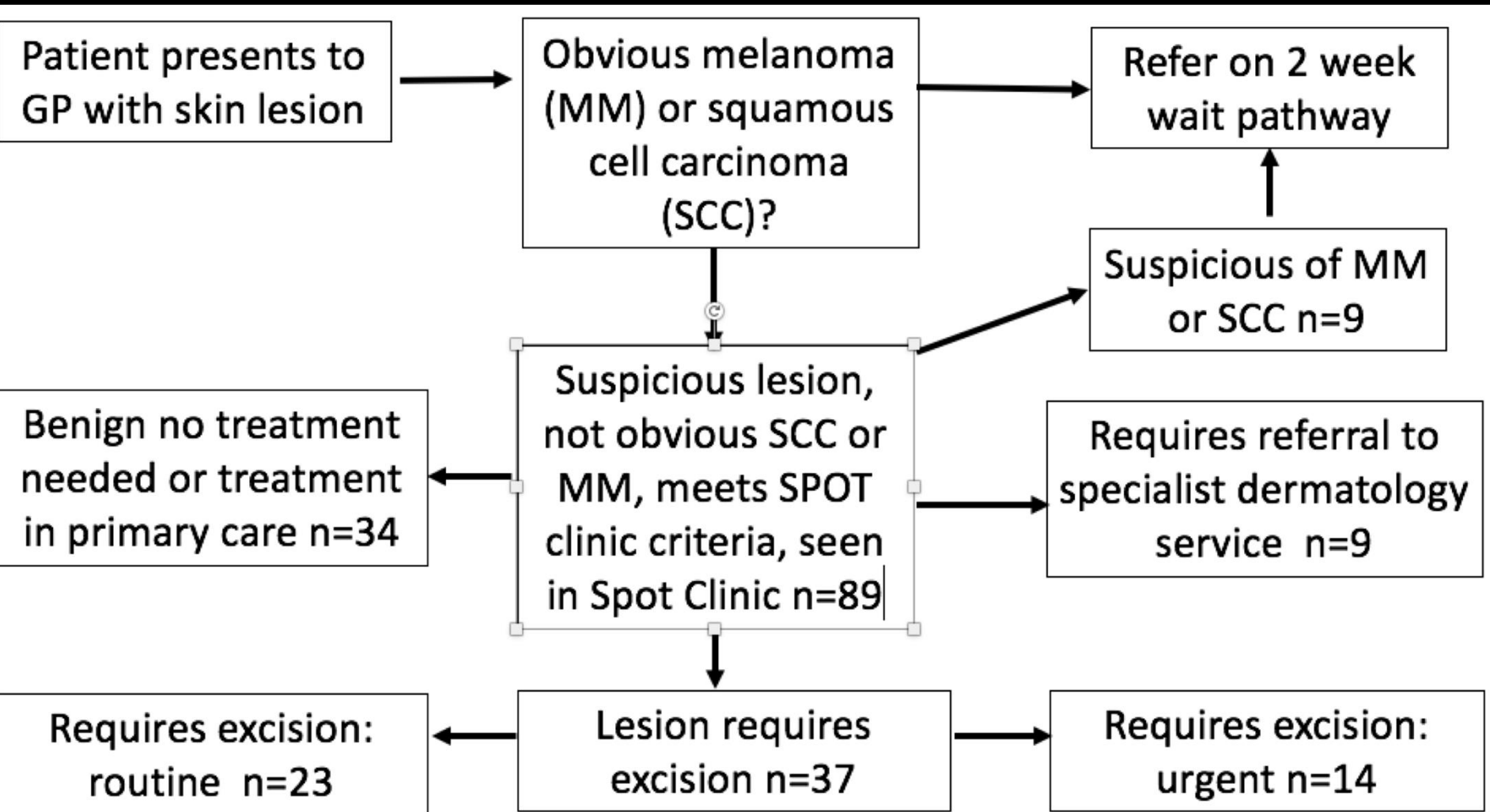
Spot clinics: ?another option

- GP surgery, face-to-face skin lesion triage service.
- 24 patients with a single suspicious skin lesion two hour clinic
- Three clinic rooms: practice nurse and two health care support workers
- Consultant dermatologist

Spot clinics: ?Another option

- Skin lesion questionnaire completed
- Patient prepared for examination
- Consultant performs clinical and dermoscopic examination
- Diagnosis and treatment plan to GP
- Skin lesion triage service: pre-2 week wait

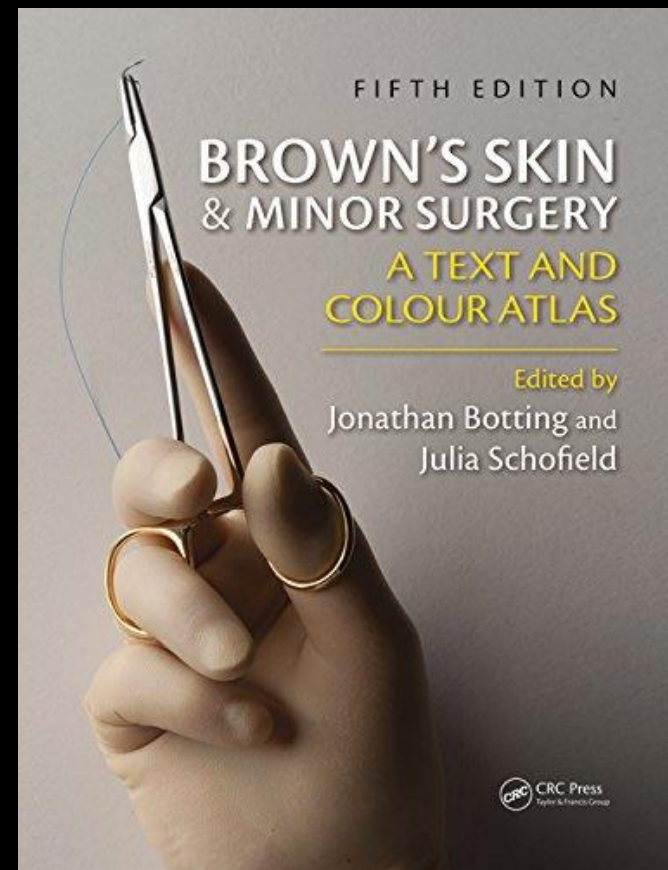
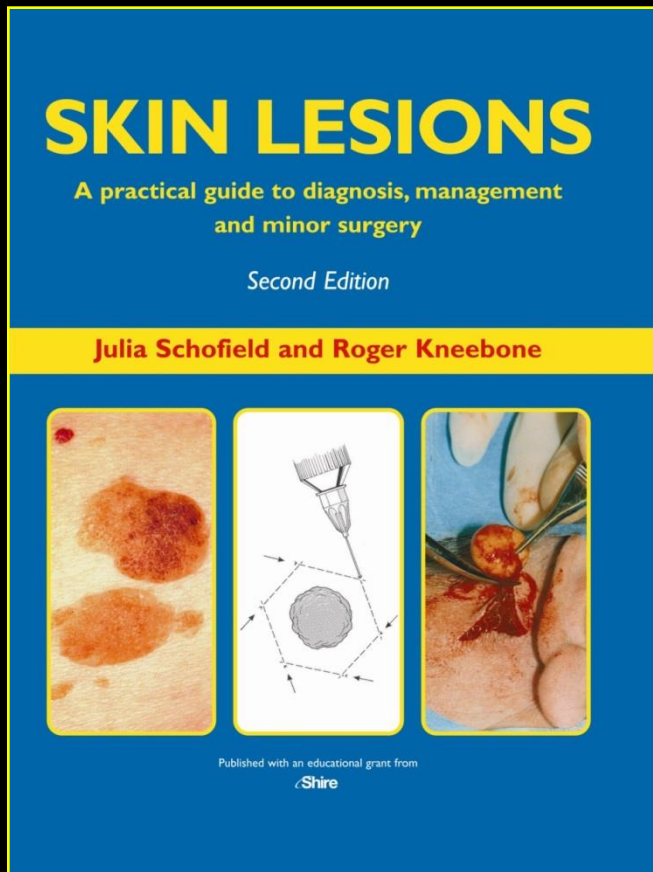
Spot clinic results: Grantham pilot



Recognising skin lesions: summary

- Take a good history
- Examine the lesion in the context of its derivation
- Make a diagnosis if possible
- If diagnosis is uncertain, decide whether benign or malignant
- Manage any uncertainty appropriately
- Tele-dermatology (C&B advice and guidance)'
- 'Spot' clinics: watch this space

If you want to read or learn more.....



University of Hertfordshire MSc dermatology skills and
treatment

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