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 nor 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
DESCRIPTION
DESCRIPTION
"DESCRIPTION"
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

<table>
<thead>
<tr>
<th>Cell Type</th>
<th>Tumours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanocytes</td>
<td>All types of melanocytic naevi and malignant melanoma</td>
</tr>
<tr>
<td>Keratinocytes</td>
<td>Seborrhoeic keratosis, solar keratosis, Bowen's disease, SCC</td>
</tr>
</tbody>
</table>

## DERMIS

<table>
<thead>
<tr>
<th>Cell Type</th>
<th>Tumours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hair follicles</td>
<td>Epidermoid cysts</td>
</tr>
<tr>
<td>Fibroblasts</td>
<td>Dermatofibroma</td>
</tr>
<tr>
<td>Blood vessels</td>
<td>Spider naevus, Campbell de Morgan spots, pyogenic granuloma</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>29%</td>
<td>Melanocytic naevus</td>
</tr>
<tr>
<td>24%</td>
<td>Seborrhoeic keratosis</td>
</tr>
<tr>
<td>16%</td>
<td>Epidermoid cyst</td>
</tr>
<tr>
<td>12%</td>
<td>Skin tag</td>
</tr>
<tr>
<td>12%</td>
<td>Other, including pyogenic granuloma</td>
</tr>
<tr>
<td>5%</td>
<td>Dermatofibroma</td>
</tr>
<tr>
<td>2%</td>
<td>Malignant lesions</td>
</tr>
</tbody>
</table>
Skin lesions: Managing uncertainty

Benign or malignant?

Benign
- Can identify

Malignant
- Can identify

Cannot identify
Skin lesions: Managing uncertainty

Benign or malignant?

Benign

Can identify

Cannot identify

Malignant

Can identify

Low priority framework
Skin lesions: Managing uncertainty

Benign or malignant?

- Benign
  - Can identify
- Cannot identify
  - Melanoma & SCC
    - 2 week wait
      - NOT BCC (routine)
Skin lesions: Managing uncertainty

Benign or malignant?

Benign
- Can identify

Malignant
- Can identify

Cannot identify
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 \(\rightarrow\) Correct Management

No Diagnosis \(\rightarrow\) 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

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**CHOOSE & BOOK TELEDERMATOLOGY PATHWAY**

1. GP appointment
   Patient presents with lesion

2. 2WW patient?
   - YES
   - NO

   **Note:** this service is only for patients who would normally require referral to secondary care

3. Patient suitable for Teledermatology? (Lesions only) Refer to referral guidelines

4. GP explains Teledermatology service and offers choice of service

5. Consent taken
   Photograph taken

6. Documents uploaded to C&B via A&G

7. Dermatology consultant reviews request and responds with diagnosis and treatment plan within 48 hours

8. GP contacts patient with outcome

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**TELEDERMATOLOGY C&B ADVICE AND GUIDANCE BOOKING PROCESS**

1. Decision to refer patient
   - Refer patient via appropriate route
   - 2WW/URGENT

2. Request Specialty: Dermatology
   Clinic Type: Skin Surgery for Benign Skin Lesions

3. Choose LINLCT Lincoln County Hospital and press request button

4. Advice request detail:
   - Attach documents and freestext information

5. Important Note:
   - Check practice work list daily for response to request and GP to action with patient

**Version:** Final v3, May 2014
**Review Date:** May 2015
Please find attached photos. It has a mole upper back which has started to itch recently.
I would be grateful for your advice.

From the history and images provided this looks to be a benign melanocytic lesion. Nothing on its own is 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 are any changes in size, shape or colour over a three month period please refer as a 2 week mark Julia.
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

Patient presents to GP with skin lesion

Obvious melanoma (MM) or squamous cell carcinoma (SCC)?

Refer on 2 week wait pathway

Suspicious of MM or SCC n=9

Suspicious lesion, not obvious SCC or MM, meets SPOT clinic criteria, seen in Spot Clinic n=89

Requires referral to specialist dermatology service n=9

Benign no treatment needed or treatment in primary care n=34

Requires excision: routine n=23

Lesion requires excision n=37

Requires excision: urgent n=14
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.......