5444 - Pathology requesting in suspected Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma

5547 - Adherence to RCPath Core Dataset Reporting in Cases of Cutaneous Malignant Melanoma

Dr Graeme Watson (Academic F2 Doctor)
Dr Ursula Earl (Audit Supervisor)

5444 - Pathology requesting in suspected Pathology requesting in suspected Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma

Dr Graeme Watson (Academic F2 Doctor)
Dr Ursula Earl (Audit Supervisor)

Aim

- In hospital requests for histopathological diagnosis for BCC, SCC and MM generated by Dermatology and Plastic Surgery colleagues.

- How closely do the clinical details supplied on the current request form match up with the UK National Histopathology Request Form for Skin Biopsies (UKHRF)

Method

- Sample size: 180 (60 per cancer sub-type)
- Time Period: 2014
- First Audit
- Quality Assurance
- Retrospective
- Computer Search of South Tees Pathology SNOMED database and DART document storage system (for scanned request forms)

The UK National Histopathology Request form for skin biopsies

Date of surgical procedure

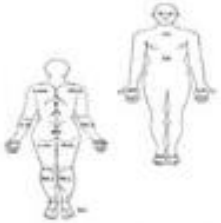
Name of surgeon

Clinical diagnosis: free text

Please attach patient details

Grade of surgeon: Nurse, Specialist trainee, Consultant, Hospital Practitioner, Other

Mandatory for Clinician to complete:	First biopsy	Second	Third	Fourth
Site Code as per image (insert LUL etc)				
Clinical Diagnosis (select either BCC, SCC, Melanoma, Atypical Mole, other tumour or other). For inflammatory lesions add clinical details as free text.				
Clinical size of lesion sampled (max diameter) (mm)				
Intention of the surgeon (select *biopsy, excision or curative curettage*				
Procedure (select *curettage, shave biopsy, punch, incisional biopsy or excision)*				
For tumours give measured surgical clinical margin (mm)				
Is this a recurrent tumour?	Y/N	Y/N	Y/N	Y/N
Is the pateint immunocompromised?	Y/N			
Is this a tumour arising in areas of radiation or thermal injury, chronic draining sinuses, chronic ulcers, chronic inflammation or Bowen's Disease	Y/N	Y/N	Y/N	Y/N
Is this a tumour arising in a genetically predisposed individual?	Y/N			



Please mark site of samples taken on the above images. For head and neck skin cancers the site code will be made up of the number in the horizontal grid and the letter from the vertical grid (e.g. for a tumour in the middle of the nose that might be code 8E). Where a lesion lies across grid lines then that grid reference in which the greater part of the tumour lies should be used OR if the lesion impacts on a grey shaded area or on the lips then that code should be used. Where the tumour is on the marked lips then the code LIP should be used. For tumours outside the head and neck the letters are indicated on the body map. e.g. a tumour on the left lower arm is LLA).

Free text

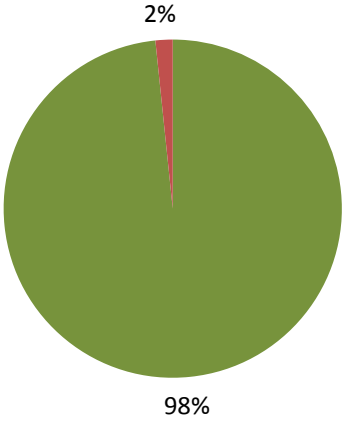
Results

- Three types of skin cancer
- Ten items on the form
- Will present breakdown per cancer subtype

Site of Lesion Stated

Anatomic site, left or right, upper or lower etc

BCC



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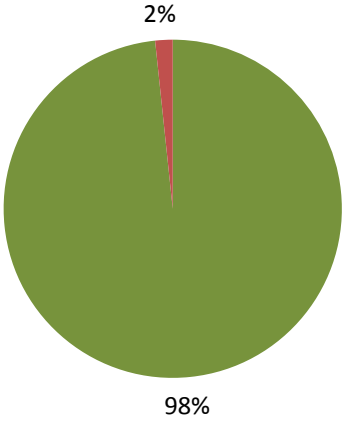
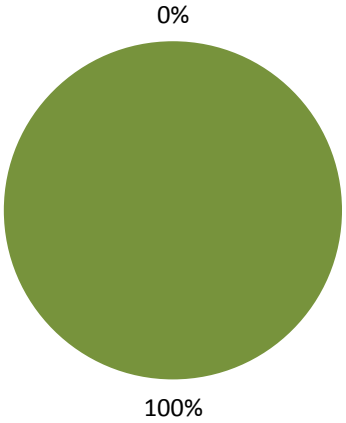


MM



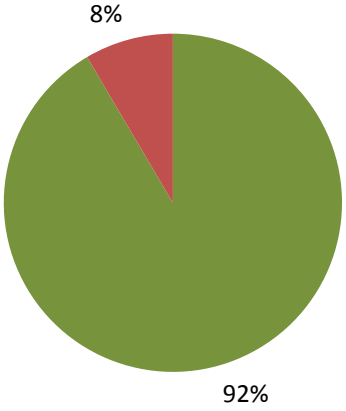
Differential Diagnosis Offered

For example ?BCC, SCC, MM
Best practice to include a diagnosis.
If there is concern about ?MM, state it on the form

Lesions identified as suspected melanoma are processed in the lab differently and are fully sectioned by BMS staff.

>Unless stated as TWO WEEK rule or MM, specimen is processed as routine, and not fully sectioned

BCC



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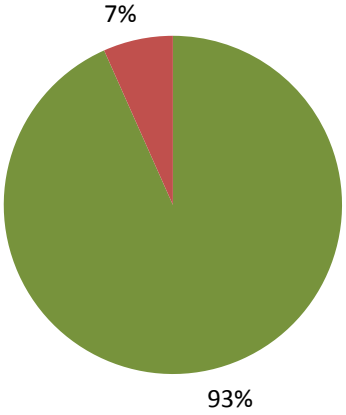
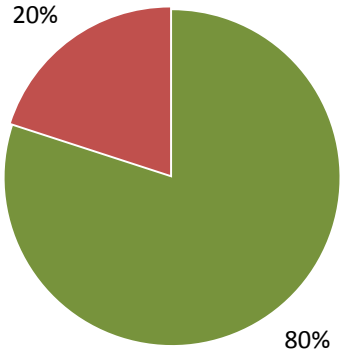


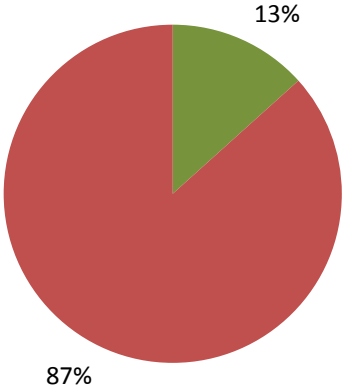
MM



Clinical Size Given

Size of lesion stated in millimetres.

BCC



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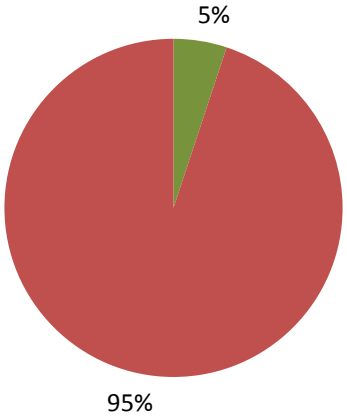

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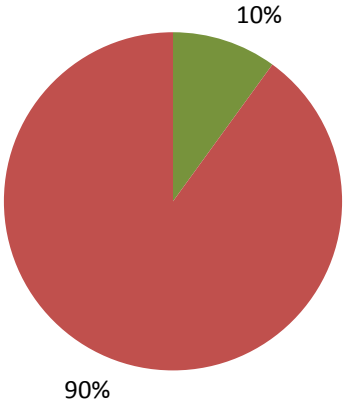
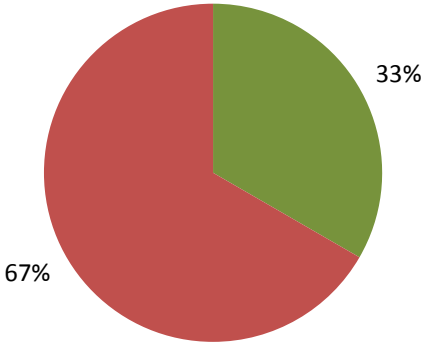


Intention of Surgery

Is this a biopsy for diagnosis?
Is this an excision with curative intent?
Is this a wider excision of biopsy proven disease?

BCC



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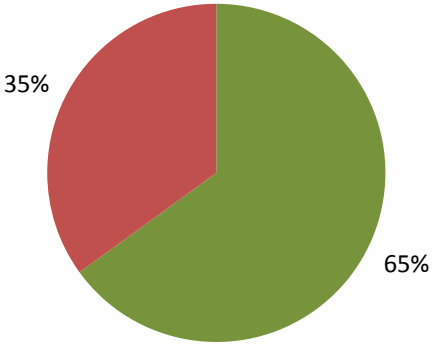

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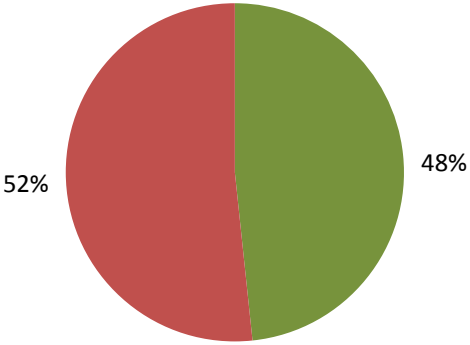
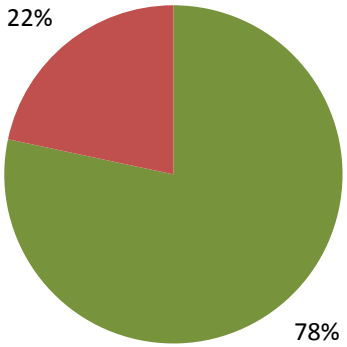


Procedure Stated

Punch biopsy, curettage, elliptical excision etc

BCC



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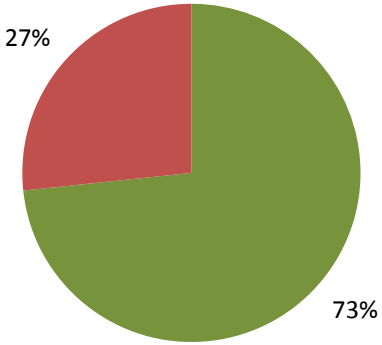

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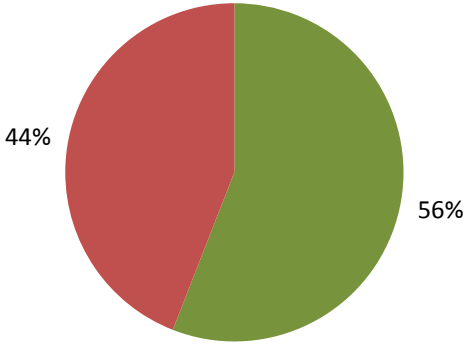
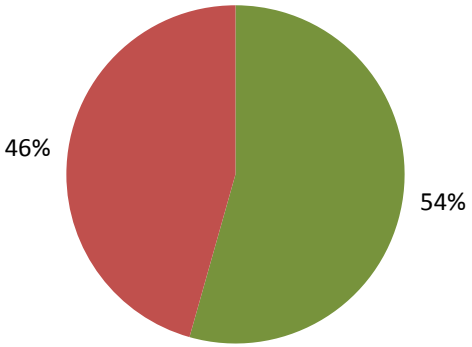


Measured Clinical Margin Stated

Size of margin stated in millimetres; applicable to excision samples only

BCC



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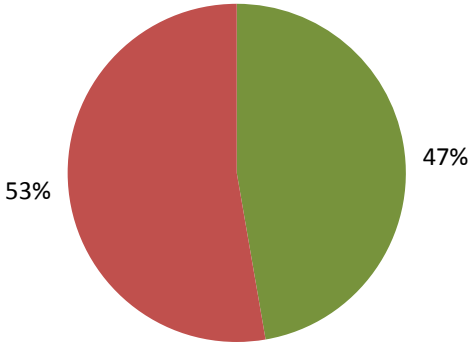

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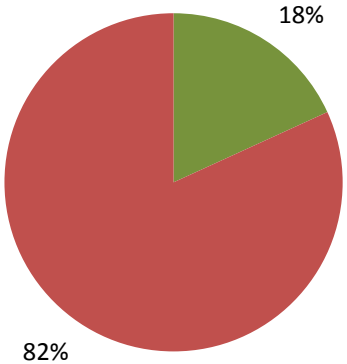
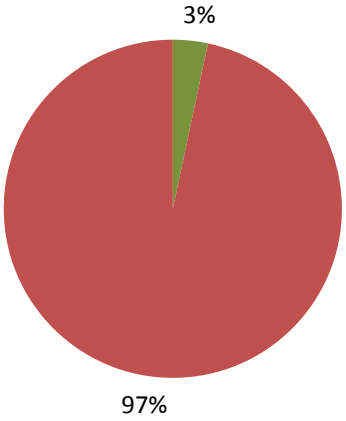


Stated if recurrent tumour OR NOT

It should be stated if this a recurrent tumour or not

BCC



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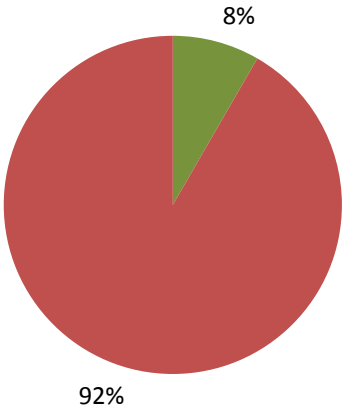

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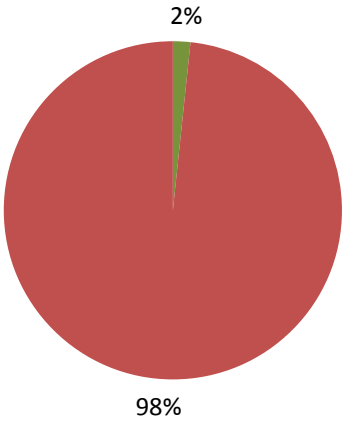
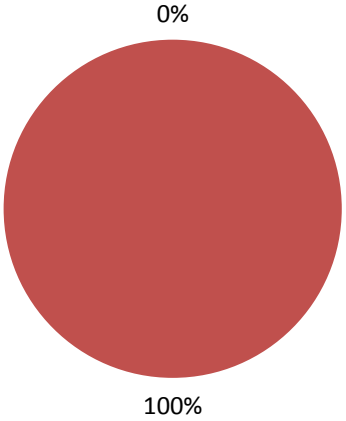


Chronic injury at skin site stated Y or N

Size of lesion stated in millimetres.

BCC



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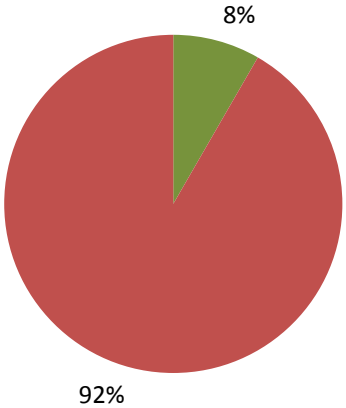

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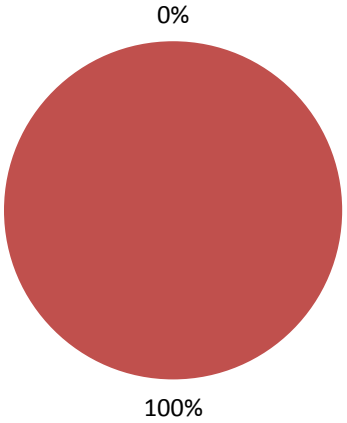
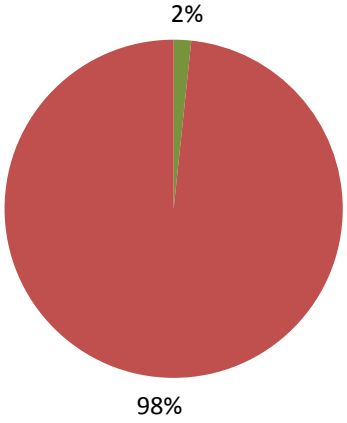


Stated if Immunocompromised Yes or No

Size of lesion stated in millimetres.

BCC



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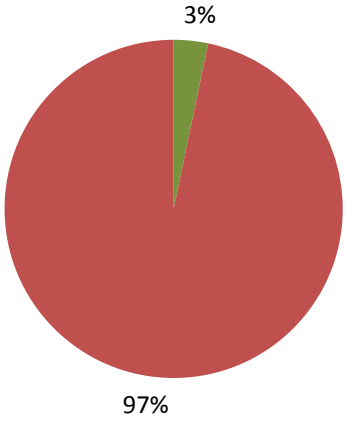

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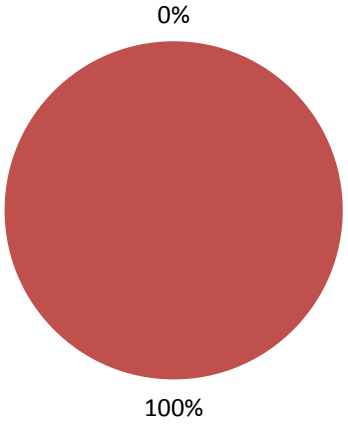
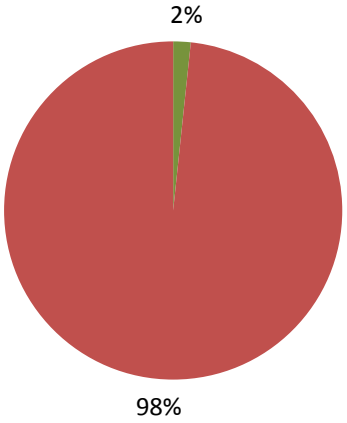


Genetic link known Yes or No

Size of lesion stated in millimetres.

BCC



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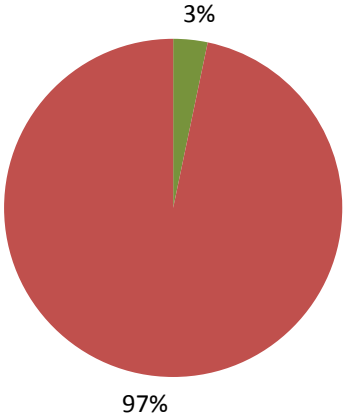

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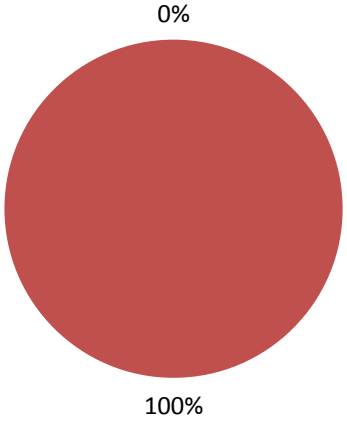


Conclusions

- In all cases details supplied most frequently are Clinical Site (99%) and Clinical Diagnosis (88%).
- The clinical size of lesions are recorded in less than 10% of total cases audited.
- A measured clinical excision margin (for excision samples) is given in 40% of all cases.

- Plastics request forms are coded for procedure performed, including nature of specimen (biopsy vs. excision vs. incision biopsy) so tend to record clinical procedure better than dermatology forms.
- There is a distinction to be made between surgical intent i.e. biopsy vs. excision, and procedure performed i.e. curettage, punch biopsy, incision biopsy, excision.

Suggestion 1: Electronic request

Pros:

Guarantees acquisition of minimum data required from the excising clinician

Same process for dermatology and plastics

Currently in use by radiology for requests

Cheap

Audit trail

Easy to adapt or change as per guidelines

Cons:

Junk characters are used to fill the request

Incorrect information could still be logged electronically (wrong consultant)
Availability of computer terminal that can handle the Web ICE system
Resistance to change

Suggestion 2: Enhanced Paper Request

Pros:

Better than current request form

Single form for dermatology and plastics

Cons:

Perception of a form with too many bits to fill in, that will go unfilled anyway

Persistence of old request forms until they have run out

Need for coding details for procedure

Resistance to change

2015 SKIN SPECIMENS FOR HISTOLOGY

Issued from Division of Pathology, The James Cook University Hospital, Middlesbrough Enquiries: 01642 854383

Tick Here If Private Patient	Urgent – Date Required	Referred Under Cancer Target

LOCATION (circle as appropriate)

JCUH Plastic Theatre (JCPTH)
Dermatology OPD (JCDO)
WARD 35 MOT (JC35)
FHN (FHOPD)
RPCH (RPCHP)
ONE LIFE (ONELP)

CONSULTANT (circle)

Plastics
Mr Allison (ALLK)
Mr Dunkin (DUNC)
Dr Erdinger (ERDK)
Mr Jones (JONAP)
Mr Muir (TM)
Mr Siddiqui (SIDH)
Mr Ramanathan (RAMC)
Mr Ajekigbe (AJEKL)

Dermatology
Dr J Azad (AZAJ)
Dr A Carmichael (CARAJ)
Dr P Cousen (COUP)
Dr S Darne (DARS)
Dr R Ellis (ELLR)
Dr S Natarajan (NATSI)
Dr D Seukeran (SEUD)

EXTRA REPORT COPIES TO:

PATIENT DETAILS

NHS NO: _____ HOSPITAL NO: _____

SURNAME: _____ FIRST NAME: _____

ADDRESS: _____

_____

DOB: _____ SEX: _____

DATE/TIME TAKEN

PREVIOUS HIST/CYT REFERENCES

Nature of Specimen:

Clinical Diagnosis: _____

_____

Anatomic Site: _____

Clinical Maximum Diameter of lesion: _____

Surgical Intention: Biopsy Excision Curative Curettage

Procedure Performed:
Curettage Shave Biopsy Punch Incisional Biopsy Excision

Measured surgical margin: _____

Is this a recurrent tumour? YES NO N/A

Is tumour on damaged skin (give details) _____

Genetically predisposed to skin tumour? YES NO UNKNOWN N/A

Patient Immunocompromised? YES NO N/A

Closure (Please Ring): Direct Flap or graft Shave Punch 2° Intent

PRINT NAME OF OPERATING SURGEON

REQUESTOR'S SIGNATURE

USER ID NUMBER	
BANDING PATHOLOGIST	
BAND A	
BAND B (1 OR 2)	
BAND C	
REPORTING PATHOLOGIST (INITIALS)	
Sha	
DISSECTOR	
CUT-UP ASSISTANT	
HSREQ	
CPRES (NAKED EYE)	
EMBEDDOR	
MODULE NO:	
QUALITY ASSESSOR	
REPORT TYPED & DATE	

5547 - Adherence to RCPath Core Dataset Reporting in Cases of Cutaneous Malignant Melanoma

Dr Graeme Watson (Academic F2 Doctor)
Dr Ursula Earl (Audit Supervisor)

Aim

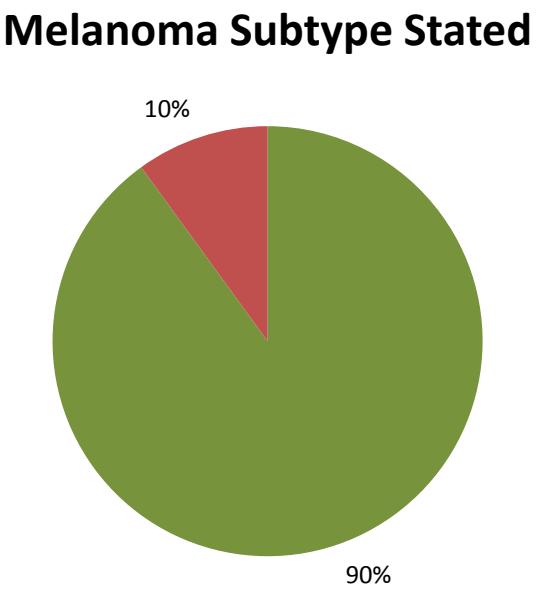
- To compare current practice in the reporting of MM against the RCPath core dataset guidance for MM

Method

- Sample size: 60 malignant melanomas (excision)
- Time Period: 2014
- First Audit
- Quality Assurance
- Retrospective
- Computer Search of pathology SNOMED database to generate cases, subsequent interrogation of WebICE to view reports and compare against RCPath core dataset

Melanoma Subtype Stated (Yes or No)

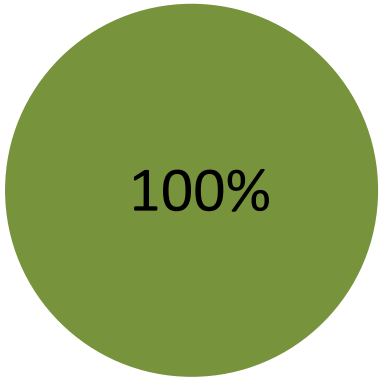
Subtype:
Lentigo Maligna
Superficial Spreading
Nodular
Acral Lentignous
Not otherwise specified
Other (Specify)



Breslow Thickness Given (Yes or No)

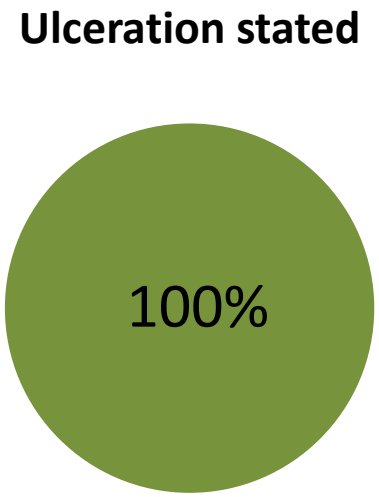
<u>Breslow Thickness</u>
>A principle T stage parameter, and important prognostic factor

Breslow Thickness Given



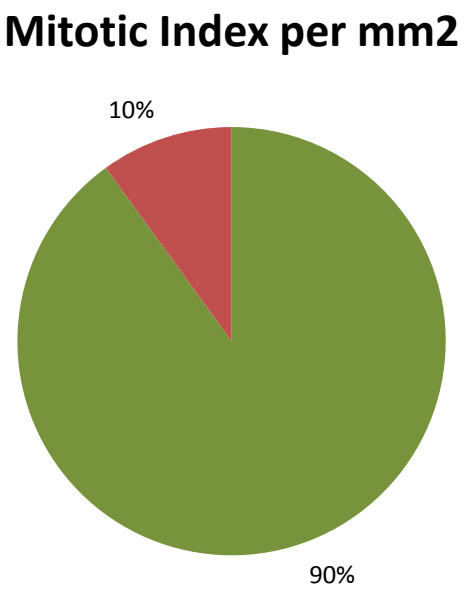
Ulceration Stated (Yes or No)

<u>Ulceration</u>
>A principle T stage parameter



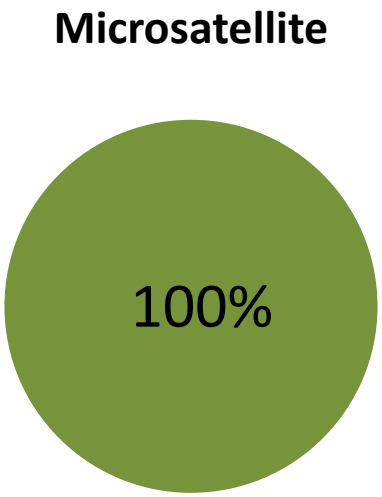
Mitotic Index given (per mm2)

<u>Mitotic Index</u>
New in AJCC7
Hot spot of mitotic activity identified, mitotic count per mm2. Previously given as number of mitotic figures per high powered field



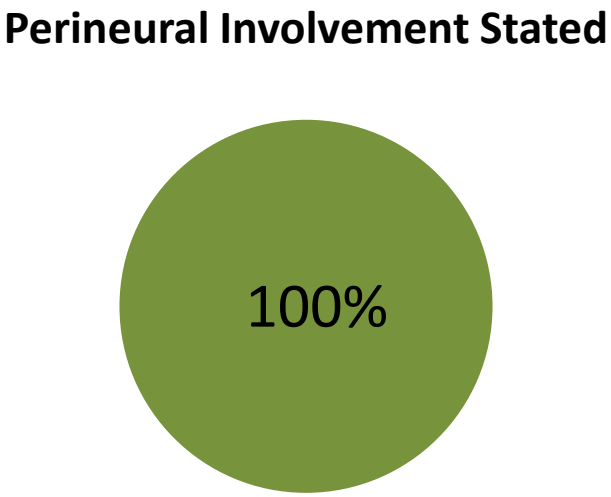
Microsatellites stated (Yes or No)

<u>Microsatellites</u>
Microsatellite/in-transit metastasis is a principal pN stage parameter in AJCC7. Its presence signifies stage pN2c
The presence of satellites, microsatellites and in-transit metastasis are associated with increased locoregional recurrence, a decreased disease-free survival rate and decreased overall survival.



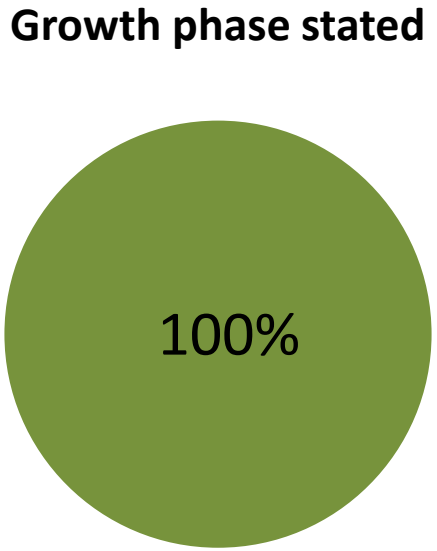
Perineural Involvement Stated (Yes or No)

The definition of neurotropism
Includes the presence of melanoma
around nerve fibres (perineural invasion) or within
fibres (intraneural invasion).
Perineural invasion/neurotropism correlates with a
higher recurrence rate.
This is particularly common in desmoplastic
malignant melanoma (so-called desmoplastic
neurotropic melanoma)



Growth Phase Stated (Yes or No)

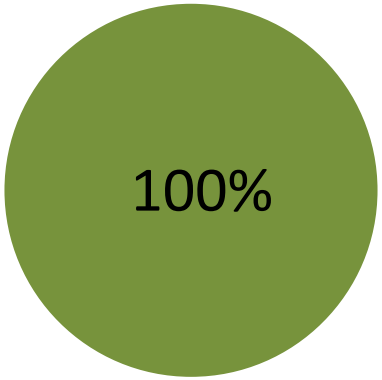
In basic terminology, malignant melanoma may be in situ (intra-epithelial or intra-epidermal) or invasive



Tumour invading lymphocytes (Stated Yes or No)

An important prognositc indicator in AJCC7. The presence of lymphovascular invasion correlates with a worse survival in melanoma

Tumour invading lymphocytes

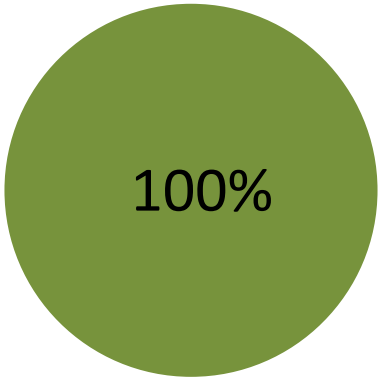


Regression (Stated Yes or No)

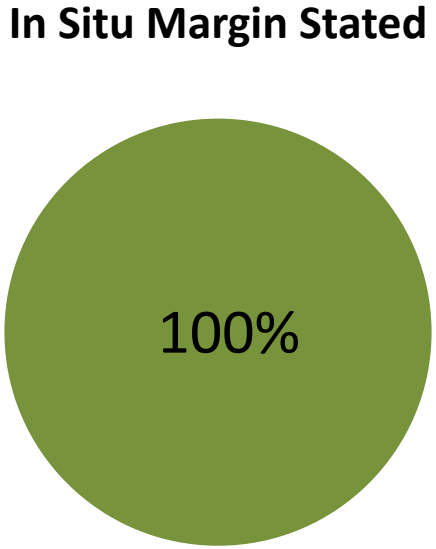
Debate continues as to its exact prognostic value.
Some evidence correlates regression with a worse prognosis (especially in so-called thin melanomas), whereas other evidence has indicated a better prognosis.

Tumours with greater than 75% regression are said to have a much worse prognosis.

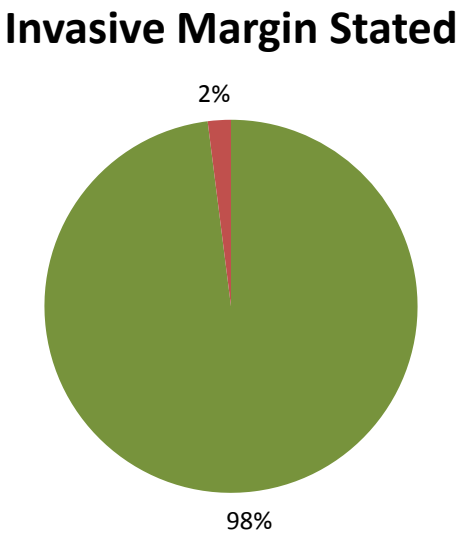
Regression Stated



In Situ Margin (Stated Yes or No)



Invasive (deep) margin (stated yes or no)



Conclusions

- This audit suggests that the use of the RCPath dataset for MM is being well-implemented currently

Conclusions

- The reports where data were not included were also "discussed/reviewed by skin pathology lead" prior to discussion at MDT
- "Mitotic index (per mm^2)": has been formally given as per high powered field; a previous audit set out to change this practice in 2014, and an improvement is seen here
- "TNM stage" is a prognostic indicator of disease (AJCC TNM). It was completed in 85% of case on the report.

Suggestions

- Electronic tools exist to aid in report generation
- Increase awareness of tools in department

Acknowledgements

- Dr Ursula Earl (Audit Supervisor)
- Jacqui Richards (Lab Manager)
- Bethany Sexton (Healthcare Science Support Worker)