

See-and-treat surgery for facial skin cancer

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Abstract

See-and-treat surgery has been described as an efficient means of streamlining specialist diagnosis and treatment, and is commonly employed in gynaecology to reduce the delay between cytological screening and definitive treatment of cervical neoplasia. Relatively young patients with predominantly benign skin lesions have been treated in see-and-treat clinics but only in the context of referrals from primary care. The author describes the treatment of tertiary referrals for facial skin malignancies under local anaesthesia at these clinics, and analyses their acceptability to patients. A total of 100 consecutive patients were included. Data on age, coexisting conditions, diagnosis, site and size of lesion, operation, and outcomes including complications and completeness of excision, were collected. A questionnaire seeking patients' opinions was also used. Ninety patients were treated and 98 lesions were removed, 94% of which were malignant. The complete excision rate was 95%. There were no complications, and 98% of patients were satisfied with the service. See-and-treat surgery is an effective, safe, and acceptable means of providing surgical management of facial skin malignancies.

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Introduction

See-and-treat clinics can deliver specialist diagnosis, assessment, and definitive treatment in a single visit to a defined population. The concept is particularly relevant at the interface of primary and secondary care, and has been tested rigorously in the field of gynaecology for the management of cervical intraepithelial neoplasia.^{1–5} The service benefits patients and healthcare providers as it reduces attendances at clinics and releases capacity.

Previous authors have described a “one stop” consultation and treatment service for the surgical management of benign and malignant skin lesions.^{6–8} Patients of various ages

were referred from a variety of sources (predominantly non-specialist primary care practitioners), and it was found to be an efficient and acceptable means of providing secondary care. See-and-treat management of tertiary referrals, specifically for patients with malignancies of the skin, has not been tested.

Malignant lesions of the skin are common, particularly in older patients. Sites around the face, head, and neck account for up to 75% of all skin malignancies and the complex anatomy of the face makes removal and reconstruction challenging.⁹ The greater incidence of coexisting conditions such as diabetes and anticoagulant treatment in elderly patients further complicates management.

Operations for facial skin malignancies have obvious implications for function and cosmesis and these must be considered when planning and discussing treatment with patients. Guidance from the United Kingdom Department of Health on obtaining patients' consent for interventions,

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which suggests that patients should have time to consider the relevant risks and benefits before treatment starts,¹⁰ could potentially conflict with the principles of see-and-treat surgery. Salam et al. reported a high rate of satisfaction in patients treated for facial lesions at a see-and-treat clinic, but did not comment specifically on whether they thought they had been given sufficient choice about their treatment.⁸

The current study evaluates a new see-and-treat clinic that is providing a tertiary referral service for surgical management of facial skin malignancies. The primary aims were to evaluate its acceptability to patients and to analyse the rate of uptake of surgery at the first appointment. Secondary aims were to audit surgical outcomes (completeness of excision and complications), and collate data on the pathological diagnoses and previous treatment of lesions.

Method

In total, 100 consecutive patients who were referred to the facial skin malignancy service at the department of oral and maxillofacial surgery (OMFS) at the author's host institution were included in the series. All were graded by the author. If the referral letter included sufficient clinical information to suggest that an operation could be done under local anaesthesia at a single visit, the patient was sent an appointment for the see-and-treat clinic. Patients for whom there was insufficient clinical information, those who were likely to need more complex operations or general anaesthesia, and those, whose referring clinician had requested an opinion on non-surgical management, were excluded. All patients were managed in accordance with the guidelines of the Trust's specialist skin multidisciplinary team and guidance from the National Institute for Health and Clinical Excellence (NICE) on improving outcomes for patients with skin cancer.¹¹

Clinics were held in a number of different hospitals where the author had surgical facilities, and included district general, and community hospitals. Patients were examined at the clinic and treatments were discussed. They were informed that if they wished to proceed they could have the operation immediately or could return on another occasion. Operations were done under local anaesthesia and lesions were excised according to published guidelines on margins.^{12–14} Where indicated, full thickness skin grafts were harvested from preauricular or postauricular skin, or the neck.

Details of provisional diagnosis (if stated on the referral letter), site of lesion, and type of reconstruction were recorded. After operation patients were given standard post-operative instructions and arrangements were made for the sutures to be removed. They were reviewed after an appropriate interval. After review the final histological diagnosis was documented together with the completeness of excision and the maximal dimension of the fixed histological specimen. One week after operation the first 50 consecutive

Table 1
Sites of lesions treated at see-and-treat clinics.

Site of lesion	No. of lesions (n = 98)
Temple	17
Cheek	16
Scalp	13
Nose (n = 12)	
Dorsum	2
Lateral	5
Ala nasi	2
Tip	3
Forehead	10
Upper lip	8
Ear (n = 8)	
Anterior rim	3
Anterior bowl	3
Posterior	2
Periorbital (n = 8)	
Eyebrow	1
Upper lid	1
Lower lid	3
Medial canthus	3
Chin	3
Neck	2
Lower lip	1

patients were sent a questionnaire which asked about their expectations and experience of the service.

Statistics

Responses to the questionnaires were analysed using the chi square test. The correlation between the sizes of specimens of completely and incompletely excised lesions was done using the Mann–Whitney *U* test. Probabilities of less than 0.05 were considered significant.

Results

All patients attended their appointments. Of 100 consecutive patients, 90 had lesions removed at the clinic. See-and-treat surgery was not considered appropriate after examination in 4 patients, and 6 preferred to have the operation at a later date. A total of 97 referrals were from consultant dermatologists, one was from a specialist primary care general practitioner, and 2 were from general practitioners.

In total, 90 patients had 98 lesions excised. The mean age of the patients was 77 years (range 44–94). Coexisting conditions included diabetes mellitus (*n* = 6), warfarin anticoagulation for atrial fibrillation (*n* = 2), and immunosuppression (*n* = 1). Two patients had mildly impaired memories and were accompanied by immediate family members who were included in the discussion about treatment.

Table 1 shows the sites of the excised lesions. Table 2 shows the types of reconstruction, and Table 3 shows the definitive histological diagnoses. The mean greatest dimension of the fixed histological specimen was 26 mm (range 9–50). As might be expected, the commonest diagnoses were

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