

Optimal care pathway for people with keratinocyte cancer (basal cell carcinoma or squamous cell carcinoma)

Quick reference guide



Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for people with keratinocyte cancer (basal cell carcinoma or squamous cell carcinoma)*.

Please note that not all patients will follow every step of the pathway. Most patients with keratinocyte cancer will not proceed beyond step 2.

Step 1: Prevention and early detection

Prevention

- Solar radiation is the major environmental cause of all skin cancers. People should be encouraged to use a combination of sun protection measures whenever UV index levels are 3 or above (during sun protection times).
- Quit smoking.
- Don't use solariums.

Risk factors

Environmental and exogenous risk factors:

- chronic sun exposure
- multiple solar keratoses
- solarium use
- intensive UV exposure in childhood and adolescence
- past exposure to arsenic.

Personal risk factors:

- some rare genetic conditions predisposing to skin cancer
- skin types I and II
- a history of blistering sunburn
- increasing age
- a previous melanoma or BCC/SCC
- solar keratoses.

Lifestyle risk factors:

- outdoor occupations

- recreational sun exposure.

Medical risk factors:

- UVA and psoralen (PUVA) treatment for psoriasis
- immunosuppression
- previous radiotherapy
- some photosensitising medications.

Screening recommendations

The patient's first point of contact for detecting keratinocyte cancer early should be their GP.

Early detection

Management of all patients should include education about skin awareness and encouraging regular self-examination, education about skin cancer prevention for the person at risk and their family, and education about average, increased and high-risk patient factors.

For most patients, screening is opportunistic, unless patients are in a high-risk category, whereby 6–12-monthly reviews with an adequately trained and experienced clinician is warranted.

See the **optimal care pathway for keratinocyte cancer** for patients considered at high-risk.

Checklist

- A total skin check conducted
- Education on self-examination provided
- Education on being sun-smart provided
- Recent weight changes discussed and the patient's weight recorded
- Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- Physical activity recorded
- Referral to a dietitian considered
- Referral to a physiotherapist or exercise physiologist considered

Step 2: Presentation, initial investigations and referral

Signs and symptoms

The following should be investigated by a GP:

- any new or changing skin lesions or lesions that do not respond to treatment

- a rapidly growing skin lesion that remains unresolved after a month.

SCC: Induration (thickening) or tenderness in the erythematous base of a scaling lesion.

Checklist

- Signs and symptoms recorded
- New or changing skin lesions assessed

Step 2: Presentation, initial investigations and referral continued

BCC: A dome-shaped skin lesion, pink or red scaly patch, waxy or pearly hard skin-coloured lesion, a sore that will not heal or with blood vessels.

GP investigations

Some lesions will be confidently diagnosed on clinical examination and history; others will require a biopsy, particularly early lesions.

The best approach for most lesions is complete excision. If complete excision is not appropriate, small representative samples, such as by one or more punch biopsies, shave biopsy or curettage, can be useful.

Most BCCs that are clinically favourable can be satisfactorily excised under local anaesthetic with direct primary closure in an ambulatory care setting.

Referral

Most BCCs/SCCs do not require referral.

For a complicated BCC, consider referral for:

- incompletely excised lesions where surgical expertise is required for appropriate margins or lesions with a high risk of recurrence
- lesions involving the central face, ears, genitalia, digits, palm of the hand or lower leg
- poorly defined lesions
- lesions fixed to underlying structures
- lesions involving or lying adjacent to significant nerves

- large lesions
- neurotropic spread
- lymphovascular invasion.

For a complicated SCC, consider referral for:

- an SCC of the central face, scalp, lip, ear or genitals
- lesions larger than 20 mm in diameter or 6 mm deep
- chronically immunosuppressed patients with multiple aggressive SCCs
- histologically aggressive head and neck SCCs
- locally recurrent and/or persistent SCCs.

Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

Checklist continued

- Dermoscopy conducted where appropriate
- Suspect lesion biopsied or completely excised
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient notified of support services such as Cancer Council 13 11 20 if required
- Referral options discussed with the patient and/or carer including cost implications

Timeframe

Investigations and/or curative treatment should be performed **within 4 weeks** of initial presentation to a GP or as soon as practicable.

If a diagnosis is required, referral to specialist should be **as soon as practicable** according to clinical concern (e.g. 4 weeks for a presumed SCC and 8 weeks for a presumed BCC).

Step 3: Diagnosis, staging and treatment planning

Diagnosis

All patients should have had a complete skin check recently.

Most diagnoses occur in the primary care setting before specialist referral.

Specialist management may include complete excision or re-excision with recommended margins, imaging including medical photography (in some circumstances), radiation therapy or reconstructive surgery.

Staging

Usually a biopsy is sufficient to diagnose keratinocyte cancer.

In cases of SCC, clinically suspected lymph node metastases should be confirmed by fine needle aspiration cytology if possible. Open surgical biopsy should be avoided.

Genetic testing

While most keratinocyte cancers develop through sun exposure, several genes and hereditary syndromes increase the risk of keratinocyte cancer development. See the **optimal care pathway for keratinocyte cancer** for more information.

Treatment planning

Selected patients with advanced stage primary keratinocyte cancer, lymph node metastases and keratinocyte cancer in unusual sites are best managed by a multidisciplinary team in a specialist facility.

Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Checklist

- Diagnosis confirmed
- Final histology obtained
- Performance status and comorbidities measured and recorded
- Patient discussed at an MDM and decisions provided to the patient and/or carer
- Clinical trial enrolment considered
- Patient referred to support services (such as Cancer Council) as required

Step 3: Diagnosis, staging and treatment planning continued

Communication

The lead clinician's¹ responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from multidisciplinary meetings (MDMs).

Checklist continued

- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Treatment costs discussed with the patient and/or carer

Timeframe

Biopsy should be considered **before referral**, where appropriate.

Step 4: Treatment

Establish intent of treatment

- Curative (most keratinocyte cancer will be cured with simple excision or radiation therapy)
- Palliative

Surgery involves excision with an adequate margin of skin and subcutaneous tissue – usually fat. Margin-control surgery may be considered for some patients. Curettage and diathermy may be an option for some keratinocyte cancers. Referral to a specialist plastic surgeon may be required.

Definitive radiation therapy should be recommended for patients who have declined or have contraindications for conventional surgery, and for cases of persistent, recurrent or advanced keratinocyte cancer where adjuvant radiation can complement surgery to improve control rates.

Adjuvant radiation therapy should be recommended for patients with incompletely excised keratinocyte cancer where re-excision would result in significant morbidity, patients with locally advanced or node-positive disease or patients with neurotropic or recurrent lesions.

Other therapies for SCC in situ and early-stage keratinocyte cancer when surgery is not suitable include curettage and electrocautery, cryotherapy, 5-fluorouracil or imiquimod cream, photodynamic therapy and oral acitretin.

Palliative care

Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <www.palliativecare.org.au>.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- Intent of treatment established
- Risks and benefits of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer and provided to the patient's GP
- Treating specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Early referral to palliative care considered
- Advance care planning discussed with the patient and/or carer

Timeframe

Surgery: Patients will usually be having active treatment **within a 3 month** period.

Radiation therapy: Adjuvant radiation therapy should start as soon as possible once surgical wounds have healed, usually **within 4–6 weeks** of surgery.

Other therapies: Treatment should start as soon as diagnosis and staging has occurred and the treatment modality becomes available, ideally **within 4 weeks** of the MDM.

¹ Lead clinician – the clinician who is responsible for managing patient care. The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 5: Care after initial treatment and recovery

All patients with a previous skin cancer are advised to undergo at least an ongoing annual skin examination.

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing

- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP
- providing information about the symptoms and signs of recurrence.

Checklist

- Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- Importance of self-examination and sun protection strategies discussed with the patient and/or carer
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Patients should be advised to be alert for any new or changing skin lesion, lumps/masses or new/persistent symptoms.

Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal care by thinking about their values

and preferences. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

Checklist

- Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Advance care planning discussed with the patient and/or carer
- Patient referred to palliative care if appropriate
- Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient referred to palliative care
- Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.