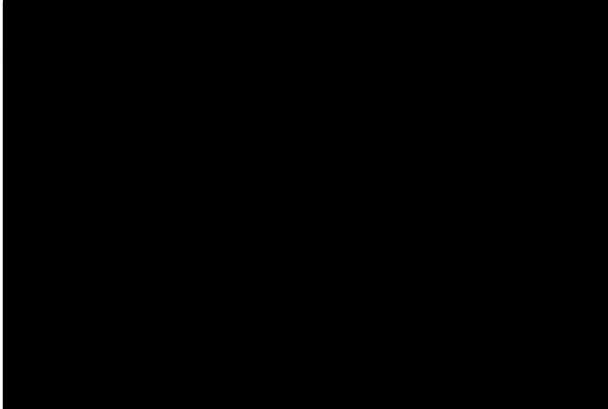


14 October 2019



[Redacted]
Email: ailsac@adhb.govt.nz

Re: Official Information Act request – Protocols relating to skin cancers

I refer to your Official Information Act request dated 1 October 2019 requesting the following information.

Could I please have a copy of your protocols relating to care for (possible) skin cancers that would have been current in 2016?

Attached the triaging protocols we had in place at the time. The management of specific skin cancers are guided by the international consensus papers and guidelines and vary for specific skin cancers.

I trust this information answers your questions.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully



Ailsa Claire, OBE
Chief Executive



Faster Cancer Treatment: High suspicion of cancer definitions

April 2016

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Introduction

The following definitions have been developed by clinically-led tumour standards working groups to support achievement of the Faster cancer treatment (FCT) health target by clarifying what constitutes a 'high suspicion of cancer' for ten tumour streams.

Faster cancer treatment health target

85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.

The FCT health target builds on the significant improvements that have been made in the quality of cancer services over recent years. It provides a lens across the whole cancer pathway to ensure people have prompt access to excellent cancer services.

The following points are applicable across all definitions:

A resource for triaging(or prioritising) clinicians

The definitions have been developed for use, in the first instance, by triaging (or prioritising) clinicians within secondary and tertiary care who are responsible for determining or confirming the 'high suspicion of cancer' flag. DHBs are encouraged to consider how the definitions can be adapted and used to support improved detection and referral of patients with a high suspicion of cancer from primary care.

Apply to the 'high suspicion of cancer' component of the health target

To be included within the FCT health target cohort a patient must have both a high suspicion of cancer *and* a need to be seen within two weeks. The definitions only apply to the 'high suspicion of cancer' component of the FCT health target and are not intended to define the urgency of the referral. The triaging clinician will need to make a separate assessment of whether a patient meets the criteria of needing to be seen within two weeks.

Guidance to help inform clinical judgement

The definitions are intended as guidance to help inform clinical judgement. If other features/symptoms/signs exist that raise concerns, the triaging clinician can still choose to triage as 'high suspicion of cancer'.

Risk factors have been included for some tumour types

Some tumour streams have included risk factors to support their high suspicion of cancer definitions, with particular consideration of specific factors that may influence the triaging process. It should also be noted that Māori present with cancer at an earlier age than non-Māori across all tumour types.

Referrals with a positive fine needle aspiration and/or biopsy

Patients referred through an outpatient pathway with a positive fine needle aspiration (FNA) and/or biopsy for cancer at the time the referral is received within secondary/tertiary care should be triaged as having a high suspicion of cancer (rather than a confirmed cancer) and included within the FCT health target cohort. This is because these patients will require further investigations and assessment before a confirmed diagnosis and decision on treatment is made. It also supports direct access to diagnostics from primary care.

1. Breast

BREAST CANCER ¹	
If the patient presents <i>with one or more</i> of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
Diagnosed cancer on fine needle aspiration or core biopsy (or results suspicious of malignancy)	
Imaging suspicious of malignancy	
Discrete, hard breast lump with fixation (with or without skin tethering)	
Discrete breast lump that presents in women <i>with one or more of the following</i> : <ul style="list-style-type: none"> • age 40 years or older, and persists after her next period or presents after menopause • aged younger than 40 years and the lump is increasing in size or where there are other reasons for concern (see risk factors below), such as strong family history • with previous breast cancer or ovarian cancer 	
Suspected inflammatory breast cancer or symptoms of breast inflammation that have not responded to a course of antibiotic	
Spontaneous unilateral bloody nipple discharge	
Women aged over 40 years with recent onset unilateral nipple retraction or distortion	
Women aged over 40 years with unilateral eczematous skin or nipple change that does not respond to topical treatment	
Men aged 50 years and older with a unilateral, firm sub-areolar mass, which is not typical gynaecomastia or is eccentric to the nipple	

¹ Risk Factors:

- A first degree relative diagnosed with breast cancer before aged 50 years
- Two or more first degree relatives on the same side of the family diagnosed with breast cancer at any age
- Two second degree relatives on the same side of the family, diagnosed with breast cancer, at least one before age 50
- First or second degree relative diagnosed with bilateral breast cancer
- First or second degree relative with male breast cancer
- Known to carry a breast cancer susceptibility gene mutation (e.g. BRCA1 or BRCA2)
- Radiation Therapy delivered to the chest or mediastinum

2. Bowel

BOWEL CANCER ²	
If the patient presents with one or more of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
Known or suspected bowel cancer (on imaging, or palpable or visible on rectal examination)	
Unexplained rectal bleeding (benign anal causes treated or excluded) WITH iron deficiency anaemia (haemoglobin and ferritin below the local reference range)	
Altered bowel habit (looser and/or more frequent) > 6 weeks duration PLUS unexplained rectal bleeding (benign anal causes treated or excluded) AND aged ≥ 50 years	

² Please note that these criteria are for high suspicion of cancer that would warrant direct access colonoscopy within two weeks - it is not an exhaustive list of the possible manifestations of bowel cancer that may warrant colonic investigation. Please interpret this guideline in conjunction with *Referral Criteria for Direct Access Outpatient Colonoscopy* (Ministry of Health, December 2012) and *Guidance on Surveillance for People at Increased Risk of Colorectal Cancer* (New Zealand Guidelines Group, 2011).

3. Gynaecological

GYNAECOLOGICAL CANCER	
If the patient presents with one or more of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
Biopsy-proven or cytology positive gynaecological malignant or premalignant disease ³ or Gestational Trophoblastic Disease	
A visible abnormality suspicious of a vulval, vaginal or cervical cancer (such as an exophytic, ulcerating or irregular pigmented lesion) ⁴	
Significant symptoms (including abnormal vaginal bleeding, discharge or pelvic pain) AND Abnormal clinical findings suspicious of gynaecological malignancy (including lymphadenopathy, vaginal nodularity or pelvic induration) ⁵	
Post-menopausal bleeding. (N.B. High suspicion of cancer may be excluded if physical examination, smear and vaginal ultrasound are normal ⁶)	
A rapidly growing pelvic mass or genital lump ⁷	
Women with a palpable or incidentally-found pelvic mass (including any large complex ovarian mass >8 cm) UNLESS investigations (ultrasound and tumour markers) suggest benign disease ⁸	
Women with a documented genetic risk who have a suspicious pelvic abnormality or symptoms ⁹	

³ Please see National Cervical Screening Programme recommendations for colposcopy referral.

⁴ Women with an undiagnosed visible genital abnormality which is not highly suspicious of malignancy should be referred for gynaecological or dermatology review or undergo a biopsy.

⁵ Women with gynaecological abnormalities or symptoms may also have gynaecological malignancy and the development of triage pathways is encouraged. Specific consideration includes premenopausal women with abnormal uterine bleeding. Those with persistent or deteriorating symptoms should be reviewed by a gynaecologist. A raised CA125 supports the need for further investigation in woman with persistent pelvic or abdominal symptoms.

⁶ Early access to vaginal ultrasound will reduce demand on secondary services. Women without post-menopausal bleeding but with a thickened endometrium should undergo gynae review but are not defined as high risk.

⁷ Discernible growth within a 3 month period is normally of concern. Undiagnosed external genital lumps with any discernible growth should normally be reviewed by a gynaecologist and/or biopsied.

⁸ The development of referral pathways is recommended to ensure rapid assessment of patients with a pelvic mass, early access to pelvic ultrasound is seen as crucial to this process.

N.B. Suspicion of ovarian malignancy is indicated by metastatic disease, ascites or radiologist's impression, a raised CA125 in a post-menopausal woman or germ cell markers in a woman under 25. The risk of malignancy index (RMI) is utilised to triage patients for subspecialty care.

⁹ Usually women with strong family history or known hereditary nonpolyposis colorectal cancer (HNPCC) or BRCA mutations.

4. Head and Neck

HEAD AND NECK CANCER - Oral/Throat/Lip Lesion ¹⁰	
If the patient presents with one or more of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
A visible or palpable Oral, Throat, or Lip Lesion and one or more of the following:	
• unexplained ulcer/lesion/lump persisting for > 3 weeks	
• leukoplakia – must be either nodular, swollen, or bleeding (flat leukoplakia requires standard referral)	
• erythroplakia	
• unexplained tooth mobility/ non-healing socket	
• persistent numbness chin, lip, palate or tongue	

¹⁰ Risk factors:

- Smoking history
- Excess alcohol intake
- Immunosuppression
- Betel nut
- Previous history of mouth cancer

HEAD AND NECK CANCER - Neck/Salivary Lump¹³

If the patient presents *with one or more* of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
An unexplained neck/salivary mass <i>and one or more</i> of the following:	
• mass > 1cm and persisting > 3weeks	
• mass is increasing in size	
• previous head and neck cancer including skin cancer	
• facial palsy	
• any new unexplained upper respiratory tract symptoms such as hoarseness, dysphagia, throat or ear pain, blocked nose or ear	

¹³ Risk factors:

- Smoking history
- Excess alcohol intake
- Past history of head and neck cancer
- Immunosuppression

HEAD AND NECK CANCER - Upper aerodigestive tract¹²

If the patient presents **with one or more** of the following red flags (new unexplained symptoms > 3 weeks), then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
New throat pain or referred otalgia	
New hoarseness with a history of smoking	
New progressive dysphagia to solids or liquids (excluding isolated globus sensation)	
Stridor/upper airway noise	
New nasal obstruction associated with another red flag	
New epistaxis associated with another red flag	

¹² Risk factors:

- Smoking history
- Excess alcohol intake
- Past history of head and neck cancer
- Immunosuppression

5. Lung

Lung Cancer	
If the patient presents <i>with one or more</i> of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
Chest x-ray or other imaging suggestive/suspicious of lung cancer (including new pleural effusion, pleural mass, and slowly resolving consolidation)	
Persistent or unexplained haemoptysis in high risk ¹³ individuals over 40 years of age	
New pathological diagnosis of lung cancer	

Notes for referrer:

A. An urgent chest X-ray is required for lung cancer in people aged 40 and over if they have:

- Any persistent or unexplained haemoptysis
- Unexplained/persistent (more than 3 weeks)
 - o cough
 - o shortness of breath
 - o chest/shoulder pain
 - o weight loss greater than 10%
 - o Abnormal chest signs
 - o Unresolved chest infection
 - o hoarseness
- Finger clubbing
- Features suggestive of metastasis from a lung cancer (e.g. in brain, bone, liver or skin) as part of appropriate work up
- Cervical and/or persistent supraclavicular lymphadenopathy

Any person who has been referred for an urgent chest x-ray for the above indications and has been found with consolidation should have a repeat chest x-ray 6 weeks later to confirm resolution.

B. **Chest x-ray normal.** If any symptoms or signs detailed above persist for longer than 6 weeks despite a normal chest x-ray, consider referral to respiratory services.

C. **Mesothelioma.** Suspected mesothelioma should also be triaged as above. It is essential that a careful career history is taken to identify any possible occupations at high risk of asbestos exposure.

All symptoms related to SVC obstruction, spinal cord compressions, airway obstruction, and massive haemoptysis, are medical emergencies and should be referred appropriately.

¹³ High risk factors

When making a decision to refer, assess and document risk factors for lung cancer. These include:

- smokers or ex-smokers
- history of exposure to asbestos,
- pre-existing lung disease particularly COPD or interstitial lung disease
- history of cancer
- family history of lung cancer

It should be noted the incidence of non-smoking related cancer is increasing particularly in women and East Asians

6. Lymphoma

LYMPHOMA	
If the patient presents with one or more of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'	
Red flags	YES or NO
Lymphadenopathy persistent for 4 weeks or lymph nodes rapidly increasing in size (otherwise unexplained)	
Lymph nodes > 2cm, widespread nature, firm, non-tender	
Unexplained drenching night sweats or fevers or weight loss of greater than 10% of body weight	
Radiology suspicious for lymphoma	

7. Melanoma

MALIGNANT MELANOMA OF SKIN	
Red flags	
<u>EITHER:</u>	
Skin lesion AND three or more of the following features:	
A. Asymmetry of shape, structure or colour	Y/N
B. Border irregularity	Y/N
C. Colour variation / multiple colours	Y/N
D. Different from other lesions ('ugly duckling')	Y/N
E. Evolving, changing	Y/N
Risk factors	
Personal history of melanoma	Y/N
Family history of 2+ first degree relatives <40 yrs diagnosed with melanoma	Y/N
<u>OR:</u>	
• Dermoscopy of skin lesion is suspicious for melanoma	Y/N
<u>IN ADDITION:</u>	
All referrals must include the following supporting results:	
Required: Size of lesion	(space to write size)
Required: Body location	(attachment or description) (space to write location)
Required: Digital macroscopic image of lesion	(attachment)
If available: Dermoscopic image of lesion	(attachment)

8. Myeloma

MYELOMA - Plasma cell neoplasms	
If the patient presents with the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
M-protein in serum and/or urine and one or more of the following	
<ul style="list-style-type: none"> otherwise unexplained hypercalcaemia (> 2.75 mmol/L) 	
<ul style="list-style-type: none"> otherwise unexplained renal impairment – creatinine clearance <40 ml/min 	
<ul style="list-style-type: none"> otherwise unexplained anaemia – Hb <100g/L 	
<ul style="list-style-type: none"> bony lytic lesions on radiologic imaging 	
<ul style="list-style-type: none"> serum monoclonal protein (IgG or IgA >30g/L or involved:uninvolved serum free light chain ratio >100¹⁴) 	

¹⁴ The serum free light chain ration is currently defined (nationally) as a Tier 2 test, which means the test cannot be requested in primary care without cost to the patient.

9. Sarcoma

SARCOMA - Soft tissue lumps (adults 15 years and older)	
If the patient presents with the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
An unexplained soft tissue mass and one or more of the following	
• mass size > 5cm in size	
• increasing in size	
• deep to fascia	
• painful	
• radiology suspicious for malignancy	
• a recurrence after previous excision	

SARCOMA - Soft tissue lumps (children up to 15 years)¹⁵

If the patient presents with **one or more** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
An unexplained soft tissue mass and one or more of the following	
<ul style="list-style-type: none"> • mass size >2cm in size 	
<ul style="list-style-type: none"> • increasing in size 	
<ul style="list-style-type: none"> • deep to fascia 	
<ul style="list-style-type: none"> • painful 	
<ul style="list-style-type: none"> • radiology suspicious for malignancy 	
<ul style="list-style-type: none"> • unexplained presence of one or more of the following: <ul style="list-style-type: none"> – proptosis – persistent unilateral nasal obstruction – aural polyps and/or aural discharge – urinary retention – blood-stained vaginal discharge – scrotal swelling 	

¹⁵ Children under the age of 16 years are not included within the Faster Cancer Treatment health target. Sarcoma have included high suspicion of cancer definitions for children as an educational tool to raise awareness of the signs/symptoms of sarcoma in children.

SARCOMA - Bone cancer (adults and children) ¹⁶	
If the patient presents with the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
An unexplained bony mass and one or more of the following	
• palpable mass fixed to bone	
• increasing in size	
• radiology suspicious for malignancy	
• a recurrence after previous excision	
• suspected spontaneous fracture	
• unexplained presence of one or more of the following: <ul style="list-style-type: none"> - increasing or persistent bone pain (especially at rest) - night pain - limp (for a child) 	

¹⁶ Children under the age of 16 years are not included within the Faster Cancer Treatment health target. Sarcoma have included high suspicion of cancer definitions for children as an educational tool to raise awareness of the signs/symptoms of sarcoma in children.

10. Thyroid

THYROID CANCER	
If the patient presents with thyroid swelling <i>and one or more</i> of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flag	YES or NO
Thyroid swelling <i>and one or more</i> of the following:	
<ul style="list-style-type: none"> unexplained voice change or stridor 	
<ul style="list-style-type: none"> thyroid nodule in a child 	
<ul style="list-style-type: none"> cervical lymphadenopathy 	
<ul style="list-style-type: none"> painless thyroid mass rapidly enlarging, i.e. over a period of 2-3 months 	
<ul style="list-style-type: none"> family history of multiple endocrine neoplasm 	
<ul style="list-style-type: none"> cytology result indicating a high risk of cancer, ie Bethesda 5-6¹⁷ 	

¹⁷ Although Bethesda 4 does not necessarily constitute a high suspicion of cancer, review by an endocrinologist or surgeon is required (risk of malignancy being up to 30%).

11. Upper GI

UPPER GI CANCER - Stomach Cancer ¹⁸	
If the patient presents with one or more of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
Unexplained weight loss with one or more of the following: <ul style="list-style-type: none"> • upper abdominal pain in patient aged > 40yrs • dyspepsia • nausea and vomiting • haematemesis /malaena • new onset heartburn 	
Upper abdominal mass consistent with stomach cancer	
Dysphagia (new onset or progressive)	
Māori or Pacific of any age with a family history of stomach cancer and one or more of the following: <ul style="list-style-type: none"> • upper abdominal pain • dyspepsia • reflux symptoms 	

¹⁸ Risk factors for stomach cancer, which when present increases the suspicion

- Excess alcohol intake
- Smoking
- High animal fat diet
- Socio-economic deprivation
- Previous gastric surgery
- Helicobacter pylori infection
- Type A blood
- Immune deficiency
- Family history of first degree relatives with stomach cancer
- Genetic syndromes (hereditary diffuse gastric cancer (CDH1), hereditary non-polyposis colorectal cancer (HNPCC), familial adenomatous polyposis (FAP, BRCA1 and 2, Li-Fraumeni syndrome, Peutz Jeher syndrome).

Investigations that would be consistent with an increased risk of stomach cancer:

- Iron-deficient anaemia/low ferritin
- Platelet count
- H.pylori infection
- Endoscopy findings of chronic gastritis

UPPER GI CANCER - Oesophageal Cancer¹⁹

If the patient presents **with one or more** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
Dysphagia (new onset and/or progressive)	
Unexplained weight loss in patients > 55 years with one or more of the following: <ul style="list-style-type: none"> • upper abdominal pain • new onset heartburn • dyspepsia • nausea/vomiting • upper abdominal pain 	
Haematemesis/malaena	
Māori or Pacific of any age with family history of oesophageal cancer with one or more of the following: <ul style="list-style-type: none"> • upper abdominal pain • new onset heartburn • dysphagia (new onset or progressive) • dyspepsia 	

¹⁹ Risk factors for oesophageal cancer which when present increases the suspicion

- Age over 55 years
- Smoking
- Male
- High animal fat diet
- Longstanding Gastro-Oesophageal Reflux Disease (GORD)
- Barrett's metaplasia of the oesophagus
- Previous gastric surgery
- Socio-economic deprivation
- Obesity/BMI >35
- Excess alcohol intake

Investigations that would be consistent with an increased risk of oesophageal cancer

- Endoscopy findings of long segment Barrett's (>3cm)
- Iron-deficient anaemia/low ferritin
- Elevated platelet count

UPPER GI CANCER - Pancreatic Cancer²⁰

If the patient presents **with one or more** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
Painless obstructive jaundice	
Unexplained weight loss with one or more of the following: <ul style="list-style-type: none">• new-onset diabetes• new onset mid-back discomfort• steatorrhea• nausea/vomiting	

²⁰ **Risk factors for pancreatic cancer (which when present increases the suspicion):**

- Smoking
- Obesity/BMI >35
- Chronic pancreatitis, especially with mass
- Family history of first degree relatives with pancreatic cancer;
- Genetic syndromes (hereditary breast and ovarian cancer syndrome, familial melanoma, familial pancreatitis, hereditary non-polyposis colorectal cancer, Peutz-Jeghers syndrome, Von Hippel-Lindau syndrome)

Investigations that would be consistent with an increased risk of pancreatic cancer

- Cholestatic liver dysfunction
- New onset diabetes
- HbA1c > 41 (pre-diabetes)
- Elevated CEA and/or Ca19-9

UPPER GI CANCER - Biliary/Gallbladder Cancer²¹

If the patient presents **with one or more** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.

Red flags	YES or NO
Painless obstructive jaundice	
Abdominal mass consistent with a gallbladder tumour	

²¹ **Risk factors for biliary/gallbladder cancer (which when present increases the suspicion):**

- Polyps (>1 cm)
- Gallstones (>20 years)
- Porcelain gallbladder
- Primary sclerosing cholangitis

Investigations that would be consistent with an increased risk of biliary/gallbladder cancer

- Cholestatic liver dysfunction
- Ultrasound ± CT showing asymmetric wall thickening or mass in gallbladder or bile duct
- Elevated CEA and/or Ca 19-9

UPPER GI CANCER - Liver Cancer ²²	
If the patient presents with the following red flag, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
Upper abdominal mass consistent with enlarged liver <i>and one or more</i> of the following:	
• unexplained weight loss	
• jaundice	
• risk factor(s)	

21. Risk factors for liver cancer (which when present increases the suspicion):

- Previous history of bowel cancer
- Chronic viral hepatitis (B or C)
- Cirrhosis
- Heavy alcohol consumption
- Family history of primary liver cancer
- Haemochromatosis
- Inherited metabolic disease

Investigations that would be consistent with an increased risk of biliary/gallbladder cancer:

- US/CT/MR showing mass(es) in liver
- Elevated AFP and/or CEA and/or Ca 19-9
- Liver dysfunction including increased INR and decreased albumin

Mohs Micrographic Surgery for an Adult in Dermatology

Document Type	Guideline
Function	Clinical Practice, Patient Care
Directorate(s)	Community and Long Term Conditions
Department(s) affected	Dermatology
Applicable for which patients, clients or residents?	Dermatology patients requiring a biopsy
Applicable for which staff members?	All clinicians in Dermatology
Key words (not part of title)	n/a
Author - role only	Staff Nurse - Dermatology
Owner (see ownership structure)	Owner: Service Clinical Director - Ambulatory Issuer: Service Lead Clinician - Dermatology
Edited by	Clinical Policy Advisor
Date first published	Yet to be determined
Date this version published	13 February 2018 - updated
Review frequency	3 yearly
Unique Identifier	PP2429/PCR/008

Contents

1. [Purpose of guideline](#)
2. [Definitions](#)
3. [Preparing the patient for micrographic surgery](#)
4. [Associated Auckland DHB documents](#)
5. [Disclaimer](#)
6. [Corrections and amendments](#)

1. Purpose of guideline

The purpose of this guideline is to facilitate the safe and effective care of a patient being prepared for Mohs micrographic surgery within Auckland District Health Board (Auckland DHB).

2. Definitions

Mohs micrographic surgery is a method of excising skin cancers in stages using mapped out peripheral sections of skin that completely encompass the whole skin lesion. This results in maximal tissue conservation while obtaining histologically clear margins.

3. Preparing the patient for micrographic surgery

The following describes the procedure for making appointments and preparing the patient for Mohs appointments:

- a. All Mohs referrals are screened and booked an appointment with a Mohs surgical consultant. The procedure is undertaken following this appointment. Referrals on Mohs waitlist are placed at the back of the surgical referrals file;
- b. A patient referred from the ophthalmology department requires coordinated appointments with ophthalmology surgical schedulers, for surgical closure usually two days later in Ophthalmology Day Stay Surgery;
- c. A minimum of two dermatology nursing staff members should be in attendance with a patient during a local anaesthetic Mohs procedure
 - o One of the staff members should be a registered nurse
 - o One is responsible for the observation of the patient and documentation
 - o The other is available to assist with the procedure as necessary
- d. A patient requiring local anaesthesia in the dermatology procedure room for investigative, invasive or operative procedures should have completed an informed consent form (see [associated Auckland DHB documents](#));
- e. A pre-op assessment should be completed following the pre-op checklist requirement form CR3971 (see [clinical forms](#)). The patient should be dressed in an appropriate gown, shoe covers and operating room cap;
- f. The designated staff member should complete the inter-operative documentation, including the
 - o Intra-operative notes
 - o Operation book in procedure room
- g. Following the first stage of the procedure
 - o Dress the wound with Kaltostat
 - o Apply temporary pressure dressing
 - o The patient can then return to recovery room until specimen is microscopically checked
 - o The patient should be checked by a nurse every 15 minutes

- h. If the margins are microscopically clear, the surgeon will close the area using a new set of instruments;
- i. If not clear, another layer will be taken and another temporary dressing applied;
- j. The patient must be given postoperative instructions on discharge;
- k. For eye micrographic surgery:
 - o When the margins are clear the wound is dressed with Kaltostat, eye pad, gauze and Fixomull
 - o The patient must be given postoperative instructions and reminded about the appointment for ophthalmology

4. Associated Auckland DHB documents

- [Admission - Dermatology](#) - restricted access
- [Allied Services](#) - restricted access
- [Biopsy Procedures](#) - restricted access
- [Clinical Equipment Management](#)
- [Dental Syringes - Use & Cleaning](#) - restricted access
- [Diathermy](#) - restricted access
- [Discharge](#) - restricted access
- [Health & Safety](#)
- [Incident Management - Policy](#)
- [Infection Prevention & Control](#)
- [Informed Consent](#)
- [Instrument Cleaning](#) - restricted access
- [Liquid Nitrogen](#) - restricted access
- [Specimen Management](#) - Perioperative
- [Standard Precautions - Infection Control](#)
- [Tikanga Best Practice](#)
- [Transfer](#) - restricted access

Clinical Forms

- Mohs Procedure booking Form
- [CR3971: Greenlane Clinical Centre Dermatology Procedure Unit Dermatology Department Outpatients Questionnaire](#)

5. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

6. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed **before** the scheduled date, they should contact the owner or the [Clinical Policy Advisor](#) without delay.

High suspicion of cancer criteria for Dermatology

Possible melanoma P1 Lesion (2 weeks)

Defined as ≥ 3 of the following:

- Asymmetry (shape, structure or colour)
- Border irregularity
- Colour variation
- Different from other lesions (ugly duckling)
- Evolution
- Personal history of melanoma
- Family history of 2+ first degree relatives with melanoma <40yrs

Referrals need to include:

- Lesion size
- Lesion location
- Digital macroscopic photograph (plus dermatoscopic for pigmented lesions if available)

Lip SCC P1 Lesion (2 weeks)

Lip lesion/ulcer/lump plus one for the following:

- Present >3 weeks
- Persistent numbness
- Nodular, swollen or bleeding leukoplakia
- Erythroplakia

