analysis. It would be interesting to re-analyse the data excluding this group of biopsy.

The rapid access pigmented lesion service in Aberdeen has undergone a significant reconfiguration since this study was undertaken. Therefore, conclusions drawn from this study cannot be compared with the service that is now being provided by the dermatology department at Aberdeen Royal Infirmary.

The issue of GP excision avoiding delay does not arise, as any lesion referred as a suspected melanoma will be seen by a specialist within 14 days. Many lesions referred urgently as suspicious are found to be benign on expert examination and do not require excision.

This problem is compounded by the issue that in many NHS Trusts, GP-derived histopathology samples are immediately graded as routine, as GPs do not have a mandate to excise malignancy. This may incur waits as long as 6 weeks for the sample to be reported, whereas in secondary care the samples are graded as urgent and reported within 3 weeks in most trusts.

Of course trained GPs can capably excise small lesions on non-critical sites, as can specialist nurses, but many lesions do not require excision. Diagnosis and treatment planning are critical. Regrettably, the medical undergraduate curriculum and GP training underemphasise dermatology. Consequently, excellent skin lesion recognition skills are not universal. The British Association of Dermatologists lobbies for better training, and with the Primary Care Dermatology Society recently sent a joint letter to the Royal Colleges, Department of Health, and other parties advocating better skin lesion diagnostic training for all GPs.

Within the Measures Document for Skin Cancer there is a provision for GPs to integrate into the local multidisciplinary team structure as Model 2 practitioners, removing lesions that have been diagnosed by accredited members of the multidisciplinary team.

Recent revision of the 2006 skin cancer IOG allows suitably-qualified GPs to treat smaller well-defined basal cell carcinomas on trunk and limbs under LES/DES schemes subject to audit. However, we should reflect that melanoma is a potentially fatal cancer. Should it be treated on a casual basis by well-meaning generalists who are inevitably behind the curve on current best evidence? Most GPs will only see one melanoma every 3 or 4 years.

Best clinical outcomes are achieved in specific areas (whether fitting IUCDs, administering cognitive behavioural therapy, or through paediatric heart surgery) by healthcare workers who practice to current best evidence in teams and are accredited and audited. This also applies to skin cancer. We believe that one study showing that GPs were capable of doing simple excisions (setting aside the above point about punch and incisional biopsies that may invalidate even this finding) gives no grounds to overturn the current status quo. We believe the emphasis instead should be to improve both patient education, as well as GP and other healthcare workers' lesion recognition skills to achieve earlier diagnosis and better outcomes in melanoma.

The direction of travel in skin cancer management is to develop integrated community-based services within an multidisciplinary team structure, that ensures clinical governance and enhances patient safety. Many excellent examples of this model already exist in the UK.

**Stephen Hayes,**
*GPwSI in Dermatology, Trustee, Primary Care Dermatology Society.*
*E-mail: nina@bad.org.uk*

**Stephen Keohane,**
*Consultant Dermatologist, Chair, Skin Cancer Sub-committee, British Association of Dermatologists.*

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# Primary excision of cutaneous melanoma

In their paper Murchie *et al* pose the question of whether it matters if the excision of primary cutaneous melanoma is performed in primary care by GPs.[1] We refute the conclusion that this is a way to expedite diagnosis or that it should lead to a change in guidelines. Their results should not be seen as providing commissioners with alternatives to referring all suspected melanomas for specialist assessment as recommended in current guidelines from National Institute of Health and Clinical Excellence and British Association of Dermatologists/British Association of Plastic Reconstructive and Aesthetic Surgeons updated last year.[2,3] Eight out of 11 studies of skin cancer excisions showed that clearance is more adequately achieved by dermatologists/specialists.

The data from 1991–2006 predate guidelines and modern skin cancer services with 21% being excised by general surgeons and only 15% by dermatologists. This is not generalisable to the rest of the UK or to our current practice. From the same population we have audit data from 2009 that reflect a change in practice with the introduction of a modern skin cancer service based on national guidelines. This has reduced waiting times with a reduction in primary care excisions and increased roles for dermatologists. There were a total of 130 melanomas in Grampian, Scotland, in 2009. Dermatologists diagnosed 60 (46%), 43 (33%) by plastic surgeons, 22 (17%) by primary care, and 5 (4%) from other sources. Of the 22 melanomas excised in primary care, 16/18 were complete excisions. The remaining four melanoma specimens were incised, shaved, or curetted, in other words, incompletely excised. Dermatologists and plastic surgeons had complete excision rates of 84% and 89% respectively, excluding incision biopsies.

Of the 22 melanomas coming from

primary care, none had a possible diagnosis of melanoma on the request form, delaying pathological diagnosis, impeding clinico-pathological correlation, and correct diagnosis. Dermatologists expected melanoma in 54/60 and plastic surgeons in 29/43.

Modern dermatological diagnosis of melanoma assisted by dermoscopy has a high sensitivity of 0.88 and specificity of 0.86.[4] In Murchie *et al*s' study the correct diagnosis was only given in 19.5% of melanomas diagnosed in primary care.

If services are provided by practitioners who are poor on diagnosis, irrespective of surgical competence, then unnecessary excisions will waste resources, and the risk of melanoma being missed is increased. The authors' assertion that if excision is complete then 'differences in diagnostic skill do not matter' is at least shortsighted or intended to provoke controversy.

**Frank Muller,**
*Consultant Dermatologist, Aberdeen Royal Infirmary, Foresterhill, Aberdeen, Scotland, AB25 2ZN. E-mail: f.muller@nhs.net*

**Fiona Meredith,**
*Specialist Trainee Dermatology, Aberdeen Royal Infirmary, Foresterhill, Aberdeen, Scotland.*

**Anthony D Ormerod,**
*Reader in Dermatology, School of Medicine and Dentistry, University of Aberdeen, Aberdeen, Scotland.*

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# Primary excision of cutaneous melanoma

I read Murchie *et al*'s article[1] concerning primary excision of cutaneous melanoma by GPs and secondary care with great interest. Evidence, as they point out, has been very varied in this area but there has been a heavy preponderance for studies that have recommended against GP excision to fail to be blinded and to all be conducted by secondary care doctors. This blinded study showed that it is far from clear whether patients would be more likely to benefit from rapid primary care excision or a referral to secondary care for further assessment.

Purdy and de Berker's editorial[2] did not share my opinion. They felt that National Institute of Health and Clinical Excellence (NICE) guidelines recommending a 2-week wait referral should stand. Their argument that it is unclear if GP excision is quicker than that of secondary care is hard to support. GPs who offer minor surgery in their clinics will almost always be able to excise a lesion within the week. Secondary care may take 2 weeks just to have the lesion assessed, let alone excised.

GPs should not be excising lesions of which they are not reasonably confident of the diagnosis, and certainly not if they are not confident of clearing the margins. More thorough training may be needed for those who wish to perform this minor surgery. However, NICE guidelines should take account of Murchie *et al*'s article; patients should be offered the choice of a quick excision in the surgery or referral for a second opinion when this is appropriate. If we can promote patient choice and reduce the burden on secondary care then everyone could benefit.

**Johnny Wake,**
*Northampton General Hospital NHS Trust, Cliftonville, Northampton, NN1 5BD. E-mail: jw@courteenhall.co.uk*

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## Authors' response

Johnny Wake's point is that once a GP has decided to remove something they will do it quicker than in secondary care. This was not the objective of Murchie *et al*'s study and is not a conclusion that is possible to draw from it.[1]

There are two groups of patients whose outcomes need to be considered if GPs without appropriate training are to remove suspicious lesions in primary care. First is the group of patients with lesions that the GPs may have chosen not to excise because their clinical threshold has not been triggered by making a diagnosis. The second is the group of patients whose numbers would increase if GPs were expected to excise all pigmented lesions of concern. As GPs would rely heavily on histology for clinical diagnosis, they would need to cut out a great many benign lesions. These two groups highlight the problem where entry into a clinical pathway requires diagnostic expertise. If you lack diagnostic expertise in pigmented lesions you need to cut out a great many to have enough sensitivity to not miss the melanomas. If you fall short of this then you will defer or decline to do surgery on patients and miss evolving melanomas. Cutting out the pigmented lesion should be the end not the beginning of the diagnostic pathway, and where NICE guidance is followed, the patient has the benefit of seeing a clinician experienced in the assessment of pigmented lesions enabling many to avoid surgery.

As Murchie *et al* state in their conclusions '… the relative outcomes of patients receiving their primary biopsy in primary or secondary care are unknown, although existing evidence suggests that survival is not compromised by having a melanoma excised in primary care.'

As we highlight in our accompanying editorial, this is reassuring, but the