

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 article¹ 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 editorial² 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