Diagnostic biopsy of melanoma: primary or secondary care?

Murchie et al\(^1\) compared morbidity and mortality in patients who had initial diagnostic excision biopsy in primary versus secondary care. The Breslow thickness of a melanoma is the main prognostic indicator in the melanoma patients included in this study. The mean thickness in both the primary and secondary care groups was ≤1mm: such patients have a 95% 10-year survival rate,\(^2\) so that mortality and morbidity are not particularly relevant endpoints.

Suspected melanoma is best managed in secondary care because meeting a patient at their initial clinic visit and diagnostic biopsy allows a more informed discussion at the MDT, leading to better management, and if the melanoma is diagnosed in secondary care, we can ensure that ‘breaking of bad news’ is made by a clinician or skin cancer support nurse, who have the knowledge and experience to explain the prognostic significance of the melanoma, the MDT decisions and the further treatments recommended.

We have looked at patients who had GP melanoma excisions in our region. In 70% of cases no clinical diagnosis was given on the pathology form, which may affect the interpretation of the pathology and the speed with which the material is processed. To improve lesion recognition and management by GPs in our region, GPs are invited to sit in on our weekly rapid access tumour clinics. We also plan to distribute a bi-monthly on our weekly rapid access tumour clinics.

We salute the excellent model of care already been started.\(^4\) Such a move is likely to improve lesion recognition of the transitions in people’s lives, and recent publications in the UK have inspired us.\(^2,3\)

The family medicine model has been fully implemented in Turkey since 2010. The new model allows doctors to have their own registered patients and the most reliable data from these registries. The opportunity here lies in the recognition of the transitions in people’s lives, as described by Eynon et al\(^1\). The unique relation of GPs with their patients and the enthusiasm of the new model facilitates communication and gives time to speak on the topics that were not previously touched.

When is the right time to discuss advance care planning? We think that earlier is better, when people are still healthy and can make sound decisions. For a population still young, but ageing very rapidly as in Turkey, discussions around advance directives have already been started.\(^4\) Such a move is likely to overcome the challenges Sharp et al mention, such as families, time, patient reluctance, or dementia.\(^2\)

It is not easy to talk on these topics. The fear and discomfort experienced by the GP might

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Authors’ response

We disagree with the correspondents’ comment that, since the mean thickness in both the primary and secondary care groups was ≤1mm, mortality and morbidity are not particularly relevant endpoints. We presented median and not mean values in our paper. In fact, over 40% of the lesions in each group of our study had a Breslow thickness ≤1mm. Furthermore, patients can die from melanoma irrespective of the Breslow thickness of the primary lesion, so mortality was the most appropriate primary outcome for our study. Similarly, morbidity, in this case, subsequent hospital attendances, must be included in any analysis where questions of surgical competence are being addressed.

We salute the excellent model of care that the corresponders are advocating, and implementing. However, they do not appear to provide any evidence as to why high quality skin biopsy of suspicious pigmented lesions in primary care could not be incorporated. We re-assess our conclusion that our study clearly signifies the need for a randomised controlled trial to establish the role of initial excision biopsy in primary care in the diagnosis and treatment of cutaneous melanoma in the UK. In the long run, this may be beneficial for both patients and the NHS.

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The future of elderly care in Turkey

Although elderly and end-of-life care have been neglected in Turkey, because older people did not constitute a high percentage of the population, the proportion of citizens aged >65 years is now 7.5%, with this proportion expected to increase to 10.2% by 2023, 21% by 2050 and 28% by 2075.\(^1\) These estimates put Turkey as one of the most rapidly ageing populations in the world and have stimulated research and discussions around healthy ageing, chronic disease management and elderly care.

Turkey has also started to observe and analyse how other countries have managed this situation. Advance care planning has also been a topic of discussion for the older population. The UK has been one of the countries that have put efforts into better care of older people, and recent publications in the BJGP have inspired us.\(^2,3\)

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It is not easy to talk on these topics. The fear and discomfort experienced by the GP might
be added to the avoidance by the patient and
care givers. We have very recently run a study
to explore views of healthcare professionals
and patients on end-of-life decisions, and
found that both sides were not comfortable
in talking about end-of life or even filling in a
questionnaire on this topic. This remains as a
challenge to overcome.

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Why all GPs should be bothered about Billy

The 2014–2015 QOF overhaul1 retires three
critical cardiometabolic indicators from the
severe mental illness (SMI) domain, keeping
only blood pressure. Yet cardiovascular
disorders, rather than suicide, remain the
single biggest contributor to 15–20 years
reduced life expectancy. Two decades of
cardiometabolic risk prevention has
successfully reduced cardiovascular mortality
in the general population but sadly eluded
those with SMI.2

Potentially modifiable cardiometabolic risks,
often appearing within weeks of commencing
antipsychotics, ultimately translate into 1.5–3-
fold increased rates of diabetes, obesity, and
dyslipidaemia than in the general population.
By age 40 years metabolic syndrome
becomes four times commoner and about
40% of individuals are biochemically at high
risk of diabetes. Furthermore the National
Audit of Schizophrenia3 found only 29% of
5091 patients from across England and
Wales had cardiometabolic risk adequately
assessed in the previous 12 months (weight,
smoking status, glucose, lipids, BMI). Weight was
unrecorded in 43%. Moreover when
cardiometabolic complications are
discovered, too often these are ignored in
clinical practice particularly when compared
with patients without mental illness.

Responding to this evidence of inequalities in
care, the Lester Positive Cardiometabolic
Resource4 embraced these to-be-retired
QOF measures with the message ‘Don’t just
screen, intervene’. This was endorsed by the
RCGP/RCPych/RCP/RCN/Rethink/Diabetes
UK and recommended by NICE [NICE CG
155] and the Schizophrenia Commission. The
resource’s lead author, the late Professor
Helen Lester, key scientific advisor to the QOF
until her death this year, challenged us to be
‘Bothered about Billy’ in the RCGP James
McKenzie Lecture 2012.

QOF aims to universalise good quality
care. The challenge is in its translation from
checklist to the human being in front of us.
Has anyone explained to a real person with
SMI or their relatives why these indicators are
checked? The human being in front of us
must be a partner in care. The challenge is in
its translation from checklist to the human being in front of us.

As a recently qualified academic GP working
out-of-hours (OOH) shifts, I read with interest
the debate and analysis section of the October
BJGP dedicated to the problem of OOH service
 provision. How should urgent primary care be
provided? Who are the key players and how
should they form an effective OOH team?
Dr Drinkwater pointed out the two key areas
where patients can actively help in alleviating
pressure on OOH services: self-management
and information. Dr Greenhow emphasised
creating a national quality contract running
through all providers to ensure coherent
clinical governance. Professor Mason

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