Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

30 June 2003

Mrs A
Consumer

Dear Mrs A

On 12 June 2003 I sent you my provisional opinion on your complaint against Dr B and invited you to respond to my decision by 30 June. You telephoned this Office and spoke to one of our Investigation Officers on 30 June and expressed your disappointment at my decision. I realise that this is not the answer you were looking for. However, I have attempted to fully and fairly investigate your complaint.

Complaint
Your complaint was summarised as follows:

From about 7 May 1998 until September 2000 Dr B did not provide you with services of an appropriate standard. In particular, Dr B:

- was cursory in her examination of your facial mole and so did not properly assess and monitor it
- did not appreciate the significance of changes in the mole
- did not refer you for specialist advice.

Investigation process
In reaching my decision I considered information obtained from you, Dr B, your lawyers, and Dr C, and your records obtained from ACC and the private hospital. Independent professional advice was obtained from Dr John Cheesman, a general practitioner.

Information gathered

Initial consultation, 7 May 1998
On 7 May 1998 you presented at a family health centre for a routine cervical smear. This was your first consultation with Dr B.

You advised me that at that consultation you informed Dr B that you had a "little freckle" on your upper lip.[1] You stated that Dr B did not examine the freckle closely

[1] Right upper nasolabial fold.

but informed you that although it looked like a freckle, it was a mole. Dr B asked you to keep a "close eye" on it for any changes. You stated that Dr B did not measure the size of the mole.

Dr B advised that on examination on 7 May 1998 your mole appeared normal. She provided you with information on observing for any changes in the size, colour, and pain or bleeding of the mole, and advised you to report back if any of these occurred. Dr B did not consider an excision biopsy to be warranted.

5 February 1999 consultation

You advised me that on 5 February 1999 you consulted Dr B regarding a "little mole" on your chest. You said that Dr B examined the mole and informed you that it appeared benign. Dr B also advised you to observe the mole for any changes. In respect of your lip mole, you said that you informed Dr B on 5 February that it was "a little bigger". Dr B looked at the mole, took no measurements and advised you to observe it for any changes.

Dr B advised me that the purpose of the 5 February 1999 consultation with you was to discuss your contraception. At the consultation Dr B made a note of a "new benign nevus" on your chest and suggested you observe it for any changes. Dr B also made a note that other moles were "unchanged". She did not consider an excision biopsy to be warranted.

30 November 1999 consultation

On 30 November 1999 you consulted Dr B regarding an allergy. You advised me that at this consultation you informed Dr B that the mole was slightly larger and had been bleeding. You also said that Dr B gave the mole only a cursory glance from a distance, did not measure its size and assured you that it was "okay".

Dr B advised me that her standard practice was to remove any mole that has changed in nature. A bleeding mole is a serious warning sign which she would have documented and acted upon. Dr B advised me that she checked your moles and found no change in their appearance. Because there had been no change in their appearance, no specific reference to the lip mole or size of any mole was recorded in her notes. Dr B stated that had you indicated that your mole had bled she would have documented it in her notes and would have referred you for a specialist assessment. Her record "moles n" [moles normal] indicated that at that stage she did not suspect a malignancy.

April 2000 consultations

You stated that at each consultation in April 2000 you asked Dr B about the moles and that she assured you each time that they were fine. You accepted her assurances. Dr B's records show that you consulted with her twice during April 2000 – on 4 April for an infection of the buttocks and on 6 April for an allergic reaction to a medication. No mention of moles was made. Dr B advised that as she had not documented anything about the moles, she presumed that they were not checked by her.

24 July 2000 consultation
On 24 July 2000 you went to Dr B for a pregnancy test which proved positive.[2] Dr B's records make no reference to the moles at that consultation. You advised me that Dr B did not examine your lip mole at this consultation but informed you that it "looked okay".

26 September 2000 consultation
On 26 September 2000 you presented to Dr B after a fainting episode. You told Dr B that the mole on your lip had grown darker and larger since being pregnant. You described the mole as "quite big and raised". You said that Dr B did not examine the mole closely and did not measure its size.

Dr B advised me that her assessment of the mole was that it was "a small slightly darkened macula" and that there were no clinical signs suggesting that it might be a melanoma. She also advised me that the mole was 3mm in diameter, mild brown in colour with regular borders. The size and description of the mole was not recorded in her notes.

Dr B advised me that she decided to refer you for an elective removal "based on the ongoing concern that [you] had about it". She also informed me that she advised you to have the mole removed to exclude any "underlying pathology". Dr B advised me that her assessment and management of skin lesions suggestive of melanoma was based on the *New Zealand Guidelines for the Management of Malignant Melanoma* (copy **enclosed**, or visit www.dermnetnz.org/dn.paper1/dn.papaer1.html) which state:

> "If a pigmented lesion is thought to be a malignant melanoma or there is a high index of suspicion (use ABCD criteria – Asymmetry, Border, Colour, Diameter) the lesion should either be removed by the general practitioner if he/she feels they are technically competent to do so or the patient should be referred to an appropriate specialist (eg. Dermatologist, Plastic Surgeon, General Surgeon, etc)."

Dr B advised me that the clinical indicators of possible melanoma were lesions asymmetrical in shape; irregular in colour, with irregular border, and more than 6mm in diameter. The appearance of your mole did not fit these criteria for clinical diagnosis of a melanoma or suggest the need for an urgent referral (within a week).

Because Dr B felt that the excision of the mole would be difficult, she suggested to you that it would be more appropriate for it to be performed by a dermatologist or a surgeon. This was not documented in her notes because "it was [her] intent to facilitate removal with subsequent histological assessment within a short time frame following this consultation …"

Dr B advised me that according to the Ministry of Health *Elective Services Guidelines* for dermatology (copy **enclosed**), she categorised your presentation as semi-urgent. This category recommends a referral within four weeks. Dr B stated that her semi-urgent referrals are handwritten and then typed by a typist and checked by her before

[2] Calculations suggest that you were about six weeks pregnant at this time.

posting. They are normally done in groups during a dedicated administrative period normally at weekly to 10-daily intervals.

Dr B also advised me that she informed you that it was unlikely that your lip mole would be excised by a specialist before you were in the second semester of your pregnancy and, given the mole's location and the potential adverse cosmetic effect, it was never her intent to remove it herself. Further, after her consultation with you, she recorded your details for a referral. She planned to do the referral on the weekend of 30 September 2000 but was unable to do so because of her personal circumstances at that time. Her plan was to refer you to the local hospital's Dermatology Outpatients. Dr B advised me that the waiting time for patients with semi-urgent dermatology referrals at that time was 2-3 months.

You advised me that Dr B did not inform you about a referral to a dermatologist or a surgeon. You said that Dr B informed you that she would excise the mole when you were 18-20 weeks pregnant.[3]

Not satisfied with Dr B's diagnosis and management of the mole, in the meantime you decided to seek a second opinion from another doctor.

Consultation with Dr C

On 4 October 2000, of your own accord, you consulted with Dr C, a general practitioner with a special interest in dermatology. Dr C examined your lip mole and described it as a "3 x 4mm raised blue-black" lesion. She informed you that the mole could be a blue nevus but that, as it could also be a malignant melanoma, an urgent excisional biopsy was required. Dr C arranged to perform the excision the following day and informed you that if a melanoma was confirmed by histology, a further wider and deeper excision would be required.

On 5 October 2000 Dr C performed the excisional biopsy of your right upper lip mole. In her letter of the same day, Dr C advised Dr B that she had excised the mole. Under the heading "follow-up arrangements" she wrote: "copy of histology to you. If this lesion is a melanoma then further surgery will be required".

Dr B advised me that on or about 5 October 2000 she was informed by Dr C that she (Dr C) had taken over the management of your mole. This negated the need for her to follow through with the referral. The planned referral letter was therefore never written by Dr B and no further documentation was made in her notes.

On 10 October 2000 Dr C received the histology result with a diagnosis of a "superficial spreading" malignant melanoma "in the vertical growth phase".[4] The mole was 2.15mm thick. The macroscopic description of the mole by the laboratory was that it was a "mid-brown macule with a regular border and a diameter of 3mm".

[3] As you were 15 weeks pregnant at that time, this suggests that the excision was planned for mid- to late October 2000.

[4] In the initial stages melanoma spreads horizontally. While in this stage melanomas are fully curable by primary excision and have no risk of spreading. Poorer prognosis is associated with the vertical growth phase which follows.

On that day Dr C discussed the result with you and made an urgent referral to Dr D, a consultant general surgeon.

On 11 October you consulted Dr D who in his letter to Dr C commented that the mole "should have [earlier] been viewed with suspicion of melanoma". Dr D advised wider excision of the mole area which he planned to perform in a week's time. After consulting your family you decided to have the wider excision done by Professor E, a Professor of Surgery who has wide experience in the management of melanomas, particularly involving the face. The referral was made by Dr C at your request.

On 17 October 2000 Professor E saw you and performed a wide excision of the scar at a private hospital. Skin biopsy taken at the time showed no residual melanoma. No evidence of the disease was noted at a follow-up appointment with Professor E on 27 October 2000. After giving birth in March 2001 you underwent sentinel node biopsy at another private hospital on 28 May 2001. Professor E performed the procedure. There was no evidence of malignancy.

ACC claim
On 31 October 2000 you consulted Dr C and lodged a claim with ACC's Medical Misadventure Unit. The basis of your claim was that you had suffered an injury as a result of delayed diagnosis of the malignant melanoma.

On 5 August 2001 you and Dr B were advised by ACC that the claim had been accepted as a medical error. The reason given for accepting the claim was that personal injury had occurred because you developed deeper melanoma, which required more extensive surgery and possibly carries poorer prognosis, because of Dr B's delayed diagnosis. Independent advice to ACC was provided by Dr F, a general practitioner, and Dr G, a dermatologist.

On 27 September 2001 an application for review of the ACC decision was lodged by Dr B's lawyer on behalf of Dr B. In a decision dated 20 August 2002, the ACC reviewer quashed the medical error finding on the basis that the weight of medical evidence did not support the earlier finding.

The reviewer placed particular weight on the opinion of Professor H, submitted on behalf of Dr B (copy **enclosed**).

Professor H was of the opinion that overall Dr B "observed a level of standard and skill reasonably to be expected of a competent New Zealand general practitioner".

Commissioner's Opinion

Cursory examination
You complained that from the time you first consulted Dr B in May 1998 about the mole on your lip, she was cursory in her examination and did not properly assess and monitor it.

Dr B stated that on the occasions when she documented that the moles were normal, she visually examined them. I found no evidence to support your allegation that Dr B's examination of your lip mole was "cursory".

There is conflicting evidence from you and Dr B regarding the consultation in November 1999. Whereas you stated that you informed Dr B that the mole was "slightly" larger and had been bleeding, Dr B said she had checked the mole and found no change in its appearance. She had no recollection of your comments and advised me that had you told her that, she would have recorded it, and in accordance with her standard practice she would have removed the mole or referred you for an excision. Because the mole appeared unchanged, she had no reason to manage it differently. While I am unable to resolve this apparent conflict of evidence, I note that the mole was never recorded as the primary reason for consultation and did not arise during the April and July 2000 consultations and over the 10-month period leading to the September 2000 appointment. At that stage the mole was still noticeably small and lacked the typical appearance of a melanoma lesion.

I have also noted Professor H's comments that it is not unusual for general practitioners not to record measurements or specific sites of moles unless they have particular concern about any of the moles. Dr B stated that as she considered the mole "normal", there was no need for more detailed documentation. In your case such a need did not arise for Dr B until the September 2000 consultation when you informed her that the mole had grown darker and larger.

While I acknowledge that Dr B's clinical notes were brief and did not record the site, measurement or change in any of the moles you showed her, in the absence of specific concern, I consider that the documentation was adequate. Nevertheless, as my expert advisor noted, more detail would have been helpful to provide a baseline for comparison.

Appreciation of the change in the mole
Regarding your complaint that Dr B failed to appreciate the significance of a change in your mole, I found no evidence to substantiate this allegation.

I note that in her report to ACC, Dr G states that the primary diagnosis of melanoma can be difficult. In his report to ACC, Professor H states that melanomas in persons of your age are rare and those of the lip even more so, and not commonly seen in a general practice.

When examining your moles Dr B considered the ABCD criteria which are used as a benchmark by general practitioners in diagnosing melanomas. Your mole showed none of the features of the ABCD criteria, even at the time of excision in October 2000, after your last consultation with Dr B.[5] As a general practitioner, given the clinical presentation of the mole over the period that you were under her care, Dr B had no reason to suspect a malignancy or to alter the course of her management of the lip mole. Although the mole subsequently proved to be malignant, in my opinion this cannot be attributed to inappropriate monitoring and management by Dr B.

[5] Dr B produced evidence to support her stance that the growth of melanomas is not affected by pregnancy.

Failure to refer
With regard to your complaint that Dr B failed to refer you for specialist advice, there is also no evidence to substantiate this allegation. At the September 2000 consultation, conscious of your ongoing concern that the mole had changed in appearance, Dr B made a decision to have the mole electively removed even though its appearance did not fit the assessment criteria. As my advisor commented, that decision was an appropriate one. An immediate referral was not indicated.

I accept Dr B's explanation that, given the location of the mole and the risk of adverse cosmetic effect, she never intended to remove the mole herself. The referral was planned on a semi-urgent basis as per Ministry of Health guidelines, but did not eventuate because, in the meantime, you consulted Dr C and had the mole excised by her. Having been informed that the mole had been removed by Dr C, Dr B had no need to follow through with her referral.

Having considered all the information available to me, including the advisors' reports, my opinion is that Dr B did not breach the Code.

I acknowledge that you developed a deeper melanoma and required more extensive surgery as a result of the time taken to make the melanoma diagnosis. The delay in diagnosis is not in dispute. Although earlier excision of the melanoma would have been preferable, I found no evidence to suggest that the delay can fairly be attributed to Dr B. Given your clinical presentation, in my opinion Dr B observed a standard of care reasonably to be expected of a competent general practitioner.

Follow-up actions
A copy of this letter, with personal identifying details removed, will be sent to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Conclusion
I trust that you understand the reasons for my decision and hope that my investigation, and my opinion that Dr B did not breach the Code of Health and Disability Services Consumers' Rights, has answered some of your concerns.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

Ref: 01/11477

Enc.

Report by Professor H

"**[DR B] – ACC – MEDICAL ERROR**

REPORT PREPARED BY [PROFESSOR H], BSc, MBCHB, MD DIPLOMA OF OBSTETRICS (Otago), FRNZCGP

I am currently [a] Professor of General Practice and have been since 1993. I have also been actively involved in general practice since 1984 and currently still care for my own practice population, seeing approximately 50-60 patients per week. I have been asked to comment on the ACC findings of Medical Error against [Dr B]. In providing this advice I have had access to:

- A letter to [Dr B's lawyer] from [Ms I], Clinical Advisor, ACC dated 15 October 2001.
- A letter to [Ms I], Clinical Advisor ACC from [Ms J] dated 3 August 2002.
- The letter to [Dr C] from [Dr D] dated 11 October 2000.
- A copy of a complaint by [Mrs A] dated 31 October 2000.
- Various letters, operation notes and pathology reports in regard to [Mrs A's] consultations with [Professor E] dated 1 November 2000, 17 October 2000, 19 October 2000, 23 November 2000, 31 May 2001, 28 May 2001 and 30 May 2001.
- A letter to [Dr C] which appear to be copies of a computer print out of the consultations that [Mrs A] had with [Dr B], dated 16 October 2000.
- A letter from [Dr D] to [Ms I], Clinical Advisor ACC, dated 20 May 2001.
- A letter to [Ms I], Clinical Advisory ACC from [Dr G] dated 16 July 2001.
- A letter to [Dr B] from [Ms I] dated 5 August 2001.
- A letter to [Mrs A] from [Ms I] ACC dated 5 August 2001.
- A letter to [Dr B] from [Dr C] dated 5 October 2000 plus associated laboratory report on 6 October 2000.
- A letter to [a] Clinical Advisor ACC from [Dr C] dated 29 November 2000.
- A letter to [the Clinical Advisor] ACC from [Dr B] dated 4 December 2000.

The issue is:

1. Whether [Dr B] failed to observe the standard of care and skill,
2. Reasonably to be expected,
3. In the circumstances,
4. Of a New Zealand registered General Medical Practitioner.

In particular, the acts of reMsion and the issues are:

1. whether personal injury occurred because [Mrs A] developed a deeper melanoma which required more extensive surgery with a poorer prognosis,
2. whether this delay can be related to failure to adequately diagnose and
3. whether this failure to diagnose is below the standard of care reasonably to be expected of a competent general medical practitioner in New Zealand.

1 Background

[Dr B] saw [Mrs A] on 7 May 1998 for a routine cervical smear. During that consultation [Mrs A] states that she brought to [Dr B's] attention a mole on her upper lip that had appeared from clear skin. She also states that without close examination [Dr B] assessed it as normal. The medical records show that moles, in this case (plural), were regarded as normal. A number of reviewers have commented on this aspect, that perhaps [Dr B's] examination was not thorough and this appears to be based on the assertion of [Mrs A]. I would however point out that at the time that the mole was excised it only had a diameter of 3 mm. This was after going through an accelerated growth phase in the previous three months. I can therefore only assume that in 1998 this was an extremely small mole and examination would have been difficult. The records then note that a new benign nevus was observed on the anterior chest, in a consultation on 5 February 1999 and that the rest of the moles were regarded as not showing any abnormality. The primary purpose of the consultation however was the discussion regarding contraception. [Mrs A], in her notes, states that the next time her moles were examined were 30 November 1999. The computer records from [Dr B] confirm this. The records state that the moles were normal. However [Mrs A] states that without examination she was assured that all was okay. Given that the examination of a mole is a visual inspection, it is difficult to be certain what examination [Mrs A] may or may not have been expecting. Again a number of commentators have picked up on this point and I will address them specifically further in the report.

The next consultation regarding to the moles was on 26 September 2000. At this stage [Mrs A] was 15 weeks pregnant. The notes at this stage state that the mole was dark and had grown, and had been present three years. The notes also recommend removal of the mole. It was at this stage that [Mrs A] sought a second opinion, which resulted in a three millimetre, mid brown macula with regular border (description from the laboratory's pathology report dated 16 October 2000) was removed. This was found to be a superficial spreading melanoma in the vertical growth phase arising in sun damaged skin.

2 The recognition of Melanoma by General Practitioners in New Zealand

The issue of the recognition and management of melanoma by general practitioners in New Zealand have been addressed previously. I have enclosed a copy (Appendix 1) of a GP Skin Cancer Survey which was undertaken by a research team headed by … and which also included myself. This research occurred in late 1993. It involved a self-administered questionnaire being sent to a random sample of 900 general practitioners and a comparison sample of 35 dermatologists. I would like to point out that this is one of the few pieces of research that has tried to look at the recognition of melanoma and other skin lesions by general practitioners compared to specialist dermatologists. You will therefore see that this research is often quoted in international literature.

In summary the findings indicated a high level of expertise in terms of diagnosis of skin lesions and identification of the need to biopsy suspicious lesions amongst

general practitioners in this country. However I would bring to your attention table 3 of the results. This was a summary of the correct diagnosis and or the need for biopsy of each of the 12 lesions. Cases 3 and 8 were early melanomas. In regard to case 3, you will see that the clinical scenario was a freckle on the left leg which had appeared in the last 12 months. I would bring to your attention, that from a medical point of view, this photograph shows it has an irregular border with a lack of uniform colour of the lesion. In regard to case 8, clinical picture was that this pigmented area had been enlarging over 12 months. I would also bring to your attention, for this case, it had an irregular border and different levels of pigmentation. Irregular borders and differing levels of pigmentation, as well as change in size are factors that should alert a clinician to the need to consider that this may be a melanoma.

The results indicated that general practitioners in 86% of the cases for case 3 would have diagnosed this as a melanoma compared to 96% of dermatologists. This also means that 14% of general practitioners and 4% of specialist dermatologists would have failed to identify this correctly as a melanoma. In regard to case 8, only 62% of general practitioners and 75% of dermatologists would have correctly diagnoses this lesion as a melanoma or 38% of general practitioners and 25% of dermatologists would have failed to diagnose it correctly. If we look at the need for biopsy, only 2% of general practitioners would not have biopsied the lesion in case 3 and all dermatologists would have, whereas in case 8, 9% of general practitioners and 8% of dermatologists would not have undertaken a biopsy. I would therefore conclude that the diagnosis of skin lesions, as to whether they are or are not a melanoma, is not an exact science and even specialist dermatologists do not get it correct 100% of the time. It is with this background that one must then consider the issue of melanoma affecting the lip.

I undertook a review of the international medical literature in regard to melanoma, and in particular melanoma of the lip. I wish to bring to your attention reference 1, 'The rational clinical examination. Does this patient have a mole or melanoma?' This was an article published in the Journal of the American Medical Association in 1998. I have included the summary and also comment, which occurred in 'Letters to the Editor' following the publication of this article. In their paper the authors looked at the issue of how one can improve the diagnosis or differentiation between a mole and melanoma in primary care / general practice. They looked at the use of two specific checklists that focused on issues such as asymmetry of the mole, border irregularity, irregular colour and diameter greater than 6 mm, and a new revised 7 point check list. They found that while physician's global assessments for detecting the absence of a melanoma are estimated to have a specificity of 96-99%, sensitivity ranges from 50-97%. They also point out that non-dermatologist's examinations are less sensitive than examinations performed by dermatologists. This reinforced the finding of the research undertaken in New Zealand. The letters to the editor focus on the debate of how easy it is or is not for a practitioner to identify moles which need excision because of the possibility of melanoma. In the words of the authors of one letter 'how can clinicians ever decide which are appropriate melanocytic lesions to remove'. This, in my view, sums up the situation in regard to the difficulty of determining what moles should

or should not be removed. I would point out that the New Zealand research is referred to in these articles.

Melanoma of the Lip

In the case of [Mrs A], it appears that her melanoma was on her upper lip. I therefore have looked at articles in regard to melanoma of the lip. References 2 and 3 point to the rarity of melanoma of the lip. Reference 3 in particular states 'that in 1986 there had only been 31 reported cases of melanoma of the lip'. If one assumes that this is worldwide it means melanoma of the lip is extremely rare and the average general practitioner is never going to see such a case. I believe that this is important background information and should be remembered when one examines the facts of the case against [Dr B].

3 Commentary on Reports

3.1 Letter to [the Clinical Advisor] by [Dr C], 29 November 2000. It appears that [Dr C] is a general practitioner with a special interest in dermatology. [Note– this is also referred to by [Dr G].] She pointed out that when she first saw the patient there was a 3 x 4 mm (pathology report 3 x 3 mm) raised blue/black (pathology report: mid brown) macule right upper lip. [Note – the pathology report stated that it had a regular border.] [Dr C] wondered whether this was possibly malignant and arranged a biopsy. In her letter [Dr C] goes onto comment in regard to [Dr B's] medical records. [Dr C] is somewhat critical in stating that [Dr B's] computer notes did not record the site, measurement or change in any mole. I would point out that, as I have stated previously, [Dr C] appears to be a practitioner with a specialist interest and/or knowledge in dermatology. However, in my work as a Professor of General Practice, I have reviewed a large number of patient records. In my experience it is not unusual to find that general practitioners neither record measurement nor specific sites of moles unless they have particular concerns about anyone mole. Note: The average person has approximately 50 moles.

I do not believe that [Dr C] necessarily has the experience to comment on what is common practice for recording moles by New Zealand general practitioners. I am sure she knows what should occur in a perfect situation, if the only reason for the encounter is examination of the mole. I would point out that on all of the occasions that [Mrs A] asked for her moles to be checked, that this was not the primary reason for the consultation, but was an 'add on'.

3.2 Letter from [Professor E] to ACC dated 23 November 2000 and 31 May 2001. I note that in neither of those letters does [Professor E] indicate any concern with the management undertaken by [Dr B].

3.3 Letter to ACC from [Dr F], 20 May 2001. I was surprised that [Dr F] has not commented on the difficulty for general practitioners to determine the difference between a benign mole and a melanoma, nor on the criteria that general practitioners should be employing ie A, B, C, D; A indicates asymmetry; B, border irregularity; C, irregular colour; and D, diameter

greater than 6 mm. You will remember that none of these features were present at the time the mole was examined by the pathologist. Nor on the rarity of melanoma affecting the lip. In regard to [Dr F's] report, the question is, would a competent general practitioner fail to diagnose correctly the mole on [Mrs A's] upper lip as a melanoma. I will summarise my views at the end of this commentary. I would agree with [Dr F] that the mole appeared to have undergone change in the early stages of pregnancy. It is hard to be certain what was meant by rapid change, given that the mole only had a diameter of 3 mm at the time of excision. However I do assume that it was an increase in size. [Dr F] correctly points out that [Professor E] does not venture an opinion on [Dr B's] care but believes that [Dr D] implies a high level of suspicion should have been maintained, I have read [Dr D's] letters and do not reach the same conclusion as [Dr F]. I would agree with [Dr F] that it is extremely rare to develop melanoma at the age of 23 and as pointed out previously, very rare for melanoma to occur on the lip. I would also agree with [Dr F] that moles often change during pregnancy without malignancy being involved.

However [Dr F] is somewhat negative in regard to [Dr B's] record. He does accept that [Dr B] has documented that the moles have been monitored but [Dr F] appears to have accepted [Mrs A's] assertion that the examination was cursory in nature. There is nothing to indicate from the records either for or against this assertion. A visual examination of a mole could well seem cursory to a patient. I would expect a general practitioner to take between 15-30 seconds to examine a mole. [Dr F] reaches a conclusion that medical error has occurred without, in my view, being fully aware of the facts and in particular the difficulty that general practitioners and specialist dermatologists have in making this diagnosis, as pointed out in the international literature.

3.4 Letter to ACC from [Dr G], Dermatologist. I will comment on specific aspects of [Dr G's] report.

(a) circumstance of events and circumstances of the health professional. I would agree completely with [Dr G] that the majority of general practitioners in New Zealand have very little training in skin diseases, both as under-graduates and as part of continuing medical education. I would also agree that general practitioners should and, in my view, do have basic knowledge about the clinical appearance and behaviour of melanoma (again I would point out that the mole on this patient's lip did not behave as a melanoma according to the international literature ie ABCD).

(b) Personal injury. I would accept that delay in diagnosis has resulted in a deeper melanoma-

(c) On the balance of probability can the alleged injury be attributed to the treatment as claimed. [Dr G] states yes, but I would have to disagree.

The basis for my disagreement is:

1. At no stage did the mole on [Mrs A's] lip have any of the diagnostic features (ABCD) that general practitioners are trained to be alert for;
2. Melanoma of the lip is exceedingly rare;
3. New Zealand research (Appendix 1) shows that between 14-38% of general practitioners and 4-25% of specialist dermatology will fail to reach the correct diagnosis regarding potential melanoma at anyone time. This is even when the lesions demonstrate features (ABCD) which indicate a need for higher suspicion.
4. Given that medical error means the failure of a registered health professional to set a standard of care and skill reasonably expected in the circumstances. We have New Zealand based research evidence that 38% of [Dr B's] colleagues (if not a higher percentage because of the lack of features to indicate concern) would not have diagnosed this lesion as a melanoma. I would point out that [Dr G] states in her letter than on 26 September 2000, [Dr B] clearly recognised that the lesion now needs to be removed or at least reviewed by a specialist. This in my opinion was the first indication that [Dr B] had, that the mole may be suspicious. [Dr G] is comfortable with the decision from [Dr B] to electively remove the lesion a few weeks later and that it would have unlikely made a significant different to the claimant's prognosis.
5. If so, is there an issue of medical error as defined by the Act? You will see that [Dr G] fails to state categorically, either for or against, that medical error as defined by the Act has occurred. [Dr G] recommends the opinion of a panel of experts is required to determine cover. In this case the expert advice should be that of general practitioners not specialist dermatologists. A general practitioner's actions should be reviewed by his or her peers and not by individuals who have specialist knowledge in the area, including general practitioners with specialist knowledge ie skin knowledge.
6. If this is not a case of error then does it fit the medical mishap criteria, ie occurs in 1% or less of cases where that treatment is given (and is rare given the individual's circumstances). I would argue in this case that melanoma of the lip is exceedingly rare according to the international literature. It therefore does meet the rarity clause for medical mishap. In the opinion of [Dr G] and [Dr D] it also meets a criteria for severity given that the patient's risk of death from melanoma is approximately 25% within the next 10 years.

3.5 Letter to ACC to [Ms J], 3 August 2001. It appears that [Ms J] is a barrister/solicitor who works for [a law firm] and has been asked to summarise the case for Accident Compensation. In regard to her comments:

(a) Item 10 [Ms J] comments that [Dr C's] report to ACC of 29 November, states that she does not believe that [Dr B's] records were adequate. I have already pointed out that in my view this is incorrect and [Dr C] does not have the experience to comment on general practitioner records within New Zealand. [Ms J] then goes onto state that [Dr B] should have

kept precise notes about all of [Mrs A's] moles include site measurement, colour, appearance and other relevant factors. I assume this is on the basis of comments by [Dr C] and as pointed out previously that is an opinion and is not what occurs in New Zealand general practice.

(b) Item 12, [Ms J] comments on the letter from [Dr D] where he states that it should have been viewed with a suspicion of melanoma for that reason alone. I point out that I do not believe that [Dr D] was fully aware of all the facts and his perspective is that of a consultant surgeon who already has the diagnosis. [Ms J] pointed out that [Professor E] does not indicate similar criticism of [Dr B].

(c) Item 13, [Ms J] then comments on the report of [Dr F], which I have previously alluded to.

(d) Item 14, she then comments on the report of [Dr G] in that she has expressed her opinion as to whether there has been medical error on the part of [Dr B] in an equivocal and uncertain manner.

(e) Based on the information available [Ms J] has reached a conclusion that [Dr B] failed to exercise a standard of care reasonably expected in the following circumstances:

- It would appear that she undertook an early consultation in May 1998, November 1999 only cursory examination of the mole.
  Comment: no evidence either for or against such a statement. The records of a general medical practitioner in New Zealand do not go into detail the type of examination undertaken. The record should indicate the results of such an examination, not necessarily what examination techniques were followed.
- As the mole appeared in previously clear skin in May 1998 it should have been viewed with suspicion of melanoma for that reason alone.
  Comment: that is one indication for suspicion but the main criteria are the internationally developed AB C D. At no stage did the mole on the patient's upper lip meet any of these criteria
- [Dr B's] notes seem inadequate. [Dr C] has commented they do not record the site measurement or change in the mole. This should have been done.
  Comment: as pointed out previously I would not agree with this. [Dr C] is commenting from the point of view of a general practitioner with a special interest in dermatology. It may be that [Dr C] primarily sees patients with skin conditions and the whole focus of her surgery is based on this. However the average general practitioner does not have the same interest nor expertise as [Dr C] and in my opinion [Dr B's] notes are that expected of a competent general practitioner in New Zealand.
- An overall failure on the part of [Dr B] to appreciate the significance of [Mrs A's] changing mole.
  Comment: on 26 September 2000 it is my view that [Dr B] did appreciate that the mole had changed, as pointed out by the patient, and this was likely to be secondary to hormonal changes associated with the pregnancy. [Dr B] made a decision to electively remove the

mole and, in the opinion of both [Dr G], and myself this was an acceptable decision.

(f) Item 16, based on the above provided commentary I therefore do not agree with the conclusions reached by [Ms J].

Summary

In summary we have a difficult diagnostic situation. General practitioners are asked to review moles on patients frequently. Because of the increased publicity the days of patients presenting with advanced melanoma ie large moles with very irregular border, multiple colours, have to a certain extent passed. General practitioners are now asked to comment on freckles and it is very difficult to determine whether these lesions should or should not be removed. Therefore international evidence has been gathered and the ABCD criteria developed. New Zealand general practitioners are encouraged to be aware of changes in symmetry, border irregularity, irregular colour and diameter greater than 6 mm. However despite the evidence and strong level of suspicion, research in New Zealand has shown that between 14-38% of melanomas may not be recognised by a general practitioner, or between 4-25% by a specialist dermatologist.

It is within this setting that [Dr B] has been charged with medical error. It is my opinion based on the material provided, that at no stage did the pigmented area on [Mrs A's] lip reach any of the criteria for ABCD and that melanoma of the lip is extremely rare. It is unlikely that a general practitioner in New Zealand would see such a case. However to her credit, [Dr B] recognised in September 2000 that there had been some changes that was going to undertake a line of management, which, in the view of [Dr G], was entirely acceptable.

Therefore the question is 'has medical error occurred?' Medical error is defined by the Act as meaning the failure of a registered health professional to observe the standard of care and skill reasonably expected in the circumstances. I believe that [Dr B] observed a level of standard of care and skill reasonably to be expected of a competent New Zealand general practitioner."

Ministry of Health's *Elective Services Guidelines* for dermatology

Elective Services

DERMATOLOGY

NAEVI - PIGMENTED NAEVI

CATEGORY DEFINITIONS
These are recommended guidelines for health professionals referring patients for assessments / treatment in a HHS.

	SEMI-URGENT	
within 1 week	within 4 weeks	within 16 weeks

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

Evaluation	Management Options	Referral Guidelines
Use the ABCD criteria.	As a general principle: Melanomas and skin cancers are rare in prepubertal children so very few naevi need to be removed in children. Changing naevi should be either reviewed in one month, referred or excised. Excision of naevi should be with a narrow margin, must be sent for histology and should only be done within the operator's skill level.	Changing naevi particularly in a patient with a family or personal history of melanoma, patients with multiple atypical naevi (greater than 7 mm in size, red or tan colored, variable shape and border), and in cases of diagnostic doubt **Category 2** SEMI-URGENT

Other References:

Differential Diagnosis in Dermatology. Richard Ashton & Barbara Leppard. Radcliffe Medical Press. 1990

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Elective Services

HEALTH

DERMATOLOGY - DESKTOP VERSION

PIGMENTED NAEVI

CATEGORY DEFINITIONS
These are recommended guidelines for HHS specialists prioritizing referrals from primary care.

[redacted] within 1 week

SEMI-URGENT within 4 weeks

[redacted] within 8 weeks

Referral Guidelines	Priority, Information Required
• Refer if suspect melanoma	[redacted]
• Refer patients at high risk of melanoma for planning of appropriate surveillance, e.g. large numbers of naevi, atypical naevi.	SEMI-URGENT

PRIMARY CARE MANAGEMENT GUIDELINES – Skin Lesions

DATE & VERSION: 11 February 2003, 17:11.30 **NATIONAL GUIDELINE** **DISTRICT HEALTH BOARD: National**

Skin lesions in this document refer to skin cancers, pigmented lesions, non-healing ulcers and other individual skin lesions.

CLINICAL PROBLEM (Critical Determinants)	ACTIONS	LOCAL IMPLEMENTATION REQUIREMENTS
PIGMENTED LESIONS		
Clinically suspicious of malignancy	Excision biopsy (not incision), full thickness, margins 2mm or greater	Discuss with or refer to Specialist Excise in 1° care if safe
Clinically not malignant	Monitor in 1° care	GP follow up
Seborrhoeic keratosis	Cryotherapy (or excision) only if symptomatic	Rarely justifies public specialist assistance
NON-PIGMENTED LESIONS		
Lesion < 5mm	Excision biopsy	Excise in 1° care if safe. Specialist assistance if beyond GP skill level
5mm or greater and clinically typical of Squamous Cell Carcinoma (SCC) or Basal Cell Carcinoma (BCC) or keratoacanthoma	Excision, full thickness, margins 2mm or greater with careful follow-up to confirm recurrence does not occur	Excise in 1° care if safe. Specialist assistance if beyond GP skill level
Clinically suspicious of malignancy or Bowen's disease	Punch biopsy	Biopsy in 1° care if safe. Specialist assistance if beyond GP skill level
Solar keratosis	Monitor for development of SCC **OR** cryotherapy **OR** 5-FU if numerous	GP follow up Remove in 1° care 5-FU requires "specialist recommendation"
HISTOLOGY KNOWN		
Melanoma	Discuss with or refer to Specialist	
Squamous cell carcinoma - excised with margin 2mm or greater	Monitor in 1° care	Review at 3 and 6 months then annually
Squamous cell carcinoma - excised incompletely or with margin < 2mm	Complete adequate excision	Excise in 1° care if safe. Specialist assistance if beyond GP skill level
Squamous cell carcinoma - with regional nodes	Specialist assistance	Proforma referral
Bowen's Disease	Complete excision or destruction (cautery, cryotherapy) **OR** 5-FU	Removal in 1° care if safe. Specialist assistance if beyond GP skill level. 5-FU requires "specialist recommendation"
Basal Cell Carcinoma - completely excised	Monitor in 1° care	Look for other skin cancers
Basal Cell Carcinoma - incompletely excised	Complete excision **OR** Destruction (curettage and cautery)	Removal in 1° care if safe. Specialist assistance if beyond GP skill level.
Local recurrence	Specialist assistance	Proforma referral
Keratoacanthoma	Complete excision or destruction	Removal in 1° care if safe. Specialist assistance if beyond GP skill level.
MISCELLANEOUS		
Non-healing ulcers	If small, excision biopsy If large, full thickness biopsy of the margin	Biopsy in 1° care if safe. Specialist assistance if beyond GP skill level
Chondrodermatitis nodularis helicis ears	Treat conservatively if small **OR** Specialist assistance for excision	
Pyogenic granuloma	Excision or biopsy then cautery with care to destroy feeding blood vessel	Excise or cautery in 1° care if safe. Specialist assistance if beyond GP skill level
Epidermoid cysts - sebaceous cysts - pilar (tricholemmal) cysts	Treat conservatively if asymptomatic **OR** excise completely	Rarely justifies public specialist assistance
Dermatofibroma	Treat conservatively	Rarely justifies public specialist assistance
Milia	Treat conservatively **OR** (rarely) incise and express intact	Rarely justifies public specialist assistance

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

NOTES:

- Removal of lesions on the eyelids, nose, lips, and ears is often beyond the skill of the average GP
- All excisions, however benign on clinical examination, should be sent for histopathological assessment
- "Specialist assistance" in this document includes Public hospital skin lesion service (which may include accredited GPs) and Plastic/General surgical service. Dermatology service may offer surgery and Ophthalmology service may offer Oculo-plastic surgery. Radiotherapy may be used to treat SCC.
- The Elective Services Dermatology National Referral Guidelines and the Skin Lesions Primary Care Management Guidelines can be found at: www.electiveservices.org.nz

Malignant melanoma Most develop de novo, 25% arise in an existing mole. Have a high index of suspicion for any mole that has changed or any new pigmented lesion (that is not clinically a seborrhoeic keratosis).

Clinically suspicious features of malignancy in a pigmented lesion include:
Asymmetry
Border - irregularity or smudging of pigment over the border
Colour variation - several different colours or increase depth of pigment within the lesion
Diameter - any pigmented lesion with **size > 1cm** or any mole that is growing
Increasing size
Any bleeding or crusting (if not clinically a seborrhoeic keratosis)

Seborrhoeic keratosis Otherwise known as senile wart occurs anywhere on the body in people aged over 40 years. It starts as a pale yellow or brownish macule with a slightly greasy feel. With time it often becomes dark or even black, with a warty, sometimes dimpled surface (like a cauliflower). It appears to be stuck on the skin rather than arising in it. Occasionally they can be pedunculated. They never become malignant so they are removed only for cosmetic reasons or because y catch on clothing.

Squamous Cell Carcinoma (SCC) Early changes can show a flat scaly erythematous macule. This usually demonstrates reasonably rapid growth resulting in a nodule that may bleed earlier than a BCC. Often tender, this nodule usually has an eroded or heaped up cauliflower appearance. It can present as an ulcer with everted edges. Generally SCCs arise in sun exposed sites, common on the lip and back of the hand. SCC metastasise in 2-3% of patients, and this is more likely if on the lips or ears.

Solar Keratosis Solar, actinic or senile keratoses arise on skin exposed to sunshine. The lesions are superficial scaly roughenings of the skin, often more easily felt than seen. They are found mainly on the face, bald scalp and the back of the hands and wrists. A small percentage may progress to SCC.

Basal Cell Carcinoma (BCC) Early: Small smooth papule, which over months enlarges to a rounded lesion with pearly nodules in a rolled edge over which dilated blood vessels course. The pearly edge is best seen when the skin is stretched. Sometimes there will be an ulcer and the central scab/crust will need to be removed to reveal the characteristic pearly edge. Rarely tender. Generally slow growing and develop over months to years. BCC can be locally invasive but rarely metastasise

Kerato-acanthoma This lesion is on the borderline between hyperplasia and neoplasia. Considered to be a self-limiting form of SCC. Generally it shows rapid enlargement for about 2 months, often reaching 1-2 cm in diameter. It remains static for a further 2 months, then over a similar period involutes often leaving a somewhat unsightly pitted scar. At its maximum it is a dome-shaped yellowish nodule with a rounded edge across which blood vessels course and a central keratinous plug which can look like a crater. If this plug is removed it reveals more keratin; this helps to distinguish it from a BCC. The speed of growth is much more rapid than that of a SCC.

Clinical features of malignancy in non-pigmented lesions are any new lesion or a lesion increasing in size; a heaped up or rolled edge; a pearly appearance when stretched; dilated blood vessels on the surface of a nodule; ulceration in an existing lesion or chronic nonhealing ulcer with everted edges. SCC generally are e rapidly growing than BCC. Ulceration or bleeding may occur early in SCCs. SCC are often tender. BCC are rarely tender.

Bowen's Disease This is intra-epidermal carcinoma in-situ (SCC in-situ). Usually presents in those aged over 50 years, more commonly in women. It can occur anywhere on the body (not just on sun exposed skin). It is often itchy or erythematous plaques and may resemble solar/actinic keratosis or a patch of psoriasis or eczema that has been present for many years and may steadily enlarge. The edge is well defined and usually irregular.

Chondro-dermatitis Nodularis Helicis Also known as Winkler's disease, this is an inflammatory condition caused by degeneration of cartilage. It characteristically presents as an exquisitely tender nodule on the top of the pinna. It can often be painful to lie on and unless the patient can find another comfortable sleeping position may need excision. Can be confused with a SCC. While it can be treated conservatively by cortisone injection this generally only provides short-term relief.

Pyogenic Granuloma This is a misnomer as it is in fact a capillary haemangioma, which grows rapidly, distends and then usually ruptures the overlying skin. This leaves a naked mass of delicate blood vessels, which bleed copiously with minimal trauma.

Epidermoid Cysts Commonly known as sebaceous cyst and occurring anywhere on the body, it is a firm, slightly soft swelling with a central punctum. The cheesy material it contains is keratin not sebum. Similar to this, usually found on the scalp, is a pilar (or tricholemmal) cyst, which arises from the hair follicle but is without the central punctum.

Dermatofibroma Is most common on exposed parts of the limb in women but can occur anywhere on the body and in men. It is a fibrous nodule that looks and feels like a lentil in the skin. It can often be larger than 5mm.

Milia These are pinhead sized glistening white epidermoid cysts most commonly seen on the upper cheeks and around the eyes in young adults, especially females. They are best treated by using a sterile hypodermic needle to incise the overlying skin, and can usually be expressed intact.

REFERENCES:

- *Parkin DM, Whelan SL, Ferlay J, Raymond L and Young J, eds (1997). Cancer incidence in five continents. Vol VII (IARC Pulications No 143), Lyon, IARC*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

...man RJ, Rigel DS, Kopf AW, et al. Cancer of the skin. Philadelphia: Saunders, 1991

Roberts DL, Anstey AV, Barlow RJ et al. UK guidelines for the management of cutaneous melanoma. Br J Dermatol 2002;146(1):7-17

This management guideline has been prepared to provide general guidance with respect to a specific clinical condition. It should be used only as an aid for clinical decision making and in conjunction with other information available. The material has been assembled by a group of primary care practitioners and specialists in the field. Where evidence based information is available, it has been utilised by the group. In the absence of evidence based information, the guideline consists of a consensus view of current, generally accepted clinical practice.

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New Zealand Guidelines for the Management of Malignant Melanoma

New Zealand Guidelines for the Management of Malignant Melanoma

DISCUSSION DOCUMENT FOR THOSE CARING FOR PATIENTS WITH MELANOMA

These guidelines do not necessarily represent current management by all practitioners.

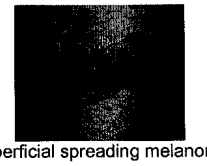
Please send written comments to :

Dr M Rademaker, Consultant Dermatologist,
Health Waikato, Private Bag 3200, Hamilton New Zealand

or e.mail at:rademaker@xtra.co.nz.

Amelanotic melanoma

Nodular melanoma on back



Superficial spreading melanoma

Initial diagnosis
If a pigmented lesion is thought to be a malignant melanoma or there is a high index of suspicion (use the ABCD criteria - Asymmetry, Border, Colour, Diameter) the lesion should either be removed by the general practitioner if he / she feels they are technically competent to do so or the patient should be referred to an appropriate specialist (eg. Dermatologist, Plastic Surgeon, General Surgeon, etc).

Symptoms at first diagnosis

Symptoms	Percent of cases

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Change in size	30.4%
Change in colour	25.7%
Change in elevation	14.7%
Bleeding	9%
Itching	4.2%
Unspecified symptoms	7.5%
One or more symptoms	50.2%

Initial treatment
Excision biopsy is the only recommended initial treatment for melanoma. Excise with a visual clear margin of 2-5 mm. Do not undermine the edge. If you feel that primary closure will not be possible, consider referring the patient to a plastic surgeon, dermatologist or general surgeon. Curettage and diathermy is not acceptable. All lesions removed from the skin must be examined by a histopathologist - it is negligent not to do so.

Histopathology reporting
Every specimen must be sent for examination. The pathologist's report will include the following details: macroscopic description of lesion, diagnosis, depth of invasion in millimeters (Breslow thickness), and width of margins (lateral and deep). The following may also be included in the report: ulceration, regression, satellitosis, lymphatic invasion, radial versus vertical growth phase.

It is a legal requirement to report cases to the National Cancer Registry.

Age of presentation of melanoma

Age	Number of melanomas
<10 years	Very rare
10 to 19 years	0.8%
20 to 39 years	20.7%
40 to 59 years	31.9%
60 to 79 years	38.0%
>80 years	7.6%

Definitive treatment
Definitive treatment for melanoma is determined by the depth of the lesion. A working guide to adequate treatment is a margin of 1 cm for every 1 mm depth of invasion.

Melanoma in situ or < 0.7 mm - the initial excision may be sufficient but it is recommended that the patient be referred to a dermatologist, plastic surgeon or surgeon with a particular interest, for review (patients should be seen within 3 weeks of referral if possible).

Melanoma 0.7 - 1.4 mm - a re-excision of the wound with a 1 cm margin and direct closure is currently recommended. This should be down to deep fat but should not routinely include fascia. This re-excision is probably best performed by a dermatosurgeon, plastic surgeon or surgeon with a particular interest, and should be done within 6 weeks of the initial excision if possible.

Melanoma >1.4 mm - a re-excision of the wound with up to a 3 cm margin and direct closure if possible is recommended. Again this should be down to deep fat but should not routinely include fascia. A skin graft may be necessary in some areas of the body. This re-excision is best performed by a dermatosurgeon, plastic surgeon or surgeon with a particular interest, and should be done within 6 weeks of the initial excision if possible.

Lymph nodes - unless clinically indicated, there is no evidence that routine regional lymph node dissection is of value.

Definitive management of subungual melanomas, melanomas on digits and on the face is best determined on an individual basis. It is recommended that these patients be referred to a dermatologist, plastic surgeon or surgeon with a particular interest in melanoma.

Advanced melanoma with secondaries is best dealt with by a combined oncology / plastic surgery / dermatology clinic.

Prognosis of melanoma

Depth of invasion	10 year survival rate
in situ	100%
<0.85 mm	95.7%
0.85 - 1.69 mm	87.1%
1.70 - 3.59 mm	66.5%
>3.60 mm	46.0%

Follow-up
It is unclear as to how long patients with melanoma should be followed up and even what the value of follow-up is. The current recommendation is as follows:

Depth	Follow-up intervals	Length of time
in situ	3/12	1 year
<1.4 mm	3/12 then 6/12	18 mths to the 3rd anniversary
>1.4 mm	3/12 then 6/12	18 mths to the 5th anniversary

What should be done at follow-up

Examine:

- For local recurrence.
- For satellite lesions (between primary site and regional lymph nodes).
- All regional lymph nodes.
- Rest of skin for new primary melanomas (occurs in 8%).

Advice:

- Sun protection advice.
- Encourage monthly self examination.

Routine investigations:
None unless clinically indicated. (eg. X-ray, blood tests)

Who should follow up the patient
All patients should probably be seen at least once by a specialist with an interest in melanoma (eg... dermatologist, plastic surgeon or general surgeon).

Melanoma in situ - after initial review by specialist follow-up should be by the general practitioner if he/she is happy to do so using set protocols.

Melanoma <1.4 mm - after definitive treatment, the specialist will enquire from the GP if they wish to be involved in shared care (eg. alternate visits) or take over the whole of the follow-up.

Melanoma >1.4 mm - after definitive treatment the specialist will follow up unless the GP arranges otherwise with the specialist.

Examination of 1st degree relatives
Following the diagnosis of melanoma the skin of first degree relatives of the patients should be examined for atypical naevi (funny moles) and melanoma. These relatives should be counselled about melanoma and sun protection. How frequently these patients should be reviewed is unclear and depends on risk factors (see guidelines on the management of atypical naevi). Patients must be encouraged to perform monthly self

examinations.

Atypical (funny) naevi
Early diagnosis of melanoma in this high risk group is possible. A degree of risk evaluation can be made using the following table:

Risk group: Atypical mole-FH atypical mole-PH melanoma-FH melanoma
A----------+
B----------+----------+
C----------+----------+----------+
D----------+----------+----------+----------+

Risk group Action

A - Counsel regarding sun protection; should be encouraged to perform monthly self examination of skin.

B - Counsel regarding sun protection; should be encouraged to perform monthly self examination of skin. Opportunistic skin checks by the GP (i.e. when coming to GP for other reasons).

C - Should be seen at a specialist clinic to have baseline colour photographs taken. Possible review in 3-6 months by specialist but then opportunistic skin checks by the GP (i.e. when coming to GP for other reasons).

D - Should be followed up in a specialist clinic with colour photographs every 3 to 12 months for an undetermined period of time (50% likelihood of developing further melanoma).

Related information

- NIWA Lauder - Discussion of Ultraviolet and Ozone levels in NZ.
- Management of cutaneous melanoma - U.K. guidelines

References:
The public health approach to melanoma control. Prevention and early detection Ed Marks R, Hill D. International Union Against Cancer 1992

Diagnosis and treatment of early melanoma. NIH consensus development panel on early melanoma. *JAMA* 268: 1314-1319

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