

# Skin cancer medicine integral to Australian general practice

**Stephen A Margolis**

*Details make perfection, and perfection is not a detail.*

– Leonardo da Vinci

Skin cancer medicine is a core component of Australian general practice and is consistently in the top 10 conditions managed.<sup>1</sup> This is not surprising as Australia has the highest incidence of melanoma in the world,<sup>2</sup> leaving melanoma the fourth most common cancer in Australia, especially in non-metropolitan locations.<sup>3</sup> Across the 20-year period 1995–2014, melanoma incidence in Queensland remained the highest recorded in the world (age-standardised incidence of invasive melanoma 572 per 100,000/annum [2010–2014]).<sup>4</sup>

Widespread public information campaigns have been effective; currently, approximately half of all new diagnoses of melanoma are initially noticed by the patient, who then approaches their clinician, usually their general practitioner (GP), for advice.<sup>5</sup> This is leading to earlier detection, known to improve survival, with the incidence of in situ melanoma rising while the incidence of invasive melanoma is stable or falling in patients aged under 60 years.<sup>4</sup> The management of melanoma continues to evolve, with the latest changes for both cutaneous and metastatic melanoma explored by Dixon et al.<sup>6,7</sup>

GPs are well positioned to play a key part in skin cancer medicine, with diagnostic acumen of similar high sensitivity and accuracy to formal skin cancer doctors.<sup>8</sup> Overall management of skin cancer in general practice is of similar quality and effectiveness to that provided by skin cancer clinic networks.<sup>9</sup> Similarly, despite patients with cutaneous melanoma having a high risk of recurrence and hence requiring careful follow-up, GP-led

follow-up for melanoma has been shown to be as effective as hospital-based care.<sup>10</sup>

What is perhaps unusual about skin cancer medicine when compared with other aspects of general practice is the type of skill required to perform diagnosis. Although the history is important, the action plan is primarily determined by carefully considering the fine details of the appearance of the individual lesion, perhaps enhanced by viewing through a dermatoscope. In addition, the formal diagnosis requires a surgical intervention rather than sending the patient to another service for imaging or pathology testing. Note that clinically suspicious pigmented lesions require excision rather than limited biopsy, as explained by Adybeik et al.<sup>11</sup>

As such, skin cancer diagnosis and management would perhaps appear more intensive in time, observation, physical dexterity skills and attention to detail than other areas of clinical practice. Some of the required skills are generic and learned across the spectrum of clinical medicine, while others are unique to skin cancer medicine. The latter are perhaps best formalised as having both a structured approach to what you see plus a high level of attention to detail.

As with most areas of clinical practice, findings can be divided into three groups: clearly normal/benign lesions, clearly abnormal/malignant lesions and lesions for which provenance is uncertain. The breadth of the third group will narrow with the GP's training and experience, while the disposition of the patient will be either excision for definitive pathological diagnosis or referral to someone with additional skills. For example, Clarke explains, 'If there is significant doubt about a seborrhoeic keratosis, the lesion should be biopsied or carefully reassessed in eight weeks, or the patient sent for a second opinion'.<sup>12</sup>

With Australia the epicenter for melanoma and general practice a key port

of call for patients who are worried about pigmented spots on their skin, GPs are ideally positioned for their pivotal role in diagnosis and management.

## Author

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