FOLLOW-UP EXAMINATION AFTER DIAGNOSIS AND TREATMENT OF SKIN CANCERS

Disease State: Cancer

Indicator Classification: Disease Management

Strength of Recommendation: B

Organizations Providing Recommendation:
- American Academy of Dermatology
- British Association of Dermatologists
- British Association of Plastic Surgeons
- Melanoma Study Group
- National Cancer Institute
- National Comprehensive Cancer Network

Clinical Intent: To ensure that all members who have been diagnosed with skin cancer receive the appropriate follow up at least annually.

Physician Specialties (suggested): Refer to PQSR 2009 Clinical Measures by Specialty.

Disease Burden:
- The American Cancer Society estimates that 61,290 people will be newly diagnosed with melanoma in 2006, making melanoma the fifth and sixth most common cancer among men and women, respectively. In addition, more than 1 million cases of cutaneous basal cell or squamous cell cancers occur yearly.
- Approximately 10,710 people will die from skin cancer in 2006, and it is estimated that 7,910 of those deaths will be from melanoma.
- Melanoma is a leading cause of cancer death in the United States. The lifetime risk for dying of melanoma is 0.36 percent in white men and 0.21 percent in white women.
- Men older than age 65 account for 22 percent of the newly diagnosed cases of malignant melanoma each year and women in the same age group account for 14 percent. While basal cell and squamous cell carcinomas are more than 10 times as common as melanoma they account for less morbidity and mortality. Squamous cell cancers, are responsible for 20 percent of all deaths from skin cancer.

Reason for Indicated Intervention or Treatment:
- Surveys of cancer and melanoma registries demonstrate that patients diagnosed with cutaneous melanoma have a 0.5-5.5% incidence of developing a second primary melanoma after the initial diagnosis [3-9], a risk that is 10-25 times greater than for
patients without a history of melanoma.[4, 5] Rates of recurrence are approximately 20%.[10-12]

- The greatest risk of developing a new or recurrent melanoma is in the first or second year after the initial diagnosis.[12-15]
- Patients with cutaneous squamous cell or basal cell carcinomas have at least a 10-fold increase in incidence of developing a subsequent cancer of the same type [16], and almost 50% of patients treated for squamous or basal cell carcinoma have another skin cancer within 5 years.[17-19]
- Approximately 95% of the recurrences and metastases of cutaneous squamous cell carcinoma occur during the first five years after treatment.[20]

Evidence supporting Intervention or Treatment

- Studies are mixed on whether patients or physicians detect more new or recurrent melanomas at follow-up. While some studies show that patients detect recurrences more frequently than their physicians (47-72%) [10-12], others indicate that physicians have a higher rate of detection.[12, 21]
- A prospective intervention study of 9000 patients diagnosed with melanoma from 1971 to 1999 showed that careful patient follow-up (biannually for the first five years and annually thereafter) allowed for earlier diagnosis of a second primary melanoma, since the tumor stage for the second melanoma was significantly lower than for the first.[22]
- However, one audit of 331 melanoma patients with recurrences indicated that even though physicians detected recurrences at earlier stages than patients, no changes in survival were seen between the two groups.[11]
- Cancers diagnosed at earlier stages are more likely to be curable, and the evidence suggests that follow-up of patients with skin cancer may be important in detecting new and recurrent cancers. Unfortunately, no studies directly examine the relationship between follow-up intervals for melanoma [12-14], squamous cell carcinoma, or basal cell carcinoma and patient outcomes.

Clinical Recommendation

- The American Academy of Dermatology (AAD), based on recommendations from a task force of recognized experts, recognizes that there is no evidence to support a specific follow-up interval for patients with primary cutaneous melanoma. However, the AAD recommends routine interval follow-up physical examinations at least annually.[23]
- The Melanoma Study Group and the British Association of Dermatologists recommend 3-month visits for 3 years for all patients with invasive melanoma. Thereafter, those with melanomas greater than 1.0 mm in depth should be followed every 6 months for another 2 years, while those with melanomas
less than 1.0 mm in depth do not require further follow-up. Patients with in situ melanoma need only one follow-up after complete excision of the primary lesion.[10, 24]

- For squamous cell carcinoma, the British Association of Dermatologists, the British Association of Plastic Surgeons and the Faculty of the Clinical Oncology of the royal College of Radiologists recommend that patients be kept under observation for 5 years by a specialist, primary care physician or patient self-examination.[25]
- The American Academy of Dermatology recommends either annual or biannual screening for all patients with a history of nonmelanoma skin cancers.[26]
- The National Cancer Institute recommended that individuals with basal cell carcinoma be clinically examined every 6 months for 5 years. Thereafter, patients should be examined for recurrent tumors or new primary tumors at yearly intervals. In addition, since squamous cell carcinomas have significant potential for metastasis, patients should be re-examined every 3 months for the first several years and then followed indefinitely at 6-month intervals.[27]
- NCCN Practice Guidelines in Oncology state that individuals with a diagnosis of melanoma or non-melanoma skin cancer (e.g., basal cell carcinoma or squamous cell carcinoma) should be clinically examined at least yearly for life.[28]
- The American Society of Plastic Surgeons recommends a follow-up physical exam including full skin assessment and lymph node palpation every 3 months for the first year, then every 6 months for 5 years, and then yearly thereafter (Level of Recommendation: B).[29]

Source
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<tr>
<th>Denominator</th>
<th>Definition</th>
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<tr>
<td>Denominator</td>
<td>Continuously enrolled members ages 19-91 years by the end of the measurement year, who had a skin biopsy followed by a diagnosis of skin cancer during the year prior to the measurement year.</td>
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<th>Denominator Exclusion</th>
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<td>Denominator Exclusion</td>
<td>Members with a diagnosis of malignant neoplasm of the vagina, labia majora, labia minora, vulva unspecified, prepuce, skin of the breast, any carcinoma in situ of breast and genitourinary system, or neoplasm of bone, soft tissue, or skin during the 0-365 days after the index date.</td>
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<th>Numerator</th>
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<td>Numerator</td>
<td>Members who had at least 1 follow-up visit or a procedure removing a benign or pre-malignant skin lesion within 90-365 days after the index date.</td>
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Physician Attribution

Physician Attribution Description

References

1. American Cancer Society, Cancer Facts and Figures 2006. 2006, American Cancer Society: Atlanta, GA.

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