The Royal Australian College of General Practitioners

RACGP Submission to House of Representatives Standing Committee on Health Inquiry into Skin Cancer in Australia

RACGP details

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1. About RACGP

The RACGP is the specialty medical college for general practice in Australia, responsible for defining the nature of the discipline, setting the standards and curriculum for education and training, maintaining the standards for quality clinical practice, and supporting general practitioners in their pursuit of excellence in patient care and community service.

2. Introduction

The incidence of skin cancer is vast, particularly for non-melanocytic skin cancers (NMSCs), which include squamous cell carcinoma (SCC) and basal cell carcinoma (BCC). Only a very tiny proportion of NMSCs cause death (and usually only when there are co-morbidities such as immunosuppression from organ transplantation, or psychiatric neglect).

Melanoma is the most serious form of skin cancer. It has a much higher death rate, comparable to solid organ cancers. Early detection before it has metastasised may provide the best opportunity for a favourable outcome. However screening for melanoma has never been tested in randomised trials.

3. Role of general practice

More than 125 million general practice consultations take place annually in Australia and 83% of the Australian population consult a general practitioner (GP) at least once a year[i].

The GP is the doctor of first contact and has an ongoing relationship with his/her patients and is therefore key to early diagnosis and treatment of skin cancer.

Prevention
Preventive healthcare is an important activity in general practice. To support GPs in delivering evidence based preventive care, the RACGP produces its *Guidelines for preventive activities in general practice (the red book).* The 8th edition was published in 2012.

The *Slip Slap Slop* message of the last few decades (primary prevention) may have contributed to the reduced increases in melanoma rates, reflected in the plateauing of numbers in the late 90s. Prevention of sunburn and excess UV exposure may reduce the incidence of both melanoma and NMSC. GPs continue to play an important role educating the public and encourage 'sun-smart' primary prevention. In addition to primary prevention in the general population, the RACGP's red book also recommends GPs provide education that raises awareness of early detection of skin cancer.

General population screening for skin cancer -- the examination of asymptomatic people in order to classify them as likely or unlikely to have a disease -- is not recommended because of the lack of evidence that this reduces deaths or morbidity. Screening is only recommended for those at higher risk of developing skin cancer.

GPs are advised to assess people opportunistically or when the patient is concerned about skin lesions or their skin cancer risk and plan appropriate strategies for their level of risk. Patients are generally encouraged to become familiar with their skin, including skin not normally exposed to the sun, and be alert for new or changing skin lesions, particularly people aged over 40 years.

For those at increased risk (family history, fair complexion, past history, high childhood UV exposure etc) opportunistic examination of the skin is recommended. For those at high risk (those with multiple atypical or dysplastic naevi and who have a history of melanoma in themselves or in a first-degree relative) examination of the skin and advice on self examination is recommended.

Diagnosis and treatment
Australian GPs diagnose the vast majority of skin cancer[ii]. Non melanoma skin cancers are managed at one in 100 general practice encounters, suggesting about 1.2 million NMSC patient-doctor encounters nationally [iii].

GPs are competent at diagnosing and treating the vast majority of these lesions[iv]. Treatment options include topical preparations, cryotherapy (using liquid nitrogen to rapidly freeze the cancer off), curettage (burning) and excision. Complex cases may be referred on to a specialist.

Improving diagnosis and treatment
There are essentially two potential ways to reduce excisions of benign lesions while keeping good accuracy for diagnosing melanoma – dermoscopy or systematic application of a simple checklist.

Dermatoscopy (which uses a dermatoscope to gain better visualisation of the patterns formed by pigment and blood vessels – critical features in the diagnosis of skin lesions), has been shown to increase diagnostic accuracy for both melanocytic and nonmelanocytic skin malignancies [v]. It is most useful for diagnosing melanoma from other melanocytic lesions (principally melanocytic naevi).

Simple diagnostic tools have also proved to be extremely effective in primary care. Tools such as the ABCDE method and 7 point checklist can give good levels of diagnostic accuracy. They also perform as well as more expensive technologies such as SIAscopy[vi].

4. Challenges and issues

Primary prevention (public health messages) has resulted in better awareness and may have stabilised rates of skin cancer. It is important that these campaigns continue. However, one consequence of their success appears to be declining healthy levels of vitamin D in the population, resulting from lack of sun exposure. Messages need to be tweaked to reassure the public that short periods of exposure maintain overall health.

The absolute death rate for melanoma has been relatively constant for decades now. Yet the incidence is steadily increasingly. This could be because:

a. the increasing incidence of melanoma is being compensated by better management; OR
b. overdiagnosis of indolent melanomas that would have never caused mortality of morbidity.

We do not have enough information to decide which (or proportions of both), and more research might help us understand the scale of this better. The second possibility seems likely with skin cancer clinics proliferating and clinicians taking a conservative approach and adopting to remove suspicious lesions (those that are unusual, new, changing or difficult to diagnose). There is definitely room for improvement in the accuracy of diagnosis and research suggests that clinicians could raise their threshold for excising pigmented lesions[vii]. Reducing rates of overdiagnosis will deliver benefits to patients (avoiding unnecessary treatment) and the taxpayer (the costs of that treatment).

General practice delivers care very effectively and efficiently and certainly just as, if not more, effectively then specialist skin clinics[viii]. The public should not be given the false impression that they will receive better care at these specialist clinics. In general practice, increased use of dermoscopy will most likely result in significant reductions in excision of benign lesions while maintaining high sensitivity for melanoma. However, this technique requires extensive training. Incentivising education and training in dermoscopy is therefore worthy of consideration.

Fundamentally, reducing skin cancer rates requires better prevention, early diagnosis and effective treatment. GPs are well placed to provide preventative care and this needs to be

better supported. GPs should be afforded the time to educate and provide health advice to the general public and perform screening on higher risk groups.

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