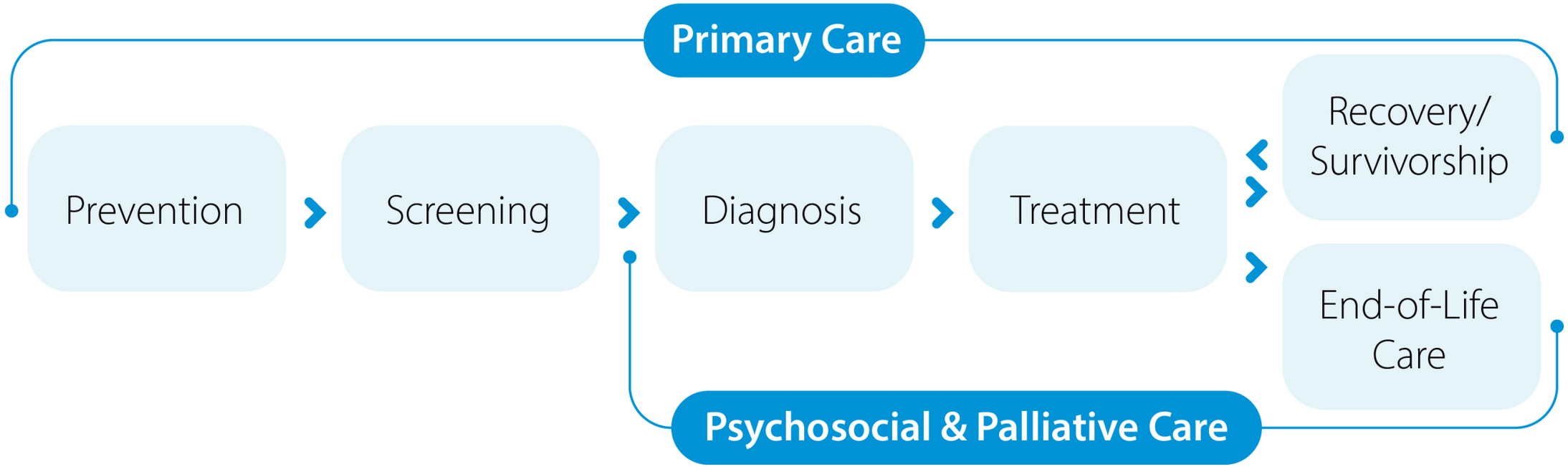
Skin Cancers Pathway Map

Version 2022.10



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Ontario Health
Cancer Care Ontario

Pathway Map Considerations

- Primary care providers play an important role in the cancer journey and should be informed of relevant tests and consultations. Ongoing care with a primary care provider is assumed to be part of the pathway map. For patients who do not have a primary care provider, Health Care Connect is a government resource that helps patients find a doctor or nurse practitioner.
- Throughout the pathway map, a shared decision-making model should be implemented to enable and encourage patients to play an active role in the management of their care. For more information see Person-Centered Care Guideline and EBS #19-2 Provider-Patient Communication.*.
- Hyperlinks are used throughout the pathway map to provide information about relevant CCO tools, resources and guidance documents.
- The term 'healthcare provider', used throughout the pathway map, includes primary care providers and specialists, e.g. family doctors, nurse practitioners, and emergency physicians.
- Complex skin cancers should be seen at either a cancer centre or a Mohs Centre, as appropriate (see Page 3).
- Physicians may work outside of a cancer centre but should participate in multidisciplinary care.
- For more information on Multidisciplinary Cancer Conferences, visit MCC Tools.
- For more information on wait time prioritization, visit Surgery.
- Clinical trials should be considered for all phases of the pathway map.
- Sexual health should be considered throughout the care continuum. Healthcare providers should discuss sexual health with patients before, during and after treatment as part of informed decision-making and symptom management. See Psychosocial Oncology Guidelines Resources.
- Currently, we are not aware of the effect of systemic agents on skin cancer patients' fertility. Healthcare providers should discuss potential effects on fertility with patients and arrange referral to a fertility specialist if appropriate. See Ontario Fertility Program.
- Psychosocial oncology (PSO) is the interprofessional specialty concerned with understanding and treating the social, practical, psychological, emotional, spiritual and functional needs and quality-of-life impact that cancer has on patients and their families. Psychosocial care should be considered an integral and standardized part of cancer care for patients and their families at all stages of the illness trajectory. For more information, visit EBS #19-3.*
- The following should be considered when weighing the treatment options described in this pathway map for patients with potentially life-limiting illness:
  - Palliative care may be of benefit at any stage of the cancer journey, and may enhance other types of care – including restorative or rehabilitative care – or may become the total focus of care.
  - Ongoing discussions regarding goals of care is central to palliative care, and is an important part of the decision-making process. Goals of care discussions include the type, extent and goal of a treatment or care plan, where care will be provided, which health care providers will provide the care, and the patient's overall approach to care.

* **Note:** EBS #19-2 and EBS #19-3 are older than 3 years and are currently listed as 'For Education and Information Purposes'. This means that the recommendations will no longer be maintained but may still be useful for academic or other information purposes.

Pathway Map Legend

Colour Guide

- Primary Care
- Palliative Care
- Pathology
- Surgery
- Radiation Oncology
- Medical Oncology
- Radiology
- Multidisciplinary Cancer Conference (MCC)
- Dermatology
- Psychosocial Oncology (PSO)

Shape Guide

- Intervention
- Decision or assessment point
- Patient (disease) characteristics
- Consultation with specialist
- Exit pathway
- Off-page reference (or)
- Referral (R)

Line Guide

- Required
- Possible

Pathway Map Disclaimer

This pathway map is a resource that provides an overview of the treatment that an individual in the Ontario cancer system may receive.

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The following definitions of **complex skin cancers** and **non-complex skin cancers** have been created based on clinical consensus from Ontario Health (Cancer Care Ontario)'s Skin Cancers Advisory Committee members. These definitions were created after conducting a literature search for classifications of skin cancers. When addressing clinical service organization and delivery of care for patients, the Advisory Committee felt the terms 'complex skin cancers' and 'non-complex skin cancers' best addressed this matter. This Advisory Committee includes clinicians from across the province and a variety of disciplines, including primary care, pathology, radiology, general surgery, plastics, dermatology, surgical oncology, radiation oncology, and medical oncology.

Complex Skin Cancers

General factors applicable to all types of skin cancer

Patient factors:

- Inoperable (patient or tumour factors)
- Initial assessment for skin cancers associated with genetic mutations (example: Gorlin's syndrome)

Tumour factors:

- Node-positive (micro and macro)
- Locally advanced skin cancers (e.g. involving muscle or bone)
- Metastatic
- Subtypes: mucosal melanoma, ocular melanoma
- Cancers that developed in a scar, burn or a site previously treated
- In-transit, satellite disease, or recurrent disease

Treatment factors:

Any patient that needs:

- Surgical treatment including lymph node dissection (modified or radical neck dissection, axillary level 1- 3 dissection, superficial and deep groin dissection), resection of metastatic disease
- A medical oncologist opinion
- A radiation oncologist opinion
- Multidisciplinary care
- Consideration for clinical trials
- Mohs Micrographic surgery at Mohs centre as per Mohs guideline

Patient Indications for Mohs Micrographic Surgery

Complex Skin Cancers, continued

Factors specific to certain types of skin cancer

Melanoma

- See general factors, Stage IIB-IV

Merkel Cell Carcinoma

- All Merkel cell carcinomas

Squamous Cell Carcinoma

- Squamous cell carcinomas that show rapid growth (i.e. within weeks)
- Histologic Features: Any of depth > 6mm, perineural invasion ≥0.1mm, sensory or motor deficits, poorly differentiated, level IV/V invasion (muscle/bone invasion)

Basal Cell Carcinoma

- Basal cell carcinomas that show rapid growth (i.e. within weeks)
- Histologic features: Perineural invasion, sensory or motor deficits, level IV/V invasion (muscle/bone invasion)

Any other skin cancer histology

- Due to their rare occurrence, any skin cancer that is non-melanoma, non-basal cell carcinoma, non-squamous cell carcinoma (i.e. sebaceous carcinoma, adnexal carcinoma, etc.) is considered complex

Considerations for genetic testing

Hereditary cancer testing should be considered in patients with:

- ≥3 invasive melanomas (page 14)
- Melanoma, especially if diagnosed ≤40 years of age and have a family history of melanoma and/or pancreatic cancer (page 14)
- ≥5 basal cell carcinomas <30 years of age or with other features of Gorlin syndrome/Nevoid Basal Cell Carcinoma Syndrome (page 21)
- MMR IHC deficient sebaceous neoplasm/carcinoma (page 11)
- melanomas identified as having germline relevant variants in tumour tissue (e.g. CDKN2A, BAP1) (page 8)

For individuals with a hereditary cancer syndrome associated with an increased risk of skin cancer, a cancer genetics clinic will advise on appropriate management and surveillance recommendations.

Non-Complex Skin Cancers

Melanoma

- Stage IA, IB, IIA cutaneous melanoma

Merkel Cell Carcinoma

- None

Squamous Cell Carcinoma (SCC)

- Any other SCC features not indicated in Complex SCC characteristics

Basal Cell Carcinoma (BCC)

- Any other BCC features not indicated in Complex BCC characteristics

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Screen for psychosocial needs, and assessment and management of symptoms. Click here for more information about symptom assessment and management tools

Prevention

The risk of developing skin cancer can be reduced by avoiding the use of indoor tanning devices. **EBS #8-8**

Before planning outdoor activities, check the UV (ultraviolet) Index forecast for your region. When the UV Index is 3 or more, or when UV rays may be intensified by reflecting off water, snow or ice, it's important to follow the 5 key sun safety strategies:

Seek shade.
Slip on protective clothing.
Slap on a hat.
Slop on sunscreen.
Slide on sunglasses.

Click here for more information about what you can do to protect yourself

Visit to healthcare provider

Suspicious skin lesion physical characteristics:
Asymmetry
Irregular border
Multicolour or colour change
Diameter >6mm
Ulcerated
Rapidly growing
Non-healing, bleeding, or painful skin lesion
Shiny or "pearly" skin nodule

Additional characteristics:
Immunosuppressed
Skin cancers associated with genetic mutations
Family history of skin cancers
Personal/past history of skin cancer

Complete removal of skin lesion by primary care provider preferred[1]
Pigmented and rapidly growing skin lesions within 2 weeks, non-pigmented skin lesions within 4 weeks.

If the primary care provider does not have biopsy capability, one of the following can biopsy the skin lesion:

- General Surgeon
- Plastic Surgeon
- Dermatology
- H&N/ENT
- Ophthalmic
- Plastic Surgeon

Pathology[2,3]
Results within 14 days

Results

- **Benign** → **Follow up as appropriate with primary care provider or specialist**
- **Merkel Cell Carcinoma** → **Proceed to Page 5**
- **Melanoma** → **Proceed to Page 6**
- **Basal Cell Carcinoma** → **Proceed to Page 8**
- **Squamous Cell Carcinoma** → **Proceed to Page 9**

[1] Biopsy can include punch biopsy, excisional biopsy, shave biopsy or incisional biopsy. For a pigmented lesion, the depth of the biopsy should be at least to deep dermis or subcutaneous tissue to ensure adequate sampling and depth assessment.
[2] If >4mm and/or node positive, send specimen for molecular testing.
[3] The Ontario Health (Cancer Care Ontario) pathology post-surgical turn-around time indicator targets 85% within 14 days.

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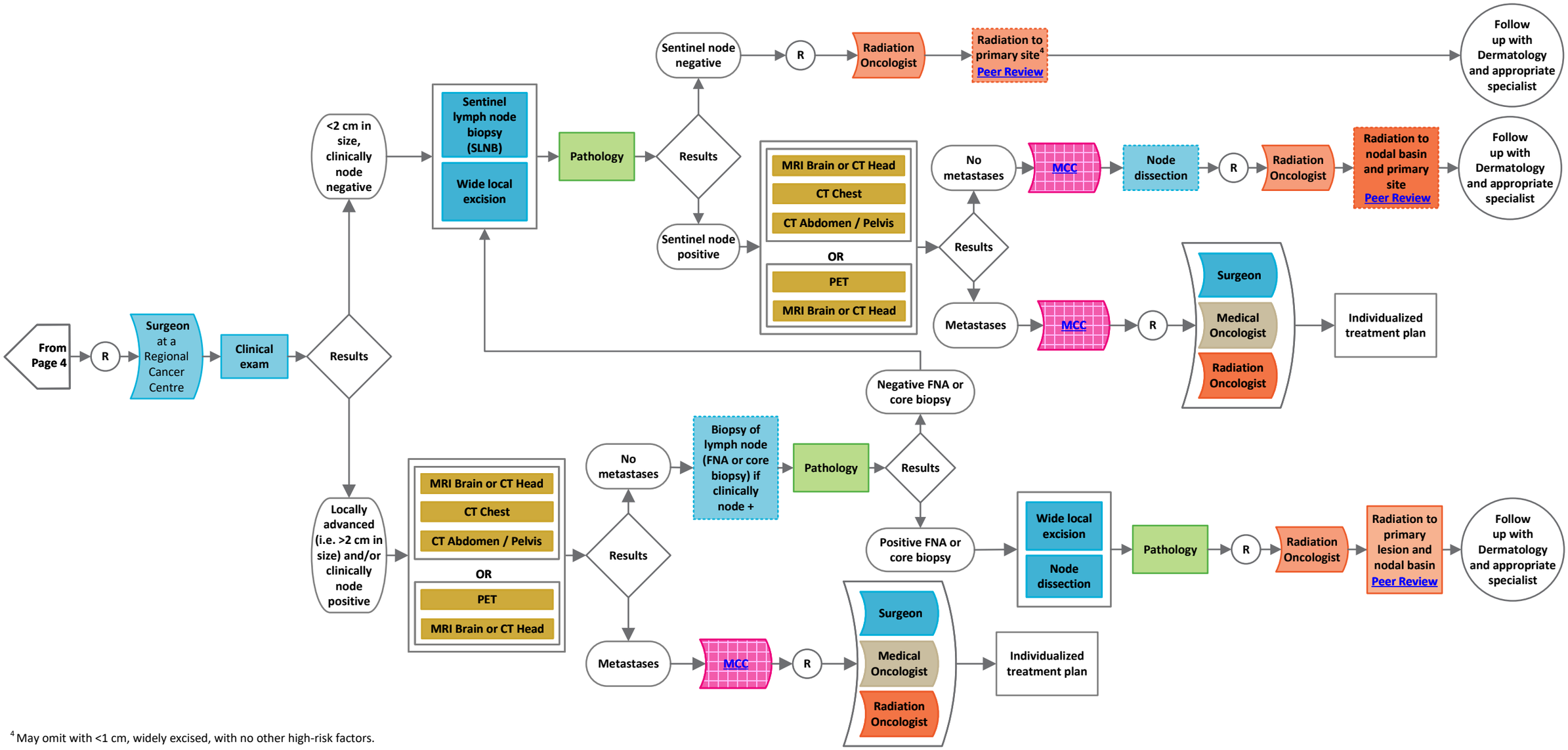

[4] May omit with <1 cm, widely excised, with no other high-risk factors.

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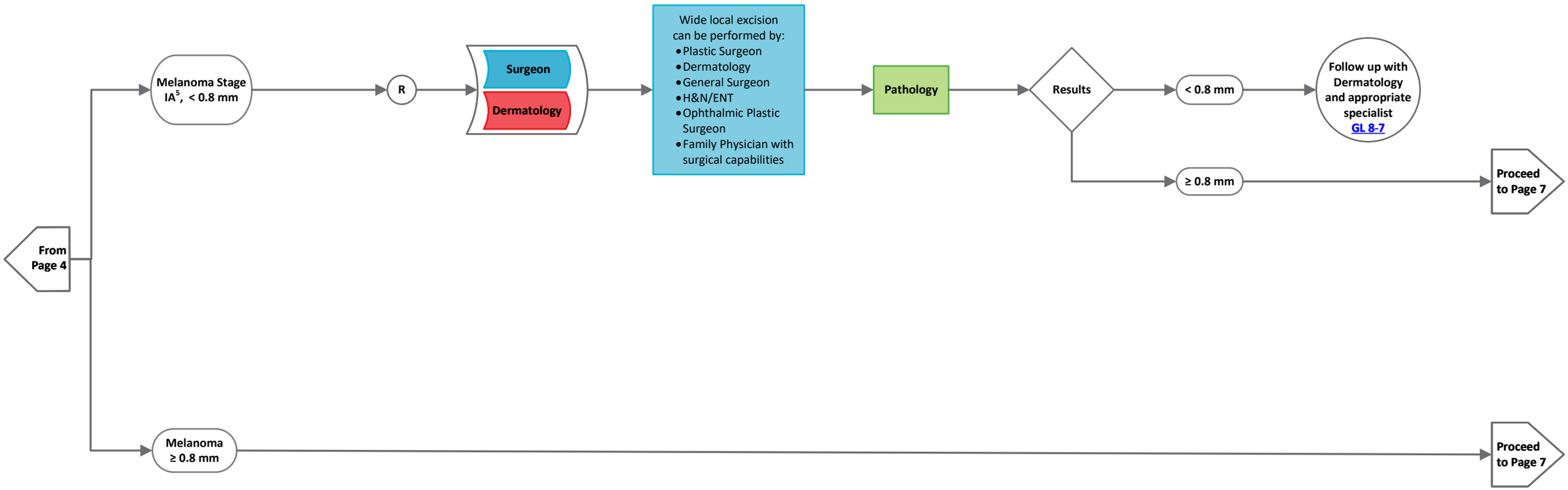

[5] <0.8mm and ulcerated or multiple mitoses may require a referral and assessment by a surgeon for sentinel lymph node biopsy.

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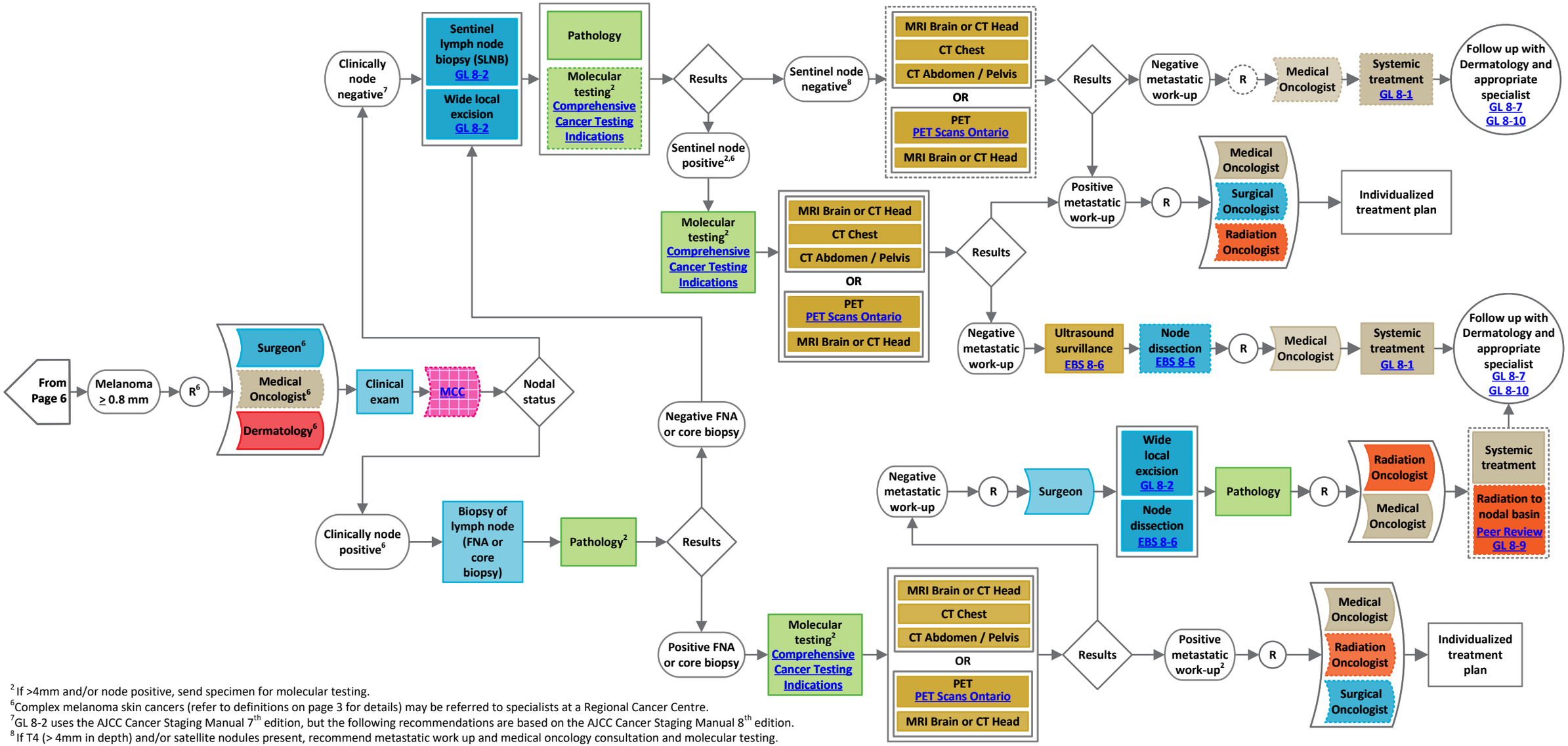

[2] If >4mm and/or node positive, send specimen for molecular testing.
[6] Complex melanoma skin cancers (refer to definitions on page 3 for details) may be referred to specialists at a Regional Cancer Centre.
[7] GL 8-2 uses the AJCC Cancer Staging Manual 7th edition, but the following recommendations are based on the AJCC Cancer Staging Manual 8th edition.
[8] If T4 (> 4mm in depth) and/or satellite nodules present, recommend metastatic work up and medical oncology consultation and molecular testing.

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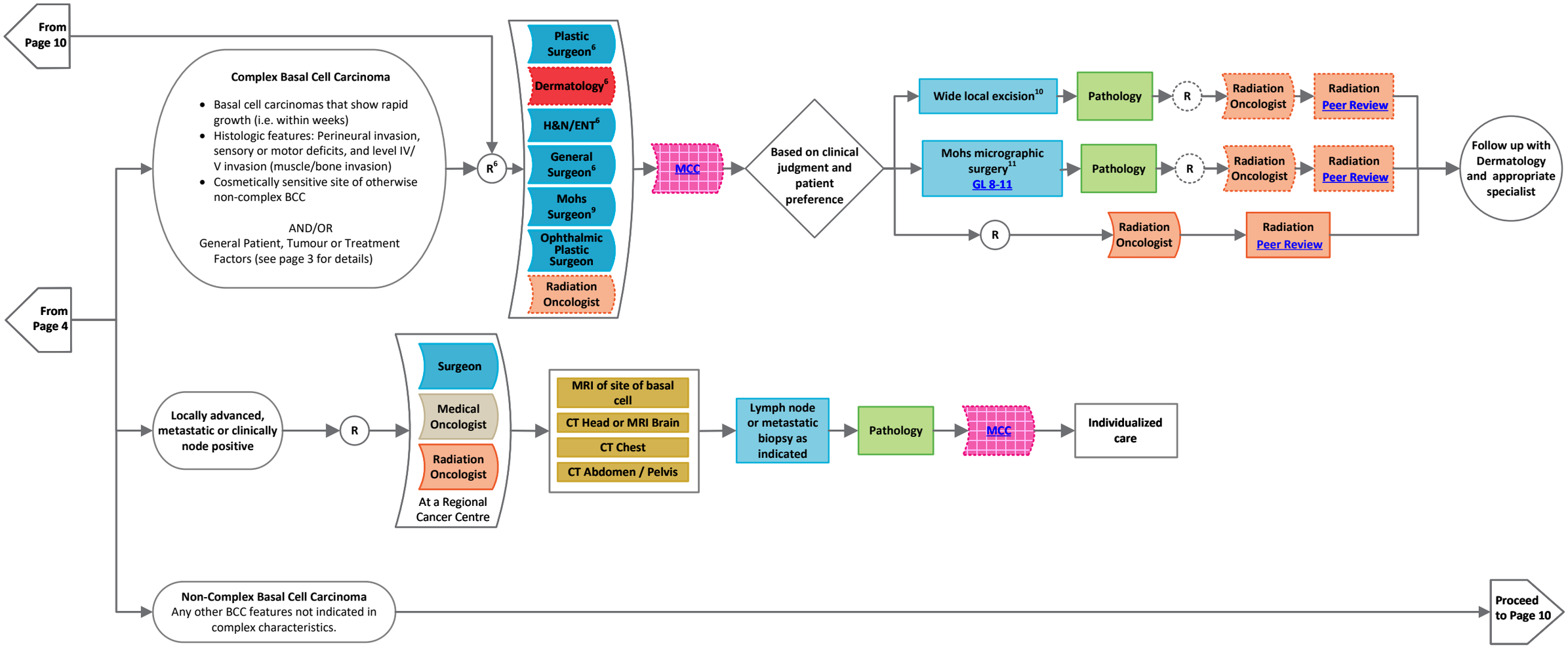

[6] Complex Basal Cell Carcinomas (refer to definitions on page 3 for details) may be referred to specialists at a Regional Cancer Centre.
[9] Complex BCC or SCC (refer to definitions on page 3 for details) may be referred to specialists at a Regional Cancer Centre or a Mohs centre if eligible for Mohs surgery. **Patient Indications for Mohs Micrographic Surgery**
[10] If positive margin, patient should be considered complex and potentially sent to Regional Cancer Centre or Mohs centre.
[11] Indications for Mohs micrographic surgery: histologically confirmed recurrent BCC of face, primary BCC of face >1cm, aggressive histology or location on the H zone of the face. Mohs surgery is recommended for SCC in some cases (as per guideline).

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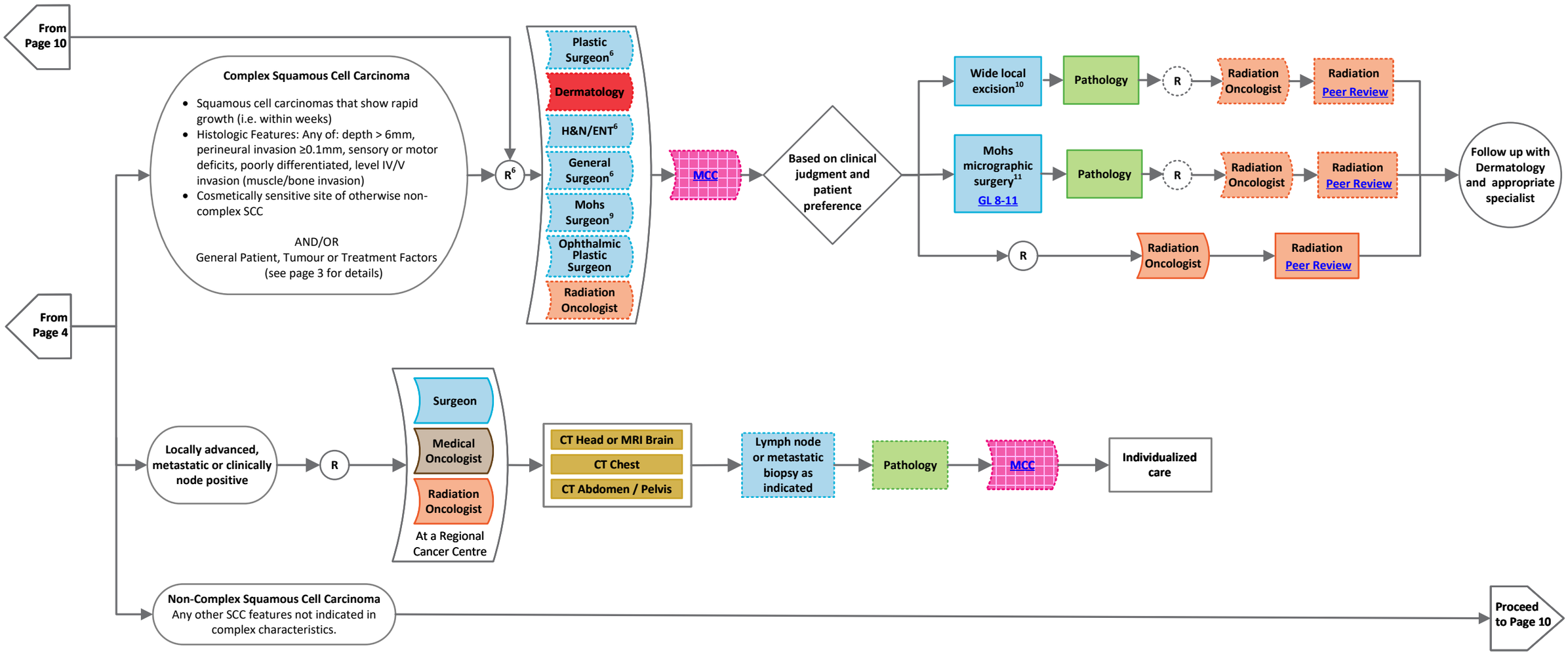

[6] Complex squamous cell skin cancers (refer to definitions on page 3 for details) may be referred to specialists at a Regional Cancer Centre.
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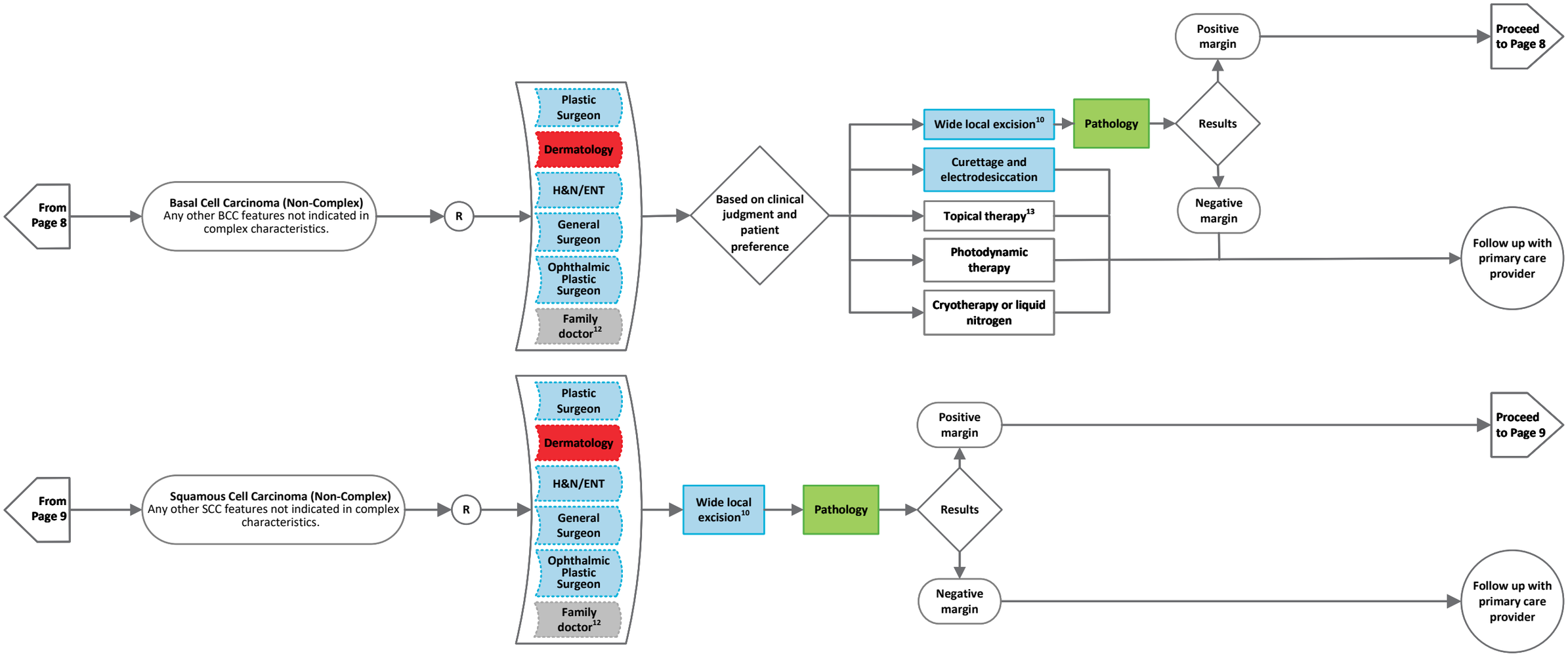

[10] If positive margin, patient should be considered complex and potentially sent to Regional Cancer Centre or Mohs centre.
[12] With special interest in surgical procedures.
[13] Superficial tumours only.

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Pathway Map Target Population:

Individuals with cancer approaching the last 3 months of life and their families.

While this section of the pathway is focused on the care delivered at the end of life, palliative care should be initiated much earlier in the illness trajectory. In particular, providers can introduce a palliative approach to care as early as the time of diagnosis.

Triggers that suggest patients are nearing the last few months and weeks of life

- ECOG/Patient-ECOG/PRFS = 4
  OR
- PPS ≤ 50
- Declining performance status/ functional ability

Screen, Assess, Plan, Manage and Follow-Up

+

End of Life Care planning and implementation
Collaboration and consultation between specialist-level care teams and primary care teams

+

Conversations to determine where care should be provided, and who will be responsible for providing the care

End of Life Care

☐ **Key conversations to revisit Goals of Care and to discuss and document key treatment decisions**

- Assess and address patient and family's information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
- Explore the patient's views on medications, tests, resuscitation, intensive care and preferred location of death
- If a patient makes any treatment decisions relevant to their current condition (i.e., provides consent), these decisions can be incorporated into their Plan of Treatment
- Review Goals of Care and patient preferences regularly, particularly when there is a change in clinical status

☐ **Screen for specific end of life psychosocial issues**

- Assess and address patient and families' loss, grief and bereavement needs including anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
- Provide appropriate guidance, support and information to families, caregivers, and others, based on awareness of culture and needs, and make referrals to available resources and/or specialized services to address identified needs as required
- Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources

☐ **Identify patients who could benefit from specialized palliative care services (consultation or transfer)**

- As patient and family/caregiver needs increase and/or change over time consult with palliative care specialists and/or other providers with additional expertise, as required. Transfer care only if/when needs become more extensive or complex than the current team can handle
- Discuss referral with the patient and their family/caregiver

☐ **Proactively develop and implement a plan for expected death**

- Explore place-of-death preferences and the resources required (e.g., home, hospice, palliative care unit, long term care or nursing home) to assess whether this is realistic
- Prepare and support the family to understand what to expect, and plan for when a loved one is actively dying, including understanding probable symptoms, as well as the processes with death certification and how to engage funeral services
- Discuss emergency plans with patient and family (including who to contact, and when to use or avoid Emergency Medical Services)

☐ **Home care planning (if this is where care will be delivered)**

- Contact the patient's primary care and home and community care providers and relevant specialist physicians to ensure an effective transfer of information related to their care. If the patient is transitioning from the hospital, this should include collaborating to develop a transition plan
- Introduce patient and family to resources in community (e.g., respite, day hospice programs, volunteer services, support groups, etc.)
- Connect with home and community care services early (not just in the last 2-4 weeks)
- Ensure resources and services are in place to support the patient and their family/caregiver, and address identified needs
- Anticipate/plan for pain and symptom management, including consideration for a Symptom Response Kit to facilitate access to pain, dyspnea, and delirium medication for emergency purposes
- If the patient consents to withholding cardiopulmonary resuscitation, A 'Do Not Resuscitate' order must be documented in their medical record, and a Do Not Resuscitate Confirmation (DNR-C) Form should be completed. This form should be readily accessible in the home, to ensure that the patient's wishes for a natural death are respected by Emergency Medical Services

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Patient Death

At the time of death:

- ☐ Pronouncement of death
- ☐ Completion of death certificate
- ☐ Allow family members to spend time with loved one upon death, in such a way that respects individual rituals, cultural diversity and meaning of life and death
- ☐ Implement the pre-determined plan for expected death
- ☐ Arrange time with the family for a follow-up call or visit
- ☐ Provide age-specific bereavement services and resources
- ☐ Inform family of grief and bereavement resources/services
- ☐ Initiate grief care for family members at risk for complicated grief
- ☐ Encourage the bereaved to make an appointment with an appropriate health care provider as required

Bereavement Support and Follow-Up

- ☐ Offer psychoeducation and/or counseling to the bereaved
- ☐ Screen for complicated and abnormal grief (family members, including children)
- ☐ Consider referral of bereaved family member(s) and children to appropriate local resources, spiritual advisor, grief counselor, hospice and other volunteer programs depending on severity of grief

Provide opportunities for debriefing of care team, including volunteers