

Referral Guideline for Mohs Surgery

The information within this document should be used only to guide the management of adult patients with complex skin cancer and who have not been entered in a clinical trial.

UNCONTROLLED WHEN PRINTED

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NOSCAN Referral Guideline for Mohs Surgery

NOSCAN (North of Scotland Cancer Network) Skin Cancer MCN (Managed Clinical Network) is a multidisciplinary advisory group of

- specialist clinicians and nurses,
- supporting services personnel,
- network management personnel

and

- service users/patient representatives

working in one or more of the six North of Scotland (NoS) Health Boards of Eileanan Siar (Western Isles), Grampian, Highland, Orkney, Shetland and Tayside.

As such, it meets 3-4 times annually to oversee and co-ordinate the specialist care of patients presenting with skin cancer in the North of Scotland, which for specialist input is primarily covered by services at Aberdeen Royal Infirmary, Ninewells Hospital in Dundee, and Raigmore General Hospital in Inverness.

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1: INTRODUCTION

The following advice for referral is taken from the developing multi-professional standards for Mohs¹ surgery, and has been prepared by the North of Scotland Cancer Network (NOSCAN) Skin Cancer MCN to ensure that the clinical management and care for this specified group of patients is more regionally consistent throughout the North of Scotland and conforms to best practice evidence from the UK and worldwide.

[A flowchart and helpful tips to aid referral are provided on page 5].

2: BACKGROUND

Mohs¹ Surgery is ideally suited to the management of complex skin cancers (defined as high risk histopathology within a high risk anatomical site) where confirmation of complete clearance prior to reconstruction is paramount.

Of all Mohs cases performed in Ninewells Hospital, >90% are for Basal Cell Carcinomas (BCCs)

High-Risk Non-Melanoma Skin Cancers (NMSCs) include:

- Recurrent and incompletely excised tumours following previous attempts at surgical excision or radiotherapy
- When the cancer is large (often more than 2cm)
- If the edges of the cancer are poorly defined: the clinician should aim to visualise with good illumination, magnification and dermoscopy
- Specific histological features associated with local recurrence e.g. micronodular, morpheic/infiltrative, perineural invasion
- All skin cancers in immunosuppressed patients.

High-Risk Sites include those where:

- deep or wide tumour extension makes standard excision challenging
- incomplete excision could have significant clinical consequences
- preservation of healthy tissue is important for maintenance of function and physical appearance eg. facial anatomical sites in the so-called “H-Zone” (ie. eyelids, medial canthus, all subunits of nose, preauricular area, ears, and lips).

¹Mohs surgery is not an acronym: it is named after Dr. Frederic Mohs, who first developed the **surgical** technique of progressively removing and examining thin layers of cancer-containing skin until only cancer-free tissue remains in the 1930s. Since then, it has been greatly modified and refined into the advanced technique in clinical use today.

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3: REFERRAL CONSIDERATION

Mohs may be appropriate when a skin cancer is either:

- at a high risk site (*see page 3*)
- or
- has high risk pathology (*see page 3*)

As not all patients will be able to tolerate Mohs (ie an 8am start, waiting 1-2 hours between stages, and potentially requiring several top-ups of Local Anaesthesia throughout the experience due to its preference over General Anaesthesia), alternative management strategies should be equally considered for all patients.

Although approximately 50% of Mohs cases achieve clearance after the 1st stage, around 10% of cases need ≥ 3 stages. Almost all cases are on head and neck sites with 1/3 of cases located on the nose.

When considering their advice on the care that is most clinically appropriate, referring clinicians should take account of the patient's individual circumstances including general health / medical morbidities, personal views and preferences as some flexibility regarding the threshold for Mohs is sensible ie a 7mm diameter primary nodular BCC on the ala nasi would be very suitable, but a 2cm infiltrative BCC on the scalp on an elderly man may be better for a standard excision with wide margins and immediate or delayed reconstruction pending histopathology result.

The top 10 Indications for Mohs

1. Recurrent BCC on head and neck (after any previous treatment modality)
2. Deeply invasive BCC on head and neck
3. Small BCC (<6mm diameter) in a critical anatomic site (such as in facial "mask" zone)
4. Large BCCs at non-critical head and neck sites
5. BCC of any size on head and neck skin in an immune-suppressed patient
6. Any BCC on head and neck with a poorly defined clinical border
7. Biopsy-proven BCC on head and neck of a histological high risk subtype (morphoeic / infiltrative, micronodular or baso-squamous)
8. Recently incompletely excised BCC on head and neck (ie high-risk subtype at margin, or 2nd re-excision)
9. Other malignant skin tumours eg. Squamous Cell Carcinoma (especially when arising at a critical anatomical site), Atypical fibroxanthoma, Dermatofibrosarcoma protuberans, Microcystic adnexal carcinoma.
10. Patients with basal cell naevus syndrome (Gorlins)

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4: MACMILLAN NOSCAN MOHS SERVICE REFERRAL GUIDE

