



**Development of guidelines for  
consistent melanoma and non  
melanoma skin cancer follow-up,  
including timelines for discharge back  
the General Practitioner (GP)**

**A Skin/Melanoma Tumour Group Project**

**September 2008**

Project Sponsor: Mr David Speakman  
Project Coordinator: Anne Adams

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## **Executive Summary**

This project aimed to develop consistent follow up guidelines at Peter MacCallum Cancer Centre (PMCC), Royal Melbourne Hospital (RMH), St Vincent's Health (STV) and Western Health (WH) due to clinicians concerns that there may be duplication of follow up. During the project it emerged that NHMRC was developing national follow up guidelines. The WCMICS Tumour group decided that it would be more useful for WCMICS to provide support to the implementation of the NHMRC guidelines when they were released, rather than develop independent guidelines. Details of the NHMRC guidelines can be found on page 4.

An audit was conducted and found there was no obvious standardisation of follow up at any of the four hospitals. It revealed that junior staff are often responsible for follow up. Special consideration must be given to how the guidelines should be disseminated to junior staff. The audit will provide a baseline, against which the success of the implementation of the NHMRC guidelines can be measured. A copy of the full audit report can be found at Appendix 7.

Focus of work therefore on is on the implementation of these guidelines. The implementation will be individualised to each hospital.

The effect on outcome will be assessed prospectively via a clinical audit which will be conducted at agreed time periods post the implementation.

## NHMRC Guidelines

NHMRC released 'Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand' (1) and 'Clinical Practice Guide Basal Cell Carcinoma, Squamous Cell Carcinoma (and related lesions)-A Guide to Clinical Management in Australia' (2) in November 2008.

Follow up intervals suggested by the melanoma guideline "are preferably six-monthly for five years for patients with stage I disease, three-monthly or four-monthly for five years for patients with stage II or III disease, and yearly thereafter for all patients. Ultrasound may be used in conjunction with clinical examination only in the follow-up of patients with more advanced primary disease for patients enrolled in clinical trials, the above recommendation may vary in accordance with the follow-up protocols of these trials." (Chapter 19, section 19.3, page 123)

The guideline acknowledged that the efficacy of routine follow up has not been proven and "while it is important that clinicians weigh up the advantages and disadvantages of undertaking routine follow-up, individual patient's needs be considered before appropriate follow-up is offered." (Chapter 19, section 19.4, page 124)

## Background

The Western and Central Melbourne Integrated Cancer Service (WCMICS) is collaboration between St Vincent's Hospital, Melbourne Health, Peter MacCallum Cancer Centre, the Royal Women's Hospital, Western Health, and Werribee Mercy Hospital, with the aim of improving patient care through reducing variations in care, improving care coordination, increasing access to psychosocial and supportive care, and facilitating multidisciplinary care.

Ten tumour groups meet quarterly to make suggestions for service improvement projects and to share progress of existing projects. Members of the WCMICS Skin/Melanoma Tumour Group include Surgeons, Medical Oncologists, Dermatologists, Plastic Surgeons, Radiation Oncologists, Nurses and Social Workers from Royal Melbourne Hospital, Peter MacCallum Cancer Centre, Western Health, St Vincent's Health and the Skin Cancer Foundation.

The WCMICS Skin/Melanoma Tumour Group was concerned that the lack of guidelines available may impact on patient outcomes with delayed treatment of recurrences, late toxicities or second malignancies. Clinicians also reported anecdotally that appointments may be duplicated when patients were followed up by multiple disciplines or hospitals.

In May 2007 the WCMICS Tumour Group agreed to initiate a project to develop follow up guidelines for melanoma and non-melanoma skin cancers. Mr David Speakman, Surgeon at Peter MacCallum Cancer Centre, was the designated Project Sponsor. Lead Clinicians at each site were:

- ⇒ Mr Rod Sinclair- St Vincent's Health
- ⇒ Mr Micklos Pohl-Western Health
- ⇒ Mr Mark Ashton-Royal Melbourne Hospital
- ⇒ Mr David Speakman-Peter MacCallum Cancer Centre

In September 2007 the Project Coordinator, Anne Adams, was appointed.

Project plans can be found at Appendix 1.

The aim of the project was to develop an evidence based standardised follow up program for melanoma and management and follow up guidelines for non melanoma skin cancers including atypical fibroxanthoma (AFX), Merkel cell carcinoma (MC) and dermatofibrosarcoma protuberans (DFSP) across four major teaching hospitals, (Peter MacCallum Cancer Centre, Royal Melbourne Hospital, St Vincent's Health and Western Health) in the WCMICS. During the project it was agreed that guidelines would also be developed for Kaposi's Sarcom (KS) and Angiosarcoma.

## **Method**

### **Literature Search**

A detailed literature search was suggested but the Project Sponsor felt this was not necessary. As the NHMRC guidelines were underway, it was suggested that the literature search they would perform in creating their guidelines would be highly regarded.

The result was that no relevant literature was located.

### **Guidelines Search**

An internet search was conducted intensively over a one week period. Clinicians were also asked if they were aware of any guidelines or organisation that may have a relevant guideline. This search netted eight guidelines that related to melanoma, one of those guidelines was the Patient Management Frameworks (1) developed by clinicians in Victoria during the inception of the Integrated Cancer Services (ICS). The draft NMHRC guidelines for the management of melanoma were included in this search. The Chair of the WCMICS Skin/Melanoma tumour group was on the review panel for the NHMRC guidelines and reported to the group that the follow up section was unlikely to change so it was considered acceptable to include in the review.

### **Structure Interviews**

Four structured interviews were conducted out of a possible 13 clinicians that were known to practice within the WCMICS catchment. Interviews covered clinician's knowledge of the existence of literature or guidelines relating to follow up and were conducted to gain understanding of their current individual practice. Repeated attempts were made to arrange interview times with clinicians. Due to the limited response, interviews were abandoned. A copy of the interview questions can be found at Appendix 2.

### **Retrospective Audit**

An audit of patient's histories was conducted in each hospital to identify what current follow up is being provided. It was aimed to audit 10 patient records in each WCMICS hospital that has a skin/melanoma service (Peter MacCallum Cancer Centre, Royal Melbourne Hospital, St Vincent's Hospital and Western Health). At Western Health only a small number of skin/melanoma patients are seen and patients are frequently referred to Peter Mac for treatment, so are often not followed up at the hospital. Only two suitable histories were obtained from Western Health. A copy of the audit form can be found at Appendix 3.

## Results

### Guidelines Search

Clinicians reported that the Peter Mac (Appendix 6) and Royal Melbourne had follow up guidelines (Appendix 7). External guidelines searches within Australia and Victoria netted 5 guidelines.

- Victorian Patient Management Framework (Melanoma) 2006 (1)
- NHMRC Draft Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand, 2007 (2)
- NCCN Clinical Practice Guidelines in Oncology-Melanoma (USA) 2008 (3)
- UK Guidelines for Management of Cutaneous Melanoma (UK) 2002 (4)
- University of Texas MD Anderson Cancer Centre Melanoma Guidelines (USA) Date Unknown (5)
- SIGN-Cutaneous Melanoma (Scotland) 2003 (6)
- Finish Medical Society Duodecim-Skin Cancer (Finland) 2005 (7)
- NICE Guidelines on Cancer Services: Improving Outcomes for People with Skin Tumours Including Melanoma (UK) 2006 (8)

The guidelines were summarised (Appendix 4) and distributed to the Tumour Group for comment.

### Structured Interviews

After four interviews and repeated attempts to contact the other clinicians who practice within the WCMICS catchment, the interviews were abandoned. This issue was raised at the Tumour Group meeting on 26<sup>th</sup> August. It was indicated that there was little support for the project due to the NHMRC guidelines being released in November. The group agreed to wind up the project and to revisit it when the guidelines were released.

### Retrospective Audit

The audit revealed that staff more junior than a consultant are often responsible for providing follow up services to melanoma patients. Consideration will be given to how to disseminate the agreed guidelines to junior staff in the implementation phase of this project.

No obvious follow up regimen emerged from the audit but most patients were seen more frequently in the first two years of follow up, with follow up usually declining in duration.

Annual skin checks were provided more often at PMCC than RMH or STV. At all hospitals Dermatologists carried out more skin checks than any other discipline. More skin checks occur in the earlier stages of follow up.

Imaging was rarely used.

Photography services were used at RMH, STV and PMCC but there was no evidence of the use of a service at WH.

Referrals rarely were made during the follow up period, this was not an unexpected result.

There was not a record of a letter being sent after every follow up visit.

At all hospitals there were many occasions where seniority and discipline of the clinician was not identified in letters or entries in the patient's history.

A copy of the full report on the audit is included at Appendix 7.

## Implementation

The implementation of the NHMRC guidelines will vary at each hospital due to the different requirements and processes in each organisation. Meetings will be scheduled with lead clinicians at each site to discuss what will best suit their organisation. The implementation of the guidelines will be assisted in each hospital with practical support from the Project Coordinator.

The Project Coordinator and the lead clinician at each hospital will present the guidelines at a multidisciplinary team meeting at each hospital.

A number of suggestions have been put forward to date to aid the implementation. Some or all of these will be undertaken in each hospital. Suggestions have included:

- Laminated guidelines cards placed in clinic rooms
- Consultation with junior medical staff as to the best way to disseminate the guidelines to juniors
- Inclusion in orientation packs for new staff
- Inclusion in policy and procedures manuals
- Inclusion on hospital intranet
- Follow up hand outs with expected duration of appointment for patients

This report will also be distributed to other ICS and the NSW Cancer Institute.

At two and five years post implementation of the guidelines, an audit will be conducted by the Project Coordinator to determine if the guidelines are being used. The results of the audits will be reported to the Tumour Group, and if uptake is not as expected, the Group may decide that further awareness raising activities are required to promote the guidelines.

## Abbreviations

AFX	Atypical Fibroanthoma
DFSP	Dermatofibrosarcoma Protuberans
GP	General Practitioner
ICS	Integrated Cancer Service
KS	Kaposi's Sarcoma
MC	Merkel Cell Carcinoma
NCCC	National Collaborating Centre for Cancer
NCCN	National Comprehensive Cancer Networks
NHMRC	National Health and Medical Research Council
NICE	National Institute for Clinical Excellence
NSW	New South Wales
PMCC	Peter MacCallum Cancer Centre
RMH	Royal Melbourne Hospital
SIGN	Scottish Intercollegiate Guidelines Network
STV	St Vincent's Health
UK	United Kingdom
USA	United States of America
WCMICS	Western and Central Integrated Cancer Service
WH	Western Health

## References

- (1) Cancer Council Australia/Australian Cancer Network/Ministry of Health, New Zealand (2008) *Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand*  
Available from:  
<http://www.cancer.org.au/File/HealthProfessionals/ClinicalPracticeGuidelines-ManagementofMelanoma.pdf>
- (2) Cancer Council Australia/Australian Cancer Network (2008) *Clinical Practice Guide Basal Cell Carcinoma, Squamous Cell Carcinoma (and Related Lesion) –A Guide to Clinical Management in Australia*  
Available from:  
<http://www.cancer.org.au/File/BasalcellcarcinomaSquamouscellcarcinomaGuideNov2008Final.pdf>
- (3) Metropolitan Health and Aged Care Services Division (2006). *Patient Management Framework (Melanoma)*. Victorian Government Department of Human Services, Melbourne, Victoria.  
Available from:  
<http://www.health.vic.gov.au/cancer/docs/pmfs/skinpmf.pdf>
- (4) National Health and Medical Research Council, (2007). *NHMRC Draft Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand*. Retrieved from :  
<http://www.cancer.org.au/Healthprofessionals/clinicalguidelines.htm>
- (5) National Comprehensive Cancer Networks, (2008) *Clinical Practice Guidelines in Oncology-Melanoma*  
Available from:  
[http://www.nccn.org/professionals/physician\\_gls/PDF/melanoma.pdf](http://www.nccn.org/professionals/physician_gls/PDF/melanoma.pdf)
- (6) British Association of Dermatologists. (2002) *UK Guidelines for Management of Cutaneous Melanoma*  
Available from:  
[http://www.bad.org.uk/healthcare/guidelines/Cutaneous\\_Melanoma.pdf](http://www.bad.org.uk/healthcare/guidelines/Cutaneous_Melanoma.pdf)
- (7) University of Texas MD Anderson Cancer Centre (Unknown Date) *Melanoma Guidelines*  
Available from:  
<http://www.mdanderson.org/departments/lacc/display.cfm?id=3E3CFF0A-FB6B-11D4-810400508B603A14&method=displayFull&pn=DC30EAAE-7545-11D4-AEC300508BDCCE3A>
- (8) SIGN (2003) *Cutaneous Melanoma*  
Available from:  
<http://www.sign.ac.uk/guidelines/fulltext/72/index.html>
- (9) Finish Medical Society Duodecim (2005) *Skin Cancer*  
Available from:  
[http://www.guideline.gov/summary/summary.aspx?doc\\_id=8262&nbr=004600&string=skin+AND+cancer](http://www.guideline.gov/summary/summary.aspx?doc_id=8262&nbr=004600&string=skin+AND+cancer)
- (10) NCCC/NICE (2006) *Guidelines on Cancer Services: Improving Outcomes for People with Skin Tumours Including Melanoma*  
Available from:  
<http://www.nice.org.uk/csgstim>

## Appendices

### Appendix 1 - Project Plans

## - *WCMICS Project Plan* -

#### PROJECT DETAILS

##### 1. WCMICS Tumour Group

Skin/Melanoma
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##### 2. Project Title (per project application)

Development of consistent follow up guidelines for melanoma and non-melanoma skin cancers across WCMICS Hospitals. ( Peter Mac, Royal Melbourne Hospital, St Vincent's Health, Western Health and Werribee Mercy Hospital)
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##### 3. Project Objective & Expected Outcomes (clearly describe the objective of the project and any expected outcomes)

<p>The objective of this project is to develop follow up guidelines for melanoma; and, management and follow up guidelines for non melanoma skin cancers including atypical fibroxanthoma (AFX), Merkel cell carcinoma (MC) and dermatofibrosarcoma protuberans (DFSP).</p>
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<p>Expected outcomes from the project include the implementation of consensus follow-up guidelines and management guidelines that are based on best practice, thereby facilitating consistent management and follow-up care across the WCMICS, improved care coordination, as well as potentially a decreased burden on WCMICS Melanoma and non-Melanoma Skin Cancer Services through the streamlining and rationalisation of care and follow-up management.</p>
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##### 4. Priority Areas Addressed by Project

	Multidisciplinary Care	<b>X</b>	Reducing Variations in Care
<b>X</b>	Care Coordination		Psychosocial/Supportive Care

## PROJECT METHODOLOGY

### 5. Project Overview (per project application with additional comments/ amendments as required)

Reducing variation in care and care coordination are two of the four key priority areas of the Victorian Cancer reform agenda. The use of clinical guidelines assists clinicians with consistent management, treatment and follow up of patients with melanoma<sup>1</sup>. Evidence based clinical guidelines are becoming increasingly common and are considered to be one method of improving the quality of care that patients receive<sup>2</sup>. Treatment that is planned and carried out according to evidence-based practice guidelines and protocols improves the quality and appropriateness of care<sup>3</sup>. The use of clinical evidence based guidelines will therefore improve care coordination and reduce variations in care.

Guidelines for the follow up of BCC and SCC are available<sup>4</sup>. However, these guidelines specifically exclude uncommon non melanoma skin cancers such as AFX, MC and DFSP. Follow up guidelines for these tumours are deficient for this uncommon group of tumours. Patients having undergone treatment, often multidisciplinary, for one of these tumours experience significant morbidity and in the case of MC a significant risk of mortality (30 – 50% die from metastases)<sup>5</sup>. There is also the potential for significant psychosocial morbidity due to limited experience of the treating doctor with these tumours, the potential for recurrent disease, and the lack of structured treatment protocols and follow up regimens.

Currently there is inconsistent use of guidelines across the WCMICS. Some sites have developed their own guidelines, and some are working towards using guidelines.

This project aims to: implement consistent patient follow up guidelines for melanoma and non-melanoma cancer patients; and review the effectiveness of the guidelines in terms of service streamlining and work load.

This project will aim to build on the work of the NHMRC and the work of the individual health services.

The project will be undertaken using a 7 stage process as outlined below. Key elements of the project will include:

- o Identification of key stakeholders
- o Identification of current practice at each of the sites
- o How does current practice align with the NHMRC guidelines and other evidence based guidelines? If there are gaps, what may be the consequences for patients?
- o Identification of opportunities for rationalizing follow-up management
- o Development of consensus guidelines
- o Scoping opportunities for sharing follow-up management with GPs and the

<sup>1</sup>National Health and Medical Research Council, Clinical Practice Guidelines: Non-melanoma skin cancer: Guidelines for treatment and management in Australia  
<http://www.nhmrc.gov.au/publications/synopses/cp87syn.htm>

<sup>2</sup> Feder, G., Eccles, M., Grol, R., Griffiths, C. & Grimshaw, J. (1999) Clinical Guidelines: using clinical guidelines. *British Medical Journal* [internet available at <http://bmj.com/cgi/content/full/318/7185/728>

<sup>3</sup> Clinical excellence in cancer care, A model for safety and quality in Victorian cancer services Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services  
<http://www.health.vic.gov.au/cancer/docs/quality/clinexcancer0703.pdf>

<sup>4</sup> Clinical Practice Guidelines: Non-melanoma skin cancer: Guidelines for treatment and management in Australia. NHMRC 2002

<sup>5</sup> MacKie R. Tumours of the Skin Appendages 37.34 In Rook's Textbook of Dermatology 7th Ed.

identification of what information and support is required by GPs to enable shared responsibility for follow-up management

- Development of a patient follow-up plan template for use across the WCMICS
- What, if any, barriers exist that may prevent adopting the use of agreed follow-up guidelines, including patient preferences?
- Developing strategies for implementing the agreed follow-up guidelines and the identification of benefits achieved
- Implementation of consensus guidelines

Key benefits of the project will include consistent melanoma and non-melanoma follow-up management across the ICS and improved care coordination, as well as potentially a decreased burden on WCMICS Melanoma and non-Melanoma Cancer Services through the standardisation of follow-up management.

Projects around the development of consistent WCMICS follow-up guidelines are also being undertaken by the breast, gynae, colorectal and upper GI Tumour Groups.

## **6. Project Scope (define the extent and limits of the project)**

*Inclusions (Clearly detail what is included as part of the project, including any anticipated improvements/changes in practice arising from the project):*

This project will include

- Identification of key stakeholders
- Identification of current practice at each of the sites
- Comparison of current practice against published evidence-based guidelines
- Identification of opportunities for rationalizing follow-up management
- Development of consensus guidelines
- Scoping opportunities for sharing follow-up management with GPs and the identification of what information and support is required by GPs to enable shared responsibility for follow-up management
- Development of a patient follow-up plan template for use across the WCMICS
- Development of strategies for implementing the agreed follow-up guidelines and the identification of benefits achieved
- Implementation of consensus guidelines

Key benefits of the project will include consistent follow-up management across the ICS and improved care coordination, as well as potentially a decreased burden on WCMICS Melanoma and non-Melanoma Cancer Services through the implementation of standardised follow-up guidelines.

*Exclusions (Clearly detail what will not be included as part of the project):*

The ongoing delivery of care and management of follow-up in accordance with and monitoring of adherence to the agreed guidelines is outside the scope of the project and will be the responsibility of the individual hospitals. KPIs for uptake and adherence to the guidelines will however be developed as part of the project to assist hospitals in this activity.

## **7. Methodology**

*Describe the project's methodology including details of how the project will be implemented. Attach detailed Gantt Chart<sup>6</sup> detailing project stages and timelines and provide summary in table below.*

This project will be undertaken using a seven stage process over 12 months as outlined below.

\*\*Project timelines to be determined post commencement of Project Coordinator.

Stage	Description	Timeline**	Outputs	Measures
1	<b>Administration</b> Recruit Project Coordinator, Draft Project Plan, Establish Project Team, Communication Strategy, Letter of Agreement	September/November	Recruitment process Project Plan Letter of Agreement	Project Coordinator in post by September Project Plan to Tumour Group by November Letter of Agreement to PMCC/SVHM/RMH by September
2	<b>Scoping</b> Define project boundaries, Identify similar projects and linkages to other projects, Literature search	November	Project boundaries defined (i.e. follow-up definition and patients to be captured) Literature search complete	Project boundaries agreed by Project Team by November
3	<b>Assessment of Current Service</b> Identify current practice	January	Current practice identified	Current practice mapped and documented by January
4	<b>New Model Development</b> Review current practice against best practice, Draft guidelines, Consultation, Finalise guidelines	May	Guidelines	Guidelines agreed by May
5	<b>Impact of New Model</b> Determine likely impact of new model	May	Potential impact of model assessed and documented	May
6	<b>Implementation</b> Implementation strategy, Implementation	May	Approval for implementation Implementation of agreed guidelines	Agreed guidelines implemented by May
7	<b>Evaluation</b> Project evaluation, KPIs, Identify transferable learning, Publication of Project Report	September	Project evaluation and Report	Project Evaluation and Project Report complete by September

	(including guidelines)			
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## 8. Changes to Project<sup>7</sup>

*Detail any changes in methodology or expected outcomes from the Project Application, specifying the reason for the change.*

Nil.

## 9. Communication Strategy/Project Stakeholders

*Detail how the project progress and outcomes will be communicated to relevant stakeholders and list all relevant project stakeholders.*

This project was identified as a priority area and agreed by the Skin/Melanoma Tumour Group through its review of the DHS Patient Management Framework.

The project outline was communicated to all Skin/Melanoma Tumour Group members via circulation of the project application and discussion of the project at the May 2007 Tumour Group meeting. The project progress and outcomes will be communicated to the Tumour Group via the monthly progress reports, other reporting requirements and project updates to be provided at each Tumour Group meeting.

Outside of the WCMICS Skin/Melanoma Tumour Group, the key stakeholders in the project are the GP sector and consumers. Accordingly, both groups will need to be consulted in the development of the consensus guidelines (and any associated tools/templates) to ensure their acceptability and appropriateness to these groups. This will be achieved in part by consultation with GP Liaison Officers at the member hospitals and through the use of consumer groups and the WCMICS Community Reference Group.

The potential impact of implementation of the consensus guidelines on individual hospitals (i.e. changes to VACS utilisation) will be communicated via a project report provided to the WCMICS CEO/Delegates Governance Group.

Details of the project have been circulated to the full WCMICS stakeholder base via the WCMICS Newsletter and Website. The project's learnings will be communicated to all other WCMICS Tumour Groups at the conclusion of the project via the WCMICS Directorate and Hospital Administrative Coordinators.

### **Project Stakeholders:**

WCMICS Skin/Melanoma Tumour Group (including Project Sponsor)  
 Other WCMICS Tumour Groups – including those undertaking similar projects  
 WCMICS Melanoma and Non-Melanoma Cancer Services  
 Other ICS undertaking similar projects  
 GP Sector – consultation to be achieved in part via hospital GP Liaison Officers.  
 Consumers

## 10. Evaluation

*Detail how the success of the project will be assessed, including how the outcomes of the project will be measured (i.e. outputs and measures) and whether the project objectives were met/delivered/evaluated.*

The objective of this project is to develop follow up guidelines for melanoma; and, management and follow up guidelines for non melanoma skin cancers including atypical fibroxanthoma (AFX), Merkel cell carcinoma (MC) and dermatofibrosarcoma protuberans (DFSP).

<sup>7</sup> "Changes to projects" - Any deviation in the project from the original submission must be discussed with, and agreed to by, the sponsoring Tumour Group and the WCMICS Directorate (please refer to "Conditions of funding and reporting requirements" noted in "WCMICS Service development Project Funding Program")

Accordingly, the success of the project will be assessed in accordance with the measures specified in **7. Methodology**. While the ongoing management of follow in accordance with the agreed guidelines and use of the patient follow-up plan is outside the scope of the project, these will be the key measures of the project's success. Accordingly, the Project Report will consider and make recommendations around a post-project audit of management and follow-up care against the agreed guidelines.

## PROJECT MANAGEMENT

### 11. Project Management Strategy

*Clearly detail how the project will be managed, including the role of the Project Sponsor, WCMICS Directorate, any specifically appointed project staff, and the host hospital and/or Project Advisory Group where applicable.*

The project will be managed by a dedicated WCMICS Project Coordinator who will be appointed full time for 12-months to support the five Tumour Group follow-up projects (i.e. salary costs to be shared amongst five Tumour Group follow-up projects). Clinical leadership and project oversight will be provided by nominated Project Sponsor from each hospital (the Project Team). Overarching oversight to the project will be provided by David Speakman. This will be in accordance with the Project Sponsor Responsibilities outlined in Attachment 1.

An overarching Project Team comprising of the Project Sponsors from the five Tumour Group follow-up projects, the Follow-up Project Coordinator and a GP representative will be established to oversight the five projects and as a mechanism for sharing information and ensuring consistency applicable.

### 12. Project Manager

Name	Position	Telephone	E-mail
Anne Adams	Project Coordinator Follow-Up Management, WCMICS	9656 2787	anne.adams@petermac.org

### 13. Project Sponsor (Tumour Group member)<sup>8</sup>

Name	Position	Telephone	E-mail
David Speakman overall lead	Surgeon	9656 1364	<a href="mailto:David.speakman@petermac.org">David.speakman@petermac.org</a>
RMH – Mark Ashton	Surgeon	9342 7410	<a href="mailto:mwashton@iimetro.com.au">mwashton@iimetro.com.au</a>
St Vincent's - Rod Sinclair	Dermatologist		<a href="mailto:lynn.daye@mh.org.au">lynn.daye@mh.org.au</a> <a href="mailto:rod.sinclair@svhm.org.au">rod.sinclair@svhm.org.au</a>

### 14. Project Team (Tumour Group members)

Name	Position	Contact Details	Responsibility
David Speakman overall lead	Surgeon	9656 1364	To provide oversight and expert clinical advice to project
RMH – Mark Ashton	Surgeon	9342 7410	
St Vincent's - Rod Sinclair	Dermatologist	9288-3293	

### 15. Project Host Site (where applicable)

Peter MacCallum Cancer Centre (Project also includes Royal Melbourne Hospital, St Vincent's Health, Western Health and Werribee Mercy Hospital)

<sup>8</sup> Project Sponsor Responsibilities provided as Attachment 2

## PROJECT BUDGET<sup>9</sup>

### 16. Changes to Project Budget

*Detail any changes in project budget from project application, specifying reason for any changes.*

Nil.

### 17. Budget Outline (attach quotes/supporting evidence as required)

Description	Budget
Project Sponsor (back-filling of Project Sponsor's time for leading project) (3 hours/month X 12 months X \$150/hour x 3 per site)	\$16,200.00
F/T Project Manager for 12 months (costs shared across five Tumour Group follow-up projects, therefore 0.2FTE incl on costs)	\$16,640.00
<b>TOTAL (pre GST)</b>	<b>\$32,840.00</b>

<sup>9</sup> Conditions of Funding provided as Attachment 2

## Attachment 1– Project Sponsor Responsibilities

The Project Sponsor will be responsible for:

- ❖ Providing leadership and oversight to the project;
- ❖ The appointment (with the assistance of the WCMICS Directorate) of any project staff, including participating on the selection panel;
- ❖ Co-managing, with the WCMICS Directorate, any project staff appointed under the project;
- ❖ Responding to matters, including e-mail communication, related to the project, meeting with relevant personnel and reviewing and providing timely comment on project related documentation;
- ❖ Liaising with all members of the Tumour Group to ensure Tumour Group wide involvement and participation in the project, including any consultation phases;
- ❖ Ensuring that the project is conducted in accordance with the methodology and timelines stated within the application, the conditions stipulated in the Funding Program Guidelines, and that any specific conditions specified by the Project Review Panel are met;
- ❖ Coordinating the preparation of, and, signing off on, the submission of a detailed project plan to the WCMICS Directorate within six weeks of the project commencement (by Friday 8 June 2007);
- ❖ Discussing and seeking endorsement of any deviation in the project with the sponsoring Tumour Group and the WCMICS Directorate;
- ❖ Ensuring that all reporting requirements are met, including
  - Providing a project update report at each Tumour Group meeting, and upon request to the WCMICS Directorate for communication to WCMICS Governance Committees
  - Monthly progress updates to the WCMICS Directorate using a standard WCMICS template
  - Coordinating the preparation of an **Interim Progress Report** and **Final Report** (including evaluation outcomes and expenditure report) for submission to the WCMICS Directorate at the project mid-point and completion, respectively;
- ❖ Liaising with the host agency (where applicable) on behalf of the WCMICS Directorate on matters related to the project, including the signing of the letter of agreement and invoicing/funding issues; and
- ❖ Ensuring that any information on the project, including any tools/resources developed, are made available on request to the WCMICS Directorate to enable promotion of the Funding Program, sharing of good practice and the transfer of learning's across the WCMICS.

The Project Sponsor will be supported in these activities by the WCMICS Directorate and/or a dedicated project manager in accordance with each project's proposal. Financial contributions to the Project Sponsor (i.e. backfilling or Project Sponsor's time for leading project) will be awarded to the Project Sponsor's principal hospital via a letter of agreement from the Peter MacCallum Cancer Centre (as the WCMICS host agency).

## Attachment 2– Conditions of Funding

Funding will be allocated to successful applicants on the basis that:

- ❖ The project has been approved for funding by the Project Review Panel, with any specific conditions specified by the Review Panel having been met;
- ❖ The project has Tumour Group wide support and has been endorsed by each hospital's lead clinician on behalf of their organisation;
- ❖ The project will be undertaken collaboratively and in consultation with all members of the Tumour Group;
- ❖ The project will be conducted in accordance with the methodology and timelines stated within the application and the conditions stipulated in the WCMICS Service Development Project Funding Program Guidelines 2006/07 (Part 2). Any deviation in the project from the original submission must be discussed with, and agreed to by, the sponsoring Tumour Group and the WCMICS Directorate;
- ❖ A detailed project plan will be submitted to the WCMICS Directorate within six weeks of the project commencement (by Friday 8 June 2007);
- ❖ Ethics applications (where necessary) are submitted in line with local requirements;
- ❖ A project update report will be provided by the Project Sponsor or Project Manager at each Tumour Group meeting, and upon request to the WCMICS Directorate for communication to WCMICS Governance Committees;
- ❖ Monthly progress updates will be submitted to the Directorate using a standard WCMICS template;
- ❖ Measures for the tracking of the project's progress will be agreed with the WCMICS Directorate;
- ❖ An **Interim Progress Report** and **Final Report** (including evaluation outcomes and expenditure report) will be submitted to the WCMICS Directorate at the project mid-point and completion, respectively; and
- ❖ Information on the project, including any tools/resources developed, will be made available on request to the WCMICS Directorate to enable promotion of the Funding Program, sharing of good practice and the transfer of learning's across the WCMICS.



**Appendix 2 - Structured Interview Form**

**Skin/Melanoma Cancer  
Follow Up Questionnaire**

Name: \_\_\_\_\_

**1. Which Hospital/s do you work for?**

- Peter Mac    RMH    St Vincent's    Western Health

**2. What is your speciality?**

- Surgeon    Medical Oncologist    Radiation Oncologist    Dermatologist

**3. Does your department have a protocol for follow up care for:**

Disease	Yes	No	Unsure
Melanoma			
KS			
Angiosarcoma			
DFSP			
Merkel			
AFX/MFH			
Microcystic Adnexal Carcinoma			

*If yes please provide copy of protocol. The next section covers specific cancers.*

**Melanoma**

**4. How do you define low risk melanoma & high risk relapse? e.g. T1, T2 etc**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**5. How frequently do you follow up Melanoma patients?**

E.g. 3,6,12 mths	High Risk	Low Risk
Year 1		
Year 2		
Year 3		
Year 4		
Year 5		
Year 6		
Year 7		
Year 8		
Year 9		
Year 10		

6. Who else follows the patient up?

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7. Is this just your regime?      Yes                      No

8. For Melanoma patients what type of follow up tests do you routinely perform?

<i>Test</i>	<i>Frequency</i>	
	<i>High Risk</i>	<i>Low Risk</i>
<i>None</i>		
<i>Blood Test</i>		
<i>Imaging</i>		
<i>Skin Check</i>		
<i>Other</i>		

9. Why do you choose to perform these tests and why do you choose this interval?

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**KS**

10. How do you define low risk KS & high risk relapse? e.g. T1, T2 etc

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11. How frequently do you follow up KS patients?

<b>E.g. 3,6,12 mths</b>	<i>High Risk</i>	<i>Low Risk</i>
<b>Year 1</b>		
<b>Year 2</b>		
<b>Year 3</b>		
<b>Year 4</b>		
<b>Year 5</b>		
<b>Year 6</b>		
<b>Year 7</b>		
<b>Year 8</b>		
<b>Year 9</b>		
<b>Year 10</b>		

12. Who else follows the patient up?

---

13. Is this just your regime?      Yes                      No

14. For KS patients what type of follow up tests do you routinely perform?

<i>Test</i>	<i>Frequency</i>	
	<i>High Risk</i>	<i>Low Risk</i>
<i>None</i>		
<i>Blood Test</i>		
<i>Imaging</i>		
<i>Skin Check</i>		
<i>Other</i>		

15. Why do you choose to perform these tests and why do you choose this interval?

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**Angiosarcoma**

16. How do you define low risk Angiosarcoma & high risk relapse? e.g. T1, T2 etc

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17. How frequently do you follow up Angiosarcoma patients?

<b>E.g. 3,6,12 mths</b>	<i>High Risk</i>	<i>Low Risk</i>
<b>Year 1</b>		
<b>Year 2</b>		
<b>Year 3</b>		
<b>Year 4</b>		
<b>Year 5</b>		
<b>Year 6</b>		
<b>Year 7</b>		
<b>Year 8</b>		
<b>Year 9</b>		
<b>Year 10</b>		

18. Who else follows the patient up?

---



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19. Is this just your regime?      Yes                      No

20. For Angiosarcoma patients what type of follow up tests do you routinely perform?

<i>Test</i>	<i>Frequency</i>	
	<i>High Risk</i>	<i>Low Risk</i>
<i>None</i>		
<i>Blood Test</i>		
<i>Imaging</i>		
<i>Skin Check</i>		
<i>Other</i>		

21. Why do you choose to perform these tests and why do you choose this interval?

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**DFSP**

22. How do you define low risk DFSP & high risk relapse? e.g. T1, T2 etc

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23. How frequently do you follow up DFSP patients?

<b>E.g. 3,6,12 mths</b>	<i>High Risk</i>	<i>Low Risk</i>
<b>Year 1</b>		
<b>Year 2</b>		
<b>Year 3</b>		
<b>Year 4</b>		
<b>Year 5</b>		
<b>Year 6</b>		
<b>Year 7</b>		
<b>Year 8</b>		
<b>Year 9</b>		
<b>Year 10</b>		

24. Who else follows the patient up?

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25. Is this just your regime?      Yes                      No

26. For DFSP patients what type of follow up tests do you routinely perform?

<i>Test</i>	<i>Frequency</i>	
	<i>High Risk</i>	<i>Low Risk</i>
<i>None</i>		
<i>Blood Test</i>		
<i>Imaging</i>		
<i>Skin Check</i>		
<i>Other</i>		

**27. Why do you choose to perform these tests and why do you choose this interval?**

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**Merkel**

28. How do you define low risk Merkel & high risk relapse? e.g. T1, T2 etc

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29. How frequently do you follow up Merkel patients?

<b>E.g. 3,6,12</b> <i>mths</i>	<i>High Risk</i>	<i>Low Risk</i>
<b>Year 1</b>		
<b>Year 2</b>		
<b>Year 3</b>		
<b>Year 4</b>		
<b>Year 5</b>		
<b>Year 6</b>		
<b>Year 7</b>		
<b>Year 8</b>		
<b>Year 9</b>		
<b>Year 10</b>		

30. Who else follows the patient up?

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31. Is this just your regime?      Yes                      No

32. For Merkel patients what type of follow up tests do you routinely perform?

<i>Test</i>	<i>Frequency</i>	
	<i>High Risk</i>	<i>Low Risk</i>
<i>None</i>		
<i>Blood Test</i>		
<i>Imaging</i>		
<i>Skin Check</i>		
<i>Other</i>		

**33. Why do you choose to perform these tests and why do you choose this interval?**

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**AFX/MFH**

34. How do you define low risk AFX/MFH & high risk relapse? e.g. T1, T2 etc

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35. How frequently do you follow up AFX/MFH patients?

<b>E.g. 3,6,12 mths</b>	<i>High Risk</i>	<i>Low Risk</i>
<b>Year 1</b>		
<b>Year 2</b>		
<b>Year 3</b>		
<b>Year 4</b>		
<b>Year 5</b>		
<b>Year 6</b>		
<b>Year 7</b>		
<b>Year 8</b>		
<b>Year 9</b>		
<b>Year 10</b>		

36. Who else follows the patient up?

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37. Is this just your regime?      Yes                      No

38. For AFX/MFH patients what type of follow up tests do you routinely perform?

<i>Test</i>	<i>Frequency</i>	
	<i>High Risk</i>	<i>Low Risk</i>
<i>None</i>		
<i>Blood Test</i>		
<i>Imaging</i>		
<i>Skin Check</i>		
<i>Other</i>		

39. Why do you choose to perform these tests and why do you choose this interval?

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### Microcystic Adnexal Carcinoma

40. How do you define low risk Microcystic Adnexal Carcinoma & high risk relapse?  
e.g. T1, T2 etc

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41. How frequently do you follow up Microcystic Adnexal Carcinoma patients?

<i>E.g. 3, 6, 12 mths</i>	<i>High Risk</i>	<i>Low Risk</i>
<b>Year 1</b>		
<b>Year 2</b>		
<b>Year 3</b>		
<b>Year 4</b>		
<b>Year 5</b>		
<b>Year 6</b>		
<b>Year 7</b>		
<b>Year 8</b>		
<b>Year 9</b>		
<b>Year 10</b>		

42. Who else follows the patient up?

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43. Is this just your regime?      Yes      No

**44. For Microcystic Adnexal Carcinoma patients what type of follow up tests do you routinely perform?**

<i>Test</i>	<i>Frequency</i>	
	<i>High Risk</i>	<i>Low Risk</i>
<i>None</i>		
<i>Blood Test</i>		
<i>Imaging</i>		
<i>Skin Check</i>		
<i>Other</i>		

**45. Why do you choose to perform these tests and why do you choose this interval?**

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### **General Information**

*This section deals with issues such as communication, test, which are relevant to all Skin/Melanoma cancers.*

**46. Are the tests scheduled for follow up appointments booked prior to appointment, during appointment or after appointment?**

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**47. Who schedules the tests?**

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**48. Medical Oncologist, Radiation Oncologist, Surgeons, Physiotherapists, Social Workers and other colleagues may see patients for follow up on a regular or unscheduled basis. Are you aware of these appointments?**

Yes                       No                       Unsure

**49. How are these appointments communicated to you?**

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**50. When do you make Tertiary referral to other health professionals?**

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**51. Who do you refer to?**

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**52. When do you refer?**

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53. What is the criteria for referral?

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54. How often and by what means do you communicated with the patients GP?

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55. Any further comments about any issue outside of the questions in the interview: \_\_\_\_\_

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*Thank you for taking the time to complete this interview. A short report will be presented to the Skin/Melanoma tumour group when the results have been collated.*

### Skin/Melanoma Follow Up Audit

		Code	1	2	3	4	5	6	7	8	9	10	
<b>F O L L O W U P 1</b>	<b>D</b>	Type of skin cancer/melanoma (TYPE)											
	<b>U</b>	Date of first follow up (DATE)											
	<b>P</b>	Who provided follow-up? (PROFESSION)											
	<b>R</b>	Referrals made at visit One? (Y/N)											
		Referrals made at visit one? (DISCIPLINES REFERRED TO)											
	<b>R</b>	Referrals made at visit One? (Y/N)											
		Referrals made at visit one? (DISCIPLINES REFERRED TO)											
	<b>R</b>	Referrals made at visit One? (Y/N)											
		Referrals made at visit one? (DISCIPLINES REFERRED TO)											
	<b>R</b>	Referrals made at visit One? (Y/N)											
		Referrals made at visit one? (DISCIPLINES REFERRED TO)											
	<b>B</b>	Blood Test Performed? Y/N											
		When was blood test booked? (DATE)											
		Whom was test booked by (DISCIPLINE)											
	<b>I</b>	Imaging Performed? (Y/N)											
		Type of Imaging (TEST NAME)											
		When was imaging test booked? (DATE)											
	<b>G</b>	Whom was imaging ordered by (DISCIPLINE)											
		Letter sent to GP (Y/N)											
	<b>L</b>	Date of Letter (DATE)											
Letter sent to other health Professionals Y/N													
<b>L</b>	Letter sent to (DISCIPLINE)												
	Date of Letter (DATE)												
<b>L</b>	Letter sent to (DISCIPLINE)												
	Date of Letter (DATE)												
<b>L</b>	Letter sent to (DISCIPLINE)												
	Date of Letter (DATE)												
<b>Note the "Follow Up 1" section will be repeated as many times as follow up visits occur</b>													
<b>D i s c h a r g e f r o m F o l l o w U P</b>	<b>D</b>	Date of discharge from hospital follow up (DATE)											
	<b>1</b>	Discharge to? (DISCIPLINE)											
	<b>D</b>	Date of Discharge (DATE) repeat?											
	<b>2</b>	Discharge to? (DISCIPLINE)											
<b>E</b>	Has the patient attended follow up elsewhere? (Y/N)												
	If Y state where they are also follow up (PLACE NAME)												

Appendix 4 - Summary of guidelines search

Focus 1: Follow Up Guidelines									
	PMF (Melanoma) Date:2006	NHMRC DRAFT clinical practice guidelines for the management of Melanoma in Australia & New Zealand Date: 2007	NCCN Clinical Practice Guidelines in Oncology- Melanoma Date: 2007	UK Guidelines for Management of Cutaneous Melanoma Date:2002	The University of Texas MD Anderson Cancer Centre Date: Unknown downloaded 2007	SIGN-Cutaneous Melanoma Date:2003	Finnish Medical Society Duodecim-Skin Cancer. Date 2005	NCCC/NICE Guidance on cancer services: improving outcomes for people with skin tumours including melanoma. Date: 2006	Key areas / questions arising for ideal pathway and reviewing current pathway
Multidisciplinary team	Follow up should involve MDT as appropriate, including social worker, physio, OT, community nursing and palliative care.	N/A	N/A	N/A	N/A	N/A	N/A		
Frequency of Follow up	The follow up plan must be made at the time of diagnosis. <b>Follow up to Detect metastatic disease and/or a secondary (new) primary, for which there is increased risk</b> <i>Tumours less than 1mm thick:</i> follow up for 2 years unless the pt is at high risk for a second primary melanoma due to multiple dysplastic naevi or a history of melanoma in close relatives. Pts should be seen 4-6mthly for two years then less frequently, according to risk factors, for an indefinite period. <i>Tumours greater than 1mm thick:</i> Follow up 3-4mthly for the first two years, 6mthly review to five years and lifelong review thereafter. <b>For follow up to manage metastatic disease:</b> Depending on clinical circumstances, pts should be seen 1-4mths for an indefinite period.	The optimal follow-up intervals: <i>Stage I:</i> Years 1-5: 6mthly Years 6+: Annually <i>Stage II or III:</i> Years 1-5: 3-4 mthly Years 6+: Annually	Stage IA: 3-6mths Stage Ib-III: Years 1-3: 3-6mths Years 4-5: 4-12mths Years 6+: Annually as clinically indicated	Pts with in situ melanomas do not require follow-up.  Pts with invasive melanomas should be followed up 3mthly for 3 years. Where the melanoma thickness was less than 1mm, the pt may be discharged; others should be followed up for a further 2 years at 6mthly intervals.	Annually	Patients who have had melanoma in situ do not require follow up.  The frequency and duration of follow up should be determined from the timing and rate of recurrence of the individual pt's melanoma, taking into account the pt's psychological and emotional needs.  Stage III pts with lymph node metastases may need lifelong follow up.	<b>Melanoma</b> Years 1-2: 3mthly Years 3-5: 6mthly If the pt has numerous naevi or the syndrome of hereditary dysplastic naevi they should be followed-up throughout their life. <b>Epidermoid Carcinoma</b> The treating unit estimates the risk of relapse and determines the need for follow-up.	Follow up may include a combination of self-surveillance, GP or other community dr, and specialist nurse or hospital specialist clinic. Pts who are immunocompromised or have a genetic predisposition to the development of skin cancers may need life long surveillance. PET scanning is not routinely recommended for follow-up; however it may be useful for a small number of pts with suspected recurrent disease when clinical doubt remains after other forms of imaging. BCC and SCC Pts with a low risk of recurrence , do not need long term surveillance and should be discharged from formal follow-up. Pts at high risk of recurrent or metachronous cancer who find self-examination difficult require formal follow-up. The period of time and frequency will depend on the degree of risk, in consultation with the pt. <b>Melanoma</b> Pts with in situ MM do not require follow-up. Pts with invasive melanoma should have a period of formal follow-up, the frequency and duration of which depends on the risk of metastatic spread and which should take into account the pt's psychological and emotional needs. Pts who have multiple primaries or those with a family history require long-term follow-up, sometimes life long.	
Which disciplines follow up?	The MDT, in consultation with the GP decides on the lead clinician who will coordinate follow up. This may be surgeon, GP, rad/med onc or dermatologist as appropriate to the patient's condition. Not all disciplines need to be involved in follow up. Where possible pts should be referred to local practitioners. F/U should involve the MDT as appropriate including social worker, PT, OT, community nursing and palliative care.	N/A	N/A	N/A	N/A	N/A	<b>Melanoma</b> The unit responsible for follow-up (hospital or primary care) can be decided on locally. It is important the same doctor always sees the pt. If the pt has numerous naevi or the syndrome of hereditary dysplastic naevi, follow-up of a melanoma should take place in a dermatological unit. <b>BCC</b> Small basiliomas in non-risk areas can be excised by the GP who is also responsible for follow-up annually.	N/A	
Suggested Tests	<b>Follow up to Detect metastatic disease and/or a secondary (new) primary, for which there is increased risk</b> Each appointment should include total skin examination and examination of lymph nodes and liver.  Asymptomatic pts in either group do not need routine periodic investigations. PT self examination is essential.	The optimum surveillance strategy is self-examination by pts. In addition, routine follow-up by the pt's preferred health professional may be appropriate. Ultrasound sound be used in conjunction with clinical examination in the follow-up of pts with more advanced primary disease.	<b>Stage 0 in situ:</b> H&P (With annual emphasis on nodes and skin) Annual skin exam for life. Consider educating pt in mthly self skin exam <b>Stage IA:</b> H&P(with emphasis on nodes and skin) Annual skin exam for life Consider educating pt in monthly self skin and node exam <b>Stage Ib-III:</b> H&P (with emphasis on nodes and skin) CXR, LDH, CBC, LFT every 3-12mths (optional) CT scans to follow-up for specific signs and symptoms At least annual skin exam for life. Consider educating pt in mthly self skin exam and lymph node exam.	Patient self examination, physician visits and continued or future pregnancy counselling. Photography may be a use adjunct. Interventions that were considered but not recommended are interferon adjuvant therapy, adjuvant vaccines, sentinel lymph node biopsy, gene testing. Regular radiological imaging is currently not a necessity. The following should be examined and details recorded at each follow-up: site of primary and adjacent skin, for local recurrences and local metastatic disease; the draining lymph node basins, for lymphadopathy; the remaining skin, for any other suspicious pigmented lesion.	Melanoma in situ-history and physical including skin exam. All others history, physical including careful skin exam, CXR, lab tests, LDH and CBC.	Routine full blood count, live function tests, tumour markers, CXR and lactate dehydrogenase are not recommended as part of a follow up schedule in the asymptomatic pt.	If the pt has numerous naevi or the syndrome of hereditary dysplastic naevi high-quality photographs facilitate follow-up.	Medical photography has a special role to play in surveillance for pts with atypical naevi.	

	<b>PMF (Melanoma) Date:2006</b>	<b>NHMRC DRAFT clinical practice guidelines for the management of Melanoma in Australia &amp; New Zealand Date: 2007</b>	<b>NCCN Clinical Practice Guidelines in Oncology- Melanoma Date: 2007</b>	<b>UK Guidelines for Management of Cutaneous Melanoma Date:2002</b>	<b>The University of Texas MD Anderson Cancer Centre  Date: Unknown downloaded 2007</b>	<b>SIGN-Cutaneous Melanoma Date:2003</b>	<b>Finnish Medical Society Duodecim-Skin Cancer. Date 2005</b>	<b>NCCC/NICE Guidance on cancer services: improving outcomes for people with skin tumours including melanoma. Date: 2006</b>	<b>Key areas / questions arising for ideal pathway and reviewing current pathway</b>
<b>Communication</b>	Responsibility for follow up investigations needs to be agreed between the designated lead clinician, GP and pt, with an agreed plan documented, including notification to the GP or MDT member if the pt does not attend. PTs requiring extra psychological support may require an individualised follow-up plan. The specialist should provide the GP with a written plan specifying prognosis and what is expected at follow-up visits, including goals, procedures, frequency, implementation and the action to be taken if a new relevant clinical finding is made. The pt should have a copy of this plan.	While it is important that clinicians weigh up the advantages and disadvantages of undertaking routine follow up, individual pts needs be considered before appropriate follow up is offered.	N/A	N/A	N/A	Pts should be educated in self assessment techniques to detect local and nodal recurrent disease and secondary lesions and apprised of the possibility of late recurrence. There should be an easy route into the clinic if problems occur between clinic visits or after discharge.		Follow up should be tailored as much as possible to the individual taking into account the pt's needs and wishes. Options and decisions regarding follow up should be made jointly with the pt. All pts should be given written and oral information about the difference types of skin cancer and instructions about self-surveillance. All pts should be given written instructions on how to obtain quick and easy access back to see a member of the MDT when necessary. GP's should be given advice about local arrangements for pts to re-access skin cancer services.	N/A

**Peter MacCallum Melanoma Unit – Guidelines for Management of New Patient Referrals**

**All Patients**

- Pathology review at PMCI.
- Advice regarding reduction of sun exposure, including to other family members.
- Emphasise need for surveillance (new melanomas & other skin cancers).
- Dermatology referral for multiple naevi, skin cancers or dysplastic naevi syndrome – consider body mapping photography.
- Consider referral to Family Cancer Clinic (two or more affected relatives on same side of family, multiple primary MM, or benefit from counselling) ? p16 gene testing.

Melanoma	Management	Initial Staging	Follow Up	Research Protocol
Hutchinson's Melanotic Freckle	WLE minimum 5mm margin or RT. Dermatology referral & consider UV photography.	Nil.	6/12 (Thursday).	
TO	WLE minimum 5mm margin.	Nil.	6/12 for 2 years (Thursday) then annually - if no skin cancers, by LMO.	Topical Imiquimod (through Alfred Hosp)
Melanoma In-situ (CL1)	WLE minimum 10mm margin.	Nil.	6/12 for 2 years (Thursday) then annually - if no skin cancers, by LMO.	
<b>Stage IA</b> T1 (<1.0mm) & non-ulcerated	WLE minimum and SNB. 10 mm minimum 10 mm min + wider margin desirable dependant on clinical circumstance.	FBE, U&E, LFT, LDH, CXR.	If SNB negative: 4/12 for 2 years, 6/12 for 2–5 years, annually after 5 years (Thursday).	
<b>Stage IB &amp; IIA</b> T1 (<1.0mm) & ulcerated or CL4 T2 (>1.0-2.0mm)	WLE minimum 20mm (T3) or minimum 20mm (T4) margin. SNB.	FBE, U&E, LFT, LDH, CXR. CT*/PET & MRI brain if considering adjuvant treatment.	If SNB negative: 4/12 for 2 years, 6/12 for 2–5 years, annually after 5 years (Friday).	
<b>Stage IIB &amp; IIC</b> T3 (>2.0-4.0mm) & non-ulcerated T3 (>2.0-4.0mm) & ulcerated T4 (>4.0mm)	WLE minimum 20mm (T3) or minimum 20mm (T4) margin. SNB.	FBE, U&E, LFT, LDH, CT*/PET & MRI brain prior to lymphadenectomy.	3/12 for 2 years, 6/12 for 2–5 years, annually after 5 years (Friday).	
<b>Stage IIIA &amp; IIIB</b> (N1a & N2a) Micro metastasis (SNB positive)	Lymphadenectomy. Consider Interferon.	FBE, U&E, LFT, LDH, CT*/PET & MRI brain prior to lymphadenectomy.	3/12 for 2 years, 6/12 for 2–5 years, annually after 5 years (Friday).	
<b>Stage IIIB &amp; IIIC</b> (N1b, N2b & N3) Macro metastasis (palpable)	Lymphadenectomy +/- adjuvant RT. Consider Interferon.	FNAC node +/- US. CT*/PET & MRI brain prior to lymphadenectomy.	3/12 for 2 years, 6/12 for 2–5 years, annually after 5 years (Friday).	TROG 02/01.
<b>Stage IV</b> (M1a, M1b & M1c)	Palliative surgery, RT, chemotherapy, isolated limb infusion as indicated. Palliative Care referral.	FBE, U&E, LFT, LDH, CT Chest*/abdo/pelvis & MRI brain. PET if considering surgical resection.	As indicated (Friday).	NY-ESO-1 CancerVax (resected to NED) Patin- 2/Tamoxolamide.

Thursday pm clinic – Surgical oncology, Dermatology, Plastic surgery. Friday am clinic - Surgical oncology, Radiation oncology, Medical oncology.  
\*CT chest & CT/PET – please request fine cut CT Lung windows to increase sensitivity of detection of metastases.

Royal Melbourne Hospital Melanoma Service – Guidelines for Management of New Patient Referrals

Melanoma	Management	Initial staging	Follow up/discharge
Hutchinson's Melanotic Freckle	WLE 5mm Minimum with Wood's lamp or XRT. Observation only in selected cases	Nil	6/12 for 2 years then annually by LMO
<b>Stage 0</b> Melanoma in-situ	WLE 5mm minimum	Nil	As above
<b>Stage IA</b> T1a (<1.0mm & non ulcerated)	WLE 10mm minimum	Nil	As above
<b>Stage IB &amp; IIA</b> T1b (<1.0 mm & ulcerated / CL4) T2a (1.1 - 2.0mm & non ulcerated) T2b (1.1 - 2.0mm & ulcerated) T3a (2.1 - 4.0mm & non ulcerated)	WLE 10mm minimum WLE 10-20mm WLE 10-20mm WLE 20mm minimum } & SNB	FBE U&E LFT CXR	If SNB negative 4/12 for 2 years Then 6/12 for 3 years Then annually at melanoma clinic CXR, LDH, FBE, LFT 6-12/12 (optional), CT/PET/MRI for specific symp/signs
<b>Stage IIB &amp; IIC</b> T3b (2.1 – 4.0mm & ulcerated) T4a (>4mm & non ulcerated) T4b (>4mm & ulcerated)	WLE 20mm minimum & SNB	FBE U&E LFT CXR Consider CT/PET/MRI brain for T4 & if SNB +ve	As above
<b>Stage IIIA &amp; IIIB</b> N1a (one node micromets) N2a (2-4 nodes micromets) } i.e. SNB +ve	WLE primary according to thickness Lymphadenectomy Consider referral for Interferon	As above Lymphadenectomy	3/12 for 2 years Then 6/12 for 3 years Then annually at melanoma clinic CXR, LDH, FBE, LFT 6-12/12 (optional), CT/PET/MRI for specific symp/signs
<b>Stage IIIB &amp; IIIC</b> N1b (1 node clinically or radiologically) N2b (2-4 nodes clinical or rad.)	WLE primary according to thickness Lymphadenectomy Consider referral for XRT and/or Interferon	As above for stage III A/B FNAC node	As above
N3 (5 or more nodes, matted nodes or in transit mets/satellites and nodes)	Surgical excision to clear margins Lymphadenectomy Consider referral for XRT and/or Interferon	As above for stage III A/B FNAC node / Biopsy lesion	As Above Consider referral for consideration of limb perfusion / Interferon / Clinical Trial / XRT

Notes:

Consider XRT for primaries with PNI or LVSI  
 Consider SNB for lesions <1mm thick if have regression or high mitotic rate or LVSI, PNI  
 For patients presenting with Stage 4 (distant metastatic disease) see Guidelines for Management of Recurrence  
 Lymphadenectomy in the groin = Superficial Lymphadenectomy. Consider Iliac Lymphadenectomy if enlarged Iliac nodes seen on CT, or if Cloquet's node +ve, or > 3 nodes

Appendix 6 - RMH Follow Up Guideline

## Appendix 7 - Retrospective Audit report

### Melanoma Follow Up Audit

#### Introduction

An audit of 10 patient histories at each WCMICS hospital with a melanoma service was undertaken in April/May 2008 to gain a snap shot to further understand follow up that patients currently receive. The audit was conducted to supplement information that was gained from structured interviews with clinicians and a survey of department heads regarding the follow up management of patients. It is acknowledged that the sample size is very small. Also there may have been appointments which are not documented either those in the public sector which have not been recorded or a copy letter included in the records and those which happen with the private system.

Only appointments that had taken place after all active, curative treatment (surgery, chemotherapy, radiotherapy) had ceased were recorded. Some patients had additional moles removed during the follow up phase.

At Western Health 12 histories were viewed, which was the complete list of melanoma patients supplied by Biogrid, however only two showed evidence of follow up. Follow up seemed to be occurring at other hospitals or privately, five had metastases so could not be included in the audit, as their hospital visits were for curative or palliative purposes so can not be considered routine follow up. After consultation with the project sponsor the audit was abandoned and no meaningful information was able to be gained. The results of the audit discussed in this report does not include the Western Health data.

A total of 247 (100 PMCC, 88 RMH and 59 SVH) follow up appointments, were provided to this group of 30 patients from 2000-2008.

#### Who provides follow-up?

At Peter Mac it was clear the overwhelming majority of patients were seen by the surgical discipline. There were four instances where it was documented that the patient was seen by both the dermatology and surgical disciplines on the same day. As Peter Mac runs a multi-medical clinic, it is possible that multiple disciplines are asked to see the patient and give an opinion on an unscheduled basis, which may not be documented.

At RMH the majority (42%) of patients were seen by an unknown discipline. In the 10 histories audited there was no record of patients being seen by multiple disciplines on the same day. As a multi-medical clinic is run at RMH it is possible that multiple disciplines are asked to see the patient and give an opinion on an unscheduled basis, which may not be documented.

At SVH 49% of patients were seen by an unknown discipline. In the 10 histories audited there was no record of patients being seen by multiple disciplines on the same day. 39% and 12% of patients were seen by the surgical and dermatology disciplines, respectively.

#### By discipline

Figure 1 depicts which disciplines followed up patients

	PMCC	RMH	SVH
Surgical	59% (n62)	26% (n19)	39% (n23)
Dermatological	23% (n24)	32% (n23)	12% (n7)
Radiation Oncological	8% (n8)	0	0
Unidentified	10% (n10)	42% (n31)	49% (n29)

Figure 1

### By Seniority

At PMCC 54% of patients are seen by either a Registrar or Fellow.

At RMH 36% of patients are seen by either a Registrar, Resident or Intern.

At STV 15% of patients are seen by a Registrar.

For some hospitals the proportion of those who have an unknown designation was higher than others, so these figures may actually be higher or lower.

Figures 2-4 depicts the seniority of the clinicians who provided follow up care at each visit.

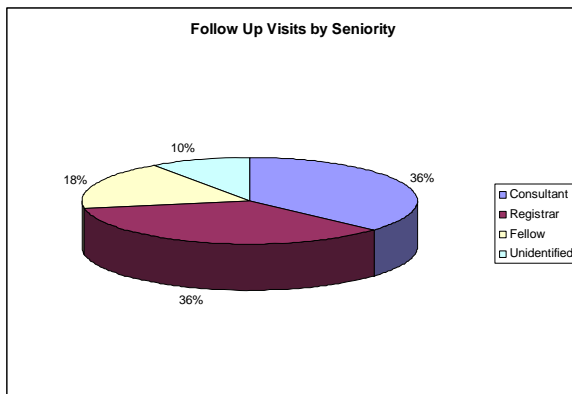


Figure 2 PMCC

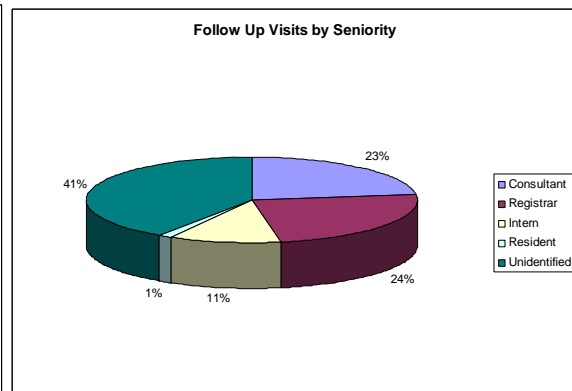


Figure 3 RMH

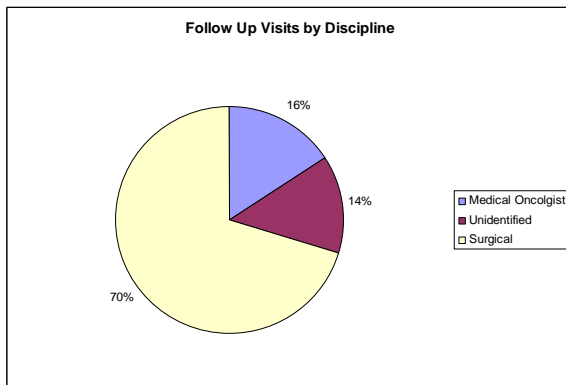


Figure 4 SVH

### When are the patients discharged and to whom?

At Peter Mac three patients were discharged (to GP, RMH as being followed up by two hospitals, and a Dermatologist as the patient moved interstate).

At RMH, two patients were discharged to their GP. One patient had shared care with their GP as they had difficulties getting to clinic.

At STV two patients were discharged (to GP and to an unidentified health professional/discipline). Two additional records noted that a patient was receiving chemotherapy at another hospital and that another patient was seeing a dermatologist privately.

All samples contains patients who are at a range of points in the follow up journey, many are not yet at the discharge stage.

### What is the follow up frequency?

This Peter Mac sample (figure 5) shows that patients receive more follow up in the first four years and that the number of follow up visits decreases over time.

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10	Total	Average
Year 1	2	6	3	4	3	3	5	4	5	2	37	3.7
Year 2	1	2	2	2	3	3	3	2	0	2	20	3.6
Year 3		1	2	1	2	1		2	2	2	13	3.3
Year 4		1	2	1	2	2		1	2	2	13	3.3
Year 5		1		1	1	3		1	2	2	11	2.8
Year 6					1	1			0	1	3	1.2
Year 7					1				1		2	2.0
Year 8									1		1	1.0
Year 9												
Year 10												

Figure 5 PMCC

The RMH sample (figure 6) shows that patients receive more follow up in the first three years. Although there are 17% (n 15) fail to attends recorded, it appears that patients are rebooked for another appointment. There was one occasion where a patient appeared to be lost to follow up with the last know follow up appointment booked in 2006 and no appointments recorded since this time, however, the patient had failed to attend on three consecutive occasions. Note that patient 8 had their procedure carried out overseas and was only referred to the hospital at year 6.

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10	Total	Average	PMCC CRC Follow Up Policy
Year 1	4	1	5	6*	5^	8^	2	0	3	2	17	1.7	
Year 2	3#	1	5*	3	1	2	4	0	2		13	2.9	
Year 3		2*		2	3*	2	2	0	1		7	2.0	
Year 4		2*		2	1	2	2	0			7	1.2	
Year 5							2	0			2	1.0	
Year 6							2^	1			1	0.5	
Year 7								3			3	3.0	
Year 8								2*			0	0.0	
Year 9													
Year 10													

\*Pt FTA 1 apt      ^Pt FTA 2 appts      #Pt FTA 3 appts

Figure 6 RMH

The STV sample (figure 7) shows that patients receive more extensive follow up in the first two years and that the number of follow up visits decreases in years 3 and 4.

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10	Total	Average
Year 1	7	4*	3	5*	5	3	4*	5*	3	3	42	4.2
Year 2	3	2			3		1	3	0	3	15	3.3
Year 3		1*			2			2^	1	1	7	1.6
Year 4									1	1	2	0.3
Year 5												
Year 6												
Year 7												
Year 8												
Year 9												
Year 10												

Figure 7 STV (\*Pt FTA 1 appt, ^Pt FTA 2 appts, #Pt FTA 3 appts)

Figures 8-10 shows the follow up according to which discipline saw the patient at each visit. At Peter MacCallum, all patients sampled saw the surgical discipline at some point in their follow up journey. In most cases, patient's follow up care is dominated by one discipline. At the other hospitals it is difficult to draw any conclusions as there are so many instances where the discipline is unknown.

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10
F/U 1	Surgical	Unknown	Rad Onc	Surgical	Surgical	Surgical	Surgical	Surgical	Unknown	Surgical
F/U 2	Surgical	Unknown	Rad Onc	Surgical	Dermatology	Surgical	Dermatology	Unknown	Surgical	Unknown
F/U 3	Surgical	Surgical	Surgical	Surgical	Surgical	Surgical	Surgical	Dermatology	Surgical	Surgical
F/U 4		Unknown	Rad Onc	Surgical	Surgical	Surgical	Unknown	Dermatology	Dermatology	Surgical Dermatology
F/U 5		Surgical	Rad Onc	Surgical	Surgical	Surgical	Unknown	Dermatology	Surgical Dermatology	Surgical
F/U 6		Surgical	Rad Onc	Surgical	Surgical	Surgical	Surgical	Dermatology	Surgical Dermatology	Surgical Dermatology
F/U 7		Surgical	Rad Onc	Surgical	Surgical	Surgical	Dermatology	Dermatology	Surgical	Surgical
F/U 8		Surgical	Rad Onc	Surgical	Surgical	Dermatology	Surgical	Dermatology	Surgical	Unknown
F/U 9		Unknown	Rad Onc	Surgical	Surgical	Dermatology		Dermatology	Dermatology	Surgical
F/U 10		Surgical			Surgical	Surgical		Dermatology	Dermatology	Surgical
F/U 11		Surgical			Surgical	Surgical			Dermatology	Surgical
F/U 12					Surgical	Surgical			Dermatology	
F/U 13					Surgical	Dermatology			Dermatology	

Figure 8 PMCC

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10
F/U 1	Surgical	Surgical	Unknown	Surgical	Dermatology	Surgical	Surgical	Dermatology	Dermatology	Surgical
F/U 2	Unknown	Dermatology	Unknown	Unknown	Unknown	Surgical	Dermatology	Unknown	Dermatology	Surgical
F/U 3	Dermatology	FTA	Dermatology	Surgical	Surgical	FTA	Unknown	Unknown	Unknown	
F/U 4	Surgical	Dermatology	Unknown	FTA	FTA	Dermatology	Dermatology	Unknown	Unknown	
F/U 5	FTA	FTA	Unknown	Dermatology	FTA	Dermatology	Unknown	FTA	Unknown	
F/U 6	FTA	Dermatology	Dermatology	Dermatology	Unknown	Unknown	Unknown	Unknown	Surgical	
F/U 7	FTA		Unknown	Surgical	Unknown	FTA	Unknown			
F/U 8			Unknown	Surgical	FTA	Dermatology	Unknown			
F/U 9			FTA	Dermatology	Unknown	Dermatology	Unknown			
F/U 10			Dermatology	Dermatology	Surgical	Surgical	Surgical			
F/U 11				Unknown		Unknown	Surgical			
F/U 12				Unknown		Unknown	Dermatology			
F/U 13				Surgical		Dermatology	FTA			
F/U 14						Unknown	FTA			

Figure 9 RMH

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10
<b>F/U 1</b>	Surgical	Unknown	Unknown	Unknown	Surgical	Surgical	Unknown	Dermatology	Unknown	Unknown
<b>F/U 2</b>	Surgical	Unknown	Surgical	Surgical	Surgical	Surgical	Unknown	Unknown	Unknown	Unknown
<b>F/U 3</b>	Surgical	Unknown	Unknown	FTA	Surgical	Surgical	Unknown	Unknown	Unknown	Dermatology
<b>F/U 4</b>	Surgical	FTA		Unknown	Unknown		FTA	FTA	Unknown	Dermatology
<b>F/U 5</b>	Surgical	Unknown		Unknown	Unknown		Unknown	Unknown	Surgical	Dermatology
<b>F/U 6</b>	Surgical	Unknown			Surgical			Unknown		Dermatology
<b>F/U 7</b>	Surgical	FTA			Surgical			Dermatology		Dermatology
<b>F/U 8</b>	Surgical				Surgical			Unknown		Unknown
<b>F/U 9</b>	Unknown				Surgical			FTA		
<b>F/U 10</b>	Surgical				Surgical			FTA		
<b>F/U 11</b>										

Figure 10 STV

Figure 11-16 show the number of months between follow up visits. These graphs show that the length of time between appointments is generally much smaller during the early stages of follow up.

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
FU1	4	0	3	5	2	7	3	1	2	6
FU2	14	1	4	5	3	3	20	2	1	6
FU3		1	6	2	4	1	4	3	1	6
FU4		4		4	4	5	3	19	6	6
FU5		4		13	7	6	3	3	17	6
FU6		6		13	6	8	2	4	6	6
FU7		6		13	6	6	3	6	7	6
FU8		6			6	6	3	6	5	6
FU9		7			6	6		18	6	0
FU10		21			6	6			10	18
FU11					6	1			18	
FU12					7	8			12	

Number of months between follow up  
Figure 11 PMCC

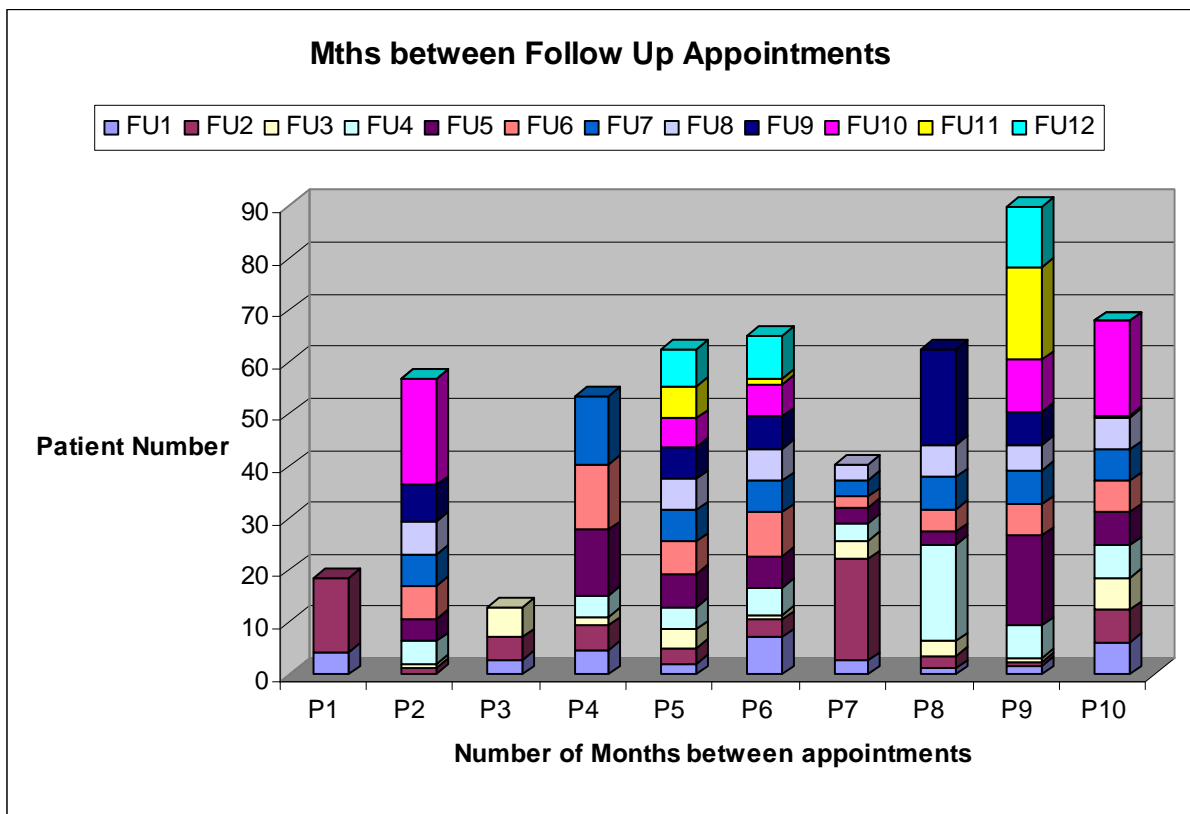


Figure 12 PMCC

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
FU1	0	1	4	1	0	1	3	3	4	4
FU2	2	1	2	2	3	3	20	4	3	2
FU3	2	0	1	2	6	1	8	2	7	6
FU4	1	3		3	13	3	14	1	14	26
FU5	1	4		3	0	3	14	4	11	
FU6	12	3		7	0	3	6	11	6	
FU7		1		1	0	10	1	13		
FU8		7			0	21	3			
FU9		7			0	12	3			
FU10		7			3					
FU11		6			13					
FU12		6								

Number of months between follow up  
Figure 13 RMH

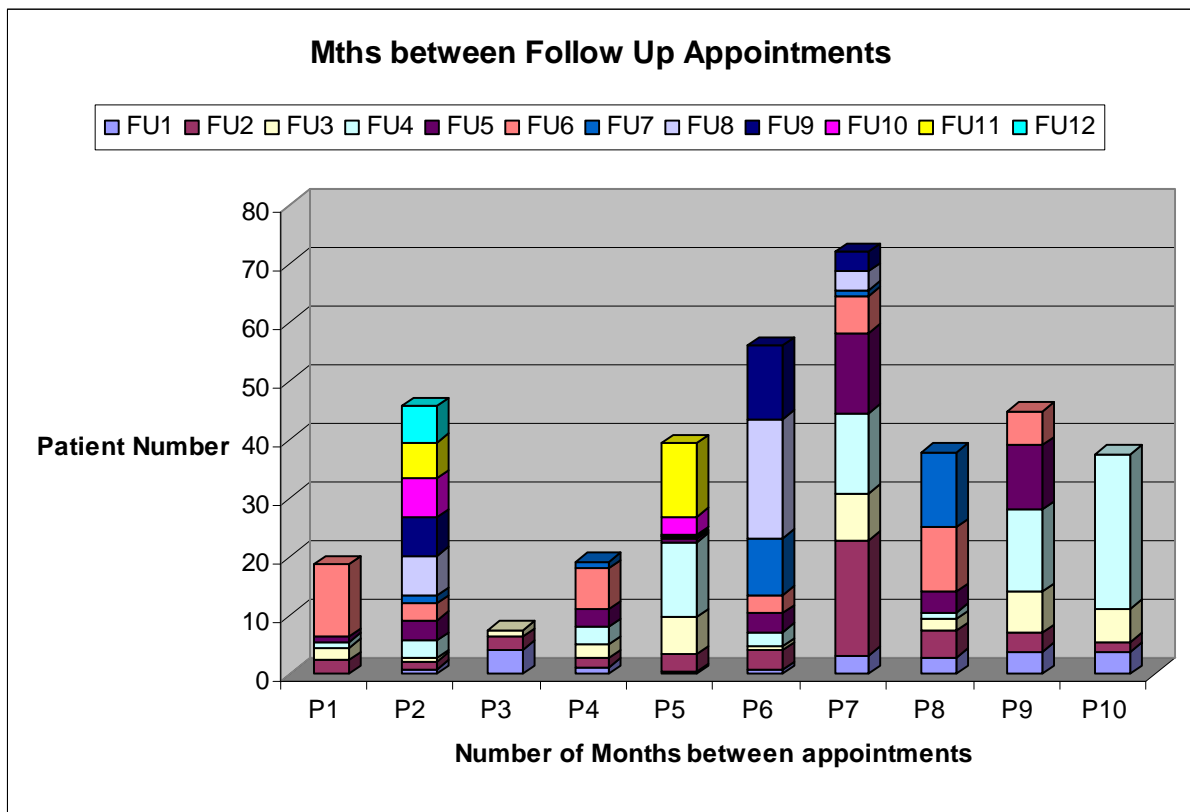


Figure 14 RMH

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
FU1	0	1	2	0	0	4	0	1	2	9
FU2	0	1	4	3	4	4	3	0	1	14
FU3	2	3		0	2		4	2	25	7
FU4	1	9		2	4		10	2	13	2
FU5	3	3			6			6		2
FU6	4	13			1			4		14
FU7	4	0			2			3		12
FU8	5	0			5			12		
FU9	3	0			5			1		

Number of months between follow up  
Figure 15 STV

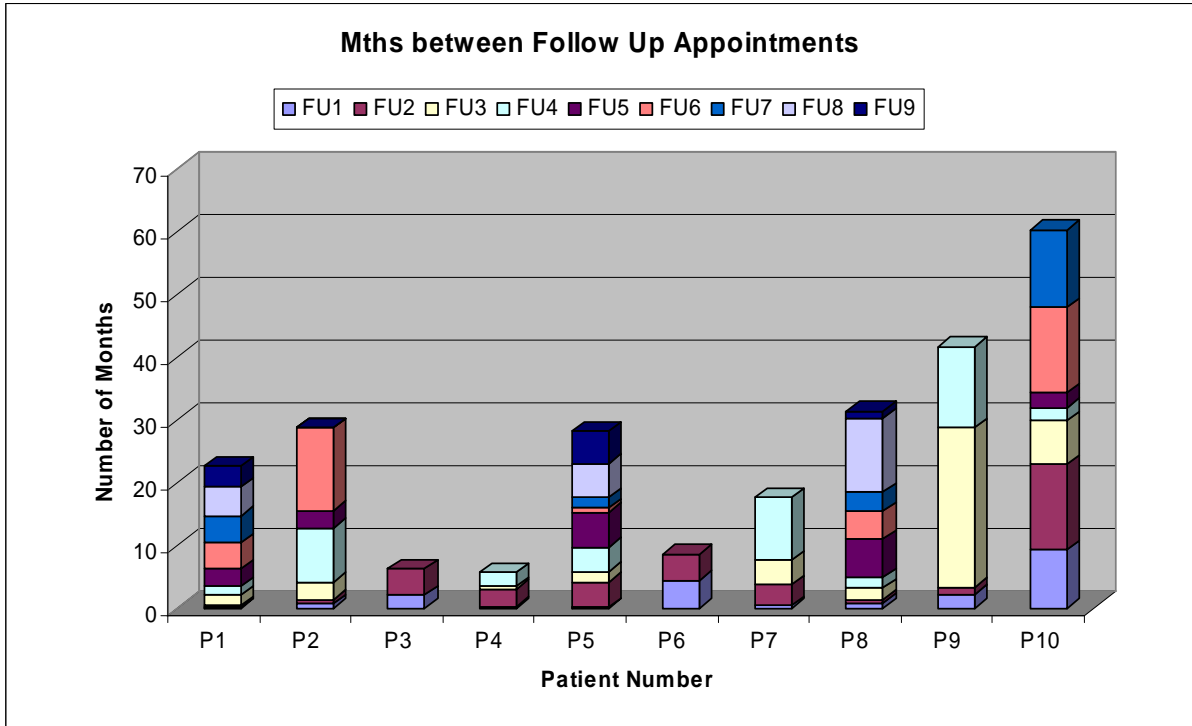


Figure 16 STV

**What tests are ordered and what is the frequency?**

*Skin Checks*

Figure 17 shows the percentage of skin checks performed at each hospital

	PMCC	RMH	SVH
<b>Skin Checks</b>	71% (71)	77% (n56)	53% (n31)

Figure 17 Percentage of Patients Who Had Skin Checks at All Hospitals

At all hospitals Dermatologists provided more skin checks than other disciplines (PMCC 27%, RMH 39% and 49% STV)

Figures 18-20 shows that at PMCC and RMH most patients have a skin check at least annually, with slightly more skin checks occurring during the first two years. At STV, while the majority of patients receive at least one skin check in the first year of follow up, no clear pattern to the frequency of skin checks is apparent. It should be noted that Patient 3's file stated that skin checks were performed by the GP.

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10	Total	Average
Year 1	1	1	0	4	3	2	3	2	5	1	22	2.2
Year 2	1	1	0	1	3	3	2	2	0	2	15	1.7
Year 3		1	0	0	2	1		2	1	2	9	1.1
Year 4		1	0	1	2	2		1	2	2	11	1.4
Year 5		1		2	1	3		1	1	1	10	2.0
Year 6					1	1			1	1	4	1.3
Year 7					1				1		2	1.3
Year 8									1			1.0
Year 9												
Year 10												

Figure 18 PMCC

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10	Total	Average
Year 1	4	0	3	2	1	6	1	0	2	2	21	2.1
Year 2	0	1	4	3	1	2	3	0	1		15	1.7
Year 3		1		2	1	2	1	0	1		8	1.1
Year 4		1		1	1	2	2	0			7	1.2
Year 5							2	0			2	1.0
Year 6							0	1			1	0.5
Year 7								2			2	2.0
Year 8								1			1	1.0
Year 9												
Year 10												

Figure 19 RMH

	Pt 1	Pt 2	Pt 3	Pt 4	Pt 5	Pt 6	Pt 7	Pt 8	Pt 9	Pt 10	Total	Average
Year 1	4	0		3	2	2	1	2	1	2	17	1.7
Year 2	3	1			2			1	0	2	9	1.0
Year 3					1				1	1	3	0.4
Year 4									1	1	2	0.3
Year 5												
Year 6												
Year 7												
Year 8												
Year 9												
Year 10												

Figure 20 STV

### Photography

At PMCC on eight occasions photography was undertaken, Four patients used the service on one instance and one patient utilised the service on four times. At RMH and STV, photography was used on one occasion.

### Imaging

Imaging services did not appear to be generally requested as part of routine follow up. Figure 21 shows the frequency of imaging performed.

	PMCC	RMH	SVH
CT	1	2	
Ultrasound		2	1
X-Ray		1	
Bone Scan			1

Figure 21

### What disciplines are referred to and how frequently?

Referrals occurred infrequently in the follow up of this sample of patients, at RMH just 1% and at both PMCC and STV 3% of visits resulted in a documented referral. Figure 22 shows where patients were referred.

	PMCC	RMH	SVH
GP	1	2	
Dermatologist	2	2	
Medical Oncologist		1	
Surgeon			1
General Medical Clinic			1

Figure 22-Referrals Made at All Hospitals

### How often are letters sent?

PMCC most frequently send a letter to the patients GP after follow up visits with 75% (n75). RMH sent letters 47% (n34) of the time and STV 44% (n26).

**How often are letters sent to health professionals other than the GP?**

There were no instances recorded of letters being sent to a health professional other than the GP at PMCC and RMH. At STV there were two recorded occasions with one being sent to a private surgeon and one to a health professional of an unknown discipline.

It is acknowledged that information may be often disseminated in a non-written way. Verbal communication may often be favoured at hospitals, due to multi-medical disciplines coming together in the same location for the clinic.

**Unidentified Clinicians**

Through this analysis there are many appointments at all hospitals where the discipline of the clinician is unknown. Hospitals may wish to consider encouraging staff to add designation to correspondence and when writing in patient histories, in order to assist new staff and locums, who may not yet be familiar with the individual clinicians.