

## **Pitfalls of the Pigmented Lesion Clinic**

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Approximately 1,000 new cases of melanoma are diagnosed in Ireland each year and the incidence is increasing annually<sup>1</sup>. The referral pathway is either by letter or using a form created by the National Cancer Control Programme (NCCP) in 2013 - the pigmented lesion referral form. This system means every patient who is referred is seen in a consultant led clinic.

We evaluated our pigmented lesion clinic in University Hospital Limerick. Data was prospectively collected at pigmented lesion clinics between August 2018 and May 2019. Clinicians were provided with data sheets and asked to provide information pertaining to both the referral and the clinical consultation.

Data was obtained from 727 consultations. The average waiting time was 28 weeks (SD±14.21). Wait times for the 11% of patients (81) whose referral reason was 'a likely melanoma' was 18 weeks. The average wait time for the 4% of patients (30) who clinically on assessment had lesions consistent with melanoma was 20 weeks.

The most common reason for referral, representing 55% of referrals (404) was "a changing mole requires assessment". Of the lesions assessed 34% (248) were benign naevi. A further 30% (223) were classified as other forms of benign lesions (seborrhoeic keratoses, dermatofibromas, solar lentigos).

Our results show that 64% of patients seen had clinically benign lesions which has led to slower access for those with melanoma. The written information in the referral did not allow us to triage or see melanoma quicker, either with the NCCP referral form or by letter.

The Covid 19 pandemic is impelling us to reevaluate our entire health system as we cope with limited clinic capacity and thus inevitably longer wait times. Teledermatology is being used in many countries and evidence supports it as a valid and accurate form of practice<sup>2</sup>. For pigmented lesions, it offers the dual advantage of identifying and discharging the clearly benign lesions while expediting review or direct excision of lesions that are clearly malignant.

Camera phone images are not sufficient to improve triage. High quality dermatoscopic images are required to safely assess and discharge patients with benign lesions. In the U.K some dermatology departments use an asynchronous model where patients are invited to attend a hub and trained dermatology nurses take gross and dermatoscopic images of lesions that are promptly assessed on a “dry round” by their consultant colleagues<sup>3</sup>. A secondary gain of this system is that it provides an educational opportunity for general practitioners by facilitating prompt visual feedback of the relevant features of the lesions they referred.

The Scheduled Care Access Plan published by the Dept of Health in March 2019 highlights dermatology as a specialty with long waiting lists in need of more resources<sup>4</sup>. The plan sets out intentions to introduce “see and treat” clinics. Our data highlights the importance of improving the triage system in place so that the appropriate patients are seen at these clinics.

High quality teledermatology combined with teledermoscopy performed in the community, in alignment with the Sláintecare model, is likely to be the pathway to help us better diagnose and triage benign from malignant.

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