

# The SCCANZ Skin Cancer Audit and Research Database (SCARD)

## TO USE THE PROGRAM ...

**At any time to clarify any issues you can contact us by email on [support@skincanceraudit.com](mailto:support@skincanceraudit.com)**

The “Notice Board” on the home-page contains just a few very important instructions. Information is added from time to time. Please read each of the messages there and check for new messages periodically

**NOTE: If at any time you see error messages on the screen, refresh Your browser’s window (usually pressing F5 will do this). If you have continual problems this may indicate that the site is undergoing maintenance. Alternatively, you may need to restart your modem**

Entering specimens is actually quite simple as you will discover but the process is described in detail.

If you prefer you can do the “10 minute tutorial” (available under “support” on the home page) before you read this manual.

After you have done that we recommend that you read through this completely first and then just refer back to it if you need to.

### **Logging on**

The first page you will be presented with after you have registered and received your “link” to [www.skincanceraudit.com/online](http://www.skincanceraudit.com/online) requests that you enter your “username” and “password”. They will have been provided to you by email. Enter them and select “login”. That is how you will activate your database from now on. You will be able to alter your username and password (under preferences). If you forget them you will need to contact us at [support@skincanceraudit.com](mailto:support@skincanceraudit.com) to reset them.

After you have logged in you will be presented with the home page of your Audit. That gives you information about your audit and links to the various parts of it.

At any stage you can go to “Click here to change your preferences” and you will be presented with a number of different options which are explained on that page.

*If you have any questions please email us at [support@skincanceraudit.com](mailto:support@skincanceraudit.com)*

## **Entering a new specimen**

When you wish to enter your first specimen select “New specimen” at the top of that home page. You will need to complete the fields for “New specimen for new patient”. Please note that when entering the patient’s “Date Of Birth” you MUST separate the date, month and year fields with a “dash” rather than a “slash” and you must use 2 digits for the date and month and 4 for the year.

When you have completed all the fields for the new patient select “Save and Add”.

You will then be presented with the page for entering the details of your specimen.

*(The option “Scheduled” should be used if you are not treating the lesion at this time. When you treat the lesion select this entry and click on “proceed”)*

Complete the fields then select “Save”

***AFTER YOU HAVE ENTERED THE FIRST SPECIMEN SELECT “SPREADSHEET” AT THE TOP OF THE PAGE. From now on it is best if you work from the spreadsheet.***

## **WHICH SPECIMENS SHOULD YOU ENTER?**

***If you have signed consent to participate in the research project it is important that you follow the instructions which follow.***

Please ***consecutively*** enter ***every*** specimen biopsied or excised due to ***any possibility of malignancy***. In every such case if the lesion is “new” you should tick either “Exclude melanoma?” or Exclude NMSC?”

In addition to this please enter ***all pigmented skin lesions*** even if removed for cosmetic reasons and please include ***all raised or nodular lesions***.

It is not necessary to enter excisions of sebaceous cysts, skin tags, unequivocal verucca vulgaris or biopsies of rashes unless malignancy is suspected.

## **PLEASE NOTE**

**You should enter a fresh entry for every procedure (not just every specimen). For example there is one entry for a biopsy of a BCC and another entry for subsequent excision or for referral to a specialist or for non-surgical treatment (eg Imiquimod)**

## **FOR FURTHER ENTRIES**

1. As stated above, on the AUDIT HOMEPAGE select “**Spreadsheet**” (It is best to work from this page and to keep coming back to this page). Alternatively select “**Patients**” and enter the patient’s name and work from that page.
2. To enter a new specimen (**existing or new patient**) select “new specimen” at the top of the “Spreadsheet” page
3. For a **new patient** go to the fields on the lower part of the page and type in **surname, first name, sex and D.O.B (dd-mm-yyyy)** then select “**Save and add specimen**”

This will take you to the “New Specimen” page

4. For an **existing patient** start typing in the surname (all lower case) in the section at the top of the page and options will be displayed of persons matching the typed details. Select the appropriate person with a left click of your mouse. Then select “Select and Add Specimen”. This will take you to the “New Specimen” page

**IMPORTANT – To avoid creating duplicate patients:-**

*Once you have a few patients on the database always type in a few letters of the patient’s surname in the section at the top of this page first to check if the patient is on the database.*

**Duplicate patients can be deleted only if no specimens have been saved – or if all specimens have been deleted- for that patient entry. (You can contact us to remove duplicate entries if necessary)**

5. On the “New Specimen” page you will fill in the fields sequentially. *It does not take long but the process will be described in detail:-*

a) **Date** – this will default to the current date. You can overwrite this to alter the date)

b) **Location** – Select from the dropdown box. **Elbow is included with forearm and knee with leg.**

c) **New Lesion?** – A tick in the box means it has *not* been previously biopsied. This field must be completed.

*If a lesion has been previously biopsied (either by you or someone else) so that the histological diagnosis has been established then this lesion is “not new”. If a lesion is recurrent, so that the diagnostic process must start again from scratch, the lesion should be regarded as “new”.*

**Linking a procedure (eg excision) to an earlier procedure (eg biopsy)**

If you have done a biopsy and as a result you now have to fully excise (or otherwise treat) that lesion find the original biopsy entry on the spreadsheet and select “Re-excision”. This will open an entry in the “New specimen” page where you can enter the details of the new procedure. It will be linked to the original biopsy (date, location, previous biopsy diagnosis already completed) so that when this procedure is marked as no further action required, the original biopsy procedure will also turn green on the spreadsheet.(colour coding explained later)

*If the lesion has been biopsied elsewhere untick the “new”box and when the dialogue box appears about linking select “Cancel”*

d) **Exclusion tests** – You must select either “Exclude melanoma?”, “Exclude NMSC?” or “N/A” (Not applicable).

If the procedure is being performed to exclude skin cancer, (even if you are sure on clinical grounds that the lesion is malignant), you should choose Yes to either Exclude melanoma or Exclude NMSC. An example of when you would select

N/A would be the removal of a sebaceous cyst or the removal of a dermal naevus or seborrhoeic keratosis for cosmetic reasons. ***You would also normally select N/A for a previously biopsied specimen.***

e) **Provisional Diagnosis** – Select the appropriate option from the drop-down box displayed. The Provisional Diagnosis is your “best guess” as to the diagnosis or in the case of a previously biopsied lesion you should insert the histological diagnosis of that biopsy result. Hence, this field should always be completed.

Use the “Other-malignant” and “Other-benign” for any lesions not described by the other options (for example if you biopsy dermatitis or a psoriatic rash)

### **BCC Sub-types**

- 1. Aggressive – If any part is micronodular, infiltrating or sclerosing (morphoeic)**
- 2. Nodular – If not aggressive and with any part solid or nodular (includes Fibroepithelioma of Pinkus variants)**
- 3. Superficial – If no aggressive or nodular component**

f) With respect to the surgical procedure you perform, you are required to select an option from **either** the **Biopsy field** or the **Definitive management** field.

***Please note that even if you treat the patient by referring to a plastic surgeon you still enter the specimen and select “Specialist referral” as the “Definitive management type”. This means that this still contributes to your diagnostic data and it can be tracked to ensure compliance***

g) **Dermoscopy used?** If dermoscopy was used at any stage for the evaluation of this lesion click with your mouse to place a tick in the box provided. Leaving the box un-ticked gives a default answer of “no”. This field is disabled for previously biopsied (not-new) specimens.

h) **Action re Digital Monitoring Change?** – Click in the field with your mouse to apply a tick if **this procedure** is being performed as a consequence of digital dermatoscopic monitoring the lesion with observed change. . Leaving the box un-ticked gives a default answer of “no”.

After you have completed these fields select **“Save”**

You will be returned to the “PATIENT’S PAGE”

From there you can either select **“Add new Specimen” to add another specimen for that patient or you can go to the top of that page and select “New Specimen” to add a specimen for a different patient.**

If you selected as the “Definitive Management” option “Specialist Referral” do not proceed further until after you have received the result (and histology) back from the specialist. That way this entry will remain colour coded ORANGE” (explained later) in the EXCEL spreadsheet view of specimens and it will be evident that it has not been finalised. Any patients who fail to keep their specialist appointment will be easily identified.

**When you receive the pathology results** for the specimen entered above (or if you are applying definitive treatment such as Freeze-thaw cycles without submitting any specimen for histology) proceed as follows :-

Select “**Spreadsheet**”

All of the specimens with histology pending will be orange.

Select the appropriate one and select “View”. Fill in the following fields:-

**Histological Diagnosis ( HD)** – Select the appropriate option from the Drop-down options. There is an option to cover every possible result so if there is not an option to match the histology you have received select “Other- malignant” or “Other-benign”.

If the histology result contains two diagnoses (eg Bowen’s disease arising in a seborrhoeic keratosis) select the one which is clinically more important (Bowen’s disease).

If the histology result is borderline (eg borderline for level 1 melanoma) upgrade the diagnosis.

*Please note that “Melanoma invasive >1mm” refers to the Breslow thickness of the melanoma.*

“**NO RESIDUAL**” is selected if there is no residual tumour present following re-excision of a previously biopsied specimen.

“**NO HISTOLOGY AT ALL**” is selected if the treatment involved no specimen being submitted and there was no previous biopsy (eg Liquid Nitrogen Freeze-Thaw cycles to a superficial BCC without a biopsy being taken.)

Select “**NOT APPLICABLE**” if a previously biopsied specimen is being treated without a further specimen being submitted (as with PDT, Imiquimod, 5FU cream or Liquid N2 Freeze-thaw.)

**Margins Adequate? (“Margins?” in spreadsheet)**- You should complete this based on your interpretation of the histology report. If you assess the margins as adequate that means they are adequate according to the “Clinical Practice Guide” (Cancer Council Australia)

<http://www.cancer.org.au/File/HealthProfessionals/ClinicalPracticeGuidelines-ManagementofMelanoma.pdf>

[http://www.cancer.org.au/File/HealthProfessionals/Basal\\_cell\\_carcinoma\\_Squamous\\_cell\\_carcinoma\\_Guide\\_Nov\\_2008-Final\\_with\\_Corrigendums.pdf](http://www.cancer.org.au/File/HealthProfessionals/Basal_cell_carcinoma_Squamous_cell_carcinoma_Guide_Nov_2008-Final_with_Corrigendums.pdf)

and that in your assessment further treatment as this time (apart from normal clinical surveillance) is not indicated.

Margin adequacy is NOT assessed for biopsies

**With respect to “Curettage and Cautery” the “Not applicable” option is selected by default as it is impossible to assess margins on this treatment option.**

**Further Action Required? (“Action?” in spreadsheet)** – Select “No” if as a result of your biopsy or procedure no further specific action is needed. ( For example if you have biopsied a benign lesion or adequately excised a BCC or melanoma). Otherwise select “yes”.

**Further Action Finalised? (“FF?”) in spreadsheet)– *This field will not normally need to be completed.*** If further action is required this field will complete automatically when the subsequent curative procedure is performed *as long as you “link” the new procedure to this one at the time of entering it.* Selecting “Yes” in this field implies that the lesion has been dealt with and cure achieved and the row turns green on the spreadsheet.

***If you have selected the preference “Show “Exact” button on spreadsheet” then on the spreadsheet you can simply select “Exact” and “Save” IF THE HISTOLOGICAL AND PROVISIONAL DIGNOSIS ARE THE SAME AND NO FURTHER TREATMENT IS INDICATE. Do not select use this short-cut IF FURTHER TREATMENT IS NECESSARY***

**Complications?** – This is an optional field with a list of potential surgical complications in a dropdown box. If a complication arises you should come back to this entry and select the appropriate option from the dropdown box. You can only select one option here. Add subsequent complications in the “notes” field.

**Notes** – This field is for your own use. For example if the PD or HD are not covered adequately in the dropdown options you may wish to make a descriptive entry in this field

**Select “Save”**

This will take you back to the colour coded EXCEL spreadsheet. **All specimens are displayed sequentially by date with the most recent at the top.** Multiple specimens on the same patient on the same date will be grouped sequentially in this way. **Multiple patients on the same date will not necessarily be grouped sequentially.**

### **The Spread-Sheet – Colour Coding**

Procedures which are scheduled but not yet performed are colour-coded **yellow**

Procedures which have been performed and for which histology results are pending are colour-coded orange.

Procedures for specimens which require further management are colour-coded red.

Procedures for specimens which have been adequately treated and for which no further action is required (apart from normal ongoing clinical surveillance) are colour-coded green.

You can re-enter the edit field for any specimen by selecting “View” in the last Column of the spreadsheet. ***The only item which cannot be edited is the “Provisional or Previous Biopsy Diagnosis”.***

**Any specimen can be deleted by selecting “view” on the extreme right of the spreadsheet row to enter the “specimen edit” field and selecting “delete”.**

**(Deletion of a specimen is not possible after the specimen has been “exported”)**

## **TO DECIDE WHETHER A PROCEDURE IS A BIOPSY**

Select from the **Biopsy (type)** field if the procedure is being performed primarily to establish a diagnosis *without attempting to achieve adequate surgical margins*.

Select from the **Definitive management (type)** field if the procedure is being performed for the purpose of achieving appropriate definitive surgical margins.

Where you perform a procedure to both establish a diagnosis and achieve appropriate surgical margins, e.g. a clinically obvious BCC, select from a Definitive management option.

At times there may be some difficulty deciding between Excisional biopsy in the biopsy column and Ellipse excision or Shave/saucerisation in the definitive surgical management column. Only use the definitive management column where you are *aiming* to remove the lesion with adequate margins. For example, excision of a suspicious naevus with only 2 mm margins, without a previous biopsy, would be an excisional biopsy, not a definitive excision. The reason you are excising it is only to exclude **melanoma**.

Another unclear situation may be when you biopsy a lesion with a punch or shave technique, and actually remove the whole lesion by doing so. Please call this a Punch removal or Shave removal as opposed to a Punch-sample or Shave-sample.

### **Examples:-**

- i) I remove a mole with 2mm margins to exclude melanoma – “Excisional biopsy”**
- ii) I remove a suspected nodular BCC with 3mm margins by direct closure – “Ellipse” (in the Definitive management field).**
- iii) I completely remove a sebaceous cyst by direct closure – “Ellipse” (in the Definitive management field).**
- iv) I re-excise a confirmed in-situ melanoma with 5mm margins by direct closure – “Ellipse” (in the Definitive management field).**
- v) I do a punch or shave biopsy partially sampling a suspected BCC – “Punch – sample” or “Shave- sample” (in Biopsy field).**
- vi) I remove a 2mm mole with a 4mm biopsy punch – “Punch-removal” (in Biopsy field).**

PLEASE NOTE – the definition you use for “biopsy” in this audit in no way affects how you bill Medicare for that procedure. At times you will excise a lesion and quite correctly use an excision item number, but actually put this procedure down as an excisional biopsy in the biopsy column of the audit.

## **PROGRAM MAINTENANCE**

### **TO EDIT PATIENT DETAILS**

On the HOMEPAGE select “ Patients”, then select the patient whose details you want to edit .

This will display “Patient details” for that patient.

Then select “Edit Patient Details”.

All details can be edited except the patient’s unique ID number.

A patient can be deleted only if no specimen details have been saved or if all associated specimens have been deleted.

### **TO REMOVE A DUPLICATE PATIENT**

In the “Edit patient details” screen a patient can be deleted if there are no specimens allocated to that patient or if all specimens for that patient have first been deleted.

### **TO EXPORT DATA**

On the homepage select “Export”

Select “Automatic Export” The process will take up to a few seconds and at the end of the “Export” a message will inform you that the process is complete.

### **TO GENERATE A REPORT OF YOUR OWN DATA**

On the Home page select “Reports”

Under “Local Reports”

Select either a date-range (drop-down calendar for date and month, change year by over-typing) or select “View all”

Your report will be displayed. It can be printed (File” “Print”) or copied and pasted to a word document.

### **TO VIEW POOLED RESULTS**

On the Home page select “Reports”

Under “Pooled Reports”

Either “Select all” or choose a date range.

### **To download a CSV backup of all of your own data**

On the home page select “Export”

At the bottom of that page select “Download CSV backup of your data”

This data can then be analysed in an EXCEL program in any way that you choose.

### **TO CHANGE YOUR EMAIL ADDRESS**

Email us on [support@skincanceraudit.com](mailto:support@skincanceraudit.com)

### **TO CONTACT US**

Email us on [support@skincanceraudit.com](mailto:support@skincanceraudit.com)

### **IF YOUR ATTEMPTS TO ACCESS THE WEB-SITE ARE NOT SUCCESSFUL**

Reboot your router (disconnect the power to it for 30 seconds then reconnect). If that fails then email us on [support@skincanceraudit.com](mailto:support@skincanceraudit.com)

### **IF YOU FORGET YOUR PASSWORD OR YOUR PASSWORD IS NOT ACCEPTED**

Email us on [support@skincanceraudit.com](mailto:support@skincanceraudit.com)

## FREQUENTLY ASKED QUESTIONS

### What lesions are “New”?

If a lesion has not been previously biopsied it is “new”.

If the histology is known by virtue of a previous biopsy (by you or anyone else) it is “not new”

If a lesion is “recurrent” following a previous adequate excision the diagnostic process starts again from scratch so this lesion is regarded as “new”

The reason for this method of classification is twofold.

Firstly you want to know how many melanomas and other lesions you “discover”.

Secondly we are looking for the true “incidence” of various lesions so we don’t want any counted twice by virtue of the fact that two different doctors have been involved.

### How do you decide between “Exclude melanoma?”, “Exclude NMSC?” or “N/A”

If you are operating on a lesion because you need to exclude melanoma choose the first option.

If you are operating on a lesion to exclude malignancy but you do not suspect melanoma choose the second option.

If you already know the diagnosis *by virtue of a previous biopsy* choose “N/A”

**Do not** choose “N/A” just because you are clinically sure of the diagnosis.

If you are removing a lesion ( like a sebaceous cyst) without any suspicion of malignancy choose “N/A”.

From time to time a lesion will be biopsied to “Exclude NMSC” but will come back as a melanoma. We will be making a note of such cases in the reporting module and those statistics will actually be very interesting and useful.

### What if you refer a lesion to a surgeon with or without doing a biopsy?

You are still diagnosing and “treating” this lesion and it should be included in your audit. That way it will be included in your diagnostic and diagnostic accuracy data and the management will be tracked.

Under “Definitive Management Type” select “Specialist Referral”. Do not complete the “Histological Diagnosis” and other related fields until you get the report back from the specialist. That way these entries will remain orange and failure of the patient to follow up with the specialist will “glow in the dark”.

### How do you enter a previously biopsied specimen which is not being managed by a surgical excision by yourself ( eg, Managed by Freeze-thaw, Imiquimod, specialist referral)

Whenever you treat a previously biopsied lesion please make a new entry.

This applies whether you excise the lesion or treat it with non-surgical treatment (eg Imiquimod) or refer it to a specialist.

“Link” the new procedure to the original biopsy by going to the original biopsy on the spreadsheet and selecting “Re-excision”.

Under the “Exclusion tests” select N/A (done automatically when “linking”)

Under PD select the “Previous biopsy diagnosis” (done automatically when “linking”)

Under Histological Diagnosis select “Not applicable” for treatments like Imiquimod or Liquid Nitrogen freeze-thaw and in the case of Specialist referral do not complete this until the results come back from the specialist

Under ‘Margins adequate?’ select N/A for treatments like Imiquimod.

Under “Further action required” leave that as “yes” until you are satisfied that the

treatment has been successful then change that to “no” and that will turn both that entry and the linked biopsy entry “green” on the spreadsheet.

**What if a patient is lost to follow up?**

If a patient is lost to follow up the procedure will always remain flagged as incomplete because that is what the status is - incomplete! That is actually a useful tool in that you will remain aware of these cases and will be prompted to follow them up as appropriate and possible. Eventually you will make notes in the "notes" section to document your attempts at follow up and then you will leave them where they belong – “in limbo”.

**Can retrospective data be entered?**

Entering retrospective data is fine. This is your tool to use as you please. As for analysing pooled data and doing research we can be selective about what data we analyse and if necessary we can exclude retrospective data by date selection.

**Do you have to send in de-identified data?**

No.

## **FORMULAS USED IN GENERATING REPORTS – Both Personal and Pooled**

### **General statistics**

#### **1. Breakdown of new lesions by HD**

This is simply a list of **all new lesions categorised according to the Histological Diagnosis** which has been entered or **categorised as “Histology Pending”** if no HD has been entered.

#### **2. Percentage of new lesions tested which were malignant**

Looks only at **new** lesions.

Diagnosis of malignancy is based on **histological diagnosis (HD)**.

**HD** field must have been completed.

**Numerator** – All new malignant lesions

**Denominator** – All new lesions

#### **3. Percentage of definitively excised lesions that were malignant.**

This is also known as the **“Hit rate”**

Applies to both **“New”** and **“Not new”** lesions

Diagnosis of **malignancy** is based on **HD**. If the HD is **“No residual”** the

**PD** is used to determine **malignancy**.

The lesion is excluded from calculation if HD is **“Still pending”**, **“No histology at all”** or **“Not Applicable”**

This looks at the first 7 categories of Definitive management only:-

( Histology must be available for this to be valid)

Ellipse

Flap

SSG

FTSG

No Closure

Shave/Saucerisation

Curettage & Cautery

**Numerator** – **Definitively managed lesions that were malignant**

**Denominator** – **All Definitively managed lesions**

#### **4. Lesions tested to find one melanoma**

New lesions only

Diagnosis of **melanoma** (in-situ, invasive, invasive >1mm or metastatic) based on **HD**

**Numerator** – **All new lesions tested to “Exclude melanoma”**

**Denominator** – **New melanomas**

*Please note that the denominator in this calculation is never zero*

*(for mathematical reasons). It is valued as “one ”even before any melanomas have been diagnosed*

## 5. Percentage of lesions tested for NMSC which were NMSC

New lesions only

Diagnosis of NMSC ( BCC IEC SCC,KA,Merkel cell tumour,NMSC metastasis, Other malignant) based on **HD**

**The lesion is excluded if there is no HD**

**Numerator** – All new lesions with HD of NMSC

**Denominator** – All new lesions tested to exclude NMSC

Converted to a percentage.

## Diagnostic Accuracy

Definitions are as follows. (BCC,s are used as an example):-

**Sensitivity** – **HD of BCC has a corresponding PD of BCC**

**Positive Predictive Value (PPV)** – **PD of BCC has a corresponding HD of BCC**

**Specificity** – **HD of “not BCC” has a PD of “Not BCC”**

The problem with reporting Specificity is that the vast majority of lesions that are suspected as “Not BCC” are not tested – they remain on the patient

Please note that the following HD options are excluded from Diagnostic

Accuracy calculations:-

“Histology Pending”, ”No residual”, “No histology at all” or “Not applicable”. The last 3 of these options would not normally apply to “new” lesions anyway.

## Overall Diagnostic Accuracy

### a) Overall Sensitivity

New lesions only

Assesses all **identified** lesions with an actual **confirmed** HD

**Numerator** – **All new lesions where the HD has a corresponding PD**

**Denominator** – **All new lesions**

This category of overall sensitivity measures the incidence of exact correlation between HD and PD. For example if a lesion was an SCC and your PD was IEC that will be measured as **incorrect**.

### b) Overall PPV

New lesions only

Assesses all **identified** lesions with an actual **confirmed** HD

**Numerator** – **All new lesions where the HD has a corresponding PD**

**Denominator** – **All new lesions**

*(This will be identical to the Overall Diagnostic Sensitivity – same numerator and denominator as includes ALL lesions with a HD)*

## Diagnostic Accuracy - Melanomas

### a) Diagnostic sensitivity – melanomas

New lesions only

Assesses all 4 categories of melanoma as one

**Numerator** – **All new melanomas where HD of melanoma any type is matched by a PD of melanoma any type**

**Denominator** – **All new melanomas ( determined by HD)**

### b) PPV Melanomas

New lesions only

Assess all 4 categories of melanoma as one

**Numerator – All new melanomas where HD of melanoma any type is matched by a PD of melanoma any type**

**Denominator – All new lesions with a PD of melanoma (any type)**

### **Diagnostic Accuracy - NMSC**

a) **Diagnostic sensitivity – all NMSC**

New lesions only

**Numerator – All new NMSC where HD of NMSC any type is matched by a PD of NMSC any type**

**Denominator – All new NMSC ( determined by HD)**

b) **PPV all NMSC**

New lesions only

**Numerator – All new NMSC where HD of NMSC any type is matched by a PD of NMSC any type**

**Denominator - All new lesions with a PD of NMSC (any type)**

### **Diagnostic Accuracy - SCC**

a) **Diagnostic sensitivity – SCC**

New lesions only

Regard SCC, IEC and KA all as SCC for this calculation

**Numerator – All new SCC,s where HD of SCC any type is matched by a PD of SCC any type.**

**Denominator - All new SCC,s any type ( determined by HD)**

b) **PPV – SCC**

New lesions only

Regard SCC, IEC and KA all as SCC for this calculation

**Numerator – All new SCC,s where HD of SCC any type is matched by a PD of SCC any type.**

**Denominator - All lesions with a PD of SCC (any type)**

### **Diagnostic Accuracy - BCC**

A) **Diagnostic sensitivity – BCC**

New lesions only

**Numerator – All new BCC,s where HD of BCC any type is matched by a PD of BCC any type .**

**Denominator - All new BCC,s any type ( determined by HD**

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b) **PPV BCC**

New lesions only

**Numerator – All new BCC,s where HD of BCC any type is matched by a PD of BCC any type .**

**Denominator - All lesions with a PD of BCC (any type)**

## **Adequacy of Surgical Margins**

**Malignancy type** is defined by an entry under **HD**. If the entry under HD is “**No residual**” then the **PD** is applied. Lesions are excluded from this calculation if the HD is classified as **Histology Pending , No histology at all or Not Applicable**

The following options of Definitive Management are assessed:-

**Ellipse**

**Flap**

**Graft - SSG**

**Graft – FTSG**

**No Closure**

**Shave/Saucerisation**

**Numerator – Number of cases where “Margins adequate?” was “Yes”**

**Denominator - Number of cases where “Margins adequate?” was “Yes” plus Number of cases where “Margins adequate?” was “No”**

This calculation is applied to the following categories

**1. BCC superficial**

**2. BCC nodular**

**3. BCC other**

**4. IEC**

**5. SCC**

**6. KA**

**7. Melanoma – in situ**

**8. Melanoma – invasive**

**9. Melanoma invasive >1mm**

**10. Other malignant**

## **Procedures used to exclude melanoma**

This is a simple breakdown applied to all lesions where “Exclude melanoma?” was selected and lists Biopsy/Definitive management techniques which were used.

## **Breakdown of Definitive Management Procedures for Malignant Conditions**

**Malignancy** is defined by **PD** ( Previous Biopsy or Provisional Diagnosis)

The procedures are listed in the same order in which they appear in the “drop-down list” in the Audit log. **The number of times each procedure has been used is indicated.**

## **Breakdown of Definitive Management Procedures for Benign Conditions**

**Benign status** is defined by **PD** ( Previous Biopsy or Provisional Diagnosis)

The procedures are listed in the same order in which they appear in the “drop-down list” in the Audit log. **The number of times each procedure has been used is indicated.**

**The reason PD rather than HD has been used here is two-fold**

**Firstly** – Certain procedures (eg PDT, Imiqimod, 5FU cream, liquid Nitrogen freeze-thaw) do not involve submission of tissue to histology so will have no entry under HD although they will have an entry under PD

**Secondly** – This calculation is looking at the procedures used as determined by what the operator believed he or she was treating. There are other calculations which assess the accuracy of diagnosis.

### **Breakdown of Melanomas by Location**

Applies to “new” lesions only

There must be an entry of melanoma (any type) under HD

The total number of new melanomas at each body site is listed

This is then expressed as a percentage of all new lesions at that site ( as determined by HD but excluding the HD categories HISTOLOGY PENDING, NO RESIDUAL,NO HISTOLOGY AT ALL, NOT APPLICABLE

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