Managing the skin cancer surge

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Non-melanoma skin cancer (NMSC) is not a one-off event for a small number of individuals. Rather it is a repeated problem affecting a large proportion of the population through the second half of their lives. Brougham and colleagues’ review\(^1\) of the possible incidence of NMSC in New Zealand suggests that the problem is both large and increasing. However we really do not know for certain as there is no reliable data on our true incidence of NMSC, let alone how the incidence is changing over time.

We have good information for the small but important sub-group of renal transplant recipients. In comparison with similar populations in other countries, patients in New Zealand have high rates of both NMSC incidence and mortality.\(^2\) For the New Zealand population as a whole, 122 deaths were attributed to NMSC in 2007 (twice that of cervical cancer).

Extrapolation of overseas data suggests that the age-specific incidence rates of NMSC are increasing relentlessly. For example, the Danish rates have more than doubled in the last 30 years,\(^3\) and Scottish rates are estimated to be increasing 1.4–5.1% year-on-year.\(^4\) This combined with a burgeoning population of fair-skinned over-60s explains the large increase in absolute numbers of patients presenting with NMSCs. More recent literature suggests that age-specific incidence rates may not be increasing across the board. The Australian paper which provides the best information from our region\(^5\) states that rates have stabilised in under 60 year-olds. Similarly, a recent Canadian study\(^6\) has shown rates stabilising for NMSCs occurring on the head and neck, but not for other sites.

In the absence of local epidemiological information, we are left to observe how individual patients with NMSC are faring. Treatment services in secondary care are struggling to meet 6-month targets despite a typical clinical priority of 6 weeks. Some services have introduced barriers to referral such as the need for histological confirmation of malignancy as described by Rademaker and Thorburn.\(^7\) This results in an unnecessary procedure for the patient and histopathology costs to the funder. For a cancer that has an estimated annual treatment cost of NZS22–50 million per year,\(^1\) the question must be asked as to whether we can afford to continue implement such inefficient and expensive barriers to patient care.

In contrast to most cancers which are primarily managed by a well circumscribed group of hospital-based specialists, NMSC treatment is provided across primary, secondary and tertiary care. Although this broad-based involvement is identified as a barrier to data collection,\(^1\) it provides the potential solution to manage what may well be the single biggest increase in demand in cancer services.

The challenge is to coordinate treatment services so that most NMSC is treated locally at the time of diagnosis and that those cases that are more complex receive expeditious specialist treatment. NMSC does not fit current hospital-based cancer
service models well and is more appropriately managed in primary care as a persistent health problem. Identifying and treating NMSC early is both beneficial to the patient and more cost effective.

Now is the time for those involved in skin cancer management to step forward and become involved in both the determination of the true incidence of NMSC in New Zealand (as requested by Brougham) and monitor the outcomes of treatment that we are currently providing. Given the predicted surge of demand coming our way, this information is vital to planning our cancer services.

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