Is melanoma treatment failing national standards?

Jeremy Simcock

In this issue, an audit of a year of melanoma treatment in one of our regions is reported.1 The focus is on timeliness of each step along the treatment pathway. In many respects the numbers present no surprises with 143 patients having melanoma treatment, of whom 66 had sentinel lymph node biopsy and 11 patients, completion lymph node dissection. They were either referred to hospital following diagnosis by GP excision biopsy (about two-thirds) or with a suspicious skin lesion (about one-third). The majority simply had adequate wide local excision without requirement for any further investigation.

What is surprising are the long waiting times for these patients. For the 83 patients who were referred with a confirmed diagnosis of melanoma, why did it take a median of 54 days (range 16–282) for them to be treated?

For the 43 patients referred with a suspicious skin lesion later found to be melanoma, why did it take a median of 114 days (range 63–320) to have their melanoma treatment? Almost half of this time was a median 51-day interval from referral to biopsy. We don’t know what this interval was for the patients having their diagnostic biopsy outside the hospital.

Provisional national standards for melanoma patients were developed by the National Melanoma Tumour Standards Working Group chaired by Richard Martin.2 They were a major step forward from the Australian and New Zealand Guidelines, which were published in 2008,3 and contained many useful good practice points but did not refer to timing of care. In contrast, the provisional standards have a strong focus on timely access to services. They also contain monitoring requirements covering timeframes along the patient pathway (MR2A, MR4M, MR5B, MR6B and MR7C). As well as the familiar overall 31- and 62-day standards, they include components of the pathway such as histological reporting within 10 working days of biopsy.

The standards are widely supported by both patient and healthcare provider groups. However, there is ongoing frustration about the delay in implementation of the standards—they remain provisional four years after they were generated at great effort. As seen in the article in this edition, reporting against the standards is an important first step, however without routine reporting and standards-driven service improvement, there remains a lost opportunity. The standards should be incorporated into both planning and provision of services. For example, pathology contracts could include a requirement to report on timeliness of melanoma reports against the standard of 10 working days. The established regional multidisciplinary meeting (MDM) structure is well placed to carry routine reporting if adequately resourced. By auditing all patients against the agreed standards, we can take a patient-focused view of cancer care rather than simply reporting hospital departmental compliance with targets. Retrospective audit will identify areas for improvement across primary and secondary care, pathology, radiology and surgical oncology. Communication and coordination of care is critical, both between providers and with patients. Prospective tracking of all cancer patients waiting for treatment as they move along their pathways is either underway or a goal for us all. Visibility of patients and the length of time that they are waiting is important. This would be the most effective method of ensuring that individual patients will receive timely cancer care.

The provisional national standards fulfil the very important role of setting the expectations of adequate melanoma care for those in secondary and primary care and importantly for patients. Through these shared expectations and reflecting on them, melanoma care will improve.
It is of interest that melanoma treatment utilises the same resources as non-melanoma skin cancer (NMSC). NMSC causes a quarter of all skin cancer deaths and occurs at more than 25 times the rate of melanoma. With an increasing disease burden of all skin cancer, we must ensure that NMSC care is also maintained despite the anomaly that it is not included as a tumour stream in the Faster Cancer Treatment programme.

I do not agree with the authors comment that it is “unlikely... that the patients... suffered any consequent deleterious effect”. While clear evidence of harm from delayed diagnosis and treatment of melanoma is currently lacking, other tumour streams evidence suggests timely management improves outcomes. In addition, melanoma patients suffer similar health-related quality of life reduction to other cancer patients. One-third of patients report clinically significant levels of distress, which peaks around the time of diagnosis and reduces following treatment. Therefore it is probable that prolonging the interval between raising a suspicion of cancer and treatment increases patients’ distress and thus reduces their quality of life.

Congratulations to the Waikato team for auditing and bravely reporting the timeliness of melanoma care in their region. It demonstrates that as a system, we have some way to go to reach an acceptable standard of care. Nationwide implementation of the provisional tumour standards is a priority. Monitoring of care against these standards has a critical role in improving both quality and equity of cancer care in New Zealand.

Competing interests:
Nil.

Author information:
Jeremy Simcock, Plastic Surgery, University of Otago, Christchurch.

Corresponding author:
Dr Jeremy Simcock, Plastic Surgery, University of Otago, Christchurch 8000.
jeremy.simcock@cdhb.health.nz

URL:

REFERENCES: