

Appendix 1 Established risk factors for cutaneous melanoma ¹

*OR = odds ratio. For example: a person with skin that does not tan easily has an approximately twofold (1.98 times) risk of developing melanoma compared to someone with skin that tans (after allowing for other risk factors).

Risk factor	OR*	Information
11–50 common moles >2 mm	1.8	The risk of melanoma rises with the number of common moles.
51–100 common moles > 2 mm	3.5	
>100 common moles >2 mm	7.6	
Family history of melanoma	1.8	Melanoma in a first-degree family member
Previous history of melanoma		Standardised incidence ratio range 4.5 to 25.6
The presence of 1–4 atypical moles	1.6 to 7.3	Atypical moles: ill-defined or irregular border; irregular pigmentation; diameter >5 mm; erythema (blanchable in lesion or at edge); accentuated skin markings.
Red or light-coloured hair	1.5 to 3.5	
Presence of actinic lentiginos	2 to 3.5	Actinic lentiginos: flat, brown skin lesions associated with acute and chronic sun exposure. No direct malignant potential.
Giant congenital melanocytic naevi ≥20 cm in diameter		Relative risk range 239 to 1,224 for extracutaneous as well as cutaneous melanoma.
Unusually high sun exposure	2.6	
Reported growth of a mole	2.3	
Skin that does not tan easily	1.98	
Light-coloured eyes	1.6	
Light-coloured skin	1.4	
Affluence		Relative risk approximately 3.0 for people residing least deprived compared to most deprived areas.
Female sex		Female: male ratio of incidence rates is 1.3: 1.0
Age		Melanoma is rare in childhood but risk begins to increase with age during adolescence, the elderly being at highest risk.

Appendix 2 Dermoscopy and mole photography

Assessing change in moles can be difficult both for patients and healthcare professionals. Monitoring moles by sequential photography might be helpful⁴. It can be helpful for patients to take photographs of their moles and store them on your computer then check them every three months to look for change. If one mole is changing compare it with the baseline photographic images, 3 months after first presentation to identify early signs of melanoma.⁴

Here is a link to add a sticker ruler to label trace printer options to give a size for comparison. It is recommended (by my IT expert!) to “ask the Practice’s IT guru to do the install one should understand where the file is going, and probably move it to the bottom of the list of templates. <http://www.quicktrace.co.uk/support/samples/misc/index.php>

MDDUS advises that the General Medical Council have published advice on taking pictures. The GMC guidance referenced above can be accessed here:

http://www.gmc-uk.org/guidance/ethical_guidance/7818.asp

They advise that verbal consent will likely be sufficient, that “using a personal smart phone is not likely to be sufficiently secure but you may wish to discuss this with the Information Commissioner's Office (ICO) on 0303 123 1113. Taking photos on a dedicated high-quality camera, which are then uploaded to the patient's file, is likely to be appropriate. These could be shared via secure email routes, subject to advice from the ICO and discussion with the receiving department.

They suggest that this issue is discussed with your Health Board's Caldicott guardian as they have a responsibility to consider the implications of the Data Protection Act, with regard to clinical services provided by the Health Board.”

Dermoscopy acts as an aid in the diagnosis of skin lesions. It must not be used in isolation but instead combined with a good history and naked eye examination. In the right hands dermoscopy can reduce referrals and unnecessary skin surgery

The main role of dermoscopy in Primary Care is to help identify benign lesions. The majority of seborrhoeic keratoses, angioma, dermatofibroma and blue naevi can be readily identified with a dermatoscope. This can help reduce referrals / unnecessary skin surgery. Dermoscopy can also aid in the diagnosis of pre-cancerous lesions such as actinic keratoses and Bowen's disease, as well as basal cell carcinoma.

Considerable experience is often required to differentiate between various benign melanocytic naevi, atypical naevi and melanoma, indeed some cases of melanoma have very subtle dermoscopic features. Accordingly, all melanocytic lesions suspicious of melanoma in terms of the history and naked-eye examination should be referred urgently to Secondary Care as a 2 Week Rule, regardless of their dermoscopic appearance.¹³

Equipment required is dermatoscope (contact or non-contact), camera and adaptor and software.¹³

For more information see PCDS, dermnetnz websites. Course are run by Ninewells hospital; RCGP and Primary care dermatology society, dermoscopy.co.uk

Appendix 3 - Medical Management of Actinic Keratoses (AK) in Primary Care ¹³

LESION SPECIFIC TREATMENT	treat individual lesions and not the surrounding skin		
CRYOTHERAPY	A single freeze-thaw cycle of 10 seconds	Avoid the gaiter area if the legs due to risk of skin ulceration	
EFUDIX CREAM (5-FU)	Apply at night for 4 weeks. Leave treated areas uncovered and wash the following morning.	Advise patients to expect mild redness and discomfort during treatment	
ACTIKERALL SOLUTION	It should be used once a day for 6-12 weeks		New treatment combining 5-FU with salicylic acid. Licensed to treat moderately thick hyperkeratotic AK.
FIELD CHANGE (SMALL)	small areas size of palm or a forehead		
ALDARA CREAM (5% IMIQUIMOD)	Use three nights a week eg Monday, Wednesday and Friday for four weeks. Apply overnight and wash off the following morning. Use for 4 weeks.	After treatment consider the use of a mild topical steroid eg 1% Hydrocortisone or Eumovate for 2-4 weeks to settle down inflammation. Follow up three months after the treatment was started and repeat if needed	Very effective in terms of clearance, and cosmetic appearance once inflammation resolved Patients should be warned to expect marked erythema with crusting of the skin. May develop flu-like symptoms. Avoid important occasions
EFUDIX CREAM (5-FU)	Use once a day for four weeks. Apply thinly in an evening with a gloved finger, alternatively wash the finger after application. The treated area should be washed the following morning. After four weeks stop the treatment	After treatment consider the use of a mild topical steroid eg 1% Hydrocortisone or Eumovate for 2-4 weeks to settle down inflammation.	Advantages and disadvantages similar to with Aldara®, although patients do not develop flu-like symptoms
PICATO GEL (ingenol mebutate, as 150 µg/g or 500 µg/g)	For the face and scalp - apply the 150 µg/g formula for 3 consecutive days only. For the trunk and extremities - apply the 500 µg/g formula for 2 consecutive days only		A new treatment- similar outcomes to the above, but a very short treatment period and recovery phase when compared to the other topical treatments
FIELD CHANGE (LARGE)			
SOLAREZE GEL (3% diclofenac in sodium hyaluronate)	Use twice a day for 12 weeks.	Review patient four weeks after treatment has finished to assess response	Well tolerated so can be used on any sized area. Viewed as a milder treatment so use where AK are thin
ZYCLARA CREAM (3.75% IMIQUIMOD CREAM)	Apply once daily for two weeks, followed by a two week treatment-free period, and then a further once daily application for two weeks		six weeks in total, but only four weeks of treatment

Appendix 4- IMAGES

BENIGN PIGMENTED

[Normal mole images](#)

[Atypical mole images](#)

[Freckle images](#)

[Solar Lentigo images](#)

[Seborrhoeic keratoses images](#)

[Melanocytic naevi images](#)

[Halo naevus images](#)

MELANOMA

[Superficial spreading melanoma images](#)

[Nodular melanoma images](#)

[Lentigo maligna melanoma images](#)

[Acral lentiginous melanoma](#) (from figure 11)

[Sub ungual melanoma images](#)

PRECURSOR LESIONS AND SCC

[Bowens disease images](#)

[Actinic keratoses images](#)

[Keratoacanthoma images](#)

[Cutaneous horn images](#)

[Squamous cell carcinoma images](#)

BENIGN NON- PIGMENTED

[Fibroxanthoma image](#)

[Merkel cell tumour images](#)

[Psoriasis images](#) SEE IMAGE 28

[Eczema images](#)

[Sebaceous gland hyperplasia images](#)

BCC

[Nodular BCC images](#)

[Superficial BCC images](#)

[Morphoeic BCC images](#)

[Baso-squamous BCC images](#)

LYMPHOMA / LEUKAEMIA

[Lymphoma and Leukaemia images](#)