Dermatology: Adult Follow-up Top Tips 'Top Tips' to ensure that the right people are offered follow-up appointments and understand how to re-access the service, if necessary.

1. Skin cancer

i. **Melanoma**

NICE guideline 2015 https://www.nice.org.uk/guidance/ng14/chapter/1-Recommendations#follow-up-after-treatment-for-melanoma-2

- **Stage 0:** Discharge after completion of treatment.
- **Stage IA:** Consider follow-up 2–4 times during the first year after treatment. Discharge at 1 year.
- **Stage 1B, II and III:** Consider follow-up every 3 months for the first 3 years, then every 6 months for 2 years Discharge at 5 years.
- **Stage IV:** Personalised follow-up as guided by SSMDT.

ii. Cutaneous squamous cell carcinoma (cSCC)

BAD guideline 2021 https://onlinelibrary.wiley.com/doi/10.1111/bjd.19621

- **Low-risk:** cSCC offer, where appropriate, a single post-treatment appointment and discharge.
- **High-risk:** cSCC follow-up 4-monthly for 12 months, then 6-monthy intervals for 12 months. Discharge at 2 years.
- **Very high-risk:** cSCC follow-up 4-monthly for 24 months, then 6-monthly intervals for 12 months. Discharge at 3 years.
- **Metastatic:** cSCC follow-up 3-monthly for 24 months, then 6-monthy for a further 36 months, with potential longer-term review dependent on patient factors.

iii. Basal cell carcinoma (BCC)

BAD guideline 2021 https://onlinelibrary.wiley.com/doi/full/10.1111/bjd.20524

- Single BCCs, usually discharge post operatively with a standard letter with histology and advice.

2. Pre-cancers, actinic keratosis (AK) and SCC *in situ*

i. AK

BAD guideline 2017 https://onlinelibrary.wiley.com/doi/full/10.1111/bjd.15107.

- Agree local primary care guidelines so referral usually only if topical treatment unsuccessful.
- In secondary care, aim to treat most on their first appointment and discharge.
- Offer information on skin surveillance/ cancer risk.
- In patients with high risk of cancer, consider PIFU post-treatment. Follow-up if very high risk (e.g. if immunosuppressed).

ii. **SCC *in situ***
Consider PIFU post-treatment if high risk of cancer. Follow-up if very high risk.

3. Multiple atypical moles

Agree local policy on criteria for follow-up of multiple atypical moles. Usually offer education then discharge with self-surveillance, unless very high risk (e.g. strong personal or family history of melanomas).

4. Inflammatory skin disease, e.g. psoriasis, eczema

i. Those managed topically.
   - Education, written treatment plans, flare plans and discharge to GP. In patients with moderate to severe disease controlled on maximal topical therapy, who may need systemics in future, consider PIFU.

ii. Those on phototherapy.
   - Aim to discharge post treatment if clear or consider PIFU. If not clear may need follow-up to discuss systemics.

iii. Those on systemics/biologics.
   - Follow monitoring guidance, ensure not doing too frequent blood tests. Consider nurse monitoring, telephone follow-up, and GP shared care.

5. Acne

i. Follow NICE management guidelines in primary care https://www.nice.org.uk/guidance/ng198.
   - Refer to secondary care as specified by NICE.
   - If not severe or unsuitable for isotretinoin, discharge with advice as per NICE guideline.

ii. Isotretinoin.
   - Follow-up according to pregnancy prevention programme for females of childbearing potential. Consider specialist nurse follow-up.

6. Post-surgery

For benign lesions/ BCCs write with results and information. No follow-up.

7. Patch tests

i. Where relevant allergen identified, provide advice on avoidance, treatment plan, etc. Consider discharge or PIFU, where appropriate.

ii. GIRFT advises coding each patch test appointments (3-4) as PT and not as follow-up.

8. Team work and roles of GPwERs, specialist nurses, physician associates and pharmacists

i. Where appropriate, consider the expertise/skills of GPwERS, dermatology specialist nurses and allied health professionals to undertake monitoring/post-surgery advice.

ii. Many dermatology follow up appointments across skin cancer, inflammatory dermatoses and surgery, can be managed by appropriately trained, competent dermatology nurses, aligned with the dermatology nurse role descriptor (https://bdng.org.uk/wp-content/uploads/2020/08/BAD-BDNG-RCN-NURSING-WORKSTREAM-A4-LANDSCAPE-002.pdf). These follow ups may involve monitoring, ongoing treatment (e.g. phototherapy) or patient education.

iii. Less experienced/temporary staff are more likely to offer follow-ups. Develop departmental follow-up guidelines. Communicate and supervise to minimise follow-ups and promote standard follow-up intervals in skin cancer pathways.
iv. Ensure the right person sees the patient first time, to avoid unnecessary follow-up. **Right person, Right treatment, First time.**

9. Education

i. Provide patients with treatment plan, online information resources and flare plans.
ii. Write to GP with clear flare plans so patients can be treated in the community where possible, and minimise referrals.

10. Threshold policies

Agree a threshold policy (e.g Procedures of Limited Clinical Value/ Cosmetic/ Evidence Based Intervention) with shared ownership between primary care, secondary care, and the CCG. Avoid referrals of people with conditions of lower priority. Discharge from secondary care, people who have conditions not covered under the threshold policy.