Periocular Skin Pathway

- Referrals to Oculoplastics
- Strong Indication:
  - Lesion within orbital rim
  - Medial and Lateral Canthal Areas
- Eyebrow involvement

- Relative Indication:
  - Glabellar
  - Forehead
  - Temple
  - Upper Cheek

### Referral
- Lethal Skin Cancer (seen within 2/52)
- Non Lethal Skin Cancer (seen routinely - currently < 6/52)

Initial Assessment with Clinical Photography

**Incisional Biopsy unless clinically very obvious**

**Clinic R/V with histology. Cancer Registration**

MDT involvement if lethal skin cancer or multidisciplinary care likely e.g. radical surgery

- **Consider reexcision i.e. treat as a recurrent tumour**
- **Suitable for Surgery?**
  - Yes
  - **Candidate for Mohs?** (See BAD guidelines)
  - **Recurrent Tumour, Deep Tethering**
  - **Indistinct margins, Morpheaform, Infiltrative, Micronodular**
  - >2cm Size, Perineural Invasion
  - Any MM
  - **No**

- **Two stage procedure possible? - Single stage excision may be appropriate for some low risk lesions e.g. small nodular BCC in low risk site**
  - **Yes**
    - **Excision with histological margin control**
    - Excise with appropriate margin
      - MM 5mm+ (At present no large series studies for periocular MM), Nodular BCC 2-3mm, Morpheaform BCC 3mm+, SCC 3-5mm, KA 3mm, SGC 5mm+ with conjunctival map biopsy
      - **Histological Confirmation of Clearance?** (Fast Paraffin preferable to frozen section)
      - **Yes**
      - **Further Excision Possible?**
        - **Yes**
          - **Reexcise**
        - **No**
          - **Reconstruct +/- combined MDT surgical approach**
      - **No**
    - **Histological Clearance of Tumour (paraffin sections)**
      - **Yes**
      - **Reexcise**
      - **No**
      - **MDT Review for non surgical management e.g. DXT**
      - **Follow Up in Clinic & MDT review if lethal skin cancer**

- **No**
  - **MDT Review for non surgical management e.g. DXT**

Evidence based practice suggests (in order of preference) for all periocular skin malignancies:
- Moh's Excision margin control using fast paraffin
- Excision with margin control using frozen section

Weaker evidence for most other treatment options
Useful Articles:

BAD Website guidelines www.bad.org

Guidelines for the management of basal cell carcinoma.
Telfer NR, Colver GB, Bowers PW. British Journal of Dermatology 1999;141; 415-423

Note periocular site is defined as a high risk site

Multiprofessional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma


Table 3. Recommended surgical excision margins

<table>
<thead>
<tr>
<th>Brodie thickness</th>
<th>Excision margins</th>
<th>Approximate 5-year survival</th>
<th>Grading of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>In situ</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 mm</td>
<td>2-5 mm clinical margins to achieve complete histological excision</td>
<td>95-100%*</td>
<td>Level B, grade III</td>
</tr>
<tr>
<td>1-2 mm</td>
<td>1-2 cm</td>
<td>80-95%</td>
<td>Level A, grade 1</td>
</tr>
<tr>
<td>2-4 mm</td>
<td>2-3 cm (2 cm permitted)</td>
<td>60-75%</td>
<td>Level A, grade 1</td>
</tr>
<tr>
<td>Greater than 4 mm</td>
<td>2-3 cm</td>
<td>50%</td>
<td>Level B, grade III</td>
</tr>
</tbody>
</table>

*In theory recurrence should never occur after in situ melanoma, but occasional cases do recur. The assumption is that regression at diagnosis obscured a more advanced tumour, or that progression occurred after incomplete removal of the in situ disease.

Malhotra R, James CL, Selva D, Huynh N, Huilgol SC.
The Australian Mohs database: periocular squamous intraepidermal carcinoma.

Malhotra R, Huilgol SC, Huynh NT, Selva D.
The Australian Mohs database, part II: periocular basal cell carcinoma outcome at 5-year follow-up.

Malhotra R, Huilgol SC, Huynh NT, Selva D.
The Australian Mohs database, part I: periocular basal cell carcinoma experience over 7 years

Malhotra R, Huilgol SC, Huynh NT, Selva D.
The Australian Mohs database: periocular squamous cell carcinoma.
### Table 2. Clinical Recommendations for Therapy: Bland Cell Carcinoma and Squamous Cell Carcinoma

<table>
<thead>
<tr>
<th>Type of Lesion</th>
<th>Recommendation</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exophytic, palpable</td>
<td>Mohs micrographic surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Volar, posterior</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Large lesion (&gt;4 cm)</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Distinct or indurated lesions</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Recurrent lesions</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Vascular or superficial cancers</td>
<td>Mohs micrographic surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Oropharyngeal lesions</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Located on tongue</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Neurocutaneous lesions</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Large or multiple lesions</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Controversial surgery</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Patient declines surgical excision</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Patient declines radiation excision</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Small superficial lesions</td>
<td>Castor oil and radiation</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Necrotic renal cortical lesions</td>
<td>Castor oil and radiation</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Irradiation</td>
<td>Castor oil and radiation</td>
<td>I (strong)</td>
</tr>
</tbody>
</table>

### Table 3. Clinical Recommendations for Therapy: Sebaceous Gland Carcinoma

<table>
<thead>
<tr>
<th>Type of Lesion</th>
<th>Recommendation</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>All lesions</td>
<td>Mohs micrographic surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Basal and squamous similar lesions</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Controversial surgery</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Patient declines surgical excision</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Patient declines radiation excision</td>
<td>Cytoreductive surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Optical devices</td>
<td>Excision</td>
<td>I (strong)</td>
</tr>
</tbody>
</table>

### Table 4. Clinical Recommendations for Therapy: Malignant Melanoma

<table>
<thead>
<tr>
<th>Type of Lesion</th>
<th>Recommendation</th>
<th>Evidence Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected eyelid lesions</td>
<td>Mohs micrographic surgery</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Intraocular</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Melanoma ≤ 1.0 mm thickness</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Melanoma 1.1-2.0 mm thickness</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Melanoma &gt;2.0 mm thickness</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Intraocular</td>
<td>Excision with 3-mm margin</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Stage I or II melanoma</td>
<td>Sentinel node biopsy and lymph node mapping</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Stage III or IV melanoma</td>
<td>Sentinel node biopsy and lymph node mapping</td>
<td>I (strong)</td>
</tr>
<tr>
<td>Stage III or IV melanoma</td>
<td>Sentinel node biopsy and lymph node mapping</td>
<td>I (strong)</td>
</tr>
</tbody>
</table>
Referral of Orbital Tumour

Oculoplastic Clinic Review with orbital imaging, orthoptic review, and Visual Fields

Referral to Regional/ Quaternary Referral Orbital Practice Necessary? e.g. posterior orbital mass, probable pleomorphic adenoma

Yes

Further Management in Regional Centre e.g. Moorfields, BMEC, Heartlands, Leicester, Manchester

No

Local Orbital Service for Further Management +/- Head/Neck MDT input e.g. Radiotherapy/ Haematology/Oncology

Joint Care

Cancer Register
Referral of Suspected Intraocular Tumour

Urgent OPA review by consultant Staff Review if necessary
+/- (AUSS, FBC, LFT, CXR, A & B-Scan Ultrasonography, IVFA)

Suspected Intraocular Tumour

Yes

Referral to Supraregional Ocular Oncology Unit e.g. Liverpool, St Barts, Sheffield

No

Indeterminate Melanocytic Lesion/High Risk Naevus

Yes

Benign Choroidal Naevus
Screen for 3 years annually, if unchanged consider discharge to optician or lifelong HES screening

No

Long Term Screening for malignant conversion with retinal photography & A-Scan Ultrasonography

Yes

Enucleation/Exenteration in Local Unit or Regional Centre
Histology to Ocular Pathologist e.g. Sheffield or UCL

No

Post Enucleation Counselling
Artificial Eye Rehabilitation

Yes

Continued Screening for Local & Systemic Recurrence in Local Centre/Regional Centre or Shared Care
Cancer Registration

No

Eye Sparing Treatment e.g. Argon Laser, TTT, Stereotactic Radiosurgery, Plaque Brachytherapy

High Risk Naevus Features
Symptoms
>2mm thickness
Yellow Pigment on surface
SRF formation
>3mm diameter
Peripapillary location

Suspected Intraocular Tumour

Yes

Indeterminate Melanocytic Lesion/High Risk Naevus

Yes

Recommending Eye Enucleation/Exenteration

No

Benign Choroidal Naevus
Screen for 3 years annually, if unchanged consider discharge to optician or lifelong HES screening

Yes

Long Term Screening for malignant conversion with retinal photography & A-Scan Ultrasonography

No

Enucleation/Exenteration in Local Unit or Regional Centre
Histology to Ocular Pathologist e.g. Sheffield or UCL

Yes

Post Enucleation Counselling
Artificial Eye Rehabilitation

No

Continued Screening for Local & Systemic Recurrence in Local Centre/Regional Centre or Shared Care
Cancer Registration

Yes

Benign Choroidal Naevus
Screen for 3 years annually, if unchanged consider discharge to optician or lifelong HES screening

No

Long Term Screening for malignant conversion with retinal photography & A-Scan Ultrasonography

Yes

Enucleation/Exenteration in Local Unit or Regional Centre
Histology to Ocular Pathologist e.g. Sheffield or UCL

No

Post Enucleation Counselling
Artificial Eye Rehabilitation

Continued Screening for Local & Systemic Recurrence in Local Centre/Regional Centre or Shared Care
Cancer Registration
Referral to Paediatric Ophthalmology Clinic e.g. Leuocoria

Urgent OPA

Suspected Diagnosis of Retinoblastoma after examination EUGA if necessary

No → Discharge

Yes → Referral to Regional Paediatric Ocular Oncology Unit e.g. Birmingham Children's Hospital

Definitive Management of Patient, Long Term Screening of Patient and At Risk Relatives, Genetic Analysis, Cancer Registration