Skin Tumour Site Specific Group meeting
Thursday 23rd May 2024
Mercure Great Danes Hotel - Maidstone
14:00-17:00

Final Meeting Notes

Present	Initials	Title	Organisation
Andrew Morris (Chair)	**AM**	Consultant Dermatologist	SCDS
Alice Hubbard	**AH**	Skin Cancer CNS	SCDS
Fatima Ismailjee	**FI**	Consultant Dermatologist	SCDS
Sam Collins	**SC**	Service Manager	SCDS
Amelia Green	**AG**	Physician Associate	SCDS
Kemal Tekeli	**KT**	Consultant – OMFS	EKHUFT
Kim Peate	**KP**	Lead Skin Cancer CNS	EKHUFT
Saul Halpern	**SH**	Consultant Dermatologist	EKHUFT
Nick Williams	**NW**	Consultant Breast & General Surgeon	EKHUFT
Andrew Birnie	**ABi**	Consultant Dermatologist & Dermatological Surgeon	EKHUFT
Nina Hayes	**NH**	Skin Cancer CNS	EKHUFT
Rhiannon Leppard	**RL**	Skin CSW	EKHUFT
Annapoorna Rai	**ARai**	Consultant – OMFS	EKHUFT
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	KMCA
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Karen Glass	**KG**	Business Support Manager	KMCA/KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Tolga Senel	**TS**	Business Development Officer	Macmillan Crossroads
Sarah Qureshi	**SQ**	Consultant Medical Oncologist	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Denise Burt	**DB**	Melanoma CNS	MTW
Ann Fleming	**AF**	Consultant Pathologist	MTW
Siva Kumar	**SK**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Caspie Graham	**CG**	Macmillan Skin Cancer CNS	QVH
Abigail Brunning	**ABr**	Macmillan Skin Cancer CNS	QVH
Chris Macdonald	**CM**	Consultant Plastic Surgeon	QVH

Apologies			
Asha Rajeev	**ARaj**	Consultant Dermatologist	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Anthi Zeniou	**AZ**	Consultant Clinical Oncologist	MTW
Nicola Perry	**NP**	GP	NHS Kent & Medway ICB
Su Woollard	**SW**	Transformation Delivery Manager (Specialised Commissioning)	NHSE
Helen Graham	**HG**	Research Delivery Manager (Cancer)	NIHR
Louise De Barra	**LDB**	Skin Cancer MDT Coordinator	QVH
Brian Bisase	**BB**	Consultant Maxillofacial/Head & Neck Surgeon	QVH
Grace Hancock	**GH**	Regional Operations Manager	Sussex Community Dermatology Service
Larry Shall	**LS**	Consultant Dermatologist	Sussex Community Dermatology Service
Sandra Varga	**SV**	Consultant Dermatologist	Whitstable Medical Practice

Item		Discussion	Agreed	Action
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • AM welcomed the members to the meeting. He will be chairing the TSSG meetings for 2024, taking over from SK who chaired the 2023 meetings. **<u>Action log Review</u>** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. • AM noted that the Skin TSSG still has no patient representatives and highlighted the importance of having patient input.		

		Review previous minutes • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.		
2.	**Crossroads Care Kent/Macmillan**	**Presentation provided by Tolga Senel** • Crossroads Care Kent (which was set up 42 years ago) help unpaid carers to make a life of their own outside caring by providing quality care services offering peace of mind while they enjoy some time to themselves. Their mission is to keep loved ones and the caring unit together. An unpaid carer is a person of any age who provides unpaid help and support to a loved one, friend or neighbour, who cannot manage without the support of a carer. • More than a third of carers asked by Carers UK (2019) had experienced a change in the amount of services they received in the previous year because: care or support arranged by social services was reduced, or closed with no replacement; the cost increased; or their personal budget no longer covers it. • It is crucial to a system reliant on informal carers that both practical and financial support are available. • Unpaid carers provide care valued at £162 billion annually, exceeding the entire NHS health service spending in England for the 2020/21 fiscal year. • In 2021, the number of unpaid carers delivering 19 or fewer hours decreased compared to 2011. This decrease is attributed to higher rates of fatality during the Covid-19 pandemic. On the other hand, the number of carers providing 20-49 hours and 50+ hours per week increased. This imposes an extra burden on carers who need support. **What's on offer for clients from Crossroads Care Kent?** • *Regular short breaks* for unpaid carers (any condition) via a Carer Support Worker – Replacement Care. • *Health appointment replacement care* – carers use this time to attend medical appointments and treatment such as screening, tests and diagnostics.		

- *Crisis response* – can be overnight, as a result of an emergency hospital admission or end of life support for a lone Carer – professional referral.
- *Dementia Outreach & Support*.
- *Young Carers Project.*
- *Carers Counselling* – up to 12 weeks free.

Macmillan Crossroads Partnership

- The partnership represents a longstanding collaboration in local service delivery for Kent & Medway between two esteemed organisations: Macmillan Cancer Support, the nation's leading cancer support charity, and Crossroads Care Kent, Kent's premier local carers support charity.
- This collaboration merges the specialised cancer expertise of Macmillan Cancer Support with the local care support proficiency of Crossroads Care Kent, resulting in a powerful alliance, ensuring comprehensive care and assistance.

Macmillan Partnership – what's on offer?

- Trained, DBS-checked volunteers offer practical assistance and companionship at home or transportation to health appointments.
- Their experts provide a wide range of useful information and guidance, available in Kent & Medway, for patients and carers.
- They offer free counselling with a counsellor in training (of which there are 40 at the moment), available for carers and supporters of a cancer patient.
- Crossroads have: supported over 200 clients across Kent & Medway, 270 active volunteers, helped 91 individuals get Macmillan grants (totaling £32,000) and 46 grants from other beneficiaries

		(totaling £18,000), and provided 3685 volunteer hours in 2023. **Carers Counselling Service** • The Carers Counselling Service offers up to 12 weeks, free therapeutic counselling for unpaid carers and supporters of cancer patients. Sessions are one-to-one with a fully supported counsellor-in-training and the service is available at locations across Kent & Medway, with options also available for online or telephone sessions remotely. This opportunity provides carers the chance to explore their own thoughts and feelings whilst learning strategies to help support them in their caring role. The counselling sessions are held in a safe, confidential environment. • Anyone can refer to the carers counselling service and this includes self-referrals. Contact can be made by telephone call (03450 956 701), email (macmillan@crossroadskent.org; referrals@crossroadskent.org; counselling@crossroadskent.org), or by filling in the online form. • The Macmillan Volunteer Service is in place for Kent & Medway. • Crossroads services are available for the Kent population only.		
3.	**Relatlimab NICE approval**	**Relatlimab NICE approval - presentation provided by Rosemeen Parkar** • RELATIVITY-047 (nivolumab in combination with relatlimab) is intended for the treatment of advanced melanoma. Opdualag (nivolumab/relatlimab) is indicated for the first-line treatment of advanced (unresectable or metastatic) melanoma in adults and adolescents 12 years of age and older. • Immunotherapy has increased survival duration for metastatic melanoma patients from a few months to about six years. • For those patients who are deemed unsuitable for Opdivo + Yervoy, Opdualag now offers another first-line dual I-O option, which targets two distinct immune-checkpoints: PD-1 and the novel LAG-3 and has demonstrated improved PFS outcomes vs. nivolumab monotherapy.		

		• NICE recommends NIVO + RELA as first-line treatment and alternative when patients are deemed not suitable for NIVO + IPI. • NIVO + RELA is recommended, within its marketing authorisation, as an option for untreated advanced (unresectable or metastatic) melanoma in people 12 years and over, only if NIVO + RELA is stopped after two years of treatment, or earlier if the cancer progresses, and the company provides it according to the commercial arrangement. • Patients for whom the NIVO + IPI combination treatment is unsuitable are the main population who could be offered NIVO + RELA. • In terms of the mechanism of action, RP stated Opdualag acts on both the LAG-3 and PD-1 receptors to increase T cell activity and anti-tumour activity. PD-L1 binds to PD-1 and inhibits T cell killing of tumour cells. Blocking PD-L1 allows T cell killing of the tumour cells. • RP outlined the study design of a RELATIVITY-047 study of 714 patients with previously untreated unresectable stage 3 or stage 4 melanoma including information on: i) Inclusion and exclusion criteria as well as primary and secondary endpoints. ii) Patient baseline characteristics. iii) Patient enrolment and randomisation. iv) 13.2-month median follow-up. Median PFS per BICR at the 13.2-month median follow-up had a range of 0–33.1. v) 19.3-month median follow-up. Overall survival at the time of the final OS analysis, which was event-driven and occurred after the final PFS analysis with a median follow-up of 19.3 months (range 0.3-41.4). vi) 13.2-month median follow-up for ORR. ORR was not formally tested based on the testing hierarchy. vii) The safety profile. In the 13.2-month median follow-up, grade 3 or 4 TRAEs occurred in 18.9% of patients receiving NIVO + RELA vs. 9.7% of patients receiving NIVO. viii) Dosing. NIVO + RELA has a fixed-dose combination administered as a 30-minute intravenous infusion every four weeks. • In terms of points to note: i) Opdualag is not replacing Ipi/Nivo, still thought to be superior, and the trial is not directly comparing the		

		two combinations. ii) It is to be used in a group of patients who might not be suitable for Ipi/Nivo but well enough to have a doublet. iii) The funding is currently available for only two years so patient selection is therefore important. iv) Funding is available if the ICI is given in the adjuvant setting/within the trial setting. v) Funding will not be available if the ICI is used in the first-line metastatic setting.		
	Radiology	**<u>Radiology – presentation provided by Rosemeen Parkar</u>** • RP's presentation provided the group with an overview of a retrospective pilot study specifically in relation to the evaluation of the efficacy of three-monthly PET-CT surveillance scans for the identification of melanoma recurrence. • The aims of the study included: i) To evaluate the efficacy of three-monthly PET-CT surveillance scans in the identification of disease recurrences in patients with melanoma (including stages II-IIIb) as per frequency. ii) To evaluate the cost-effectiveness of three-monthly PET-CT surveillance scans in such patients. iii) To extrapolate the impact of reviewing the frequency of surveillance scans in this patient cohort. iv) To create patient inclusion/exclusion criteria for three-monthly PET-CT surveillance scans. • Surveillance scans constitute the monitoring of stable disease or disease progression. • For melanoma patients, after baseline imaging, three-monthly PET-CT scans form part of surveillance. • This retrospective study allowed the review of the efficacy of frequent surveillance scans in monitoring recurrences and the impact on hospital costs. • Patients with a diagnosis of melanoma presenting to clinic at the local DGH in Maidstone Hospital in 2023 were pulled from their database. • Patient clinic letters and scan results were analysed to gather data using the KOMS, Sunrise and PACS systems.		

		• Data was gathered on: age, gender, melanoma histology - *incomplete reporting*, location of melanoma primary, melanoma staging as per AJCC 8th edition criteria, treatment given (adjuvant vs. palliative), if recurrence was identified on PET-CT scan, and the number of scans required to identify recurrence. • RP outlined the inclusion and exclusion criteria. • 159 patients were identified from the database - 123 were excluded and 36 patients met the inclusion criteria. Of the 36 patients, 10 developed recurrence and 26 did not develop recurrence. • From the sample, 27% of patients (10/36) were identified to have a recurrence with three-monthly PET-CT scans. • There was no significant difference in gender between the no recurrence and recurrence group (65% male and 35% female in no recurrence vs. 70% male and 30% female in recurrence, p=1.00). • There was no significant difference in age between the two groups (mean 64.50 +/- 15.68 in no recurrence vs. 69.80 +/- 9.95 in recurrence, p=0.329). • Stage 3 melanoma was the most common stage in both groups (77% in non-recurrence, 90% in recurrence). • The proportion of stage 2 melanoma in non-recurrence was 15% vs. 10% in recurrence. • The proportion of stage 3 melanoma in non-recurrence was 77% vs. 90% in recurrence. • The most prevalent subtype of stage 3 melanoma in both groups was 3c (46% in non-recurrence vs. 50% in recurrence). • RP outlined the primary melanoma sites in non-recurrence and recurrence groups. • The average number of scans to identify a recurrence across all stages was 2 (+/- 2.0, rounded to the nearest whole number).		

- The average number of scans to identify recurrence in stage 3a was 4 (rounded to the nearest whole number) and the average number of scans to identify recurrence in stage 3c was 2 (rounded to the nearest whole number).

- In conclusion:

i) Stage 3 melanoma was observed to have the highest rate of recurrence, with stage 3c being the most prevalent.
ii) Consideration can be given to reducing the frequency of scans for melanoma patients diagnosed with stages 3a and 3c e.g. 4-6 monthly. Patients undergoing adjuvant treatment can be given PET scans 3 monthly.
iii) Age and gender did not have a significant difference on recurrence rates in this sample.
iv) It is important to monitor the impact of revised inclusion/exclusion criteria on disease recurrence.

- In terms of improvements and future considerations:

i) A larger sample size and a longer time frame is needed.
ii) It would be helpful to include other variables in the data such as smoking status, ethnicity, melanoma histology and skin type.
iii) It is worth considering calculating the cost-benefit analysis on changes to scan frequency.

- KP highlighted that EKHUFT are offering patients on adjuvant treatment PET-CT scans for the first two years (as the patient is most likely to have recurrence within this time period) and are then switching to CT scans thereafter.

- RP has been in contact with Alliance Medical and has confirmed that 4000 PET scans were requested for melanoma in Kent in 2023.

- RP stated PET CT scans cost in the region of £1200 whereas CT scans are in the region of £200 to £300.

Update provided by Siva Kumar

- SK stated MDTs have expanded with the inclusion of double reporting of scans and meetings are therefore lasting longer. He believes this needs to be reviewed (especially as only two scans have ever been changed) and highlighted the need to identify a more efficient process, for example having pre-

		MDMs to discuss such cases. **Action - AM to push on encouraging more attendance from Radiologists at the Skin TSSG meetings.**		**AM**
4.	**TSSG Clinical Leadership**	**<u>Update provided by Andrew Morris</u>** • AM highlighted the importance of having adequate representation at the TSSG meetings including from pathology, radiology and primary care. • Funding has been secured for 1 PA for TSSG Chairs and 0.5 PA for other Lead roles within the TSSG. • JB highlighted the importance of there being educational opportunities in place for primary care staff around skin cancer awareness and when to refer patients in to secondary care. • JB mentioned that the Alliance will embed primary care leadership within all TSSGs. He believes there needs to be further discussion around who should be able to send referrals, including ACPs and nurses. **Action - The Alliance are pushing on having discussions with teams around MDT streamlining, including having pre-MDMs. AM and RC to link in to discuss how this can be taken forward for the teams within the TSSG.** • The Alliance are also having discussions around MDT governance.		**AM/RC**
5.	**Atypical Fibroxanthoma**	**<u>Presentation provided by Andrew Morris</u>** • AM stated most cases of AFX are low-risk, however some can be high-risk. • AM provided the group with an overview of the comparisons between AFX and PDS including: i) AFX being a superficial sarcoma whereas PDS affects the subcutis and deeper. ii) Recurrence of AFX is uncommon whereas in a retrospective study with 92 PDS patients, 19.6 % of patients developed local recurrence or skin metastases, 3.3% had lymph node metastases, and 5.4% had metastases in the lungs. Two of the three patients with lung metastases had underlying		

		haemato-oncological disease. iii) While AFX is confined to the dermis and is associated with an overall favourable prognosis, PDS is aggressive, more invasive, and tends to be infiltrative with a significantly higher rate of metastasis and local recurrence. • The group agreed low-risk AFX lesion (<5mm) patients can be seen once and then discharged. Follow-up for PDS tends to be for five years.		
6.	**CNS updates**	**<u>EKHUFT</u>** • A Nurse Consultant post will be put in to place in a couple of weeks and a Lead Nurse position will also be brought in. **Action - PSFU is currently on hold pending clarification around additional skin staff resourcing from KMCA. Update to be provided at the next meeting.** • There are currently three CNS' and one CSW in place for the team. **<u>MTW</u>** • A CNS and Nurse Consultant have left the Trust since the last meeting but the team hope to recruit in to the CNS post at least. **<u>QVH</u>** • No update provided. **<u>SCDS</u>** • SCDS are hoping to make CNS appointments across both the West Kent and North Kent localities. **Action - KP and Skin Cancer CNS' to arrange a CNS meeting outside of this meeting.**		**KP/KMCA** **All CNS'**

7.	**Performance data**	• Both FDS and 62d performance are above the England average. • The presentation provided the group with an overview of the: i) Median waiting time from referral to FDS diagnosis in days at EKHUFT, QVH and SCDS between April 2023 and March 2024. ii) Median waiting times from referral to milestones in the pathway in days at EKHUFT, QVH and SCDS between January and December 2023. iii) Percentage of day case and outpatient procedures which are delivered in outpatient settings at EKHUFT and QVH for Q3 2023/24. iv) Ratio of follow-up to first outpatient attendances (excluding procedures) at EKHUFT and QVH for Q3 2023/24. v) Percentage of first outpatient attendances (including procedures) where the patient is discharged at EKHUFT and QVH for Q3 2023/24. vi) DNA rate in outpatient attendances (including procedures) at EKHUFT and QVH for Q3 2023/24. vii) Percentage of day case spells and outpatient attendances (including procedures) which are biopsies at EKHUFT and QVH for Q3 2022/23. viii) Monthly numbers of procedures and outpatient attendances for dermatology at EKHUFT between January 2021 and January 2024. **EKHUFT – update provided by Andrew Birnie** • ABi highlighted the need for additional theatre capacity and staff to man this. ABi and KT also highlighted the issue that Mohs patients requiring MaxFax reconstruction were waiting significant periods of time, often 9-12 months, as MaxFax were prioritising long waiters e.g. wisdom teeth. **MTW** • No update provided. **QVH** • No update provided.		

		SCDS – update provided by Andrew Morris • SCDS have been successful in recruiting additional Consultant Plastic Surgeons to support with capacity but are struggling with histology. • SCDS do not provide first telephone consultations as the other organisations do. • AM encouraged the members to let him know if they would like to see additional data at future meetings. In addition, he believes it would be helpful to have some data on Mohs. Mohs surgery at QVH is currently at about 9 months and it is around 12 months at EKHUFT. **Action - AM to highlight to RC the long waiting times for Mohs surgery that required Maxillofacial reconstruction at EKHUFT.**		**AM**
8.	**Clinical Pathways update**	**High Operational Policy** • The HOP document is being phased out for all tumour sites so this item was not discussed. **Pathway of Care documents** • The PoC documents are now several years out of date and require updating as a matter of urgency. These documents are available to view on the KMCC website and having out-of-date information on there, especially pertaining to clinical practice, poses risks. • ABi stated he does not currently have the capacity to update the Basal Cell Carcinoma PoC and asked for someone else to take this responsibility on. • KP mentioned she had worked with AW on updating the Melanoma PoC document but this has been time-consuming and she has not made as much progress with this as she would have liked due to her very busy workload. **Action - AM stated he would review the PoC documents to identify what needs to be updated.**		**AM**

9.	**AOB**	• With regard to NICE guidance, AM highlighted that there is promising evidence for epidermal radiotherapy using rhenium-188 paste for non-melanoma skin cancer. • **All presentations/documentation for this meeting were circulated to the group on 24.05.2024.**		
	Next Meeting	• Thursday 21st November 2024 – further details to be confirmed in due course.		