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Commentary

Evaluation of Treatment Timeliness of Melanoma in New Zealand: Are we Meeting Standards?

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DESCRIPTION

Melanoma, a formidable skin cancer, poses a substantial health challenge in New Zealand with the highest reported age-standardized incidence, cumulative risk, and mortality in the world [1]. Despite such health burden, public hospital waitlists for melanoma treatment are very long. In Waikato, New Zealand, there exists a suspected skin cancer pathway in which general practitioners can electronically refer suspicious skin lesions to a dermatologist for virtual diagnosis, who then supports diagnostic biopsy and treatment excision for clinically proven melanoma or Melanoma-*In-Situ* (MIS). These can be performed by a trained general practitioner or a private plastics surgeon as self-funded procedures, or a public hospital plastics surgery team which is subsidised by the Government. This clinical audit on the "Treatment Timeliness of Cutaneous Melanoma with Dermatology, General Practice, Plastics Surgery collaboration: Are we meeting standards?" evaluates and compares the timeliness of melanoma diagnosis and treatment between these different services, and whether these comply with our national MelNet Quality Statements (2021) guidelines [2,3].

The investigation spans from June 2020 to July 2022, encompassing 43 melanoma cases and 105 cases of MIS. It is a retrospective clinical audit analysing time intervals between key states of diagnostic and treatment processes including: Timeliness of first cancer treatment (Wide Local Excision, WLE) after referral (62 days), timeliness of dermatologist response to referral (14 days), timeliness of diagnostic excision following dermatologist recommendations (14 days), and timeliness of first cancer treatment from the decision to treat (31 days) etc.

The findings revealed that overall compliance with the Melnet Quality Statements was poor, aside from teledermatology response rates, in which all teledermatology referrals were answered within a 14 day timeframe (100% compliance) [3]. For confirmed melanomas (n=43), plastics-led diagnostic excisions at hospital had occurred 51.8 days after dermatologist recommendation (7.7% compliance to the 14 day standard), compared to 18 days in Private Plastics Surgery (16.7% compliance) and 12.6 days in General Practice (65.2% compliance) [3]. Plastics-led WLEs occurred after an average of 106.3 days (7.7% compliance to the 62-day standard) following referral, compared to 67.6 days in Private plastics surgery (33% compliance) and 46 days in General Practice (50% compliance) [3]. A larger sample size exploring confirmed MIS (n=105) shows similar statistics. Biopsy was performed after an average of 56 days in a public hospital, 19.6 days in Private Plastics Surgery, and 17.3 days in General Practice [3]. The average days to WLE following referral were 116.5 days in hospital, 63 days in private plastics surgery and 63.3 days in primary care [3].

Our audit has confirmed that teledermatology allows rapid assessment of lesions suspicious of melanoma, but subsequent diagnostic excision and treatment of confirmed melanoma and MIS is often delayed beyond acceptable standards [3]. Teledermatology not only provides quicker and more convenient responses, but also reduces the amount of unnecessary excisions of benign lesions, subsequently improving the cost-effectiveness and value of melanoma treatment [4-6]. The long delays to melanoma treatment in public hospital may represent the lack of suitably trained specialists in surgery, resource and cost restraints, administrative failures, increasing burden of skin cancer in an ageing population, and impacts of the COVID-19 pandemic. In contrast, melanoma treatment occurred quicker in primary care, which supports the need for increased training and health service funding for surgical treatments by General Practitioners. Although the impact of a long wait to WLE following biopsy on patient outcomes may be clinically minor, initial excision of melanoma is required promptly to avoid tumour growth and metastatic spread; and also reduce patient distress and improve quality of life [2,7-9].

In conclusion, our Waikato study advocates for rapid widespread access to teledermatology, training and health service funding for surgical treatments in primary care, and reinforcement for similar standards-driven approaches to address these challenges.

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