Appendix 2 London Choosing Wisely

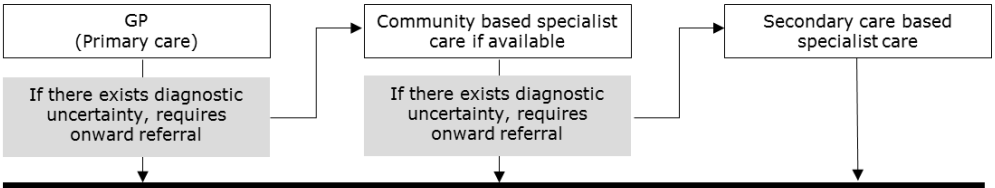
Draft Policy Template:

Procedures and Interventions for Benign Skin Lesions

Version	Date	Notes
Draft for T&F 1	11/04/18	Initial Draft
Revised version post T&F 1	26/04/18	Introduction updated to reflect clinical setting Criteria for commissioning Rationale for commissioning completed Governance Statement completed Updated ICD-10 and OPCS codes
Revised version post T&F 2	02/05/18	Updated list of included/excluded lesions Updated criteria for commissioning Warts included specifically in the criteria for commissioning Evidence relating to BCCs and AKs removed to avoid confusion (evidence summary and appendix) Evidence summary removed from Appendix to avoid duplication
Revised version post T&F chair's final amendments	09/05/2018	Minor amendments to the criteria for commissioning to fully reflect T&F group decisions Column added to the summary of policies (Appendix 2) to include the LCW policy criteria.
Revised version post T&F group comments	14/05/2018	Incorporates final comments from T&F group
Revised version	29/05/2018	Amendments by T&F group chair following comments from soft launch phase
Final version	06/06/2018	Amendments by T&F group chair following additional feedback from soft launch phase and Steering Group

COMMISSIONING STATEMENT

Intervention	Procedures and Interventions for Benign Skin Lesions
Date Issued	
Dates of Review	
Pan-London Commissioning Recommendation Overview – full details within policy document	**This policy relates to benign skin lesions only, as described in detail below. Any lesion that is suspicious of malignancy is excluded from this policy and should be managed via the two-week wait pathway (or the relevant local pathway for the management of BCCs). This policy should be applied where there is diagnostic confidence that lesions are of a benign nature.** For the lesions included the following criteria for commissioning apply:



At the point at which there is diagnostic confidence, the following criteria apply:

Procedures and interventions for lesions **will be** commissioned* if:	Notes: Clinicians are expected to apply reason to the criteria which will always have an element of subjectivity.
The lesion is unavoidably and significantly traumatised on a *regular* basis AND The lesion has been significantly infected, requiring more than 2 courses of antibiotics (oral or IV) OR The location of the lesion obstructs an orifice, impairs vision or significantly restricts usual function, causes *regular* pain AND Education: Recurrence and complication rates have been discussed with the patient	• E.g. catching on clothes daily, regularly disturbed by combing of hair, under the waistband or bra strap causing clothes to be unwearable • Relevant to the patient e.g. lesions preventing children playing sport, lesions affecting ability to write/type • Education does not constitute consent for the procedure, rather ensures need and desire for onward referral
Secondary care procedures & interventions for warts **will be** commissioned if: Warts are: Extensive OR Facial OR The patient is immunocompromised AND Conservative treatments have failed	
Procedures and interventions for lesions **will NOT be** commissioned for solely cosmetic reasons. * Some CCGs may request supporting information. Interventions and procedures for benign skin lesions not meeting the above criteria will be managed in line with local CCG policy. .	

Prepared By	London Choosing Wisely, Commissioned by NHSE	
Approved By	**Date Approved**	**Notes**
Benign Skin Lesion Task & Finish Group, London Choosing Wisely	01/05/2018	
LCW Steering Board	04/06/2018	

Main Policy Document

Policy Statement

London Choosing Wisely (LCW) was commissioned to carry out this work on behalf of all London Clinical Commissioning Groups (CCGs), in order to promote equitable access to certain treatments and the cost-effective use of healthcare resources. All London CCGs will commission procedures and interventions for benign skin lesions in accordance with the criteria outlined in this document.

In creating this policy, LCW convened a Task and Finish Group focused on developing this policy and has reviewed this clinical condition and the evidence supporting treatment leading to this commissioning decision.

1. Introduction

There are a number of very common skin lesions that are benign in nature and represent little or no risk to patients. Whilst procedures and interventions for these lesions are effective, the reason for requesting intervention is often cosmetic. All London CCGs have published commissioning policies regarding benign skin lesions and are broadly similar in not routinely commissioning intervention for solely cosmetic reasons. The existing policies differ in the criteria under which procedure or intervention would be undertaken. There is also a difference in clinical setting of care depending on CCG, with some GPs offering minor skin surgery under Local or Direct Enhanced Services (LES/DES), some areas having community dermatology and Telederm services and some areas undertaking all dermatology procedures and interventions in secondary care. In addition, this policy applies to all care settings and specialties including (but not limited to) dermatology, maxillofacial surgery, plastic surgery and general surgery.

This policy applies at any and all levels of clinical care regarding benign skin lesions, and it is the responsibility of all clinicians to apply the commissioning criteria when a patient reaches their care setting. This pan-London policy serves to standardise the criteria for commissioning the excision of benign skin lesions in all clinical settings, and applies to both adults and children.

Any lesion suspicious of malignancy is not covered under this policy and should be managed via the two-week wait pathway (or the relevant local pathway for the management of BCCs). This policy should be applied where there is diagnostic confidence that lesions are of a benign nature.

2. Key Definitions

Benign pigmented moles / melanocytic naevus – a benign growth on the skin (usually tan, brown or flesh-coloured) that contains a cluster of melanocytes and supporting supportive tissue.

Lipoma – a lipoma is a soft fatty lump. It is always benign (non-cancerous) and is made up from fat cells that clump together. A lipoma can occur in any part of the body where there are fat cells. Any lesion suspected of being a liposarcoma should be referred urgently to a specialised sarcoma unit.

Molluscum Contagiosum – molluscum contagiosum is a viral skin infection caused by a type of Poxvirus. It is common in children and is usually self-limiting.

Epidermal/Epidermoid Cysts – also known as epithelial or infundibular cysts are intradermal or subcutaneous tumours. They may occur anywhere on the body but most often occur on the face, scalp, neck, back and scrotum.

Pilar Cysts – also known as trichilemmal cysts are clinically indistinguishable from epidermal cysts. They contain keratinous material, are usually multiple and there is often an autosomal dominant inheritance.

Sebaceous Cysts – a less common type of cyst that is filled with a clear oily liquid made by sebaceous (grease) glands.

Seborrhoeic Keratoses – including basal call papillomas. These are benign wart-like growths that occur on the skin and usually do not require treatment.

Skin tags – also known as acrochordons are small, often pedunculated, skin-coloured or brown papules that occur most frequently where there are skin folds. Common sites are the neck, axilla, groins and eyelids. They are typically 0.2-0.5cm in diameter.

Telangiectasia – also known as thread veins, are a common problem occurring in about half of adults in western countries. There are very fine dilated veins lying in the skin. They come from normal veins in the skin which grow much bigger than their usual size. They often occur near the ankle, over the inside of the knee and outside of the thigh.

Warts – are small rough lumps on the skin. They are caused by human papillomavirus which causes a reaction in the skin. They can occur anywhere on the body and commonly on hands and feet. They range from 1mm to 1cm and can be solitary or several occurring in the same area.

Verruca – verrucae are warts that occur on the soles of the feet. They are the same as warts on any other part of the body however they may look flatter as they tend to get trodden in.

Diagnostic confidence – there are a number of commonly occurring benign skin lesions where normal practice is to make a diagnosis based on appearance alone and not require specialist input. Diagnostic confidence is when a clinician is suitably confident in the diagnosis such that they do not require specialist opinion. If the clinician has concerns that a lesion or lesions may signify an underlying syndrome they should refer urgently to secondary care.

Diagnostic uncertainty – where there is uncertainty in the diagnosis of a benign condition, where there is suspicion of malignancy, or where there is concern that the condition may be part of an underlying syndrome.

3. Aims & Objectives

Across London there are five Sustainability and Transformation Partnerships (STPs), including 32 CCGs, representing 1,400 GP practices serving our population of almost nine million Londoners. This policy aims:

- To reduce unwarranted variation in access to procedures and interventions for benign skin lesions across London, removing the postcode lottery

- To ensure that procedures and interventions for benign skin lesions are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness
- To promote the cost-effective use of healthcare resources for Londoners. It is estimated that reducing spend on benign skin lesions by 10% each year (based on 2016 activity data) would release savings equivalent to employing an additional 25-30 Band 5-6 nurses across London (Agenda for Change).

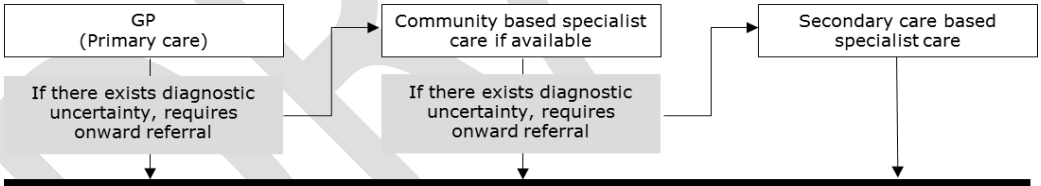
4. Criteria for commissioning

This policy relates to both adults and children. Any lesion suspicious of malignancy is not covered under this policy and should be managed via the two-week wait pathway (or the relevant local pathway for the management of BCCs). This policy should be applied where there is diagnostic confidence that lesions are of a benign nature.

The following lesions are included in this policy and therefore **treatment will not be funded unless the criteria below are met:**
Benign pigmented moles / melanocytic naevus
Comedones
Corn/callous
Lipoma
Milia
Molluscum contagiosum
Cysts (epidermal, pilar, trichodermal, sebaceous)
Seborrhoeic keratoses (basal cell papillomata)
Skin tags including anal tags (acrochordon)
Warts including plantar warts, mosaic warts
Neurofibromata
Telangiectasia / Thread Veins
Dermatofibroma
Capilliary Haemangioma / Campbell de Morgan
Xanthelasma

For reference, the following lesions are **excluded** from this policy and therefore **not subject to the criteria below**. Please **review relevant policies relating to these lesions to establish when/if treatment is funded**. This is not an exhaustive list but includes lesions considered by the Task and Finish Group
Any lesion not stated in the adjacent inclusion table
Malignant lesions (2WW)
Pigmented lesions with malignant potential
Lesions with diagnostic uncertainty
Lesions undergoing rapid growth
Actinic keratosis (AK)
Scars (hypertrophic, keloid)
Congenital Naevi
Vascular birth marks in children
Naevus of Ota / Naevus of Ito
Café au lait patches
Genital warts (should be referred to sexual health clinic)

For the lesions included above the following criteria for commissioning apply:



At the point at which there is diagnostic confidence, the following criteria apply:

Procedures and interventions for lesions **will be** commissioned* if:	Notes: Clinicians are expected to apply reason to the criteria which will always have an element of subjectivity.
The lesion is unavoidably and significantly traumatised on a *regular* basis AND The lesion has been significantly infected, requiring more than 2 courses of antibiotics (oral or IV) OR The location of the lesion obstructs an orifice, impairs vision or significantly restricts usual function, causes *regular* pain AND Education: Recurrence and complication rates have been discussed with the patient	• E.g. catching on clothes daily, regularly disturbed by combing of hair, under the waistband or bra strap causing clothes to be unwearable • Relevant to the patient e.g. lesions preventing children playing sport, lesions affecting ability to write/type • Education does not constitute consent for the procedure, rather ensures need and desire for onward referral
Secondary care procedures & interventions for warts **will be** commissioned if: Warts are: Extensive OR Facial OR The patient is immunocompromised AND Conservative treatments have failed	
Procedures and interventions for lesions **will NOT be** commissioned for solely cosmetic reasons. * Some CCGs may request supporting information. Interventions and procedures for benign skin lesions not meeting the above criteria will be managed in line with local CCG policy. .	

5. Evidence Summary

A detailed evidence review including full references can be found in Appendix 1.

Any lesions suspected of malignancy should be referred via the two-week wait pathway in line with NICE recommendations (or the relevant local pathway for the management of BCCs).

The majority of skin lesions are benign and although treatments are effective, they achieve relatively minor outcomes of avoiding mechanical irritation and minor skin infections. As per Appendix 2, all London CCGs have a similar policy relating to these conditions and do not support routine commissioning for cosmetic reasons.

The evidence base for the treatment of benign skin lesions is scarce, and where available is focused on the efficacy of different treatment options rather than addressing questions of when/if to treat as asked within this review. There is only Level 1 evidence relating to Molluscum Contagiosum. There is Level 3 evidence relating to low risk basal cell carcinomas and Level 4 evidence relating to Lipomas. There exists no other Level 1-4 evidence. There is Level 5 evidence for all skin lesions, provided in expert opinion from the Royal College Guidelines and the Primary Care Dermatology Society. In addition, NHS Evidence and NICE CKS webpages often link directly to patient.co.uk articles. Whilst these do not constitute evidence, with the lack of alternative sources these have been included in the evidence review in order to aid discussion of the Task and Finish Group in considering the commissioning position.

Footnotes within this summary refer to the numbered references in Appendix 1.

1) What are the key clinical criteria (e.g. function, pain, infection) for which the evidence shows value in removing the lesion?

There is no high quality evidence to answer the research question. Where there is lower quality evidence, predominantly expert opinion, this is often relating to the criteria that may warrant a referral to a specialist (dermatologist) and not the criteria for removing the lesion.

Warts / Verrucae – There is no level 1-4 evidence on the key clinical criteria for removing Warts and Verrucae. The main evidence here comes from the NICE CKS (7) and focuses more on the efficacy of alternative treatment options than on the clinical criteria indicating the value of treatment, but does make recommendations about undertaking treatment in primary care, and when referral to secondary care may be considered. The main evidence used to form the CKS is expert opinion (level 5 - British Association of Dermatologists Guidelines, Sterling et al 2014). The evidence about spontaneous resolution of warts was based on an observational study (level 4 – Bruggink et al, 2013).

The evidence suggests that warts do not usually require any intervention as rates of spontaneous resolution are high. Topical treatments may need prolonged duration and some can be painful or lead to other complications such as scarring. Referral to secondary care may be considered if there is diagnostic uncertainty, compromised immunity, a facial wart, extensive affected areas of skin or multiple persistent warts unresponsive to standard topical therapies.

Patients with anogenital warts should be referred to sexual health clinic as screening for other sexually transmitted infections is essential (https://cks.nice.org.uk/warts-anogenital#!scenario).

Lipoma / Liposarcoma – There is no level 1-3 evidence on the key clinical criteria for removing lipomas. Evidence relating to liposarcomas is generally of higher quality but is not relevant to this review as they are malignant and should be managed via the two week wait pathway. Liposarcoma is rare with an age-standardised incidence rate of 6.2 per million population in 2007-2009 (NCIN), equating to approximately one case per GP practice in England every 20 years (based on a population of 60 million and 8,000 GP practices nationally).

Evidence regarding lipomas comes from a level 5 BMJ Best Practice Review (11), which summarises evidence from a number of level 4 case reports and level 5 expert opinions. These state that although lipomas are benign and usually require no treatment, surgical excision can be used for symptomatic lesions, or enlarging lesions on sites that are likely to become symptomatic, for cosmetic appearance or if there is a concern regarding a potential liposarcoma. The level 5 evidence (expert opinion) found on the website of the Primary Care Dermatology Society (9) adds that frontal lipomas (on the forehead) are often more complicated to manage and may warrant referral to secondary care.

Cysts – Sebaceous, Epidermoid, Pilar – There is no level 1-4 evidence regarding the criteria for removal of cysts. Expert opinion (level 5) about when to remove cysts comes from the British Association of Dermatologists (16) and include the following: 1. if the cyst is unsightly and easily seen by others. 2. If it interferes with everyday life, for example by catching on your comb. 3. If the cyst becomes infected.

The search of NHS Evidence provides a link to a patient.co.uk article (15) for medical professionals. It does not constitute expert opinion but is provided within this evidence review for information and for a lack of better quality evidence. The article states that the vast majority of epidermoid or pilar cysts are of no great consequence. If a cyst is uncomplicated then no treatment is usually advisable. The cyst may disappear spontaneously, leaving no trace. Even the most skilful excision will leave a permanent scar. If the cyst is red and hot it is probably infected and the patient may benefit from antibiotics. If the cyst is troublesome or if the patient, after counselling, is eager to have it removed then the entire cyst should be excised as a surgical procedure.

Molluscum Contagiosum – There is a Cochrane review (19, level 1) undertaken in 2009 that identified a total of 11 studies aiming to assess the effects of management strategies for cutaneous non-genital molluscum contagiosum in otherwise healthy people. The result of this review was that no single intervention has been shown to be effective in the treatment of molluscum contagiosum. The review does not state any criteria for which treatments are more or less effective as per the research question.

A NICE CKS (17, level N/A) offers criteria that may warrant referral to secondary care including: Children with extensive problematic lesions may need referral to a dermatologist, patients with eyelid-margin or ocular lesions and associated red eye require an urgent referral to an Ophthalmologist; HIV-positive people with extensive lesions may require an urgent referral to an HIV Specialist. Adults with anogenital lesions should be referred to GUM (genito-urinary medicine), as they may require screening for other sexually transmitted infections. The NICE CKS is formed from UK Guidelines written by the British Association for Sexual health and HIV, expert opinion from the Primary Care Dermatology Society and The College of Optometrists and a review article in The Lancet Infectious Diseases (Chen et al, also cited in Appendix 1, reference 20).

Telangiectasia / Thread Veins – There is no high quality evidence relating to the criteria warranting treatment of telangiectasia. Expert opinion in the Primary Care Dermatology Review (21) states that patients with potentially more serious conditions (such as

hereditary haemorrhagic telangiectasia or poikilodermatous mycoses fungoides) need referral to secondary care, however it does not specific the clinical criteria that would indicate the referral.

Seborrhoeic Keratosis / Basal Cell Papilloma – There is no level 1-4 evidence defining key criteria for treatment of seborrhoeic keratoses. Expert opinion (level 5) in the BMJ Best Practice review (24) states they are usually asymptomatic but can become irritated and inflamed spontaneously or because of friction from clothing. Treatment is not necessary because of their benign nature, but if irritated, itching, and displeasing, they can be initially treated with cryotherapy and curettage. Most important for differential diagnosis, and of patient concern, is malignant melanoma. The BMJ Best Practice Review was formed primarily from medical textbooks and guidelines from the Indian Journal of Dermatology.

Skin tags / Acrochordon – There is no evidence showing value in excision of a skin tag. NHS Choices, a patient facing advice website, advises patients who want treatment to seek this privately. (NHS Choices)

2) Does the evidence describe specific parameters of these criteria where therapeutic value is achieved? (e.g. size of lesion, number of infective episodes)

The evidence does not sufficiently describe specific parameters of criteria where therapeutic value is achieved.

There is no evidence relating to number of infective episodes a benign skin lesion has undergone to warrant excision.

There is no evidence relating to a defined reduction in quality of life or activities of daily living to warrant excision of a benign skin lesion.

Lipomas – There is a 2007 paper presenting eight case reports of patients with lipomas (13). This paper suggests that whilst lipomas are always benign, lipomas over 5cm in diameter have an increased chance of being missed liposarcomas and thus should be referred to secondary care for further investigation by USS or MRI. This position is also presented in the NHS Evidence linked to patient.co.uk where it is suggested that lipomas over 5cm can sometime be mistaken for liposarcomas and should be referred. Liposarcoma is rare with an age-standardised incidence rate of 6.2 per million population in 2007-2009 (NCIN).

Whilst not directly related to the search question, the following parameters have been presented by NICE Guidelines on suspected cancer (1) to provide a scoring system for when to refer a skin lesion. Whilst the evidence is of low quality, this has been included to assist the Task and Finish group with their discussion on the commissioning policy.

Refer any suspicious pigmented skin lesion with a weighted 7-point checklist score of 3 or more.

Weighted 7‑point checklist

Major features of the lesions (scoring 2 points each):
- change in size
- irregular shape
- irregular colour

Minor features of the lesions (scoring 1 point each):

- largest diameter 7 mm or more
- inflammation
- oozing
- change in sensation

3) Are there any comorbid conditions that would indicate removal of benign skin lesions?

There is limited evidence to support this research question. There is no level 1-4 evidence.

Warts / Verrucae – There is no level 1-4 evidence on the comorbid conditions that would indicate removing Warts and Verrucae. The main evidence here comes from the NICE CKS (6) and focuses more on the efficacy of alternative treatment options, but does suggest immunosuppressed patients are less likely to resolve spontaneously and are more recalcitrant to treatment. The main evidence used to form the CKS is expert opinion (level 5 - British Association of Dermatologists Guidelines, Sterling et al 2014). The evidence about spontaneous resolution of warts was based on an observational study (level 4 – Bruggink et al, 2013).

Molluscum Contagiosum – The British Association for Sexual Health and HIV has published a UK national guideline (expert opinion, level 5) for the management of genital molluscum in adults (18). The evidence suggest immunocompromised patients are at higher risk of having a lesion and may warrant referral to appropriate secondary care e.g. GUM services. The evidence does not suggest indication for removal of lesion in this patient group and thus does not directly answer the research question but is of relevance to consider within the Task and Finish Group discussion.

4) Does the evidence document risk of physical harm by not removing the skin lesion?

There is no evidence to answer the research question. The only documented risk of harm relates to lesions that have the potential to be malignant. The evidence is clear that **any lesion of uncertain diagnosis or suspicious for malignancy should be referred to the appropriate specialist**. Malignant lesions are not covered by this evidence review. Potential psychological harm from skin lesions was not featured in the evidence reviewed.

6. Rationale behind Policy Statements

In drafting this commissioning policy, the Task and Finish Group considered the evidence presented, the current position of CCGs both within and outside of London, and their clinical experience.

The Task and Finish Group noted that the vast majority of benign skin lesions are harmless but may be unsightly and cause distress for patient. There are occasional circumstances in which a procedure or intervention for benign skin lesions is clinically indicated, these circumstances are listed in this policy. The policy ensures that lesions are not removed for solely cosmetic reasons. The Task and Finish group accepted that there are sometimes circumstances of exceptionality that may require an intervention and that these would follow the existing Individual Funding Request (IFR) route.

The Task and Finish Group noted that there is generally low level evidence surround the interventions for benign skin lesions, and where evidence is available it is focused on the efficacy of intervention, rather than the criteria whereby intervention is supported.

Inclusion/Exclusion: The Task and Finish Group concluded that any malignant and potentially pre-malignant lesions are excluded from this policy which should solely relate to benign skin lesions. For this reason actinic keratosis (AK) are also excluded from this policy. Scars, including keloid and hypertrophic scars, were excluded from this policy as they in some CCGs they are covered under alternative policies. The Task and Finish Group noted that lesions with an uncertain diagnosis or rapid growth present a potential risk to patients and thus these commissioning criteria should only be applied when there is diagnostic confidence.

Criteria for commissioning: The Task and Finish Group noted the difficulty in prescribing specific, evidence based criteria for when a lesion should undergo intervention. There will always be a subjective definition of *recurrent* trauma and *restricted* function, and so clinicians will need to apply reason to this judgement, understanding that it is the responsibility of all clinicians to appropriately use resources. The group agreed that most commonly used criteria for commissioning are recurrent trauma leading to antibiotic requirement, restricted function due to pain, and these are reflected in this policy.

Equality: Although the equality and equity assessments for this policy will be undertaken at CCG level, the Task and Finish Group used an ethical framework to ensure fairness of commissioning decision making. It was noted that some patients may have benign skin lesions not meeting the commissioning criteria treated privately, if they can afford to, and this policy therefore unfairly disadvantages those that cannot afford this option. Whilst this is not a desirable outcome the Task and Finish Group noted that the aim of this policy is to promote cost-effective use of NHS resources based upon clinical need.

7. Adherence to NICE Guidelines

There are no NICE guidelines specific to the management of benign skin lesions. Where relevant, this policy adheres to NICE guidelines relating to the management of skin cancer.

NG12: Suspected cancer: recognition and referral

CSG8: Improving outcomes for people with skin tumors including melanoma

QS130: Quality Standard: Skin Cancer

8. Codes for procedures

Suggested OPCS and ICD-10 Codes covered within this evidence review (and ultimately policy).

Note: This list is not exhaustive and can be amended at CCG level during implementation of policy.

OPCS Codes (Procedure codes)	
C101	Excision of lesion of eyebrow
C122	Cauterisation of lesion of eyelid
C123	Cryotherapy to lesion of eyelid

C124	Curettage of lesion of eyelid
C125	Destruction of lesion of eyelid NEC
C126	Wedge excision of lesion of eyelid
C128	Other specified extirpation of lesion of eyelid
C129	Unspecified extirpation of lesion of eyelid
D021	Excision of lesion of external ear
D022	Destruction of lesion of external ear
D028	Other specified extirpation of lesion of external ear
D029	Unspecified extirpation of lesion of external ear
E091	Excision of lesion of external nose
E094	Shave of skin of nose
F021	Excision of lesion of lip
F022	Destruction of lesion of lip
F028	Other specified extirpation of lesion of lip
F029	Unspecified extirpation of lesion of lip
S048	Other specified other excision of skin
S049	Unspecified other excision of skin
S051	Microscopically controlled excision of lesion of skin of head or neck using fresh tissue technique
S052	Microscopically controlled excision of lesion of skin using fresh tissue technique NEC
S053	Microscopically controlled excision of lesion of skin of head or neck using chemosurgical technique
S054	Microscopically controlled excision of lesion of skin using chemosurgical technique NEC
S055	Microscopically controlled excision of lesion of skin of head or neck NEC
S058	Other specified microscopically controlled excision of lesion of skin
S059	Unspecified microscopically controlled excision of lesion of skin
S061	Marsupialisation of lesion of skin of head or neck
S062	Marsupialisation of lesion of skin NEC
S063	Shave excision of lesion of skin of head or neck
S064	Shave excision of lesion of skin NEC
S065	Excision of lesion of skin of head or neck NEC
S066	Re-excision of skin margins of head or neck
S067	Re-excision of skin margins NEC
S068	Other specified other excision of lesion of skin
S069	Unspecified other excision of lesion of skin
S078	Other specified photodynamic therapy of skin
S079	Unspecified photodynamic therapy of skin
S081	Curettage and cauterisation of lesion of skin of head or neck
S082	Curettage and cauterisation of lesion of skin NEC
S083	Curettage of lesion of skin of head or neck NEC
S088	Other specified curettage of lesion of skin
S089	Unspecified curettage of lesion of skin
S101	Cauterisation of lesion of skin of head or neck NEC
S102	Cryotherapy to lesion of skin of head or neck
S103	Chemical peeling of lesion of skin of head or neck
S104	Electrolysis to lesion of skin of head or neck
S105	Electrodessication of lesion of skin of head or neck

S108	Other specified other destruction of lesion of skin of head or neck
S109	Unspecified other destruction of lesion of skin of head or neck
S111	Cauterisation of lesion of skin NEC
S112	Cryotherapy to lesion of skin NEC
S114	Electrolysis to lesion of skin NEC
S115	Electrodessication of lesion of skin NEC
S118	Other specified other destruction of lesion of skin of other site
S119	Unspecified other destruction of lesion of skin of other site
S608	Other specified other operations on skin
S609	Unspecified other operations on skin
Y064	Excision of scar tissue NOC

For the following ICD-10 codes:

With the following ICD-10 diagnosis code(s):	
B07.X	Viral warts (includes plantar warts)
B08.1	Molluscum contagiosum
D17.0	Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck
D17.1	Benign lipomatous neoplasm of skin and subcutaneous tissue of trunk
D17.2	Benign lipomatous neoplasm of skin and subcutaneous tissue of limbs
D17.3	Benign lipomatous neoplasm of skin and subcutaneous tissue of other and unspecified sites
D22.0	Melanocytic naevi of lip
D22.2	Melanocytic naevi of ear and external auricular canal
D22.3	Melanocytic naevi of other and unspecified parts of face
D22.4	Melanocytic naevi of scalp and neck
D22.5	Melanocytic naevi of trunk
D22.6	Melanocytic naevi of upper limb, including shoulder
D22.7	Melanocytic naevi of lower limb, including hip
D22.9	Melanocytic naevi, unspecified
D23.0	Other benign neoplasms of skin of lip
D23.2	Other benign neoplasms of skin of ear and external auricular canal
D23.3	Other benign neoplasms of skin of other and unspecified parts of face
D23.4	Other benign neoplasms of skin of scalp and neck
D23.5	Other benign neoplasms of skin of trunk
D23.6	Other benign neoplasms of skin of upper limb, including shoulder
D23.7	Other benign neoplasms of skin of lower limb, including hip
D23.9	Other benign neoplasms of skin, unspecified
H02.6	Xanthelasma of eyelid
I78.1	Naevus, non-neoplastic
I84.6	Residual haemorrhoidal skin tags
L72.0	Epidermal cyst
L72.1	Pilar and trichodermal cyst
L72.8	Other follicular cysts of the skin and subcutaneous tissue
L72.9	Follicular cyst of the skin and subcutaneous tissue, unspecified
L82.X	Seborrheic keratosis
Q82.5	Congenital non-neoplastic nevus

Q85.0	Neurofibromatosis (non-malignant)

Equality & Equity Statement

The Equality and Equity Assessments for this policy will be undertaken at CCG level. Please contact the relevant London CCG for further details of their Equality Impact Assessment.

Governance statement

In mid-2017, London's CCG Chief Officers supported a pan London programme to ensure equitable treatment access for all Londoners that is consistent, clinically appropriate and based on robust evidence that supports improved patient outcomes for certain treatments across London.

NHS England (London) commissioned Healthy London Partnership (HLP) to facilitate the programme management and communications work of the programme, known as 'London Choosing Wisely'. A London Choosing Wisely Steering Group was formed, chaired by the NHSE (London) Medical Director, Dr Vin Diwakar, and included clinical leaders representing each sustainability and transformation partnership (STP), the clinical leads appointed to the review of each area of care, patient representatives, and public health experts.

The London Choosing Wisely programme specifically looked at the following eight procedures: the surgical removal of benign skin lesions; hip arthroplasty; knee arthroplasty; knee arthroscopy; interventional treatments for back pain; varicose vein procedures; shoulder decompression and cataract surgery.

Six Task and Finish Groups were established to review the evidence and draft the policy documentation for each of the eight identified procedures (with hip and knee policies being considered together). Each group was chaired by a primary care clinical lead, who also sat on the Steering Group. All groups included primary and secondary care clinicians and patient representatives from across the London region and were supported by independent public health experts. Upon consideration of the evidence, the Task and Finish Group drafted and agreed the commissioning policy which was subsequently presented to the Steering Group for approval. The Steering Group's role was to ensure that a robust and rigorous review process had been carried out and to agree a final draft for each pan London policy.

Appendix 1 – Detailed evidence review & References

London Choosing Wisely

Evidence Review Summary: **Benign Skin lesions**

Version	Date	Notes
Draft for PH Lead	12/04/18	Initial Draft
Draft for T&F Group	17/04/18	Significant changes made to structure of evidence summary and Appendix 1 - evidence presentation.
Revised version post T&F 1	26/04/18	Additional Liposarcoma figures included Clarity on psychological harm included List of ICD-10 and OPCS codes edited
Revised version post T&F 2	02/05/18	Evidence relating to BCCs and AKs removed to avoid confusion
Final version	29/05/2018	Amendments by T&F group chair following comments from soft launch phase

1.0 Introduction

(What?)	This evidence review will focus on excision of benign skin lesions. The aim of this evidence review is to present the available evidence to the task and finish group in order to support informed decision making regarding the commissioning policy. **Any lesion that is suspected of malignancy should be referred via the two week wait pathway and is not covered by this evidence review (or the relevant local pathway for the management of BCCs). This policy should be applied where there is diagnostic confidence that lesions are of a benign nature.** Specifically covered by this evidence review are: benign pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrhoeic keratoses (basal cell papillomata), skin tags including anal tags (acrochordon), spider naevus (telangiectasia), warts and neurofibromata and mosaic warts. The above list is intended to better define the commonly used phrase 'benign skin lesions'. It is not an exhaustive list but is the same list that is used in multiple existing CCG policies. A list of ICD-10 and OPCS codes relevant to this evidence review (and ultimately the commissioning policy) are included in Appendix 3. Again this list is not exhaustive and can be added to at CCG level during implementation of the policy. It is noted that issues around coding of diagnoses and procedures can affect adherence to commissioning policies but this does not negate the need for the policy to state the ICD-10 and OPCS codes included.
(Who for?)	The evidence review includes the adult and child populations.
(Why is the procedure carried out?)	The excision of benign skin lesions is often requested by patients to improve cosmetic appearance, although there are scenarios in which the procedure is undertaken to improve function and/or reduce pain. The procedure is usually highly effective at removing the lesion although recurrence is common, at the same site or at a new site. The methods used for removal of benign skin lesions are generally considered low risk, but can be associated with pain and risk of infection.
(Why an issue?)	All London CCGs have a commissioning policy relating to the excision of benign skin lesions. These are mostly similar and no CCG routinely funds excision of a benign skin lesion for purely cosmetic purposes. However, the criteria whereby excision would be funded differ between CCGs
(Who else does what?)	See Appendix 2 for a detailed table of current CCG policies relating to the excision of benign skin lesion. No London CCGs routinely commission excision of benign skin lesions for cosmetic reasons. CCGs only commission the procedure if certain criteria are met, but these criteria differ between CCGs. For example, some CCGs state that if the lesion is unavoidably and significantly traumatised, such that the patient requires two or more courses of antibiotics over a year, the lesion should be excised; whereas other CCGs do not state frequency or timescales, rather the lesion is *'significantly infected'* and the lesion requires '*repeated treatment'* with antibiotics. Similarly, some CCGs state a minimum size for the excision of facial lesions (e.g. 1cm) whereas others do not state any detail.

	Through these are minor policy discrepancies there is potential for patients to not be receiving equal access to treatments across London.

2.0 Search strategy:

The London Choosing Wisely team drafted the proposed scope, following which views were sought from the wider membership; including GP and Consultant representatives across London.

Core search questions:

1) What are the key clinical criteria (e.g. function, pain, infection) for which the evidence shows value in removing the lesion?
2) Does the evidence describe specific parameters of these criteria where therapeutic value is achieved? (e.g. size of lesion, number of infective episodes)
3) Are there any comorbid conditions that would indicate removal of benign skin lesions?
4) Does the evidence document risk of physical harm by not removing the skin lesion?

Search Terms:

Search Terms: All terms related to benign skin lesions, including benign pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrhoeic keratoses (basal cell papillomata), skin tags including anal tags (acrochordon), spider naevus (telangiectasia), warts (excluding anogenital warts) and neurofibromata, mosaic warts.

2.1 Search Method

An initial search was undertaken of national guidelines and other CCG policies (where available). The literature review was then conducted according the following table, with Level 1 evidence sought first, continuing through to Level 5 evidence.

Level 1	Meta-analyses, systematic reviews of randomised controlled trials
Level 2	Randomised controlled trials
Level 3	Case-control or cohort studies
Level 4	Non-analytic studies e.g. case reports, case series
Level 5	Expert opinion

Using the above search terms, the following databases were searched for evidence pertaining to the excision of benign skin lesions. The databases were searched in the following order:

- National Institute of Clinical Excellence (NICE) including guidelines and Clinical Knowledge summaries (CKS)
- Scottish Intercollegiate Guidelines Network (SIGN)
- Other national and CCG policies (where publically available)
- NHS Evidence
- Cochrane Library
- PubMed/MEDLINE
- British Medical Journal (BMJ) including BMJ Best Practice and BMJ Clinical Evidence

- Royal College of Dermatologists (guidelines)
- Royal College of Plastic Surgeons (guidelines)

Where evidence was limited, expert opinion was also reviewed including

- Primary Care Dermatology Society (PCDS)
- Patient.co.uk – only if redirected from NHS Evidence or NICE CKS webpages

2.2 Inclusion / Exclusion Criteria:

Inclusion:

Unlimited date range
Evidence relating to adults and children included

Exclusion:

Non English Language papers

3.0 Summary of findings

A detailed evidence review including full references can be found in Appendix A.

Any lesions suspected of malignancy should be referred via the two-week wait pathway in line with NICE recommendations (or the relevant local pathway for the management of BCCs).

	Summary of grade of evidence found					**Other**	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**
Benign Skin Lesions					✓	✓	✓
Warts / Mosaic Warts / Verrucas					✓		✓
Lipoma				✓	✓		✓
Cysts – Sebaceous, Epidermoid, Pilar					✓		✓
Molluscum Contagiosum	✓				✓		✓
Telangiectasia / Thread veins					✓		✓
Seborrhoeic Keratosis / Basal Cell Papilloma					✓		✓
Skin Tags / Acrochordon							✓

The evidence summary is included within the main policy document (section 5, pages 6-9 and is therefore not duplicated here)

Appendix A - Detailed evidence review & References

Benign Skin Lesions

Warts / Mosaic Warts / Verrucas

Lipoma / Liposarcoma

Cysts – Sebaceous, Epidermoid, Pilar

Molluscum Contagiosum

Telangiectasia / Thread veins

Seborrhoeic Keratosis / Basal Cell Papilloma

Skin Tags / Acrochordon

Benign Skin Lesions		

	Summary of grade of evidence found					Other	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines,**	**other CCG Policies**
Benign Skin Lesions	**Nil**	**Nil**	**Nil**	**Nil**	✓	✓	✓

NICE NICE CKS NHS Evidence SIGN	**1** **Suspected cancer: recognition and referral;** NICE Clinical Guideline (2015)	**Evidence Level: N/A** Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for melanoma if they have a suspicious pigmented skin lesion with a weighted 7‑point checklist score of 3 or more. [new 2015] Weighted 7‑point checklist Major features of the lesions (scoring 2 points each): • change in size • irregular shape • irregular colour Minor features of the lesions (scoring 1 point each): • largest diameter 7 mm or more • inflammation • oozing • change in sensation Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) if dermoscopy suggests melanoma of the skin. [new 2015] Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for melanoma in people with a pigmented or non‑pigmented skin lesion that suggests nodular melanoma. [new 2015]
	2 **Benign Skin Tumours** NHS Evidence – linked to patient.co.uk Dr Colin Tidy: October 2015	**Evidence Level: 5** The vast majority of skin tumours are benign. There are a few very common benign skin tumours. It is very common for doctors to be asked about such lesions and very often advice is sought when consulting about something else (or quite often outside formal consultation). Referral: It is worth considering NICE guidance on referral if cancer is suspected. Refer a patient presenting with skin lesions suggestive of skin cancer or in whom a biopsy has confirmed skin cancer to a team specialising in skin cancer.

		Malignant melanoma of skin: Skin lesion (pigmented and suspicious) with a weighted 7-point checklist score of 3 or more: refer people using a suspected cancer pathway referral (for an appointment within two weeks). Skin lesion (pigmented or non-pigmented) that suggests nodular melanoma: consider a suspected cancer pathway referral (for an appointment within two weeks). Squamous cell carcinoma: Skin lesion that raises the suspicion of a squamous cell carcinoma: consider a suspected cancer pathway referral (for an appointment within two weeks). Basal cell carcinoma: Skin lesion that raises the suspicion of a basal cell carcinoma: consider routine referral. Only consider a suspected cancer pathway referral (for an appointment within two weeks) if there is particular concern that a delay may have a significant impact, because of factors such as lesion site or size.
British Association of Dermatologists Royal College of Plastic Surgeons Various societies	Nil found specific to benign skin lesions. Various clinical guidelines relating to specific lesions are described in the sections below.	
Cochrane BMJ Best Practice PubMed	**3** **Skin conditions: benign nodular skin lesions** Nguyen T., Zuniga R. Fp Essentials, 2013 Apr;407:24-30	**Evidence Level: 5** Benign subcutaneous lesions are a common reason that patients visit family physicians. Lipomas are the most common of these lesions; they most often occur on the trunk and proximal extremities. Recent data show that as many as half of the fat cells in lipomas are atypical. Ultrasound is used increasingly to confirm lipoma diagnosis, but deep lesions should be evaluated with magnetic resonance imaging study or computed tomography scan to exclude involvement of underlying structures and/or liposarcoma. Small lesions can sometimes be managed with serial injections of midpotency steroids. Larger lesions (larger than 5 cm), those compressing other structures, or those suspicious for malignancy should be excised using standard surgical excision or, when possible, the newer minimal-scar segmental extraction technique. Ganglion cysts are another common lesion, the presence of which often is confirmed with ultrasound if the diagnosis is not clinically apparent. Management includes splinting, aspiration, and/or injection of steroids, with or without hyaluronidase. Epidermal inclusion cysts, also called sebaceous cysts, typically are asymptomatic unless they become infected. Ultrasound can aid in diagnosis. The only definitive management is surgical excision with complete removal of the cyst wall or capsule, using minimal-scar segmental extraction or conventional surgical removal.
Case Reports	**4**	**Evidence Level: 5**

Expert Opinion	**The management of benign skin lesions** Steven Lamb, Consultant Dermatologist, Department of Dermatology, Green Lane Clinical Centre and Auckland Dermatology NZCGP Volume 33 Number 5, October 2006	Benign skin lesions are often encountered in day-to-day general practice. The majority of lesions do not require treatment; however, occasionally patients will request the removal of lesions which are symptomatic or unsightly. It is important to make the correct diagnosis to avoid the inappropriate treatment of malignant lesions. Making the diagnosis of a benign skin lesion is often based on the history and then recognising the clinical appearance, but taking a biopsy is sometimes necessary in situations when uncertainty arises. It is also important to be aware that occasionally malignant lesions can appear within, or adjacent to, some benign lesions, and malignant lesions can mimic some benign lesions, i.e. keratoacanthomas.
	5 **Common Benign Skin Tumors** Mark C. Luba, M.D. et al American Family Physician February 15, 2003 / Volume 67, Number 4	**Evidence Level: 5** Benign skin tumors are commonly seen by family physicians. The ability to properly diagnose and treat common benign tumors and to distinguish them from malignant lesions is a vital skill for all family physicians. Any lesions for which the diagnosis is uncertain, based on the history and gross examination, should be biopsied for histopathologic examination to rule out malignancy. Lipomas are technically subcutaneous soft tissue tumors, not skin tumors, and controversy exists about whether keratoacanthomas have malignant potential; however, both are discussed in this article because they are common tumors evaluated by family physicians. Diagnosis usually is based on the appearance of the lesion and the patient's clinical history, although biopsy is sometimes required. Treatment includes excision, cryotherapy, curettage with or without electrodesiccation, and pharmacotherapy, and is based on the type of tumor and its location. Generally, excision is the treatment of choice for lipomas, dermatofibromas, keratoacanthomas, pyogenic granulomas, and epidermoid cysts. Cherry angiomas and sebaceous hyperplasia are often treated with laser therapy and electrodesiccation. Common treatments for acrochordons and seborrheic keratoses are cryotherapy and shave excision. Referral is indicated if the family physician is not confident with the diagnostic evaluation or treatment of a lesion, or if a biopsy reveals melanoma.

Warts / Mosaic Warts / Verrucas

	Summary of grade of evidence found					**Other**	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**
Warts / Mosaic Warts / Verrucas	**Nil**	**Nil**	**Nil**	**Nil**	✓	**Nil**	✓

NICE NICE CKS NHS Evidence SIGN	**6** **NICE CKS: Warts and Verrucae** Revised December 2014	**Evidence Level: N/A** Cutaneous warts are common, and most people will have them at some point in their life. Benign warts in immunocompetent people almost never undergo malignant change. Although warts can be cosmetically unsightly, they are not harmful, usually do not cause symptoms, and most resolve without treatment. Advice should be offered on reducing the risk of transmission and limiting personal spread of warts. Treatment should be considered if a wart is painful, cosmetically unsightly, persistent, or the person requests treatment. For the treatment of other warts in adults and older children, options are topical salicylic acid, cryotherapy, or a combination of both (cryotherapy is not recommended for younger children). Warts can generally be managed in primary care, but referral to a dermatologist is necessary if the person has: An uncertain diagnosis, a facial wart, multiple recalcitrant warts, compromised immunity, extensive warts, persistent warts that are unresponsive to available primary care treatments Treatment options in secondary care include: Physical ablation (for example surgery, laser treatment, and photodynamic treatment), Antimitotic treatments (for example topical podophyllotoxin and topical or oral retinoids), Immunomodulatory treatments such as topical sensitizers, Virucidal treatments such as formaldehyde and glutaraldehyde).
British Association of Dermatologists Royal College of Plastic Surgeons Various societies	**7** **British Association of Dermatologists' guidelines for the management of cutaneous warts 2014** J.C. Sterling, S. Gibbs, S.S. Haque Hussain, M.F. Mohd Mustapa and S.E. Handfield-Jones July 2014	**Evidence Level: 5** The term 'warts' includes all morphological varieties of warts and may sometimes be used to name wart-like lesions, such as seborrhoeic keratoses or seborrhoeic 'warts', which are not caused by HPV infection. In this guideline the term 'warts' deals only with warts due to HPV infection. HPV-associated warts are subdivided on anatomical or morphological grounds into (i) common wart (Verruca vulgaris); (ii) wart on the sole of the foot, plantar wart (Verruca plantaris); (iii) flat wart or plane wart (Verruca plana) and (iv) genital wart (Condyloma accuminatum). Depending on their site and size, warts may be just a minor nuisance. If the affected individual is immunocompetent, then an expectant approach to management is entirely acceptable. Some warts can be uncomfortable or interfere with function, or may be a major cosmetic bother and embarrassment when numerous or on sites such as the face. Under these circumstances, a number of different treatments may be considered. Warts are one of the most common skin infections and can persist for many years, but the evidence base for treatment is, for the most part, weak. Evaluating the results of studies of the large number of available treatments for warts has often been hampered by flaws in study design. In the future, the evidence for management of warts would be helped by studies in which (i) children and adults are separated into distinct treatment groups; (ii) the duration of warts before the study commences is recorded; (iii) study groups are of an adequate size; (iv) treatment runs for up to 6 months; (v) left- vs. right-side studies are avoided; (vi) treatment success is measured as clearance of all treated warts; and (vii) recurrence at 3 and 6 months

		following completion of treatment is included whenever possible. For relatively easily available, inexpensive and well-tolerated treatments, a number of questions need resolution
	8 **Primary Care Dermatology Society: Warts** Information on website Last Updated: November 2017	**Evidence Level: 5**
		Warts are growths of the skin caused by infection with the Human Papillomavirus (HPV). More than 70 HPV subtypes are known. Management Step 1: prevention Warts are contagious but the risk of transmission is low Children with warts should NOT be excluded from physical activities, but should take care to minimise transmission: Cover the wart with a waterproof plaster when swimming, wear flip-flops in communal showers, and avoid sharing shoes, socks and towels. Limit personal spread by: avoiding scratching lesions, avoiding biting nails or sucking fingers that have warts, keeping feet dry and changing socks daily. Step 2: notes on plantar warts In general, plantar warts are very difficult to treat - provide a patient information leaflet. The pain caused by plantar warts results from thickening of the skin, accordingly the mainstay of treatment should be regular pairing in order to make the feet comfortable. Only in exceptional circumstances should patients receive cryotherapy - the reasons to highlight with patients are that: cryotherapy is unlikely to help, on the occasions where cryotherapy does help many treatments are usually required, cryotherapy of the feet is very likely to be painful and can cause blistering. Step 3: general management notes (excluding anogenital warts) No treatment - this is always an option if the warts are not causing any problems. The natural history of warts should also be considered. Up to 90% of warts in young children will resolve in two years. However warts in adults, those with a long history of infection and in immunosuppressed patients are less likely to resolve spontaneously and are more recalcitrant to treatment. Step 3: anogenital warts Patients with anogenital warts should be referred to a local GUM service
Lipoma		

	Summary of grade of evidence found					**Other**	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**

Lipoma	**Nil**	**Nil**	**Nil**	✓	✓	**Nil**	✓

British Association of Dermatologists Royal College of Plastic Surgeons Various societies	**9** **Primary Care Dermatology Society: Lipoma** Information on website Last Updated: July 2016	**Evidence Level: 5** A lipoma is a common benign tumour of adipose tissue. Lipomas are usually found in the subcutaneous tissue and less commonly in internal organs. Lesions are solitary or multiple and usually of no significance, however, they can be associated with neurofibromatosis and rarely a number of other syndromes. Lipomas can occur at any age, however, they tend to arise in adulthood Solitary lipomas are more common in women whilst multiple lipomas occur more frequently in men. Lesions are often asymptomatic unless large in which case they can cause pain through pressure on various structures. Management Lipomas may be significantly larger than they appear on clinical examination - the excision of lipomas should only be undertaken by health professionals who have had the appropriate training in skin surgery and understand the anatomy of where the lipoma is found and are able to use surgical techniques that close the dead space following the removal of the lipoma Frontal lipomas - are found on the forehead and are often mistaken for epidermoid cysts. They arise from within the frontalis muscle or from deeper structures, are more complicated to manage and so must be excised only by health professionals trained to a high standard of skin surgery.
	10 **Primary Care Dermatology Society: Liposarcoma** Information on website Last Updated: November 2014	**Evidence Level: 5** A liposarcoma is a malignant tumour of fat cells. They are most commonly found in the extremities; in the retroperitoneum; and less often in the head and neck area. Whilst liposarcomas are the most common soft tissue sarcomas in adults, their primary occurrence in the skin (cutaneous liposarcoma) is rare. Management Management is in Secondary / Tertiary care - all suspicious lumps of unknown diagnosis should be referred urgently as 2 Week Rules. Management is surgical with wide local excision. The prognosis depends on the sub-type, site and size of lesion at point of treatment
Cochrane	**11**	**Evidence Level: 5**

BMJ Best Practice PubMed	**BMJ Best Practice Review: Lipoma** Dalal KM., DeMartini ST. Updated December 2017	Lipomas are slow-growing, benign, mesenchymal tumours that form well-circumscribed, lobulated lesions composed of adipocytes. They are demarcated from surrounding fat by a thin, fibrous capsule. They comprise 50% of soft-tissue neoplasms and are commonly encountered by primary care physicians, surgeons, and pathologists. Lipomas usually arise in the subcutaneous tissues and may occur in any area of the body, although they most frequently occur on the trunk and proximal limbs. They have no malignant potential, but the differential diagnosis includes liposarcomas, which do have this potential, so this must always be considered. Lipomas can occur in a wide variety of sites. The position, size, likely differential and other characteristics of a lesion determine what treatments are feasible and appropriate. Since lipomas do not have malignant potential they do not necessarily have to be removed, but this course of action depends on a number of factors, the most notable being the likelihood that the lesion could be a liposarcoma. Superficial cutaneous lipomas on trunk or extremity Lipomas of this type are often removed for a number of reasons; for cosmetic appearance, if they are painful or bothersome, if they increase in size, if there is concern regarding a potential liposarcoma. If it is decided between patient and clinician that the lipoma is to be treated, there are 3 possible options: Excision, Liposuction, Lipolysis.
	12 **Lipoma Excision** Gohar A. Salam, M.D. American Family Physician March 1, 2002 / Volume 65, Number 5 901-904	**Evidence Level: 5** Lipomas are slow-growing, nearly always benign, adipose tumors that are most often found in the subcutaneous tissues. Most lipomas are asymptomatic, can be diagnosed with clinical examination and do not require treatment. These tumors may also be found in deeper tissues such as the intermuscular septa, the abdominal organs, the oral cavity, the internal auditory canal, the cerebellopontine angle and the thorax. Lipomas have been identified in all age groups but usually first appear between 40 and 60 years of age. Congenital lipomas have been observed in children. Some lipomas are believed to have developed following blunt trauma. Lipomas usually present as nonpainful, round, mobile masses, with a characteristic soft, doughy feel. The overlying skin appears normal. Lipomas can usually be correctly diagnosed by their clinical appearance alone.
	13 **Giant lipomas of the upper extremity** Allen B., Rader C., Babigian A. Can J Plast Surg. 2007 Autumn; 15(3): 141–144.	**Evidence Level: 4** All lipomas in the upper extremities measuring larger than 5 cm in a single dimension should be surgically removed due to malignant potential. Preoperatively, imaging is important to delineate the extent of the lesion and to assist in operative planning. We recommend MRI for its ability to discern tissue planes. Surgical removal of lipomas may require significant dissection and mobilization of neurovascular structures for successful resection, and preoperative discussions with patients regarding potential loss of function are essential. Any lipomatous mass may recur with incomplete excision, and liposarcomas may require a larger repeat excision, chemotherapy or radiation.
NHS Evidence	**14**	**Evidence Level: 5**

	NHS Evidence – Lipoma Linked to Patient.co.uk Dr Mary Harding July 2016	A lipoma is a non-cancerous (benign) fatty lump that usually causes no symptoms or problems. Most lipomas are small and are best left alone. However, a lipoma that develops under the skin can sometimes look unsightly. If required, it can be removed by a simple operation done under local anaesthetic. In themselves, lipomas are not serious and most lipomas cause no symptoms or problems. Usually if you have a lipoma, it does not cause any symptoms but you notice a painless lump. Lipomas grow very slowly. Sometimes a lipoma under the skin can be unsightly if it grows to be several centimetres across. Rarely, a lipoma may press on another structure and cause problems. For example, if one presses on a nerve it may cause pain. Also, rarely, a lipoma may develop in the gut wall and cause problems such as pain or a blockage of the gut. Sometimes a scan or other investigation that is done for other reasons may detect a lipoma inside the body by chance. There is a condition called familial multiple lipoma in which groups of fat cells occur under the skin and then produce multiple fatty lumps. This is an uncommon condition and runs in families. Note: lipomas are always benign. There is no scientific evidence that a lipoma increases the risk of developing a cancer in the future. However, lipomas can sometimes be mistaken for a cancerous tumour called a liposarcoma. These are usually large (5 cm or more in diameter) and grow rapidly. If you are concerned about a lipoma which has started to increase in size you should consult your doctor.

Cysts – Sebaceous, Epidermoid, Pilar

	Summary of grade of evidence found					Other	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**
Cysts – Sebaceous, Epidermoid, Pilar	**Nil**	**Nil**	**Nil**	**Nil**	✓	**Nil**	✓

NICE NICE CKS NHS Evidence SIGN	**15** **Sebaceous Cysts (Epidermoid and Pilar cysts)** **NHS Evidence** – linked to patient.co.uk Dr Louise Newson: August 2015	**Evidence Level: N/A** The vast majority of epidermoid or pilar cysts are of no great consequence. Epidermal cysts (also known as epithelial or infundibular cysts) are intradermal or subcutaneous tumours. Epidermoid cysts may occur anywhere on the body but occur most often on the face, scalp, neck, back and scrotum. Pilar cysts (also called trichilemmal cysts) are clinically indistinguishable from epidermal cysts. They contain keratinous material, are usually multiple and there is often an autosomal dominant inheritance. They are both extremely common and probably most people will have at least one over the course of a lifetime. They can often resolve spontaneously. Most people with an epidermoid or pilar cyst never seek medical attention.

		If a cyst is uncomplicated then no treatment is usually advisable. The cyst may disappear spontaneously, leaving no trace. Even the most skilful excision will leave a permanent scar. If the cyst is red and hot it is probably infected. An antibiotic effective against staphylococci should be used - eg, flucloxacillin. Infection may be mixed and, in lesions of the scalp and anogenital area, anaerobic flora are more likely. If the cyst has ruptured, the contents can be expressed. However, the cyst may well re-form. An inflamed but uninfected cyst may respond to intralesional injection of steroid but it is not easy to tell if an inflamed cyst is infected or not and this is not usually recommended. If the cyst is troublesome or if the patient, after counselling, is eager to have it removed then the entire cyst should be excised as a surgical procedure.
British Association of Dermatologists Royal College of Plastic Surgeons Various societies	**16** **British Association of Dermatologists Information leaflet Epidermoid and Pilar Cysts** 13 April 2012	**Evidence Level: 5** In the past, pilar and epidermoid cysts were wrongly known as 'sebaceous' cysts but this term should be used only for a quite different and much less common type of cyst that is filled with a clear oily liquid made by sebaceous (grease) glands. Epidermoid and pilar cysts are common, not cancerous, and not contagious. There are several simple and effective ways of removing them under local anaesthetic. However, it is fairly common for new cysts to grow at a later date, especially on the scalp or genital skin. How can they be treated? Epidermoid and pilar cysts are harmless, and small ones that give no trouble can safely be left alone. Your doctor may give you an antibiotic if your cyst becomes infected. Both types of cyst are easy to remove under a local anaesthetic but this does leave a scar. Reasons for removal may include the following: 1. If the cyst is unsightly and easily seen by others. 2. If it interferes with everyday life, for example by catching on your comb. 3. If the cyst becomes infected. It is important that the doctor removes the whole of the lining during the operation (and doesn't just cut into it to remove the contents), as doing so cuts down the chance of the cyst growing back.
Cochrane BMJ Best Practice PubMed	Multiple case studies of excision of cysts. Nil found regarding criteria for cyst removal	

Molluscum Contagiosum

	Summary of grade of evidence found					Other	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**
Molluscum Contagiosum	✓	**Nil**	**Nil**	**Nil**	✓	**Nil**	✓

NICE NICE CKS NHS Evidence SIGN	**17** **NICE CKS: Molluscum Contagiosum** Revised March 2017	**Evidence Level: N/A** Molluscum contagiosum is a viral skin infection caused by molluscum contagiosum virus (MCV), a type of Poxvirus. Transmission occurs directly by close personal contact, or indirectly via fomites (contaminated surfaces) such as shared towels and flannels. Molluscum contagiosum is common, especially in children and in people who are immunocompromised. The exact prevalence is uncertain as many people never seek medical care. The majority of cases occur in children with the maximum incidence in preschool children aged 1–4 years. Complications from molluscum contagiosum are uncommon but can include scarring, conjunctivitis, keratitis, bacterial superinfection, and psychological distress. Molluscum contagiosum is a self-limiting condition which typically resolves spontaneously within 18 months. Treatment is not usually recommended, although certain techniques may be used to treat lesions causing symptoms or super-infection. Eczema or inflammation can develop around lesions prior to resolution. Treatment may be required if: (1) Itching is problematic — an emollient and a mild topical corticosteroid (for example, hydrocortisone 1%) may be useful. (2) The skin looks infected — a topical antibiotic (for example, fusidic acid 2%) may be useful. Referral may be necessary in some circumstances: Children with extensive problematic lesions may need referral to a Dermatologist. People with eyelid-margin or ocular lesions and associated red eye require an urgent referral to an Ophthalmologist. HIV-positive people with extensive lesions may require an urgent referral to an HIV Specialist. Adults with anogenital lesions should be referred to GUM (genito-urinary medicine), as they may require screening for other sexually transmitted infections.
British Association of	**18**	**Evidence Level: 5**

Dermatologists Royal College of Plastic Surgeons Various societies	**UK national guideline for the management of Genital Molluscum in adults, 2014 Clinical Effectiveness Group, British Association for Sexual Health and HIV** Imali Fernando, Jill Pritchard, Sarah K Edwards and Deepa Grover, International Journal of STD & AIDS, Int J STD AIDS OnlineFirst, published on October 19, 2014 as doi:10.1177/0956462414554435	Management General advice Patients must be warned of risks of autoinoculation and, for example, advised against shaving or waxing their genital regions, to prevent further spread of lesions. Similarly, patients should be advised against squeezing molluscum spots, both due to risk of superinfection and also as the central plug is full of infectious virus that is easily spread to uninfected skin. Towels, bed linen, clothes etc. should not be shared when active lesions are present, to reduce risk of onward transmission. Lesions should be covered with waterproof bandages or clothes, if possible, prior to using swimming pools. With genital molluscum, condoms may reduce transmission, but this is not absolute. Further investigation Patients who develop molluscum at their genital regions have usually acquired infection via a sexual route, and should be offered routine STI screening for other infections. In patients with immune suppression disseminated fungal infections should be excluded. Treatments Recommended. Expectant management (no treatment) is recommended for immunocompetent patients (although this recommendation is guided by a Cochrane review of molluscum treatments at nongenital sites). (Level of evidence I, A.) Patients seek treatment from various motives, including for cosmetic reasons, stigma, symptoms (pruritus, secondary infection) and concerns regarding transmission and autoinoculation. Some treatments may shorten the disease course, but this requires to be balanced against possible side effects. Molluscum infection itself, resolving naturally, usually leaves no long-term sequelae, and it is important therefore that any therapy chosen is also gentle and has minimal side effects. It is difficult to advocate one single treatment above others and choice is influenced by a number of factors, including comparative efficacy, side effects, cost and ease of use. The patient's views should be considered in the decision-making process. If patients opt for treatment, they must be informed that new lesions can appear for a while, necessitating more than one treatment course.
Cochrane BMJ Best Practice PubMed	**19** **Interventions for Cutaneous Molluscum Contagiosum (Review)** Van der Wouden JC et al 2009 Cochrane Database Syst Rev. 2009 Oct 7;(4):CD004767	**Evidence Level: 1** BACKGROUND: Molluscum contagiosum is a common skin infection, caused by a pox virus. The infection will usually resolve within months in people with a normal immune system. Many treatments have been used for molluscum contagiosum but a clear evidence base supporting them is lacking. This is an updated version of the original Cochrane Review published in Issue 2, 2006. OBJECTIVES: To assess the effects of management strategies (including waiting for natural resolution) for cutaneous, non-genital molluscum contagiosum in otherwise healthy people. SEARCH STRATEGY: In June 2009 we updated our searches of the Cochrane Skin Group Specialised Register, the Cochrane Central Register of Controlled Trials (CENTRAL) in The Cochrane Library (Issue 2, 2009), MEDLINE, EMBASE, and LILACS. We also searched ongoing trials registers, reference lists, and contacted pharmaceutical companies and experts in the field.

		SELECTION CRITERIA: We investigated randomised controlled trials (RCTs) for the treatment of molluscum contagiosum. We excluded trials on sexually transmitted molluscum contagiosum and in people with lowered immunity (including those with HIV infection). DATA COLLECTION AND ANALYSIS: Two authors independently selected studies, assessed methodological quality, and extracted data from selected studies. MAIN RESULTS: Eleven studies, with a total number of 495 participants, examined the effects of topical (9 studies), systemic, and homoeopathic interventions (1 study each). Limited evidence was found for the efficacy of sodium nitrite co-applied with salicylic acid compared to salicylic acid alone (risk ratio (RR) 3.50, 95% confidence interval (CI) 1.23 to 9.92); for Australian lemon myrtle oil compared to its vehicle, olive oil (RR 17.88, 95% CI 1.13 to 282.72); and for benzoyl peroxide cream compared to tretinoin (RR 2.20, 95% CI 1.01 to 4.79). No statistically significant differences were found for 10 other comparisons, most of which addressed 2 topical treatments. Study limitations included no blinding (four studies), many dropouts (three studies), and no intention-to-treat analysis; small study sizes may have led to important differences being missed. None of the evaluated treatment options were associated with serious adverse effects. AUTHORS' CONCLUSIONS: No single intervention has been shown to be convincingly effective in the treatment of molluscum contagiosum. The update identified six new studies, most of them reporting on interventions not included in the original version. However, the conclusions of the review did not change.
	20 **Molluscum contagiosum virus infection** Chen X, Anstey AV, Bugert JJ. Lancet Infect Dis. 2013 Oct;13(10):877-88. doi: 10.1016/S1473-3099(13)70109-9. Epub 2013 Aug 21	**Evidence Level: 5** Molluscum contagiosum virus is an important human skin pathogen: it can cause disfigurement and suffering in children, in adults it is less common and often sexually transmitted. Extensive and persistent skin infection with the virus can indicate underlying immunodeficiency. Traditional ablative therapies have not been compared directly with newer immune-modulating and specific antiviral therapies. Advances in research raise the prospect of new approaches to treatment informed by the biology of the virus; in human skin, the infection is localised in the epidermal layers, where it induces a typical, complex hyperproliferative lesion with an abundance of virus particles but a conspicuous absence of immune effectors. Functional studies of the viral genome have revealed effects on cellular pathways involved in the cell cycle, innate immunity, inflammation, and cell death. Extensive lesions caused by molluscum contagiosum can occur in patients with DOCK8 deficiency-a genetic disorder affecting migration of dendritic and specialised T cells in skin. Sudden disappearance of lesions is the consequence of a vigorous immune response in healthy people. Further study of the unique features of infection with molluscum contagiosum virus could give fundamental insight into the nature of skin immunity.
Telangiectasia / Thread veins		

	Summary of grade of evidence found					Other	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**
Telangiectasia / Thread veins	**Nil**	**Nil**	**Nil**	**Nil**	✓	**Nil**	✓

British Association of Dermatologists Royal College of Plastic Surgeons Various societies	**21** **Primary Care Dermatology Society: Telangiectases** Information on website Last Updated: April 2017	**Evidence Level: 5** Telangiectases result from the chronic dilatation of pre-existing capillaries or venules. They appear on the skin and mucous membranes as small red, linear, stellate or punctate markings. Telangiectases can be primary or secondary in origin and while most are harmless a few types are associated with serious underlying conditions. Primary telangiectases While there are different types, this chapter will only discuss the following: Spider telangiectases (syn. spider naevus), Costal fringe, Generalised essential telangiectasia, Hereditary haemorrhagic telangiectasia (syn. Rendu-Osler-Weber syndrome), Angioma serpiginosum, Unilateral naevoid telangiectasia, Poikilodermatous mycoses fungoides (syn. poikiloderma atrophicans vasculare) Secondary telangiectases There are many causes eg rosacea, prolonged UV exposure, steroid atrophy, radiodermatitis and connective tissue disorders Management Most telangiectases are self-limiting. For cosmetically sensitive areas of the body: Gentle cautery can be used for small numbers of lesions, Laser therapy is also an effective treatment and can be used for larger numbers of lesions. Patients with potentially more serious conditions such as hereditary haemorrhagic telangiectasia or poikilodermatous mycoses fungoides need referring, the latter may need observation and multiple biopsies before the condition is diagnosed

Seborrhoeic Keratosis / Basal Cell Papilloma

		Summary of grade of evidence found					Other	
		Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**
	Seborrhoeic Keratosis / Basal Cell Papilloma	**Nil**	**Nil**	**Nil**	**Nil**	✓	**Nil**	✓

British Association of Dermatologists Royal College of Plastic Surgeons Various societies	**22** **Primary Care Dermatology Society: Seborrhoeic Keratosis** Information on website Last Updated: 27 November 2014	**Evidence Level: 5** A seborrhoeic keratosis (SK) is a benign overgrowth of epidermal keratinocytes, and is of unknown aetiology. Management: Provide a patient information leaflet. Most SK do not need treatment but for those that do the majority can be treated by liquid nitrogen. Very thick lesions are best removed by curettage and cautery - all samples should be sent for histology. If there is any uncertainty about the clinical or dermoscopic findings the patient should be referred to Secondary Care as a 2 Week Rule
	23 **British Association of Dermatologists Patient Information Leaflet: Seborrhoeic Keratoses** Produced November 2004, Updated September 2011, September 2014	**Evidence Level: 5** Despite their name, seborrhoeic keratoses are nothing to do with sebaceous glands or viral warts: • They are benign growths due to a build up of ordinary skin cells. • There is some suggestion that it is related to exposure to sunlight. • In the UK more than half the men and more than third of women would have at least one seborrhoeic keratosis. By the age of 40 30% of the population would be affected while by the age of 70 it increases to 75%. They are also found in younger people. • Some people will have only few seborrhoeic keratoses, while others will have large numbers. • They are not infectious and do not become malignant. As seborrhoeic keratoses are so common, it would be impossible to routinely treat every individual and every single keratosis. Most need no treatment anyway as they are harmless and cause no symptoms.
Cochrane BMJ Best Practice PubMed	**24** **BMJ Best Practice Review: Seborrhoeic Keratosis** Braun, R, Updated November 2017	**Evidence Level: 5** Lesions are common, multiple, benign tumours of the skin. Most people over the age of 50 years are affected. They appear as well-circumscribed 'stuck-on' plaques or papules and may look like warts. They are usually asymptomatic but can become irritated and inflamed spontaneously or because of friction from clothing. Treatment is not necessary because of their benign nature, but if irritated, itching, and displeasing, can be initially treated with cryotherapy and curettage. Most important differential diagnosis, and of patient concern, is malignant melanoma. Treatment is not always necessary because of the benign nature of seborrhoeic keratosis. Lesions are generally asymptomatic but can become irritated and inflamed either spontaneously or because of

		friction from clothing. Treatment is given for cosmetic reasons and to decrease irritation. Numerous methods are effective. The most frequently used methods are cryotherapy, curettage (shaving), and surgical excision. Patients who elect for treatment are likely to see good results. Complications of treatments Hyperpigmentation can occur after any treatment, but is common after cautery. Hypopigmentation can also occur after any treatment, but is common following cryotherapy. Scars and keloids can both occur after any treatment but are more common after cautery than curettage. Emerging treatments - Topical dobesilate Topical dobesilate interferes with FGF (fibroblast growth factor) receptor coupling. Successful treatment has been described in one case report. A patient with 2 facial seborrhoeic keratoses received a single daily application over 6 months and achieved complete clearance of the seborrhoeic keratosis lesions with good cosmoses. This suggests that this compound may be a safe and effective candidate for the treatment of seborrhoeic keratoses

Skin Tags / Acrochordon

	Summary of grade of evidence found					Other	
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**National guidelines**	**Other CCG Policies**
Skin Tags / Acrochordon	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	**Nil**	✓

Other	**25** **Patient.co.uk – Skin Tags** Dr Mary Harding December 2016	**Evidence Level: N/A** Skin tags are small, often pedunculated, skin-coloured or brown papules that occur most frequently where there are skin folds. Common sites are the neck, axillae, groin and eyelids. They are also known as acrochordons. They are usually 0.2 to 0.5 cm in diameter. Skin tags are very common and may occur in up to half of the population. They occur in men and in women and incidence increases with age. They occur more commonly in pregnancy. The most common sites for skin tags are the neck, the axillae and the groin. They are more common in patients with type 2 diabetes and those with obesity and they appear to have an association with the metabolic syndrome. It may be that skin tags are caused by irritation and chaffing as skin folds rub together. They may be more common at sites where rubbing of clothing over skin occurs. Insulin resistance may play a part. Human papillomavirus (HPV) may possibly play a role in pathogenesis. Primary care management Skin tags do not have malignant potential but are often removed due to irritation or for cosmetic

		reasons. Small skin tags may be removed by snipping off with a pair of sharp scissors or by applying a ligature round the base. If the base is fine no anaesthetic is needed and little bleeding occurs. Cryotherapy is sometimes also used. Larger ones will need local anaesthetic and can be removed by shave and cautery, or by cutting cautery alone.
	26 **NHS Choices – Skin Tags** Updated November 2016	**Evidence Level: N/A** Skin tags are small, soft, skin-coloured growths that hang off the skin and look a bit like warts. They're very common, harmless, and can vary in colour and size – from a few millimetres up to 5cm (about 2 inches) wide. Skin tags are usually found on the neck, armpits, around the groin, or under the breasts. They can also grow on the eyelids or under the folds of the buttocks. Both men and women can develop skin tags. They tend to occur in older people and people who are obese or have type 2 diabetes. Pregnant women may also be more likely to develop skin tags as a result of changes in their hormone levels. Some people develop them for no apparent reason. Skin tags tend to grow in the skin folds, where the skin rubs against itself, such as on the neck, armpits or groin. This is why they tend to affect overweight people who have excess folds of skin and skin chafing. Skin tags are harmless and don't usually cause pain or discomfort. However, you may consider having skin tags removed if they're affecting your self-esteem, or if they snag on clothing or jewellery and bleed. You'll usually need to pay to have this done privately. This is because skin tag removal is regarded as cosmetic surgery, which is rarely available through the NHS. Cosmetic surgery is usually only available on the NHS if the problem is affecting your physical or mental health. Sometimes, skin tags fall off on their own if the tissue has twisted and died from a lack of blood supply. Don't try to remove a skin tag without speaking to your GP first. If you have a skin tag that's causing problems, consider making an appointment with a privately practising GP to have it removed. Skin tags can easily be burnt or frozen off in a similar way to how warts are removed. They can also be surgically removed, sometimes using local anaesthetic. Freezing or burning skin tags can cause irritation and temporary skin discoloration, and the skin tag may not fall off and further treatment may be needed. Surgical removal has the advantage of removing the skin tag completely, but there is a risk of minor bleeding. If your skin tag is small with a narrow base, your GP may suggest that you try to remove it yourself by: tying off the base of the skin tag with dental floss or cotton to cut off its blood supply and make it drop off (ligation) cutting it off with fine sterile scissors

Appendix 2 – Current CCG policies and new LCW policy

North East London (NEL)		**North Central London (NCL)**	**South West London (SWL)**	**South East London (SEL)**	**North West London (NWL)**	**LCW**
WELC	**BHR**	**NCP Pod**		**SEL TAP**		
City & Hackney Newham Tower Hamlets Waltham Forest	Barking Havering Redbridge	Barnet Camden Enfield Haringey Islington	Croydon Kingston Merton Richmond Sutton Wandsworth	Bexley Bromley Greenwich Lambeth Lewisham Southwark	Brent Central Ealing Hammersmith & Fulham Harrow Hillingdon Hounslow West London	
Latest policy 2015-16	Latest policy 2018	Latest policy 2015-16	Latest policy 2017-18	Latest policy 2017	Latest policy 2017-18	June 2018
Commissioning Position						
Excision of skin and subcutaneous lesions: ▪ These procedures are not routinely funded by WELC CCGs. ▪ A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate specialist for urgent assessment. ▪ Benign skin lesions may occasionally be excised for a differential diagnosis. Clinically benign moles should not be referred for cosmetic reasons. ▪ Suspicious pigmented lesions	Excision of skin and subcutaneous lesions are not routinely funded by BHR CCGs. ▪ A patient with a skin or subcutaneous lesion that has features suspicious of malignancy must be referred to an appropriate specialist for urgent assessment. ▪ Benign skin lesions may occasionally be excised for a differential diagnosis. Clinically benign moles should not be referred for cosmetic reasons. ▪ Suspicious pigmented lesions should always be subjected to excision	Cosmetic minor skin lesions (treatment of) ▪ This procedure is not routinely funded by the NCL CCGs and will only be considered for funding if the criteria below are met and evidenced.	This procedure is not routinely funded by SWL CCGs and will only be considered for funding if the below criteria are met and evidenced	Some benign skin lesions will continue to be excised in the acute sector for differential diagnosis. Some GPs also offer these procedures as part of their general practice, although not all patients currently have access to these services. i) Pigmented Lesions Removal of obviously clinically benign moles is not available on cosmetic grounds. In most cases the distinction between suspicious and purely benign moles is clear cut but suspicious pigmented lesions should always be subjected to excision	NWL CCGs will not routinely fund excision of benign skin lesion for aesthetic reasons. NHS NWL CCGs will fund the appropriate investigation and removal of any lesion or lump if any of the below criteria are met.	Procedures and interventions will be commissioned if the following criteria are met. Any lesion that is suspicious of malignancy is excluded from the policy and should be managed via the two-week wait pathway (or the relevant local pathway for the management of BCCs). This policy should be applied where there is diagnostic confidence that lesions are of a benign nature.

should always be subjected to excision biopsy and sent for histology, if referred to secondary care this should be to a pigmented lesions clinic.	biopsy and sent for histology, if referred to secondary care this should be to a pigmented lesions clinic.			biopsy.		
Criteria for Commissioning						
For benign skin lesions the CCG will only routinely fund surgery in patients meeting the following criteria: · The lesion is unavoidably and significantly traumatised on a regular basis AND · This results in significant infections such that the patient requires 2 or more courses of oral or intravenous antibiotics per year OR · The lesion is obstructing an orifice OR impairing field vision OR · The lesion significantly impacts on function e.g. restricts joint movement by >20 degrees.	**With prior approval**, funding will be considered for all other benign skin lesions for patients who meet both criteria 1(a) and 1(b), or one of criteria 2 or 3 1a) the lesion is unavoidably and significantly traumatised on a regular basis AND 1b) associated trauma results in significant infections such that the patient requires two or more courses of oral or intravenous antibiotics per year OR 2. the lesion is obstructing an orifice or impairing field vision OR 3. the lesion significantly impacts on function e.g. restricts joint movement by >20	For all other benign skin lesions the NCL CCGs will only routinely fund surgery in patients meeting the following criteria: · The lesion is unavoidably and significantly traumatised on a regular basis with evidence of this. AND · This results in infections such that the patient requires 2 or more courses of oral or intravenous antibiotics per year OR · The lesion is obstructing an orifice or impairing field vision OR · The lesion significantly impacts on function e.g. restricts joint movement OR · Greater than 1cm	Clinical threshold SWL CCGs fund this procedure when at least one of the following criteria (1-3) are met. NB: Scars (keloids) are covered in the Scar Revision Surgery clinical threshold 1. Patient has a large proven lipomata (>5cms) NB. The size and location of the lipomata will need to be provided on the Tickbox form. OR 2. Patient has a skin lesion that causes serious functional limitation on movement resulting in impairment of activities of daily living* NB. Impairment of activities of daily living and its severity will need to be provided on the Tickbox form.	The general remarks about other cosmetic procedures also apply to the excision of benign skin lesions. Other Benign Skin Lesions Other benign skin lesions e.g. skin tags, fibroepithelial polyps, dermatofibromata, seborrhoeic warts will not be removed on cosmetic grounds. However, if symptomatic and inflamed at the time of consultation, removal will be considered Epidermoid (Sebaceous) cysts are always benign and are not removed in the Dermatology Department. Some may become infected and symptomatic and referral to General Surgeons is indicated in these cases Viral Warts and	NHS NWL CCGs will fund the appropriate investigation and removal of any lesion or lump if any of the following criteria are met: Benign Lesions · The lesion is unavoidably AND significantly traumatised on a regular basis. · The lesion obstructs an orifice or movement or vision1,2. · The lesion is significantly infected AND the patient required repeated treatment with oral or intravenous antibiotics. Mucoid cyst · causing disturbance of nail growth · tendency to discharge Removal of warts	Procedures and interventions **will be** commissioned* if The lesion is unavoidably and significantly traumatised on a *regular* basis AND The lesion has been significantly infected, requiring more than 2 courses of antibiotics (oral or IV) OR The location of the lesion obstructs an orifice, impairs vision, significantly restricts usual function, causes *regular* pain AND Education: Recurrence and complication rates have been discussed with the patient

	degrees	facial lesions that cause significant disfigurement OR · Congenital deformity (this does not include normal variation). Applications should clearly evidence the size and site of the lesion, and the impact on the patient. e.g. a lesion of 1.5cm diameter, on the chin, which bleeds every time the patient shaves. e.g. a lipoma measuring 20cm x 25cm raised by 2cm lying across the left shoulder which restricts full joint movement. e.g. a sebaceous cyst measuring 1cm x 1cm on the right ear which regularly becomes infected and has twice required antibiotic treatment in the previous 12 months	OR 3. Patient has a skin lesion that is causing recurrent symptoms such as bleeding, infection or discharge over at least three months, and has not responded to appropriate conservative treatment over this period NB. Recurrent symptoms and their severity will need to be provided on the Tickbox form. * For the purposes of this policy, 'activities of daily living' covers functions such as dressing, personal hygiene (washing and toileting), functional mobility (moving from one place to another to perform activities required in the home or at work) and meeting nutritional needs (shopping, preparing and eating food Please note: Asymptomatic conditions which could be submitted for consideration via IFR may include severe disfiguring non-	Molluscum Contagiosum in Children under 16 Years of Age These are self-limiting viral infections. Warts are appropriately treated in Primary Care by topical keratolytics. Cryotherapy is too painful and no other treatment is offered in Secondary Care for either condition Viral Warts in Adults Properly compliant treatment with keratolytics is as effective as cryotherapy	(non-genital) · Viral warts will only be eligible for removal if the following criteria are met: where painful, persistent or extensive warts (particularly in immuno-suppressed patients)3 Lipomata · lipoma(-ta) of any size causing symptoms or demonstrable functional impairment · larger than 5 cm · deep-seated · the lump is rapidly growing or abnormally located (e.g. sub-fascial, submuscular, thigh) · patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis. If Liposarcoma is suspected referrals should be made using the 2 week wait service. Patients with a previous history of malignancy (excluding Basal Cell Carcinoma) are at greater risk of developing lipo-sarcoma, therefore	Secondary care procedures & interventions for warts **will be** commissioned: Warts are: Extensive OR Facial OR the patient is immunocompromised AND Conservative treatment have failed Procedures and interventions for lesions **will NOT be** commissioned for solely cosmetic reasons. *Some CCGs may request supporting information. Interventions and procedures for benign skin lesions not meeting the above criteria will be managed in line with local CCG policy.

			malignant lesions of the face, or severe port wine stains (haemangiomas) that extend onto the face and/or neck.		clinical judgement should be used in these cases.	
Conditions Included						

▪ The following common, clinically benign skin lesions should not be excised for cosmetic reasons: 1. Skin tags including anal skin tags 2. Seborrhoeic keratoses 3. Hand or foot viral warts in adults 4. Comedones 5. Corn/callouses 6. Lipomas 7. Milia 8. Molluscum contagiosum 9. Sebaceous (epidermoid or pilar) cysts 10. Spider Naevus (telangiectasia) 11. Xanthelasma 12. Neurofibromata 13. Angioma Keratoma 14. Benign Naevi 15. Haemangiomas	Not specifically stated	Minor skin lesions include pigmented moles, comedones, corn/callous, lipoma, milia, molluscum contagiosum, sebaceous cysts (epidermoid or pilar cysts), seborrhoeic keratoses (basal cell papillomata), skin tags including anal tags, spider naevus (telangiectasia), warts, xanthelasma and neurofibromata.	Not specifically stated	Not specifically stated	Not specifically stated	The following lesions are included in this policy and therefore treatment will not be funded unless the criteria below are met: Benign pigmented moles/melanocytic naevus Comedones Corn/callous Lipoma Milia Molluscum contagiosum Cysts (epidermal, pilar, trichodermal, sebaceous) Seborrhoeic keratoses (basal cell papillomata) Skin tags including anal tags (acrochordon) Warts including plantar warts, mosaic warts Neurofibromata Telangiectasia / Thread Veins Dermatofibroma Capilliary Haemangioma / Campbell de Morgan Xanthelasma