GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester EUR Policy Statement on:

Common Benign Skin Lesions

GM Ref: GM013

Version: 3.3 (28 January 2019)

Commissioning Statement

Common Benign Skin Lesions	
Policy Exclusions **(Alternative commissioning arrangements apply)**	**All suspected malignant lesions are excluded from this policy – these should be managed via the 2 week wait with the exception of Basal Cell Carcinoma (BCC), where low risk BCC may be removed in the community in line with NICE recommendations and high risk BCC should be referred through the usual pathway.** This policy does not apply to minor surgery undertaken in primary care which is outside of the remit of this policy as it falls under the commissioning responsibility of NHS England. Treatment/procedures undertaken as part of an externally funded trial or as a part of locally agreed contracts / or pathways of care are excluded from this policy, i.e. locally agreed pathways take precedent over this policy (the EUR Team should be informed of any local pathway for this exclusion to take effect).

Policy Inclusion Criteria	**NOTE:**
	• For **skin resurfacing techniques** please see the GM Skin Resurfacing Techniques Policy
	• For **surgical revision of scarring** please see the GM Surgical Revision of Scarring Policy
	• For the following, please see the GM Other Aesthetic Surgery Policy:
	  ○ **Rhinophyma**
	  ○ **Birthmarks**
	  ○ **Other skin conditions not covered in this policy**
	• For **anal skin tags** please see the GM Surgical management (including banding) of haemorrhoids and anal skin tags Policy
	
	Benign skin lesions
	
	Removal of benign skin lesions will only be considered if **ONE** of the following applies:
	• Impairment of function or significant facial disfigurement, e.g. large lipoma.
	• Rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular).
	• There is significant pain as a direct result of the lesion.
	• There is a confirmed history of recurrent infection / inflammation.
	• There is reason to believe that a commonly benign or non-aggressive lesion may be changing to a malignancy, or there is sufficient doubt over the diagnosis to warrant removal.
	
	The following additional criteria are also applicable to the lesions listed below and referral may be made if the patient meets the criteria for that specific lesion **AND / OR** the mandatory criteria above:
	
	Lipoma (fatty lump)
	• The lump is over 5cm in diameter (due to the increased risk of missed diagnosis of a liposarcoma).
	• Where there are any concerns, the soft tissue guidelines should be followed.

	Warts • The diagnosis is uncertain. **OR** • There are multiple recalcitrant warts and the person is immunocompromised. **OR** • The person has areas of skin that are extensively affected, for example, mosaic warts. **Verrucas** • The person has diabetes. **Actinic/Solar Keratosis** • If there is any reason to suspect that it is one of the small percentage at high risk of undergoing malignant change and transforming into a squamous cell carcinoma. The referral should include details of the reasons the referrer has for this suspicion. **Funding Mechanism** Monitored approval: Referrals may be made in line with the criteria without seeking funding. **NOTE:** May be the subject of contract challenges and/or audit of cases against commissioned criteria.
Clinical Exceptionality	Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. Exceptionality means 'a person to which the general rule is not applicable'. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is: • Significantly different to the general population of patients with the condition in question. ***and as a result of that difference*** • They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.
Fitness for Surgery	**NOTE:** All patients should be assessed as fit for surgery before going ahead with treatment, even though funding has been approved.
Best Practice Guidelines	All providers are expected to follow best practice guidelines (where available) in the management of these conditions.

Contents

Policy Statement

Greater Manchester Health and Care Commissioning (GMHCC) Effective Use of Resources (EUR) Policy Team, in conjunction with the GM EUR Steering Group, have developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission treatments/procedures in accordance with the criteria outlined in this document.

In creating this policy GMHCC/GM EUR Steering Group have reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

Equality & Equity Statement

GMHCC/CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved, as enshrined in the Health and Social Care Act 2012. GMHCC/CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. In carrying out its functions, GMHCC/CCGs will have due regard to the different needs of protected characteristic groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

In developing policy the GMHCC EUR Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as *more equal* than any other protected characteristic group. This is because their 'starting point' is considered to be further back than any other group. This will be reflected in GMHCC evidencing taking 'due regard' for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Joint Commissioning Board (GMJCB) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the GM EUR Operational Policy.

Aims and Objectives

This policy document aims to ensure equity, consistency and clarity in the commissioning of treatments/procedures by CCGs in Greater Manchester by:

- reducing the variation in access to treatments/procedures.

- ensuring that treatments/procedures are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- reducing unacceptable variation in the commissioning of treatments/procedures across Greater Manchester.
- promoting the cost-effective use of healthcare resources.

Rationale behind the policy statement

The vast majority of benign skin lesions are harmless but may be unsightly. There are occasional circumstances in which the removal of a benign skin lesion is clinically indicated, these circumstances are listed in this policy. The policy ensures that lesions are not removed for solely aesthetic reasons.

Treatment / Procedure

The vast majority of skin tumours are benign. There are a few very common benign skin tumours 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, keloid scars, spider naevus (telangiectasia), warts and neurofibromata. Whilst removal of these lesions are very effective, they are of low therapeutic value and not commissioned for aesthetic reasons.

Actinic / solar keratosis: Actinic keratosis (Primary Care Dermatology Society (PCDS): Actinic Keratosis), also known as solar keratoses, are dry scaly patches of skin caused by damage from years of sun exposure. The patches are usually harmless but can be itchy and look ugly; there is a small risk of actinic / solar keratosis progressing into squamous cell carcinoma (SCC).

Basal cell papilloma / seborrhoeic keratosis / keratotic warts: non-cancerous (benign) warty growths that occur on the skin. They usually do not need any treatment.

Benign pigmented moles: A benign growth on the skin (usually tan, brown, or flesh-coloured) that contains a cluster of melanocytes and surrounding supportive tissue.

Epidermoid / sebacous cyst: Epidermoid and pilar cysts look like small smooth lumps under the skin surface. They are benign (non-cancerous) and usually cause no harm or problems. If required, they can usually be removed easily by a small operation done under local anaesthetic. The main reason why some people want them removed is for cosmetic reasons, as they can look unsightly.

Lipoma: A lipoma is a soft fatty lump. It is a non-cancerous (benign) growth made up from fat cells that clump together. A lipoma can occur in any part of the body where there are fat cells.

Neurofibromata: A benign neoplasm composed of the fibrous elements of a nerve.

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, axilla, groins and eyelids. They are also known as acrochordons. They are usually 0.2 to 0.5 cm in diameter.

Anal skin tags: This is a fibrous polyp of skin located at the anus.

Thread veins are a common problem and occur in about half of adults in western countries. These 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.

Telangectasia is a condition characterized by dilatation of the capillaries causing them to appear as small red or purple clusters, often spidery in appearance, on the skin or the surface of an organ.

Warts are small rough lumps on the skin. They are caused by a virus (human papillomavirus) which causes a reaction in the skin. Warts can occur anywhere on the body but occur most commonly on hands and feet. They range in size from 1 mm to over 1 cm. Sometimes only one or two warts develop. Sometimes several occur in the same area of skin. The shape and size of warts vary, and they are sometimes classed by how they look. For example, common warts, plane (flat) warts, filiform (finger-like) warts, mosaic warts, etc.

Verrucas 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.

Epidemiology and Need

Benign skin lesions are very common and the vast majority cause no problems other than aesthetic ones. Whilst these can be removed effectively they are of low clinical value.

About 1 in 1,000 people develop one or more lipomas.

Adherence to NICE Guidance

NICE have not currently issued guidance on this treatment.

Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

Date of Review

Five years from the date of the last review, unless new evidence or technology is available sooner.

The evidence base for the policy will be reviewed and any recommendations within the policy will be checked against any new evidence. Any operational issues will also be considered at this time. All available additional data on outcomes will be included in the review and the policy updated accordingly. The policy will be continued, amended or withdrawn subject to the outcome of that review.

Glossary

Term	Meaning
Acrochordon (Skin tags)	An acrochordon is a small benign tumor that forms primarily in areas where the skin forms creases, such as the neck, armpit, and groin. They may also occur on the face, usually on the eyelids. Acrochorda are harmless and typically painless, and do not grow or change over time.
Basal Cell Carcinoma	A type of skin cancer, also known as a rodent ulcer or BCC, that occurs most commonly on the face or neck.
Benign	(Of a disease) not harmful in effect.
Callous	A thickened and hardened part of the skin or soft tissue, especially in an area that has been subjected to friction.
Cellulitis	Inflammation of subcutaneous, loose connective tissue (formerly called cellular tissue).

Comedones	Technical term for blackhead (a plug of sebum in a hair follicle, darkened by oxidation).
Corn	An accumulation of dead skin cells on the foot, forming thick, hardened areas. They contain a cone-shaped core with a point that can press on a nerve below, causing pain.
Epidermoid or Pilar cyst	A common cyst of the skin.
Fascia	A structure of connective tissue that surrounds muscles and the overlying affected skin.
Immunocompromised	Having the immune response attenuated by administration of immunosuppressive drugs, by irradiation, by malnutrition, or by certain disease processes (e.g., cancer).
Keloid scar	A keloid is the formation of a type of scar which, depending on its maturity, is composed mainly of either type III or type I collagen. It is a result of an overgrowth of granulation tissue at the site of a healed skin injury which is then slowly replaced by collagen type 1.
Lipoma	A benign tumour of fatty tissue.
Liposarcoma	Sarcoma of fat cells.
Malignant	Unregulated cell growth. In cancer, cells divide and grow uncontrollably, forming malignant tumors, and invading nearby parts of the body.
Milia	A small, hard, pale keratinous nodule formed on the skin, typically by a blocked sebaceous gland.
Molluscum contageosum	A chronic viral disorder of the skin characterised by groups of small, smooth, painless pinkish nodules with a central depression that yield a milky fluid when squeezed.
Mosaic warts	Plantar growth of numerous closely aggregated warts forming a mosaic appearance, frequently caused by human papillomavirus type 2.
Neurofibromata	A benign neoplasm composed of the fibrous elements of a nerve.
Naevus	A birthmark (or a mole on the skin – see below), especially a birthmark in the form of a raised red patch often referred to as a strawberry naevus.
Pigmented Naevus	Mole / brown lesion of the skin, sometimes raised, sometimes hairy, which can in certain circumstance become malignant (= malignant melanoma)
Preseptal	Infection involving the superficial tissue layers anterior to the orbital septum.
Prophylactic	Preventing disease
Recalcitrant	Not responsive to treatment
Rosacea	Chronic vascular and follicular dilation involving the nose and contiguous portions of the cheeks; may vary from mild but persistent erythema to extensive hyperplasia of the sebaceous glands, seen especially in men in the form of rhinophyma and of deep-seated papules and pustules; accompanied by telangiectasia at the affected erythematous sites.
Sarcoma	A malignant tumour of connective or other non-epithelial tissue.

Sebaceous cyst	A swelling in the skin arising in a sebaceous gland, typically filled with yellowish sebum.
Seborrhoeic keratosis (basal cell papilloma)	A seborrheic keratosis is a noncancerous benign skin growth that originates in keratinocytes.
Spider naevus / Telangiectasia	A cluster of minute red blood vessels visible under the skin
Squamous Cell Carcinoma	Squamous cell carcinoma (SCC) is an uncontrolled growth of abnormal cells arising in the squamous cells, which compose most of the skin's upper layers (the epidermis). SCCs often look like scaly red patches, open sores, elevated growths with a central depression, or warts; they may crust or bleed. SCCs may occur on all areas of the body including the mucous membranes and genitals, but are most common in areas frequently exposed to the sun, such as the rim of the ear, lower lip, face, bald scalp, neck, hands, arms and legs.
Sub-facial	Beneath a fascia.
Sub-muscular	Situated underneath a muscle or muscles.
Symptomatic	Exhibiting or involving medical symptoms.
Tumour	A swelling of a part of the body, generally without inflammation, caused by an abnormal growth of tissue, whether benign or malignant.
Verruca / Plantar wart	A contagious and usually painful wart on the sole of the foot.
Warts	A small, hard, benign growth on the skin, caused by a virus.

References

1. GM EUR Operational Policy

Governance Approvals

Name	Date Approved
Greater Manchester Effective Use of Resources Steering Group	17/09/2014
Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning	20/10/2014
Greater Manchester Association Governing Group	04/11/2014
Bolton Clinical Commissioning Group	28/11/2014
Bury Clinical Commissioning Group	04/02/2015
Heywood, Middleton & Rochdale Clinical Commissioning Group	21/11/2014
Central Manchester Clinical Commissioning Group	15/01/2015
North Manchester Clinical Commissioning Group	12/11/2014
Oldham Clinical Commissioning Group	04/11/2014
Salford Clinical Commissioning Group	04/11/2014

South Manchester Clinical Commissioning Group	14/01/2015
Stockport Clinical Commissioning Group	03/12/2014
Tameside & Glossop Clinical Commissioning Group	05/11/2014
Trafford Clinical Commissioning Group	18/11/2014
Wigan Borough Clinical Commissioning Group	05/11/2014

Appendix 1 – Evidence Review

Common Benign Skin Lesions
GM013

Search Strategy

The following databases are routinely searched: NICE Clinical Guidance and full website search; NHS Evidence and NICE CKS; SIGN; Cochrane; York; and the relevant Royal College and any other relevant bespoke sites. A Medline / Open Athens search is undertaken where indicated and a general google search for key terms may also be undertaken. The results from these and any other sources are included in the table below. If nothing is found on a particular website it will not appear in the table below.

Summary of the evidence

The vast majority of benign skin lesions are harmless, many are self-limiting. Most removals are requested for aesthetic reasons however for some specific conditions there are criteria for consideration of referral for further treatment over and above the general criteria of:

- Lesion is symptomatic
- Lesion is causing functional impairment
- Lesion is rapidly growing or abnormally located
- There is significant pain as a direct result of the lesion
- There is a confirmed history of recurrent infection / inflammation/injury

The evidence

Levels of 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

Benign Skin Lesions

Database	**Result**
NICE	NICE IPG155: Photodynamic therapy for non-melanoma skin tumours (including premalignant and primary non-metastatic skin lesions) (Added at review: Nov 2015)
NHS Evidence and NICE CKS	patient.co.uk website (Site is now patient.info – added at Nov 17 review)
General Search (Google)	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
	Common Benign Skin Tumors, Mark C. Luba, M.D. et al, American Family Physician February 15, 2003 / Volume 67, Number 4

	Various websites including Patient.co.uk, medscape and clinic sites (general information - not cited below)
	TEXTBOOK: British Association of Dermatologists' Management Guidelines, Neil Cox (Editor), John English (Editor) ISBN: 978-1-4443-3552-1 344 pages March 2011, Wiley-Blackwell (not cited below)
Other	British Association of Dermatologists' guidelines for the management of squamous cell carcinoma in situ (Bowen's disease), British Journal of Dermatology (2014) 170, pp245–260 C.A. Morton, A.J. Birnie and D.J. Eedy (Added at review: Nov 2015)

1. 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.

2. LEVEL 5: EXPERT OPINION

Common Benign Skin Tumors, Mark C. Luba, M.D. et al, American Family Physician February 15, 2003 / Volume 67, Number 4

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. (Am Fam Physician 2003;67:729-38. Copyright© 2003 American Academy of Family Physicians.)

3. LEVEL N/A: CLINICAL GUIDELINES

British Association of Dermatologists' guidelines for the management of squamous cell carcinoma in situ (Bowen's disease), British Journal of Dermatology (2014) 170, pp245–260, C.A. Morton, A.J. Birnie and D.J. Eedy

This guideline update reviews the evidence level for treatments in common use for SCC in situ, as well as identifying novel and combination therapies where the evidence level is typically restricted to case reports/series. The quality of evidence is strongest for PDT, 5-FU and imiquimod, as well as cryotherapy (often a comparator in trials), but this may be influenced by the more rigorous assessment required for newer therapies seeking regulatory approvals. Surgical excision and curettage remain in common use,

although with lower quality evidence available. Treatment choice (Table 2) should take into account evidence of efficacy and tolerability, access to the therapy, cost-effectiveness and patient preferences. Specific therapeutic challenges are observed for SCC in situ located around the nail and for genital disease.

4. LEVEL N/A: NICE INTERVENTIONAL PROCEDURE GUIDANCE

NICE IPG155: Photodynamic therapy for non-melanoma skin tumours (including premalignant and primary non-metastatic skin lesions)

1 Guidance

1.1 Current evidence suggests that there are no major safety concerns associated with photodynamic therapy for non-melanoma skin tumours (including premalignant and primary non-metastatic skin lesions).

1.2 Evidence of efficacy of this procedure for the treatment of basal cell carcinoma, Bowen's disease and actinic (solar) keratosis is adequate to support its use for these conditions, provided that the normal arrangements are in place for consent, audit and clinical governance.

1.3 Evidence is limited on the efficacy of this procedure for the treatment of invasive squamous cell carcinoma. Recurrence rates are high and there is a risk of metastasis. Clinicians should ensure that patients understand these risks and that retreatment may be necessary. In addition, use of the Institute's information for the public is recommended.

Lipoma

Database	Result
NHS Evidence and NICE CKS	Websites: NHS choices, patient.co.uk and cancerhelp.uk (only patient.co.uk site cited below)
BMJ Best Practice	Information on diagnosis and management of Lipomas with references to cases, case series and unusual presentations (not cited below)
	Lipoma Excision, GOHAR A. SALAM, M.D., American Family Physician MARCH 1, 2002 / VOLUME 65, NUMBER 5 901-904 (article on 'how to' - not cited below)
General Search (Google)	Various websites including NHS choices, Patient.co.uk, Cancer Research UK and clinic sites (only patient.co.uk site cited below)

5. LEVEL 4/5: EXPERT ADVICE

Website: Lipoma, Patient.co.uk (Site is now patient.info – added at Nov 17 review)

Tumours that have characteristics consistent with a malignant liposarcoma include those that are:[14]

- Greater than 5 cm in diameter
- Located in the extremities, retroperitoneally, in the groin, in the scrotum or in the abdominal wall[14]
- Deep (beneath or fixed to superficial fascia)
- Exhibiting malignant behaviour (rapid growth or invasion into nerve or bone)

(14) Costea R, Vasiliu E, Zarnescu NO, et al; Large thigh liposarcoma--diagnostic and therapeutic features. J Med Life. 2011 May 15;4(2):184-8. Epub 2011 May 25

Epidermoid / Sebacous Cyst

Database	Result
NHS Evidence and NICE CKS	British Association of Dermatologists Information leaflet: Epidermoid and Pilar Cysts (13 April 2012)

York	Some case studies and series of unusual presentations and different removal techniques (not cited below)
General Search (Google)	Various websites including NHS choices, dermnet, patient.co.uk, and clinic sites (not cited below)

6. LEVEL 5: EXPERT OPINION

British Association of Dermatologists Information leaflet: Epidermoid and Pilar Cysts (13 April 2012)

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 cysts affect young and middle aged adults. They can come up after a hair follicle has been inflamed, so they are common in acne.

Pilar cysts affect women more often than men, and tend to come up in middle age. They run strongly in families.

Both types grow slowly. Some become infected (red and sore) from time to time. They may then discharge cheesy foul-smelling pus. Those on the scalp can catch on the comb: others may look embarrassing.

They can occur anywhere on the skin, but:

- *Pilar cysts* are most common on the scalp, where several can often be found.
- *Epidermoid cysts* are most common on the face, neck and upper trunk.

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 include the following:

1. If the cyst is embarrassing 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 as doing so cuts down the chance of the cyst growing back.

Skin Tags

Database	Result
General Search (Google)	Various websites including NHS choices, medscape, patient.co.uk, and clinic sites (not cited below)

Basal Cell Papilloma / Seborrhoeic Keratosis / Keratotic Warts

Database	Result
Cochrane	Reviews for BCC found, nil for BCP (not cited below)
BMJ Best Practice	Info found on BCC found, nil for BCP (not cited below)
General Search (Google)	British Association of Dermatologists Patient Information Leaflet: Seborrhoeic Keratoses, Produced November 2004, Updated September 2011, September 2014,

	(Added at review: Nov 2015)
	Primary Care Dermatology Society website: Seborrhoeic Keratosis, Last Updated: 27 November 2014 (Added at review: Nov 2015)
	Various websites including NHS choices, medscape, Dermnet NZ, and clinic sites (not cited below)

7. LEVEL N/A: EXPERT ADVICE LEAFLET

British Association of Dermatologists Patient Information Leaflet: Seborrhoeic Keratoses, Produced November 2004, Updated September 2011, September 2014

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.

8. LEVEL N/A: EXPERT ADVICE

Primary Care Dermatology Society website: Seborrhoeic Keratosis (Last Updated: 27 November 2014)

Management

- Provide a patient information leaflet (follow link for British Association of Dermatologists)
- 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
- The Leser-Trélat sign - this is characterised by the abrupt appearance of very large numbers of seborrhoeic keratoses that rapidly increase in their size and number. There is debate as to whether or not this is a paraneoplastic phenomenon, associated in particular with adenocarcinoma of the stomach or colon. Some people now believe that this is not the case, however, should lesions erupt in the presence of weight loss, GI symptoms, malignant acanthosis nigricans or other 'red flags' then patients should be referred urgently for further investigations.

Neurofibromata

Database	Result
General Search (Google)	Various medical 'notebook' websites, patient information and clinic sites (not cited below)

Warts and Verrucas

Database	Result
NHS Evidence and NICE CKS	NICE CKS: Warts and verrucae
Cochrane	Review of topical treatments (not cited below)
BMJ Clinical Evidence	BMJ Clinical Evidence Review: Warts (non-genital), Steven King-fan Loo and William Yuk-ming Tang, Search date: October 2013 (Added at review: Nov 2015)
BMJ Best Practice	Information on specific treatments only (not cited below)
General Search (Google)	Various websites including NHS choices, patient.co.uk, Dermnet NZ, and clinic sites (not cited below)
	Primary Care Dermatology Society website: Warts, Last Updated: 30 October 2015 (Added at review: Nov 2015)

9. LEVEL 4/5: NICE CKS

NICE CKS: Warts and Verrucae

In general, warts can be managed in primary care, however a number of specialized treatments are available in secondary care.

Refer to a dermatologist if:

- The person has a facial wart and requests treatment.
- The diagnosis is uncertain.
- There are multiple recalcitrant warts and the person is immunocompromised.
- The person has areas of skin that are extensively affected, for example mosaic warts.
- The person is bothered by persistent warts which are unresponsive to both topical salicylic acid and cryotherapy.
- The person is bothered by persistent warts which are unresponsive to topical salicylic acid and cryotherapy is contraindicated.

For those people with diabetes and a verruca – refer to diabetic foot services for management.

10. LEVEL 1: SYSTEMATIC REVIEW

BMJ Clinical Evidence Review: Warts (non-genital), Steven King-fan Loo and William Yuk-ming Tang, Search date: October 2013

ABSTRACT

Introduction: Warts are caused by the human papillomavirus (HPV), of which there are over 100 types. HPV probably infects the skin via areas of minimal trauma. Risk factors include use of communal showers, occupational handling of meat, and immunosuppression. In immunocompetent people, warts are harmless and resolve as a result of natural immunity within months or years.

Methods and Outcomes: We conducted a systematic review and aimed to answer the following clinical question: What are the effects of treatments for warts (non-genital)? We searched: Medline, Embase, The Cochrane Library, and other important databases up to October 2013 (Clinical Evidence reviews are updated periodically; please check our website for the most up-to-date version of this review).We included harms alerts from relevant organisations such as the US Food and Drug Administration (FDA) and the UK Medicines and Healthcare products Regulatory Agency (MHRA).

Results: We found 17 studies that met our inclusion criteria. We performed a GRADE evaluation of the quality of evidence for interventions.

Conclusions: In this systematic, review we present information relating to the effectiveness and safety of the following interventions: intralesional bleomycin; intralesional candida antigen; contact immunotherapy; cryotherapy; duct tape occlusion; photodynamic treatment; pulsed dye laser; surgical procedures; and topical salicylic acid.

A copy of the review is available on request.

11. LEVEL N/A: EXPERT ADVICE

Primary Care Dermatology Society website: Warts, (Last Updated: 30 October 2015)

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
    - 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**
- The pain caused by plantar warts results from thickening of the skin, accordingly the **mainstay of treatment should be regular pairing** (as referred to in step 3) 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
- **Formaldehyde solution** - this can be useful for some patients with plantar warts, but again should be considered only in **exceptional circumstances**. It is prescribed as a 4 or 5% solution and used OD for six weeks. Please refer to the 'patient information leaflet' section of the website for more information on how to use the treatment. Note that the price of formaldehyde solution varies substantially between different pharmacies and it **can be very expensive** - this may be worth discussing with your local pharmacy advisor

Step 3: General management notes (excluding anogenital warts)

- Provide a patient information leaflet (follow link for British Association of Dermatologists and search for 'plantar 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
- **Pairing of warts** - the discomfort caused by warts results from thickened skin. Pairing of warts reduces discomfort and helps improve the efficacy of the treatments discussed below. The technique for pairing is as follows:
    - Soak in warm water for 5-10 minutes
    - Pair away the dead skin using a disposable emery board / nail file
    - Perform once to twice a week

- **Salicylic acid** - there are various lotions, paints and special plasters available over the counter. These should be used every night for at least three months. As with other treatments it is important to make sure that warts are regularly paired down. An alternative to salicylic acid is gluteraldehyde. Topical treatment are best avoided on the face due to the risk of irritation and scarring
- **Duct tape** - the wart is occluded with duct tape for six days after which time the wart should be soaked in warm water for five minutes and paired down. The wart is then left uncovered overnight and the duct tape put on the next day for a further six days. This should be continued until the wart resolves
- **Cryotherapy** - see notes below. Inbetween treatments of liquid nitrogen the use of other treatment modalities such as duct tape or salicylic acid may be of additional benefit
- **Curettage and cautery** - can be useful for filiform warts, especially on the face. It can also be used for other warts that have failed to respond to other treatments. The main problem with this technique is that recurrence rates are up to 30%
- **Laser therapy** - has been used with some success in warts unresponsive to other treatments
- **Other treatments** - small studies have shown a number of other treatments to be of benefit in some patients. These treatments are off-label but appear to be safe:
    - Efudix ® cream (5-FU cream) - applied once a day at night under occlusion. Wash the hand thoroughly that was used to apply the cream. Wash the treated area the following morning. Review after four weeks
    - Aldara ® cream (5% imiquimod cream) - may help in cases of persistent facial warts. Apply three nights a week (eg Monday, Wednesday, Friday) until the wart resolves. Wash off the following morning
    - Topical retinoids applied once to twice a day
    - Oral cimetidine

Cryotherapy

- **Liquid nitrogen** is used to treat numerous conditions such as **warts, seborrhoeic keratoses and actinic keratoses**. Treatment must only be given if the lesion can confidently be diagnosed as benign, if not a biopsy is required for histological purposes
- Liquid nitrogen should be **avoided** on the gaiter area of legs in older patients and others at risk of leg ulcers. It should also be avoided on distal extremities in patients with Raynaud's syndrome, peripheral vascular disease and peripheral neuropathy
- There are several methods of **administering** liquid nitrogen:
    - Cryogun (spray / probe) - is the most effective
    - Cotton bud technique - the cotton bud is dipped in to liquid nitrogen and then applied on to the skin. The destructive energy released by this technique is substantially less than with the cryogun, but can be useful especially in younger patients and in areas such as the face where careful application is important. Cotton buds should not be placed directly in to containers of liquid nitrogen as the virus can survive in liquid nitrogen and may be passed on to other patients
    - Histofreeze canisters - theoretically avoid the need for storage of liquid nitrogen HOWEVER as with the cotton bud technique the energy released is much less. Neither histofreeze or cotton buds are likely to be successful on plantar and other stubborn warts
- **Technique for wart treatment**
    - Pair down lesions
    - If using a cryogun hold the tip approximately 5 mm away from skin
    - Spray until the wart and 2 mm of normal surrounding skin have gone white and then continue to keep topping up the liquid nitrogen so the area remains white for the appropriate freeze time
- **Freeze times**
    - Freeze times are counted from when the target area goes white
        - In general, a single 15 to 30 second freeze is adequate for most warts
        - Shorter freeze times, eg 10 to 15 seconds, are preferable on the face and fingers

        - Longer freeze times, eg 20-30 seconds (sometimes a double cycle may be needed), are required if used to treat plantar warts
    - Repeat treatment every two to three weeks, leaving greater intervals between treatments may reduce efficacy
    - The application of topical salicylic acid preparations in between treatments may improve efficacy
- **Adverse effects**
    - Blistering
    - Pain for up to 48 hours afterwards
    - Post inflammatory hypo / hyperpigmentation, particularly in darker skin - one has to very wary of using liquid nitrogen on cosmetically sensitive areas in darker skinned patients
    - Treatment around nail folds occasionally causes permanent nail dystrophy and so shorter freeze times should be used
    - Damage to tendons with eventual rupture can occur, albeit rarely, to the extensor tendons of the fingers. The highest risk areas are the dorsal aspects of the MCP and DIP joints. Again shorter freeze times are recommended
    - Leg ulceration - most commonly arises in the gaiter area of the lower leg
    - Occasional hair loss in the beard area
    - Provide a patient information leaflet on cryotherapy (follow link for British Association of Dermatologists)

For more information on liquid nitrogen please refer to the Skin Surgery and Cryosurgery section of the website.

Step 3: Anogenital warts

- Patients with **anogenital warts** should be referred to a local GUM service

Thread Veins and Telangectasia

Database	Result
Cochrane	Sclerotherapy for Lower Limb Telangiectasias, Schwartz L, Maxwell H., Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD008826. DOI: 10.1002/14651858.CD008826.pub2
General Search (Google)	NHS choices and various clinic websites, Primary Care Dermatology society website – general information (not cited below)

12. LEVEL 3: PROSPECTIVE COHORT STUDY

Sclerotherapy for Lower Limb Telangiectasias, Schwartz L, Maxwell H., Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD008826. DOI: 10.1002/14651858.CD008826.pub2

Spider or thread veins (telangiectasias) are small superficial veins that widen and become visible, often on the legs. They are sometimes, but not always, associated with chronic venous disease affecting the deeper veins. Risk factors for developing spider veins include a family history, pregnancy, taking female hormones, topical steroid use, local trauma, and prolonged sitting or standing. Some people experience pain, cramps, burning, throbbing, itching or leg fatigue, and women in particular may be concerned about the cosmetic appearance. People are increasingly seeking treatment.

Sclerotherapy has been used for centuries to treat spider veins. The technique involves the injection of a chemical into the veins. This is sometimes followed by compression with bandages or stockings.

The liquid or foam sclerosing agent is injected into the vein to cause localised damage to the inner lining (endothelium) of the vein. This leads to inflammation, a blood clot, collapse and thickening or scarring of the vessel. The blood stops flowing and the vein loses its red or purple appearance. There is currently

no agreement about which sclerosing agent is most effective with the fewest side effects and least discomfort to patients.

We included 10 randomised controlled trials involving 484 people in our review. Sodium tetradecyl sulfate (STS), polidocanol (POL), and heparsal (20% saline mixed with heparin 100 units/mL) cleared the veins more effectively than an injection of normal saline. There was no evidence that one agent was better than any other sclerosant, that patients were more satisfied with one agent than another, and which dose of an agent was best. There was some evidence that POL was less painful than heparsal and STS, and that STS was more painful than heparsal. At higher doses, some of the agents appeared to cause more pain and side effects such as mild brown discoloration, a flare or blush next to the injected vein, or itching; however, we do not have enough evidence to determine the optimal concentration to use. The trials were designed in very different ways and used various agents, which meant we were unable to combine the studies to help form firm conclusions. The amount of available evidence was limited and the overall methodological quality of the research was poor, as was the quality of reporting.

Molluscum Contagiosum

Database	Result
NICE	Nil specific mention in TA82: Tacrolimus and pimecrolimus for atopic eczema
NHS Evidence and NICE CKS	Public Health England website page (not cited below)
	British association for sexual health website page (not cited below)
Cochrane	Interventions for Cutaneous Molluscum Contagiosum (Review), Van der Wouden JC et al 2009 (not cited below)
BMJ Clinical Evidence	Nil specific mention in a systematic review of eczema
BMJ Best Practice	UK Guidelines on the Management of molluscum contageosum (2007)
	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 Int J STD AIDS Online, First, published on October 19, 2014 (Updated copy added at Nov 2015 review)
General Search (Google)	Patient.co.uk, NHS choices

13. LEVEL 4/5: EXPERT OPINION

UK Guidelines on the Management of Molluscum Contageosum

General advice

- As the natural history is of spontaneous regression of lesions, treatment is offered for cosmetic reasons only.

Further investigation

- As other STIs may co-exist, a full screen for these should be undertaken.
- HIV testing is recommended in patients presenting with facial lesions.

Treatment

The aim is tissue destruction with viral demise accompanying this. There are no medicines licensed for the treatment of MC in the UK.

See guidelines for detail.

14. LEVEL N/A: CLINICAL GUIDELINES

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, Int J STD AIDS Online, First, published on October 19, 2014

This guideline offers recommendations on diagnosis, treatment regimens and health promotion principles needed for the effective management of genital molluscum, including management of the initial presentation and recurrences. It primarily focuses on infection that affects the genital area and has a sexual mode of transmission. It is aimed primarily at patients aged 16 years or older presenting to health care professionals working in departments offering level 3 care in sexually transmitted infection (STI) management within the United Kingdom. However, the principles of the recommendations should be adopted across all levels – level 1 and 2 providers may need to develop local care pathways where appropriate

A copy of the review is available on request.

Actinic/Solar Keratosis

Database	Result
NICE	IPG155: Photodynamic therapy for non-melanoma skin tumours (including premalignant and primary non-metastatic skin lesions) (see above)
NHS Evidence and NICE CKS	Primary Care Dermatology Society website (general information - not cited below)
BMJ Best Practice	European Dermatology Forum: Guidelines on the management of actinic keratosis (not cited below – available on request)
General Search (Google)	• British Association of Dermatologists Information Leaflet: Actinic Keratoses also known as Solar Keratoses • Patient.co.uk and NHS choices as well as clinic websites (not cited below)

15. LEVEL 4/5: EXPERT OPINION

British Association of Dermatologists Information Leaflet: Actinic Keratoses also known as Solar Keratoses

It is advisable to protect the skin from further sun damage (for example, by wearing a hat, long sleeves and a sunscreen with a high sun protection factor).
Occasionally, small actinic keratoses may go away spontaneously, but generally they are treated as there is a small risk that some might transform into a skin cancer.
Treatments used for actinic keratoses include the following:

- *Freezing with liquid nitrogen (Cryotherapy).* This is an effective treatment which does not normally leave a scar, but it can be painful. (See Patient Information Leaflet on Cryotherapy).
- *Surgical removal.* This requires local injection into the affected skin with anaesthetic, after which the actinic keratosis can be scraped off with a sharp spoon-like instrument (a curette), or it can be cut out and the wound closed with stitches. Surgical removal leaves a scar but provides a specimen that can be analysed in the laboratory to confirm the diagnosis.
- *Creams.* Courses of creams containing drugs which may include 5-fluorouracil, imiquimod or Ingenol mebutate gel are useful treatments for actinic keratoses, especially if there are many of them. These preparations appear to selectively destroy the abnormal cells in sun-damaged skin. However, they often cause a lot of temporary inflammation of the treated areas. Diclofenac and retinoic acid are other drugs in cream or ointment form that are helpful when applied to milder actinic keratoses.

- *Photodynamic therapy.* A special light activates a cream which has been applied to the affected area of skin. This treatment is only available in certain hospitals.
- Laser treatment may be useful particularly for actinic keratosis on the lips.

Benign Pigmented Moles

Database	Result
NHS Evidence and NICE CKS	NICE CKS: Melanoma and pigmented lesions (not cited below)
SIGN	Nil specific – mentioned in SIGN 72 Cutaneous Melanoma
BMJ Best Practice	General information on the management of naevi (not cited below)
General Search (Google)	patient.co.uk (not cited below)

Appendix 2 – Diagnostic and Procedure Codes

Common Benign Skin Lesions
GM013

(All codes have been verified by Mersey Internal Audit's Clinical Coding Academy)

GM013 - Common Benign Skin Lesions Policy	
Excision of lesion of eyebrow	C10.1
Excision of lesion of external ear	D02.1
Destruction of lesion of external ear	D02.2
Other specified extirpation of lesion of external ear	D02.8
Unspecified extirpation of lesion of external ear	D02.9
Excision of lesion of external nose	E09.1
Destruction of lesion of external nose NEC	E09.2
Laser destruction of lesion of external nose	E09.6
Excision of lesion of lip	F02.1
Destruction of lesion of lip	F02.2
Other specified extirpation of lesion of lip	F02.8
Microscopically controlled excision of lesion of skin of head or neck using fresh tissue technique	S05.1
Microscopically controlled excision of lesion of skin using fresh tissue technique NEC	S05.2
Microscopically controlled excision of lesion of skin of head or neck using chemosurgical technique	S05.3
Microscopically controlled excision of lesion of skin using chemosurgical technique NEC	S05.4
Microscopically controlled excision of lesion of skin of head or neck NEC	S05.5
Other specified microscopically controlled excision of lesion of skin	S05.8
Unspecified microscopically controlled excision of lesion of skin	S05.9
Marsupialisation of lesion of skin of head or neck	S06.1
Marsupialisation of lesion of skin NEC	S06.2
Shave excision of lesion of skin of head or neck	S06.3
Shave excision of lesion of skin NEC	S06.4
Excision of lesion of skin of head or neck NEC	S06.5
Re-excision of skin margins of head or neck	S06.6
Re-excision of skin margins NEC	S06.7
Other specified other excision of lesion of skin	S06.8

Unspecified other excision of lesion of skin	S06.9
Curettage and cauterisation of lesion of skin of head or neck	S08.1
Curettage and cauterisation of lesion of skin NEC	S08.2
Curettage of lesion of skin of head or neck NEC	S08.3
Other specified curettage of lesion of skin	S08.8
Unspecified curettage of lesion of skin	S08.9
Laser destruction of lesion of skin of head or neck	S09.1
Laser destruction of lesion of skin NEC	S09.2
Photodestruction of lesion of skin of head or neck NEC	S09.3
Infrared photocoagulation of lesion of skin of head or neck	S09.4
Infrared photocoagulation of lesion of skin NEC	S09.5
Other specified photodestruction of lesion of skin	S09.8
Unspecified photodestruction of lesion of skin	S09.9
Cauterisation of lesion of skin of head or neck NEC	S10.1
Cryotherapy to lesion of skin of head or neck	S10.2
Chemical peeling of lesion of skin of head or neck	S10.3
Electrolysis to lesion of skin of head or neck	S10.4
Electrodessication of lesion of skin of head or neck	S10.5
Other specified other destruction of lesion of skin of head or neck	S10.8
Unspecified other destruction of lesion of skin of head or neck	S10.9
Cauterisation of lesion of skin NEC	S11.1
Cryotherapy to lesion of skin NEC	S11.2
Chemical peeling of lesion of skin NEC	S11.3
Electrolysis to lesion of skin NEC	S11.4
Electrodessication of lesion of skin NEC	S11.5
Other specified other destruction of lesion of skin of other site	S11.8
Unspecified other destruction of lesion of skin of other site	S11.9
With the following ICD-10 diagnosis code(s):	
Viral warts	B07.X
Molluscum contagiosum	B08.1
Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck	D17.0
Benign lipomatous neoplasm of skin and subcutaneous tissue of trunk	D17.1

Benign lipomatous neoplasm of skin and subcutaneous tissue of limbs	D17.2
Benign lipomatous neoplasm of skin and subcutaneous tissue of other and unspecified sites	D17.3
Benign lipomatous neoplasm of intrathoracic organs	D17.4
Benign lipomatous neoplasm of intra-abdominal organs	D17.5
Benign lipomatous neoplasm of spermatic cord	D17.6
Benign lipomatous neoplasm of other sites	D17.7
Benign lipomatous neoplasm, unspecified	D17.9
Melanocytic naevi of lip	D22.0
Melanocytic naevi of ear and external auricular canal	D22.2
Melanocytic naevi of other and unspecified parts of face	D22.3
Melanocytic naevi of scalp and neck	D22.4
Melanocytic naevi of trunk	D22.5
Melanocytic naevi of upper limb, including shoulder	D22.6
Melanocytic naevi of lower limb, including hip	D22.7
Melanocytic naevi, unspecified	D22.9
Other benign neoplasms of skin of lip	D23.0
Other benign neoplasms of skin of ear and external auricular canal	D23.2
Other benign neoplasms of skin of other and unspecified parts of face	D23.3
Other benign neoplasms of skin of scalp and neck	D23.4
Other benign neoplasms of skin of trunk	D23.5
Other benign neoplasms of skin of upper limb, including shoulder	D23.6
Other benign neoplasms of skin of lower limb, including hip	D23.7
Other benign neoplasms of skin, unspecified	D23.9
Naevus, non-neoplastic	I78.1
Residual haemorrhoidal skin tags	I84.6
Actinic keratosis	L57.0
Rhinophyma	L71.1
Other rosacea	L71.8
Rosacea, unspecified	L71.9
Epidermal cyst	L72.0
Trichilemmal cyst	L72.1
Seborrhoeic keratosis	L82.X

Hypertrophic scar	L91.0
Other hypertrophic disorders of skin	L91.8
Exceptions (ICD-10); the following in a primary or secondary diagnostic position:	
Malignant melanoma of lip	C43.0
Malignant melanoma of ear and external auricular canal	C43.2
Malignant melanoma of other and unspecified parts of face	C43.3
Malignant melanoma of scalp and neck	C43.4
Malignant melanoma of trunk	C43.5
Malignant melanoma of upper limb, including shoulder	C43.6
Malignant melanoma of lower limb, including hip	C43.7
Overlapping malignant melanoma of skin	C43.8
Malignant melanoma of skin, unspecified	C43.9
Other malignant neoplasms of skin of lip	C44.0
Other malignant neoplasms of skin of ear and external auricular canal	C44.2
Other malignant neoplasms of skin of other and unspecified parts of face	C44.3
Other malignant neoplasms of skin of scalp and neck	C44.4
Other malignant neoplasms of skin of trunk	C44.5
Other malignant neoplasms of skin of upper limb, including shoulder	C44.6
Other malignant neoplasms of skin of lower limb, including hip	C44.7
Other malignant neoplasms of overlapping lesion of skin	C44.8
Malignant neoplasm of skin, unspecified	C44.9
Malignant neoplasm of labium majus	C51.0
Malignant neoplasm of labium minus	C51.1
Malignant neoplasm of clitoris	C51.2
Malignant neoplasm of overlapping lesion of vulva	C51.8
Malignant neoplasm of vulva, unspecified	C51.9
Malignant neoplasm of prepuce	C60.0
Malignant neoplasm of glans penis	C60.1
Malignant neoplasm of body of penis	C60.2
Malignant neoplasm of overlapping lesion of penis	C60.8
Malignant neoplasm of penis, unspecified	C60.9
Malignant neoplasm of scrotum	C63.2

Appendix 3 – Version History

Common Benign Skin Lesions
GM013

The latest version of this policy can be found here: GM Common Benign Skin Lesions policy

Version	Date	Summary of Changes
0.1	10/03/2014	Initial draft
0.2	24/03/2014	Amendments made by GM EUR Steering Group on 19/03/2014: • Typographical errors corrected • Bullet point 2 under Mandatory Criteria - "Treatment of multiple lipomatosis or neurofibromatosis" has been removed, as the policy would be applied to each separate lipoma. • 'Causing functional impairment' has been included within each lesion specific criteria. Xanthelasma - the criteria has been amended to state: larger lesions causing functional impairment, such as interfering with vision. Under the 'treatments for Xanthelasma' section, the second and third bullet points should be removed.
0.3	09/04/2014	• Statement regarding treating disabled people as more equal than other protected characteristic groups added to Equality and Equity section. • Ratification through CCG Governing Bodies added to 'Governance Arrangements'. • Removal of 'suspicious or potentially malignant lesions' from Mandatory Criteria section. Such lesions are excluded from the policy and should be referred on the appropriate pathway without prior funding approval. Rationale for policy development included.
0.4	29/05/2014	Amendments made by GM EUR Steering Group on 21/05/2014: • Mandatory criteria simplified and repetition under the additional criteria removed. • Draft policy approved for consultation following the above amendments. • Policy published for consultation from 09/07/2014 to 03/09/2014.
0.5	25/09/2014	Amendments made by GM EUR Steering Group on 17/09/2014 following a review of the feedback from the consultation: • Policy renamed 'Common' Benign Skin Lesions. • Spelling of Nevi changed to Naevus within the glossary • Separate definition for pigmented naevus relating to moles included in the glossary. • Additional statement included to confirm that any lesions where there may be diagnostic uncertainty should be referred. • Statement added under policy exclusions section to confirmed that this policy does not apply to minor surgery undertaken in primary care, which falls under the commissioning responsibility of NHS England. • Bullet point added to the lipoma section, in section 4, to state 'the soft tissue guidelines should be followed if there are any concerns'. • Chalazion, xanthelasma and dermatochalasis removed from policy and included in a separate eyelid lesion policy. • Statement regarding actinic/solar keratosis amended to state that there is a small risk that they can transform to Squamous Cell Carcinoma. • Specific criteria for actinic/solar keratosis included under section 4 mandatory criteria to state that referrals may be made if there is a risk of

		transforming into squamous cell carcinoma/malignant change. • All lesions definitions included under section 5 description of epidemiology and need, moved to section 2 definition. • Original statement under section 2 definition moved to section 1 introduction. Squamous Cell Carcinoma included in glossary.
	17/09/2014	Policy approved by GM EUR Steering Group, subject to amendments above.
0.6	07/10/2014	Branding changed following creation of North West CSU on 01/10/2014.
1.0	17/09/2014	Policy approved by GM EUR Steering Group – required amendments have been made.
2.0	18/11/2015	Annual review of policy by GM EUR Steering Group – no material changes necessary to the current policy: • Rhinophyma and Anal Skin Tags added to the list of lesions covered by the policy. • Added that Skin resurfacing and revision of scarring are covered by separate policies • Added that locally commissioned treatment as part of a pathway of care within a contract or service level and treatment as part of previously agreed and externally funding trial are excluded from this policy. Evidence Review section updated
2.1	04/05/2016	• List of diagnostic and procedure codes idded as Appendix 2. • Policy changed to Greater Manchester Shared Services template and references to North West Commissioning Support Unit changed to Greater Manchester Shared Services. Wording for date of review amended to read *"One year from the date of approval by Greater Manchester Association Governing Group thereafter at a date agreed by the Greater Manchester EUR Steering Group (unless stated this will be every 2 years)"* on 'Policy Statement' and section '13. Date of Review'.
2.2	14/12/2016	Appendix 2 - The following procedure codes have been removed: • B35.3 Expiration of lesion of nipple; • D08.1 Extirpation of lesion of external auditory canal; • N01.2 Excision of lesion of scrotum; • N01.3 Destruction of lesion of scrotum; • N27.1 Excision of lesion of penis; • N27.2 Cauterisation of lesion of penis; • N27.3 Destruction of lesion of penis NEC; • P05.4 Excision of vulva NEC; • P06.1 Laser destruction of lesion of vulva; • P06.2 Cryosurgery to lesion of vulva; • P06.3 Cauterisation of lesion of vulva; • P11.1 Excision of lesion of female perineum; • P11.2 Laser destruction of lesion of female perineum; • P11.3 Cauterisation of lesion of female perineum; • P11.4 Destruction of lesion of female perineum NEC; • P11.8 Other specified expiration of lesion of female perineum; P11.9 Unspecified expiration of lesion of female perineum; T29.1 Excision of umbilicus; • T29.2 Excision of urachus • T29.3 Expiration of lesion of umbilicus
2.3	05/10/2017	<u>Criteria for Commissioning</u>

		• Note added to state 'If conditions are not covered here, please also see the GM Other Aesthetic Surgery Policy' Under 'Rhinophyma' the following added: 'This condition is now covered by the GM Other Aesthetic Surgery Policy'
3.0	15/11/2017	Review of policy by GM EUR Steering Group: • Policy moved to new format and criteria slightly reworded for clarity • Policy Inclusion Criteria: NOTE at beginning of section reworded and *'Birthmarks'* added to bullet point that refers to GM Other Aesthetic Surgery Policy. Section on *'Rhinophyma'* also moved to same set of bullet points. • Treatment/Procedure: **Link to *'Primary Care Dermatology Society (PCDS): Actinic Keratosis'*** added to Actinic / solar keratosis paragraph. • Date of Review: Standard wording on next review amended to state *'5 years'* • Appendix 1: *'(Site is now patient.info – added at Nov 17 review)*' added after Patient.co.uk references The above changes were not considered to be material and therefore it was not necessary for the revised policy to go back through the governance process again.
3.1	06/06/2018	Following codes added in Appendix 2: • OPCS-4 code F02.9 Unspecified extirpation of lesion of lip • Exception code E88.2 Lipomatosis, not elsewhere classified
3.2	05/10/2018	• Policy Inclusion Criteria: Anal skin tags section removed and bullet point with link added to start of same section as this is now covered by the GM Surgical management (including banding) of haemorrhoids and anal skin tags Policy. • 'Fitness for Surgery' section added • Branding changed to reflect change of service from Greater Manchester Shared Services to Greater Manchester Health and Care Commissioning.
3.3	28/01/2019	• Links updated as documents have all moved to a new EUR web address. • Commissioning Statement: o *'Fitness for Surgery'* section moved to bottom of *'Commissioning Statement'* o *'Best Practice Guideline'* section added