

PanMidlands Ocular Cancer Pathway March 2008  
Approved by The Midland Oculoplastic Surgery Society

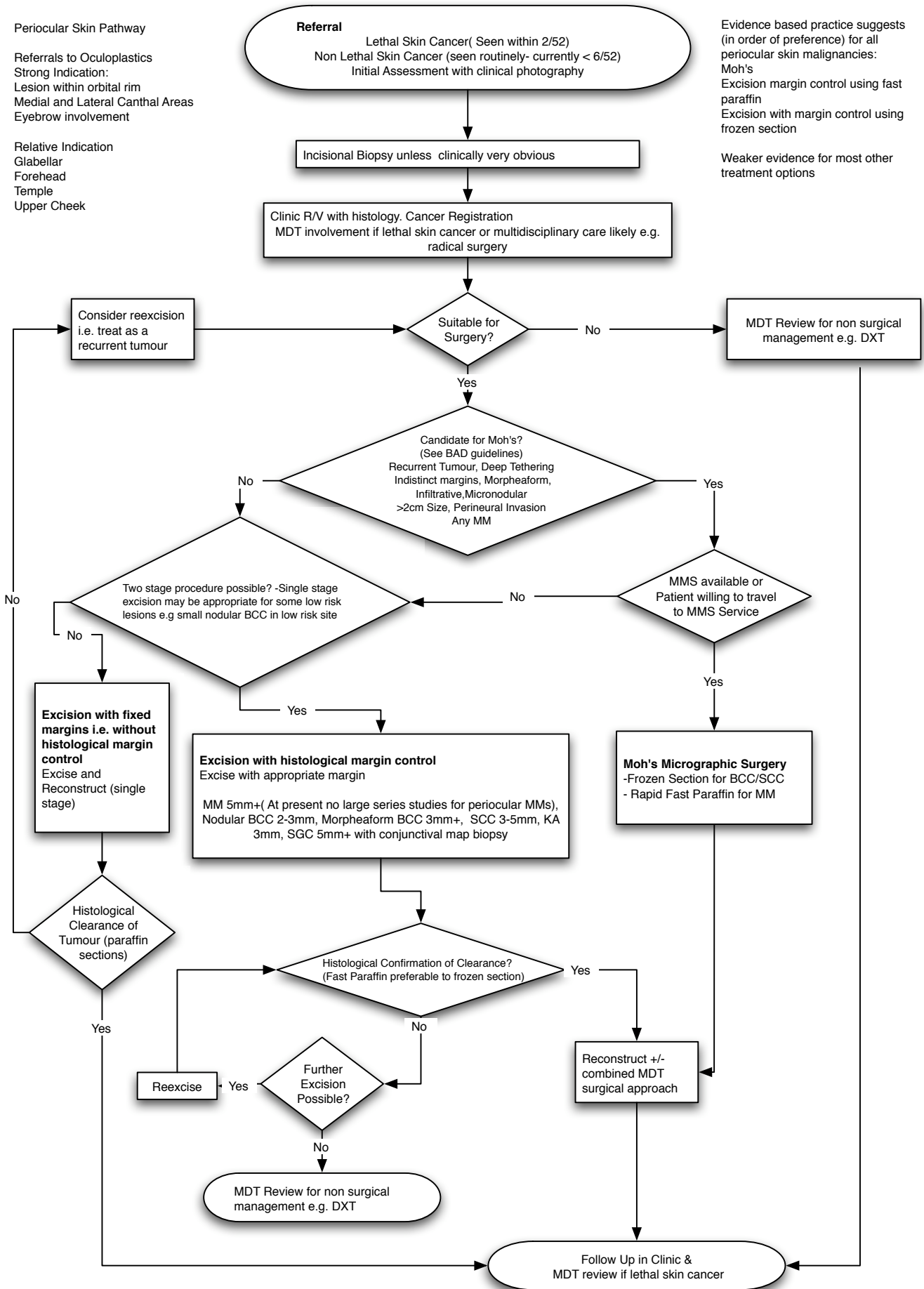
**Periocular Skin Pathway**

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

Relative Indication  
 Glabellar  
 Forehead  
 Temple  
 Upper Cheek

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

Weaker evidence for most other  
 treatment options



Useful Articles:

BAD Website guidelines www.bad.org

Guidelines for the management of basal cell carcinoma.

Telfer NR, Colver GB, Bowers PW. British Journal of Dermatology 1999;141; 415-423

Table 3. Primary (previously untreated) basal cell carcinoma: influence of tumour type, size (large > 2 cm) and site on the selection of available forms of treatment

Basal cell carcinoma X histology X size X site	Topical therapy including photodynamic therapy	Curettage and cauterization	Radiation therapy	Cryosurgery	Excision	Mohs micrographic surgery
Superficial, small and low-risk site	*	**	?	**	?	x
Nodular, small and low-risk site	#	**	?	**	***	x
Morphoeic, small and low-risk site	#	*	*	*	***	?
Superficial, large and low-risk site	*	**	*	***	*	?
Nodular, large and low-risk site	x	**	**	**	***	?
Morphoeic, large and low-risk site	x	#	*	*	***	**
Superficial, small and high-risk site	x	*	**	**	***	*
Nodular, small and high-risk site	x	#	*	*	**	***
Morphoeic, small and high-risk site	x	#	*	*	**	***
Superficial, large and high-risk site	x	#	**	*	**	**
Nodular, large and high-risk site	x	x	**	*	**	***
Morphoeic, large and high-risk site	x	x	*	x	*	***

\*\*\*, Probable treatment of choice; \*\*, generally good choice; \*, generally fair choice; ?, reasonable, but not often needed; #, generally poor choice; x, probably should not be used.

Table 4. Recurrent BCC: influence of tumour type, size (large > 2 cm) and site on the selection of available forms of treatment

Basal cell carcinoma histology site	Topical therapy including photodynamic therapy	Curettage and cauterization	Radiation therapy	Cryosurgery	Excision	Mohs micrographic surgery
Superficial, small and low-risk site	x	*	*	**	***	?
Nodular, small and low-risk site	x	**	**	**	***	?
Morphoeic, small and low-risk site	x	-	**	**	***	*
Superficial, large and low-risk site	x	*	**	***	*	*
Nodular, large and low-risk site	x	-	*	*	***	*
Morphoeic, large and low-risk site	x	-	*	*	**	**
Superficial, small and high-risk site	x	-	*	*	**	**
Nodular, small and high-risk site	x	-	*	*	***	**
Morphoeic, small and high-risk site	x	x	*	*	**	***
Superficial, large and high-risk site	x	x	*	-	**	**
Nodular, large and high-risk site	x	x	*	-	**	***
Morphoeic, large and high-risk site	x	x	*	-	*	***

\*\*\*, Probable treatment of choice; \*\*, generally good choice; \*, generally fair choice; ?, reasonable, but not often needed; -, generally poor choice; x, probably should not be used.

Note periocular site is defined as a high risk site

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

Motley R, Kersey P, Lawrence. British Journal of Dermatology 2002;146: 18-25

UK Guidelines for the management of cutaneous melanoma. Roberts DLL, Anstey AV, Barlow RJ et al. British Journal of Dermatology 2002;146: 7-17

Table 3. Recommended surgical excision margins

Breslow thickness	Excision margins	Approximate 5-year survival	Grading of evidence
In situ	2-5 mm clinical margins to achieve complete histological excision	95-100% <sup>a</sup>	Level B, grade III
Less than 1 mm	1 cm (narrower margins are probably safe in lesions less than 0.75 mm in depth)	95-100%	Level A, grade I
1-2 mm	1-2 cm	80-96%	Level A, grade I
2-4 mm	2-3 cm (2 cm preferred)	60-75%	Level A, grade I
Greater than 4 mm	2-3 cm	50%	Level B, grade III

<sup>a</sup>In theory recurrence should never occur after in situ melanoma, but occasional cases do recur.<sup>59,60</sup> The assumption is that regression at diagnosis obscured a more advanced tumour, or that progression occurred after incomplete removal of the in situ disease.

Malhotra R, James CL, Selva D, Huynh N, Huilgol SC.

The Australian Mohs database: periocular squamous intraepidermal carcinoma. Ophthalmology. 2004 Oct;111(10):1925-9.

Malhotra R, Huilgol SC, Huynh NT, Selva D.

The Australian Mohs database, part II: periocular basal cell carcinoma outcome at 5-year follow-up. Ophthalmology. 2004 Apr;111(4):631-6.

Malhotra R, Huilgol SC, Huynh NT, Selva D.

The Australian Mohs database, part I: periocular basal cell carcinoma experience over 7 years Ophthalmology. 2004 Apr;111(4):624-30.

Malhotra R, Huilgol SC, Huynh NT, Selva D.

The Australian Mohs database: periocular squamous cell carcinoma. Ophthalmology. 2004 Apr;111(4):617-23.

Treatment Options and Future Prospects for the Management of Eyelid Malignancies: An Evidence-based Update  
Cook BE, Bartley GB. Ophthalmology 2001;108: 2088-98

Table 2. Clinical Recommendations for Therapy: Basal Cell Carcinoma and Squamous Cell Carcinoma

Type of Case or Lesion	Recommendation	Evidence Rating
Experienced pathologic available Mohs' surgeon available	Mohs' micrographic surgery Excision with frozen-section control	I (strong) <sup>3,36-44</sup>
Large lesions (>2 cm) Medial canthal lesions Lateral canthal lesions Distinct or indistinct borders Recurrent lesions Multiple superficial cancers Superficial lesions	Photodynamic therapy Carbon dioxide laser treatment Electron beam radiotherapy	II (substantial) <sup>45-47,50</sup> II (substantial) <sup>50,51</sup> II (substantial) <sup>52-55</sup>
Contraindications to surgery Patient declines surgical excision Palliation for advanced tumors Nontresectable lesions Large or multiple lesions Contraindications to surgery Patient declines surgical excision	Chemotherapy	II (substantial) <sup>48</sup>
Contraindications to surgery Patient declines surgical excision Patient declines surgical excision Small superficial lesions Selected medial canthal lesions Multiple skin cancers Systemic disease	Cryotherapy  Retinoids and $\alpha$ -interferon	II (substantial) <sup>49,56-58,62</sup>  II (substantial) <sup>59</sup>

Table 3. Clinical Recommendations for Therapy: Sebaceous Gland Carcinoma

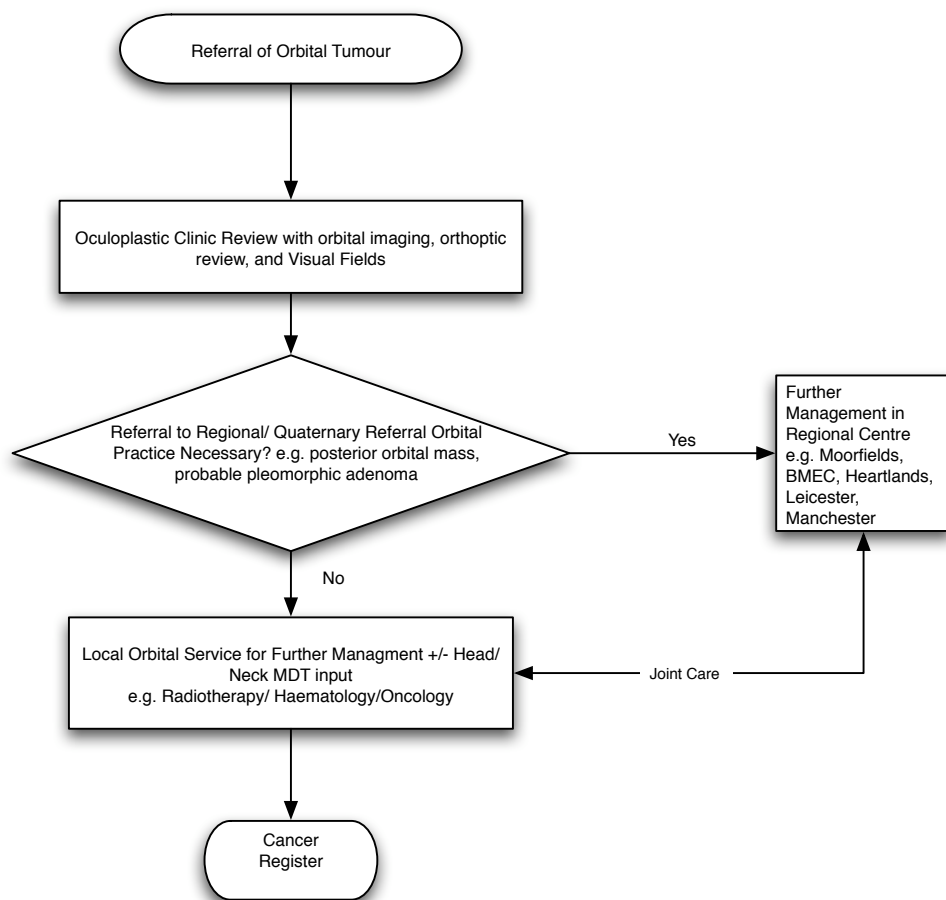
Type of Case or Lesion	Recommendation	Evidence Rating
All lesions	Mohs' micrographic surgery/Excision with frozen-section control (both including conjunctival map biopsies)	I (strong) <sup>10,29,69-73</sup>
Residual conjunctival intraepithelial disease Contraindications to surgery Patient declines surgical excision Palliation for advanced tumors	Excision with adjunctive cryotherapy Electron beam radiotherapy	II (substantial) <sup>74</sup> II (substantial) <sup>75-77,79</sup>
Orbital invasion	Exenteration	II (substantial) <sup>76,80-82</sup>

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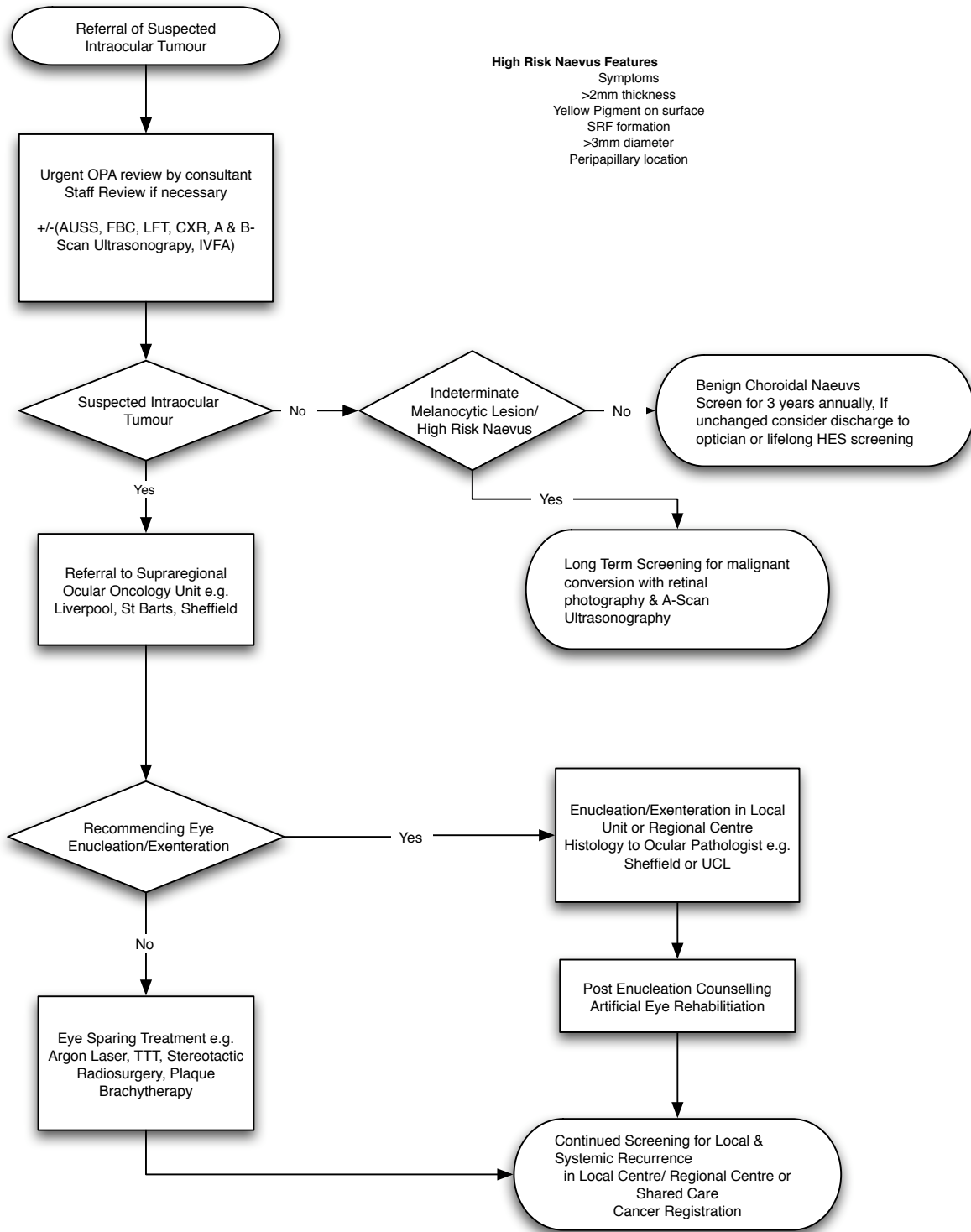
Table 4. Clinical Recommendations for Therapy: Malignant Melanoma

Type of Case or Lesion	Recommendation	Evidence Rating
Selected eyelid margin lesions Discrete borders	Mohs' micrographic surgery Excision with frozen-section control	II (substantial) <sup>86</sup>
Melanomas <1.0 mm Breslow thickness	Excision with 1.0-cm margins	II (substantial) <sup>84-88</sup>
Melanomas 1.0-2.0 mm Breslow thickness	Excision with 3.0-cm margins	II (substantial) <sup>89,90</sup>
Melanomas >2.0 mm Breslow thickness	Unclear	III (consensus) <sup>87</sup>
Selected melanomas	Gene transfer	II (substantial) <sup>106</sup>
Stage III or IV melanoma	Limited/selective lymph node dissection	II (substantial) <sup>91,92</sup>
Stage III or IV melanoma	Sentinel node biopsy and lymph node mapping	II (substantial) <sup>101,103-105</sup>
Stage II-IV melanoma	Adjuvant interferon	I (strong) <sup>97-99</sup>

Orbital Tumour Pathway



Intraocular Tumour Pathway



Retinoblastoma Pathway

