A variety of specialties have liability claims related to the diagnosis and treatment of various skin cancers. Family practice and internal medicine physicians are involved on the diagnostic end as well as the early treatment aspect of these conditions. Plastic surgery and dermatology are also at risk for litigation per our experience with closed claims.

In this article, we discuss basal cell cancer, squamous cell cancer and melanoma. Basal cell and squamous cell are the most common kinds of skin cancer. There are two million new cases of basal and squamous cell skin cancer in the U.S. each year, with approximately 3,000 deaths annually. Melanoma, while having a much lower incidence than others, is easily the most lethal. There are approximately 68,100 new cases of melanoma each year and 8,700 deaths annually. Only 36 percent of people with metastatic melanoma are alive five years after being diagnosed with melanoma. When melanoma is caught in its early stage, the five-year survival rate is 98 percent and even after melanoma spreads to the lymph nodes, the five-year survival rate is 62 percent if it has not metastasized. Skin cancer often begins as a precancerous lesion on the skin. For example, melanoma may begin as a precancerous mole called dysplastic nevi. These moles are often difficult to remove and biopsy. Even more difficult can be the decision as to which lesions to biopsy. Patients can have numerous nevi of many different appearances. Medical records with a regular following of conditions that include documented descriptions of appearances or pictures of nevi that you choose not to biopsy can assist in defending your choice of which to biopsy.

Case Study #1
A woman with a history of actinic keratoses, basal cell cancer and melanoma saw her primary care physician for a checkup. She mentioned the new lesion on her right shoulder. The physician did a cursory exam and did not document the presence of the lesion. The patient returned three months later and requested a referral to a dermatologist. When finally seen by the dermatologist, a larger reticulate black patch with satellite lesions was noted. A biopsy was performed, which revealed melanoma in situ. The patient was angry that there was delay in care of her skin cancer.

Lessons #1

If there is a skin lesion that is suspicious for a cutaneous malignancy (especially melanoma) and you do not perform biopsies, a referral to the appropriate specialist should be done in a timely fashion. Failure to diagnose or a delay in diagnosis are major issues in litigation around skin cancers. In patients who have a prior history of melanoma, a complete skin exam should be performed on a routine basis. Documentation of such an exam should also be performed.

Case Study #2

A patient presents with a dark mole that the primary care provider feels is a dysplastic nevus. A shave biopsy is performed and the diagnosis turns out to be melanoma. The patient is referred to a plastic surgeon who does a wide excision with no remaining melanoma on pathology. The patient is referred to an oncologist. The stage and depth of the lesion is uncertain based on the preliminary shave and subsequent wide excisional biopsy.

Lessons #2

The accuracy of clinically diagnosing melanoma is about 50 percent. A variety of pigmented skin lesions, from seborrheic keratoses to melanocytic nevi of various types, can simulate melanoma, and many melanomas have a deceptively bland clinical appearance. Diagnosis must be confirmed by pathologic examination. Physicians should be very suspicious of pigmented lesions; when in question, these lesions should be biopsied or excised completely. An essential point is that change in a pigmented lesion is always suspicious. Changes in benign nevi evolve in an imperceptibly slow manner. Any sudden change should prompt immediate attention. It is exceedingly important to maintain a high index of suspicion and to biopsy any pigmented skin lesions that present a reasonable risk of melanoma. The same is true for any pigmented lesions that the patient says have changed. Examination under good lighting is important, and a magnifying light is helpful. The best way to biopsy most pigmented skin lesions is by a simple, complete excision. Partial biopsy of a clinically suspicious pigmented lesion is never appropriate. The advantages of this technique are twofold. First, pathologic examination of melanocytic neoplasms depends in part on ascertaining architectural features such as symmetry and circumscription. These attributes cannot be evaluated if the lesion is transected. Second, even if the diagnosis of melanoma is missed pathologically, many melanomas may be cured by excision with free margins of only a few millimeters (although this is obviously not optimal for known melanomas). Shave and punch biopsies are essential procedures for physicians who manage skin conditions, but are not to be done for potential melanomas.

Case Study #3

A fair-skinned young man presents to the dermatologist with two worrisome skin lesions. One is on the right shoulder and the other is on the left chest. Both are excised. The report on the right shoulder lesion describes a melanoma with incomplete margin resection, the report on the chest lesion is a benign pigmented nevus with no concerning features. When a complete excision on the right shoulder is done, interestingly, there is no residual melanoma. Sixteen months later the patient returns with a 2-cm lesion on the site of the chest scar, the site of the normal biopsy. The dermatologist realizes that the two specimens at the time of the first biopsy must have been mixed up at some point from biopsy to report, and the chest melanoma has gone untreated. Unfortunately, the patient died of malignant melanoma after a difficult chemotherapeutic course. It is alleged and litigated successfully for the patient that the 16-month delay caused a poor prognosis and contributed to his death.

Lessons #3

Fair-skin patients are often in need of having several lesions removed at the same time. In this particular office,
specimens were labeled prior to the biopsies and there was not a good process of read back. Mandatory read back should involve both the physician doing the biopsy and the assistant collecting the specimens verifying the accuracy of the label for patient name, date and site. The documented records should include detailed locations of the biopsy sites.

Key Suggested Guidelines:

- Assess if a biopsy is indicated for lesions that are clinically suspicious for a cutaneous malignancy.
- Perform a regular full-skin exam in patients with a history of melanoma.
- Excisional biopsy is preferred to shave or punch biopsies in patients with pigmented lesions.
- Follow-up on biopsy results. Read the complete report.
- Perform a time out and read backs for skin biopsies. These are surgical procedures.
- Discuss skin changes and sun protection with patients, especially those with a history of skin lesions.
- Document discussions and recommendations in the medical record.

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