The 5 point skin checklist

The 5 point checklist every GP needs to use when conducting a skin check:

✓ **Listen to your patient:** The patient may be presenting about something entirely unrelated, but if concern is addressed about a particular skin lesion, stop what you are doing and assess it with focussed attention. Patient concern about a particular "spot" is a valuable piece of information because it tells you something more than can be gleaned from examination – that the lesion "has changed" and/or that it is "symptomatic". Both can be clues to malignancy. As medical students we are taught that history-taking is the first step in a successful consultation. Volunteered, unsolicited history is in fact the most valuable.

✓ **Examine a lesion of concern effectively:** If you have not inspected, palpated and examined a lesion of concern with a dermatoscope then the examination is incomplete. The clue to a large melanoma which at first glance looks like a seborrhoeic keratosis may be that it is not palpably raised. If subsequent examination reveals that it is not sharply demarcated over the total periphery then careful examination for clues to malignancy is warranted.

✓ **Recall high-risk patients for skin-screening examinations:** Patients with a relative risk (RR) greater than 5 are high risk and according to Australasian guidelines should have a total body skin examination every 6 months. This includes those who have already had a melanoma (RR 10) and those with >100 naevi (RR 7). It does not include those with a family history of melanoma (RR 2), or those with a history of solarium use (RR 1.34). High risk patients should also be instructed in self-examination of their skin. Patients at intermediate risk may reasonably be screened every 12 months.

✓ **Record certain items of basic history at every scheduled screening examination.** These include any significant change in health status (including allergies, medication, illnesses, operations and family history of skin cancer), any skin lesions of concern and any lesions in body parts which may not be routinely examined, such as genitalia.

✓ **Establish and follow a protocol for skin-screening examinations:** Such examinations are critical to your patients' well-being and deserve an organised, well-illuminated work area, adequate time (this may vary from 15 minutes for most, to up to 45 minutes for exceptional patients), and an organised work-flow. Ensure that make-up is not obscuring facial skin – have wipes available and offer them when necessary. It is a good idea to start with what you might otherwise forget – inspection of the oral cavity and eyes with the patient seated and with examination of lymph node basins as the first thing when the patient adopts the recumbent position. The examination must include the scalp, even under thick hair – best performed with the patient recumbent and repeated during the examination of each quadrant respectively, the palms and soles and the nails.

A well-organised approach to skin examination is important for your patient and it also identifies you to your patient as a competent professional.

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