Multiple Moles (melanocytic naevi)

Patients with a greater number of moles are at greater risk of melanoma. 40% of melanoma originates from existing moles. Self-examination is crucial as a late presentation is almost always associated with a poor prognosis.

All patients should be encouraged to regularly self-examine and be given advice on good UV protection.

The Primary Care Dermatology Society provides useful documents to share with patients:
Self-examination: http://www.pcds.org.uk/ee/images/uploads/general/skin-cancer-detection-patient-advice-07-2012.pdf

UV protection:
http://www.pcds.org.uk/ee/images/uploads/general/UV__protection_(2).pdf

Atypical moles
For description and images: http://www.pcds.org.uk/clinical-guidance/atypical-dysplastic-melanocytic-naevus

Patients with only a few atypical moles which have not changed and without a family history of melanoma need not be referred.

The patient should take and store photographs at home and self-examine every 3 months for evidence of change.

When should a patient be referred to the Community Dermatology Service?

1. Large numbers of moles, both typical and atypical:

Atypical Mole Syndrome (AMS) is defined as patients with at least 50 moles, at least 2 of which appear atypical. Patients with AMS have approximately a 3% risk developing a melanoma de novo and should be referred routinely to the Community Dermatology Service.

2. Familial Atypical Mole and Melanoma Syndrome (FAMM):

Large numbers of typical and atypical moles AND a family history of Melanoma in one or more 1st or 2nd degree relatives. These patients have a high risk of melanoma and should be referred routinely to the Community Dermatology Service.

3. Clinical suspicion of melanoma:

The patient should be referred via the 2ww pathway even if the criteria are not met where there is a strong clinical suspicion of melanoma. Suspicious pigmented lesions can also be referred urgently via the e-referral system when 2ww criteria are not met. The chosen referral pathway will depend on the clinician's level of suspicion.

Mole surveillance
The Community Dermatology Service only carries out surveillance on moles if there is a history of Dysplastic Naevus Syndrome (Atypical Mole Syndrome post histology) or melanoma.

Mole Mapping
The Community Dermatology Service is not able to undertake mole mapping but following triage will consider referring patients to secondary care for a consultant opinion. Appropriate cases will then be referred to the mole mapping clinic by the consultant.

Imperial Mole Mapping Referral Criteria

Guide – Prepared by Professor Anthony Chu 2014

Mole Mapping

Mole mapping uses a digital imaging system which downloads images onto a specific computer program. The system we use is the Fotofinder Mole Mapping System. This allows images of different body sites to be taken and specific moles of interest are identified. These moles are then imaged using a dermatoscope and these images are recorded. At subsequent visits, the previous images are uploaded and mole of interest screened and compared for any change.

Eligible Patients:
- Patients with FAMMM syndrome
- Patients with previous medical history of Melanoma
- Patients with multiple clinically dysplastic/atypical moles
- Patients with more than 50 moles

Protocol:
- All patients referred for mole mapping from a GP or other external agencies, should be initially seen by a dermatologist, who will assess if the patient does indeed meet the eligibility criteria for mole mapping and will also check if there is any suspicious lesion already present. Following this consultation the patient will then be booked into the mole mapping clinic for the next available appointment.

- Patients with FAMMM (Familial Atypical Multiple Mole Melanoma) syndrome, or previous melanoma and multiple dysplastic nevi, should have lengthy, regular screening at 6-12 monthly intervals, depending on clinical need/presentation

- Patients with multiple clinically dysplastic nevi should be mapped at 6 – 12 monthly intervals for 2 years, and if no change is noted, should be discharged back to GP with information on what changes to look for and documentation of which moles to observe.

- Patients with more than 50 moles but with no clinically dysplastic nevi should be mole mapped 6 months after original mapping, then 12 months and then if no change noted in any moles, discharged back to GP

- If a significant change is identified within a mole, this should be checked by a dermatologist during clinic, and booked for excision. The patient's next mole mapping appointment should then be 6 months later.

- A documentation sheet should be completed for all patients, which is then posted to the GP surgery. A copy of this documentation sheet is also placed in the Structured Notes section of Cerner.

Updated April 2017

Reference: The Primary Care Dermatology Society. Atypical (dysplastic) melanocytic naevus. Last updated 28/12/14. Available at: http://www.pcds.org.uk/clinical-guidance/atypical-dysplastic-melanocytic-naevus