East Midlands cancer alliance

BREAST SKIN LESIONS

Primary care assessment and referral guide

ROUTE BY CLINICAL ORIGIN, NOT BY LOCATION

A lesion on breast skin is not automatically a breast referral. Use breast USC only when features suggest an underlying breast malignancy.

1 MANAGE IN PRIMARY CARE

Where the diagnosis is clinically clear:

- Epidermoid/sebaceous cyst with no suspicious features.
- Folliculitis, boil or localised superficial infection.
- Intertrigo or irritant/contact dermatitis in the inframammary fold.
- Typical seborrhoeic keratosis, skin tag, wart or cherry angioma.
- Localised eczema away from the nipple-areola complex.

INITIAL MANAGEMENT

- Treat in line with local primary care guidance.
- Document site, size, appearance, duration and change; check for an underlying breast lump.
- Photograph where appropriate and consented; review response.
- Safety-net for enlargement, bleeding, ulceration, recurrence or other change.

Do not excise if malignancy is suspected or the diagnosis is uncertain.

2 DERMATOLOGY / SKIN

Use dermatology, teledermatology or local A&G when:

- The lesion is confined to the skin and diagnosis is uncertain.
- Dermoscopy or specialist assessment is required.
- A presumed benign lesion persists, recurs, is symptomatic or does not respond as expected.
- Suspected basal cell carcinoma: usually routine dermatology; use urgent skin referral only if site or size makes delay a concern.

URGENT SUSPECTED SKIN CANCER

- Pigmented lesion with weighted 7-point score ≥3: change in size, irregular shape/colour; diameter ≥7 mm, inflammation, oozing or sensory change.
- Dermoscopy suggests melanoma, or lesion suggests nodular melanoma.
- Raised, enlarging, ulcerated, keratinised or crusting lesion suspicious for squamous cell carcinoma.

If skin cancer is suspected, use the SKIN cancer pathway, not breast USC.

3 URGENT BREAST USC

Refer where skin or nipple change suggests an underlying breast process:

- New unilateral persistent nipple eczema, ulceration or crusting, especially if not responding to appropriate topical treatment (consider Paget disease).
- New nipple inversion or distortion.
- Peau d'orange, skin oedema, tethering or dimpling.
- Diffuse unilateral erythema, warmth and swelling that is unexplained, atypical for infection or fails to improve promptly.
- Skin ulceration arising from, fixed to, or associated with a breast mass.
- Any skin/nipple change with a suspicious breast lump or axillary lymphadenopathy.

SAFETY POINT

- For presumed mastitis/infection, arrange a documented short-interval review and escalate if response is incomplete or atypical.
- Do not delay urgent breast referral for primary care imaging when breast cancer is suspected.

ASSESS BEFORE ROUTING

History: onset, duration, evolution, pain/itch/bleeding/discharge and treatment response. **Examination:** inspect lesion and nipple-areola complex; palpate both breasts and axillae; check for tethering, oedema or an underlying mass.

QUICK DECISION GUIDE

Clearly benign / inflammatory	Skin lesion uncertain / suspicious	Breast-origin red flags?
↓	↓	↓
PRIMARY CARE + SAFETY NET	DERMATOLOGY / SKIN PATHWAY	YES: BREAST USC | NO: SKIN ROUTE