British Journal of Plastic Surgery (2003), **56,** 83
© 2003 Published by Elsevier Science Ltd on behalf of The British Association of Plastic Surgeons
doi:10.1016/S0007-1226(03)00027-4

BRITISH JOURNAL OF PLASTIC SURGERY

EDITORIAL

Guidelines

Guidelines should particularly assist the clinician in the management of common clinical conditions, and aid in standardisation of care quality across providers.

Where possible, such guidance should be evidence based, sometimes using the results of controlled clinical trials to give precise and specific advice. More often, however, guidelines represent a consensus statement of best current practice when suitable comparative studies are lacking.

Although guidelines were initially produced locally, there has been an increasing trend (facilitated by the advent of the National Institute for Clinical Excellence) for such advice to be generated nationally—produced by specialty groups and associations.

In plastic surgery few guidelines appear to have been produced, but, commendably, some of those that do exist have resulted from multidisciplinary/professional collaboration, such as those for patients with primary squamous cell carcinoma of the skin[1] and cutaneous malignant melanoma.[2,3] To achieve a broad consensus for these two conditions across plastic surgery, dermatology and clinical oncology is a significant achievement by those involved, and reflects a considerable degree of 'give and take' and inevitable compromise.

Healthy and friendly cooperation in producing such guidelines should be a natural extension of the firm clinical links and multidisciplinary team working that are the basis for our routine clinical practice.

Production of these guidelines has interestingly exposed how few quality prospective comparative studies have been performed in relation to skin-tumour management, and one outcome of this process has been to highlight the need for more basic comparative research and audit. The findings of the British Association of Plastic Surgeons/Melanoma Study Group trial of excision margins will be important when the melanoma guidelines are revisited and modified in the future.

The guidelines for management of patients with primary squamous cell carcinoma of the skin, which appear in this issue, have been previously published in the *British Journal of Dermatology*,[1] and we are grateful to the Editor of the *British Journal of Dermatology* for allowing them to be reproduced here.

They represent a consensus statement of present best practice; however, they are not and cannot be perfect. Critical debate has already begun; we have read letters of 'polite dissent' for melanoma guidelines,[4–12] and, therefore, comment on the squamous cell carcinoma recommendations can be expected. Even with constant maintenance and refinement over time, there will be areas in any guidelines that are weak simply because clear evidence on the efficacy of a treatment is lacking. However, this is not a criticism of those drawing up the guidelines—it reflects the inherently imperfect nature of clinical practice.

We must all work not only to refine guideline advice within hospital practice but also to improve the pathways of referral from primary care. In the future, general practitioners 'with a special interest' will need to be recognised and involved in guideline production to cover primary, secondary and tertiary referral and management in a seamless fashion. Continuing cooperation between all interest groups is essential since, in present clinical practice, no one group has a monopoly on the management of any single clinical condition.

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