Skin Cancer Clinical Negligence Claims: A Practical Guide to Delay and Causation

Skin cancer delay claims can appear straightforward at first glance: a lesion is missed, diagnosis is delayed, and the patient later requires more extensive treatment or faces a more uncertain prognosis. In practice, these claims are often far more complex. The key issue is not simply whether there was a delay, but whether earlier diagnosis would have made a material difference to treatment, outcome or prognosis.

This eBook explores the clinical and evidential issues solicitors should consider when investigating skin cancer clinical negligence claims. It focuses on the distinction between breach and causation, the different behaviour of common and rare skin cancers, the impact of modern melanoma treatment, and the importance of understanding whether disease progression was avoidable or already biologically inevitable. The aim is to help solicitors approach these claims with greater precision, ask better questions of the evidence, and identify where the real value - or weakness - in a case may lie.

This eBook has been produced by INNEG and is based on key clinical insights shared during our webinar, Skin Cancer Clinical Negligence Claims, presented by Dr Stephen Falk, Consultant Oncologist

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Introduction

Skin cancer claims can look simple from a distance. A lesion appears. A patient seeks medical advice. The lesion is dismissed, monitored or treated as something benign. Months later, it is confirmed to be cancer. By then, the treatment is more extensive, the prognosis more uncertain, or the patient has developed metastatic disease.

That kind of chronology is often enough to make a potential claim feel compelling. But it is not enough to make it legally strong.

The central issue in many skin cancer claims is not whether there was delay. It is whether the delay made a material difference. A breach of duty may be clear. A referral may have been missed. A follow-up plan may not have been carried out. A suspicious lesion may not have been biopsied. But unless earlier diagnosis would probably have changed the outcome, causation may still fail.

For solicitors, this is the key discipline in skin cancer litigation: do not confuse a poor clinical pathway with a successful claim. The two may overlap, but they are not the same.

Skin cancer is also not one condition. Basal cell carcinoma, squamous cell carcinoma, melanoma and rarer tumours behave differently. They spread differently. They are treated differently. They raise different questions about prognosis. A delay of three months may be irrelevant in one case and critical in another. The solicitor's task is to understand which is which before the case is pleaded, valued or settled.

This guide focuses on the practical issues that matter most in claims involving delayed diagnosis, missed referral and disputed causation.

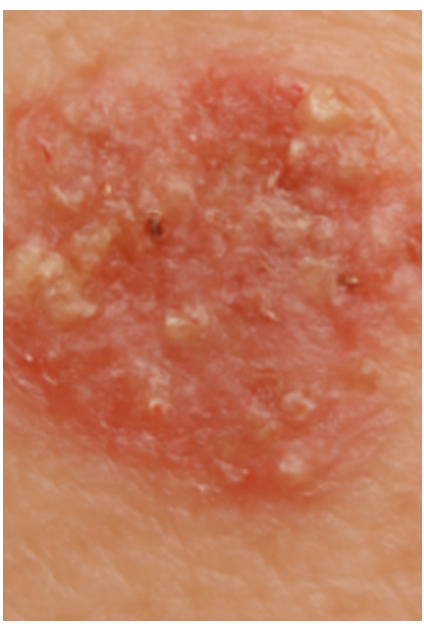
Skin Lesions are not Always Easy to Classify

One of the reasons skin cancer creates litigation risk is that clinicians often begin with visual assessment. Sometimes that assessment is supported by dermatoscopy or teledermatology. Sometimes it is not. Either way, skin lesions do not always announce themselves clearly.

Actinic keratoses, also known as solar keratoses, are common scaly patches of sun-damaged skin. They are often not serious, but some can become malignant. They are commonly diagnosed clinically without biopsy, yet there is an unavoidable grey area between benign, pre-malignant and malignant change.

That matters in negligence claims because a later diagnosis of cancer does not automatically prove that the earlier assessment was negligent. Some lesions are genuinely difficult. Some sit on a continuum.

Some require judgement. But the reverse is also true: a clinician cannot simply hide behind diagnostic uncertainty if the lesion had features that should have triggered escalation.

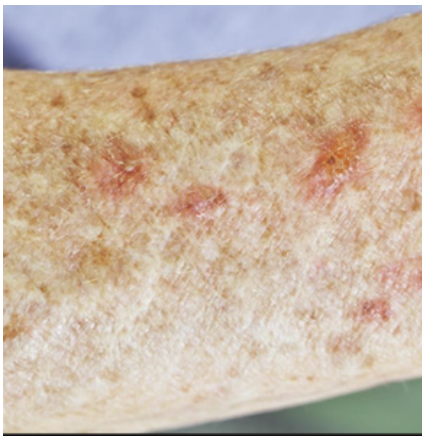


The same issue arises when trying to distinguish basal cell carcinoma from squamous cell carcinoma. A basal cell carcinoma may have a pearly raised edge and visible small blood vessels. A squamous cell carcinoma may ulcerate. But in practice the distinction is not always obvious by sight alone. That distinction can matter legally, because a squamous cell carcinoma carries a greater risk of spread and may justify a more urgent pathway.

This is why solicitors need to pay close attention to the contemporaneous description of the lesion. A note that simply says “mole”, “rash” or “skin lesion” is weak evidence. A proper assessment should capture what made the lesion concerning or reassuring: whether it was new, growing, itchy, bleeding, ulcerated, pigmented, painful, irregular or failing to heal. The absence of that detail may itself become important.

Photographs can be powerful evidence. A clear image taken at the time may show whether a lesion looked obviously suspicious, whether ulceration was present, or whether later growth was dramatic. In teledermatology cases, the quality of the photograph and the adequacy of the information sent for review may be central.

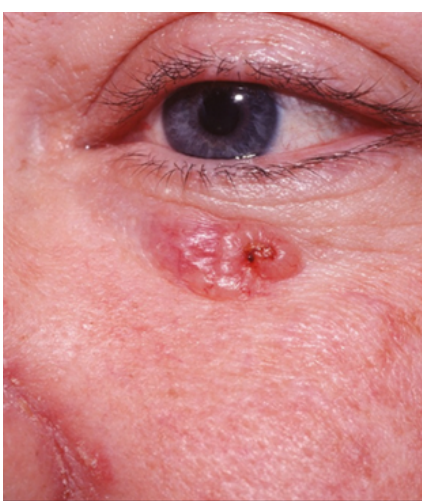
A solicitor assessing the case should therefore start with a simple but demanding question: what exactly did the clinician know, see and record at the relevant time?



Delay is Not the Same as Causation

The most common error in these claims is assuming that because the cancer was diagnosed late, every later consequence flows from that delay. That is a weak assumption.

A patient may have been treated negligently and still have suffered the same outcome. The cancer may already have been too advanced. Microscopic spread may already have occurred.



The treatment may have been the same even with earlier diagnosis. The patient may have remained curable despite the delay.

One example makes the point starkly. A patient had a small squamous cell carcinoma on the ear. It was referred, biopsied and removed with clear margins. The multidisciplinary plan was for follow-up in accordance with the relevant risk-based protocol. That follow-up did not happen, and the patient was discharged. A few months later, he developed a large parotid metastasis and required major surgery followed by radiotherapy.

On the face of it, this looks like a strong case. There was an agreed failure to follow up. There was then a serious

recurrence requiring aggressive treatment. But causation failed.

The reason was that follow-up would not have prevented the metastasis from occurring. Follow-up exists to detect recurrence or spread earlier; it does not stop the biology of the disease. Even if the patient had been reviewed, he would still probably have developed the parotid disease, still required surgery and radiotherapy, and still ended up cured. The breach was real. The causative link was not.

For solicitors, this is a brutal but necessary distinction. The fact that a patient was lost to follow-up may establish breach, but it does not answer what would have happened with competent care. The claim only becomes strong if earlier review would probably have detected disease at a stage where the treatment, prognosis or injury would have been materially different.

The same logic applies to cases involving delayed investigation. A patient may present with a lesion that is already deep, aggressive or locally advanced. In one case, a patient presented with a lump on the hand. By the time diagnosis was confirmed, the lesion had ulcerated and below-elbow amputation was required. That sounds like a classic delay claim until the first presentation is examined more carefully. The lump was not simply a superficial skin lesion. It was already under the skin and involved deeper tissues. On that analysis, the patient was never likely to be cured by simple local excision. Amputation was probably inevitable.

The legal question is not “was the final treatment severe?” It is “would earlier diagnosis probably have avoided that treatment?”

Those are very different questions.

Basal Cell Carcinoma: Do Not Overstate the Claim

Basal cell carcinoma is usually slow-growing and rarely spreads. It can still cause serious local damage, especially on the face, nose, eyelid or ear, but it is not usually the basis for a claim involving metastatic disease or major loss of life expectancy.

That does not mean BCC claims lack value. A delayed BCC diagnosis may lead to a larger excision, a more visible scar, a flap or graft, radiotherapy, cosmetic deformity or psychological injury. The real loss may be the difference between a small procedure and a more invasive one.

This is particularly important with lesions on the nose. The nose is anatomically difficult because of cartilage and cosmetic visibility. A small BCC may be removed relatively simply, and Mohs surgery may be used in suitable cases to remove tissue gradually until the margins are clear. That approach can preserve tissue and reduce disfigurement. If delay means the patient loses the chance of a less invasive procedure, there may be a viable claim.

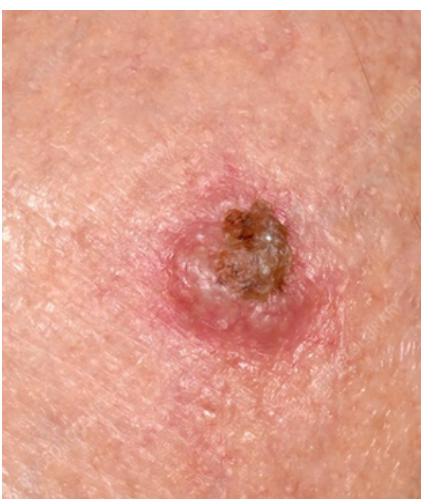
But the claim should be framed accurately. It is not enough to say that cancer treatment was delayed. The solicitor must identify what additional treatment was caused by the delay. Was the scar larger? Was reconstruction required? Was radiotherapy needed because surgery would have been too mutilating? Was function affected? Was appearance significantly worsened?

A BCC case is usually won or lost on local consequences, not dramatic oncology arguments.

Squamous Cell Carcinoma

Squamous cell carcinoma has greater metastatic potential than BCC. It may arise from sun-damaged skin, actinic keratoses, chronic ulcers or old scars. It can spread to regional lymph nodes and may require surgery, radiotherapy or more radical treatment.

But SCC claims still require careful causation evidence. The presence of spread does not automatically mean that earlier diagnosis would have prevented it.



A recurring theme in SCC claims is whether the disease was already biologically committed to the later outcome. If microscopic spread had occurred before the breach, earlier treatment may not have changed the eventual nodal or metastatic disease. If local invasion was already extensive at first presentation, earlier diagnosis may not have changed the need for major surgery.

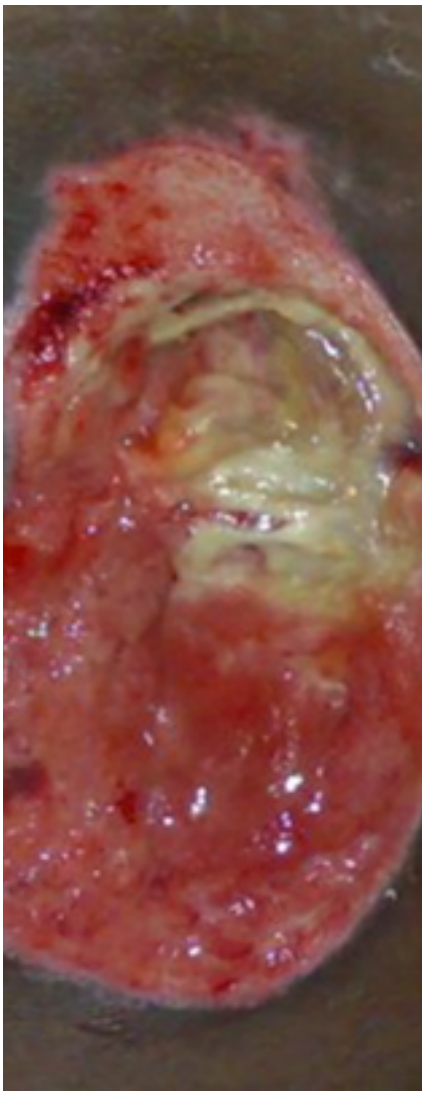
Actinic keratosis cases need particular care. Actinic keratoses are common. They may be safety-netted rather than formally monitored, unless the patient has a history of multiple skin cancers or other significant risk factors. That creates a subtle litigation issue. The negligent act may not be failure to biopsy every actinic keratosis. That would be unrealistic. The issue may instead be failure to advise the patient properly, failure to arrange review in a higher-risk

case, or failure to respond when the lesion changed.

Safety-netting should not be treated as a vague reassurance. It should mean the patient is told what to look for and when to come back. Growth, bleeding, ulceration, pain and failure to heal are not trivial changes. If a patient returns with those features and the lesion is again dismissed, the breach argument becomes stronger.

A chronic wound or scar that changes also deserves attention. A squamous cell carcinoma can develop in the site of an old injury, burn, osteomyelitis or longstanding ulcer. These cases can be missed because the abnormal area has existed for years. But longevity is not proof of benignity. A longstanding ulcer that becomes worse, larger, painful or more destructive may need biopsy.

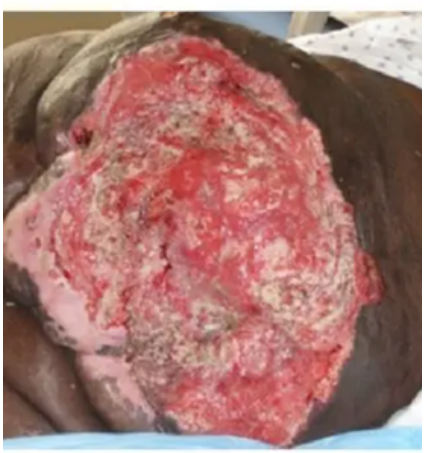
Solicitors should be especially alert to cases where a chronic lesion is normalised for too long.



Melanoma

Melanoma remains one of the most important skin cancers in clinical negligence litigation. It may begin as a changing pigmented lesion, and delay can allow progression to nodal or distant metastatic disease. Historically, advanced melanoma carried a very poor prognosis. That made delayed diagnosis claims potentially high value.

The problem is that the treatment landscape has changed. Modern immunotherapy has transformed outcomes for many patients with advanced melanoma. A patient



with metastatic disease may now respond dramatically and remain disease-free. That does not make the delay harmless, but it may fundamentally alter causation and valuation.

Consider a typical delayed melanoma scenario. A young patient attends with a new black lesion on the arm. It is dismissed as a freckle. Months later, it is larger and itchy, but reassurance is given again. Later still, it bleeds, prompting urgent referral. Biopsy and imaging then show metastatic disease in lymph nodes and organs. Ten years ago, this might have been approached as a devastating fatal claim. Today, if combination immunotherapy produces complete response, the claim may look very different.

The solicitor should not assume that metastatic melanoma still means inevitable death within months. If the patient is disease-

free after treatment, the claim for reduced life expectancy may be far weaker than expected. The viable losses may instead be avoidable pain, distress, systemic treatment, immunotherapy toxicity, psychiatric injury, surveillance, loss of amenity and the burden of living with a metastatic diagnosis.

That is not a minor point. It changes the centre of gravity of the claim.

The other complication is occult disease. Melanoma may spread microscopically before it is detectable. A patient may appear clear after removal of the primary lesion, while microscopic cells are already present elsewhere. Those cells may later become visible as nodal or distant disease. If spread had already occurred before the alleged breach, earlier diagnosis may not have prevented the later outcome.

This is where expert evidence must be precise. It is not enough to say the melanoma should have been removed sooner. The expert needs to address whether earlier removal would probably have prevented metastasis, whether occult disease was already present, how the tumour's depth and features affected risk, and whether modern treatment changes the prognosis.

Features such as depth of invasion, ulceration, histological subtype, lymphovascular invasion and mitotic rate all matter. Even a thin melanoma carries some risk of metastasis, while thicker melanomas carry substantially greater risk. Nodular melanoma and acral melanoma may behave aggressively. A line in the nail may be dismissed as trauma, but in some cases it may represent melanoma arising at the periphery. These are not details to be left until exchange of expert evidence. They are central to the initial case theory.

Lead Time Bias

Lead time bias is one of the most important concepts in delayed cancer diagnosis claims. It means that earlier diagnosis may increase the measured time from diagnosis to death without changing the date of death itself.

Put simply, the patient knows about the cancer earlier, but the disease reaches the same endpoint at the same time.

For a solicitor, this is dangerous because it can make a claim look stronger than it is. Earlier diagnosis always feels beneficial. But the legal question is whether it would have changed the biology, treatment or outcome. If it would merely have started the clock earlier, causation may fail.

This issue is especially relevant where the same stage of disease would probably have been present, the same treatment options would have applied, or there is little evidence that earlier treatment would have improved survival.

Claimant solicitors should test this before the defendant does. Defendant solicitors should recognise when it is the strongest causation argument available. Either way, the question for the expert should be direct: would earlier diagnosis have improved the outcome, or only extended the period during which the patient knew they had cancer?

That distinction may decide the case.

Stronger Cases Start with the Right Medical Expert

Oncology issues can sit at the centre of complex clinical negligence and personal injury claims, particularly where questions arise around diagnosis, treatment pathways, prognosis, causation or the long-term impact of cancer care.

INNEG supports solicitors nationwide with access to a panel of more than 13,000 vetted medical experts across 112+ disciplines, including **1,144 oncology-related experts.**

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