North of Scotland Clinical Management Guideline (CMG): Cutaneous Melanoma Last Updated 20/07/2021

For symptoms of suspected Skin Cancer, please refer to the Scottish Referral Guidelines for Suspected Cancer

Document Control

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MDT Components

It is the ultimate responsibility of the clinician in charge of the patient to ensure that:

- All invasive melanoma cases are MDT discussed after initial histology and at any relevant milestones throughout the patient journey
- Any further treatment is arranged
- Communication of results and management plan is made in a timely manner with the patient and their GP

Each multi-disciplinary team must include at least:

- Dermatologist
- Melanoma Nurse Specialist
- Oncologist
- Pathologist
- Radiologist
- Surgeon

All members of the MDT should have an interest in skin cancer.

MDTs should ideally take place weekly and at least fortnightly and agreed outcomes should be available to the MDT members and GP within a timely manner.

Confirm Diagnosis

All Patients

- Full history & physical examination including draining lymph nodes
- Skin excision biopsy – 2mm margin - margins must be documented

Consider

- SLNB – if eligible and patient wishes

If stage 3 or 4 disease

- BRAF, C-Kit + NRAS
- LDH status
- Staging CT of head, chest, abdomen and pelvis (also stage 2c)
- Include CT neck for head and neck melanoma
- Brain CT for high risk stage 3 and 4 patients and consider brain MRI
- PET Scan

Histology (ensure minimum dataset)

- Site
- Type
- Depth of invasion/Breslow
- Ulceration
- Lymphovascular space invasion
- Microscopic satellites
- Growth phase
- Mitotic count
- Perineural invasion
- Margins
- Regression
- Tumour infiltrating lymphocytes

Other Considerations

All patients should be referred to an appropriate clinical nurse specialist for assessment and ongoing advice, education, support and coordination of care for the patient and their relatives throughout the treatment pathway.

A written personalised treatment plan should be provided to all. This summary document can be adjusted as investigations proceed and treatment plans and follow up develop.

Where available, clinical trials should be considered as the preferred option for all eligible patients

Information on staging within this document, refers to 8th Edition AJCC Melanoma Staging System (see page 7, 8, 9)

Cutaneous melanoma care should be provided in accordance with QPI standards

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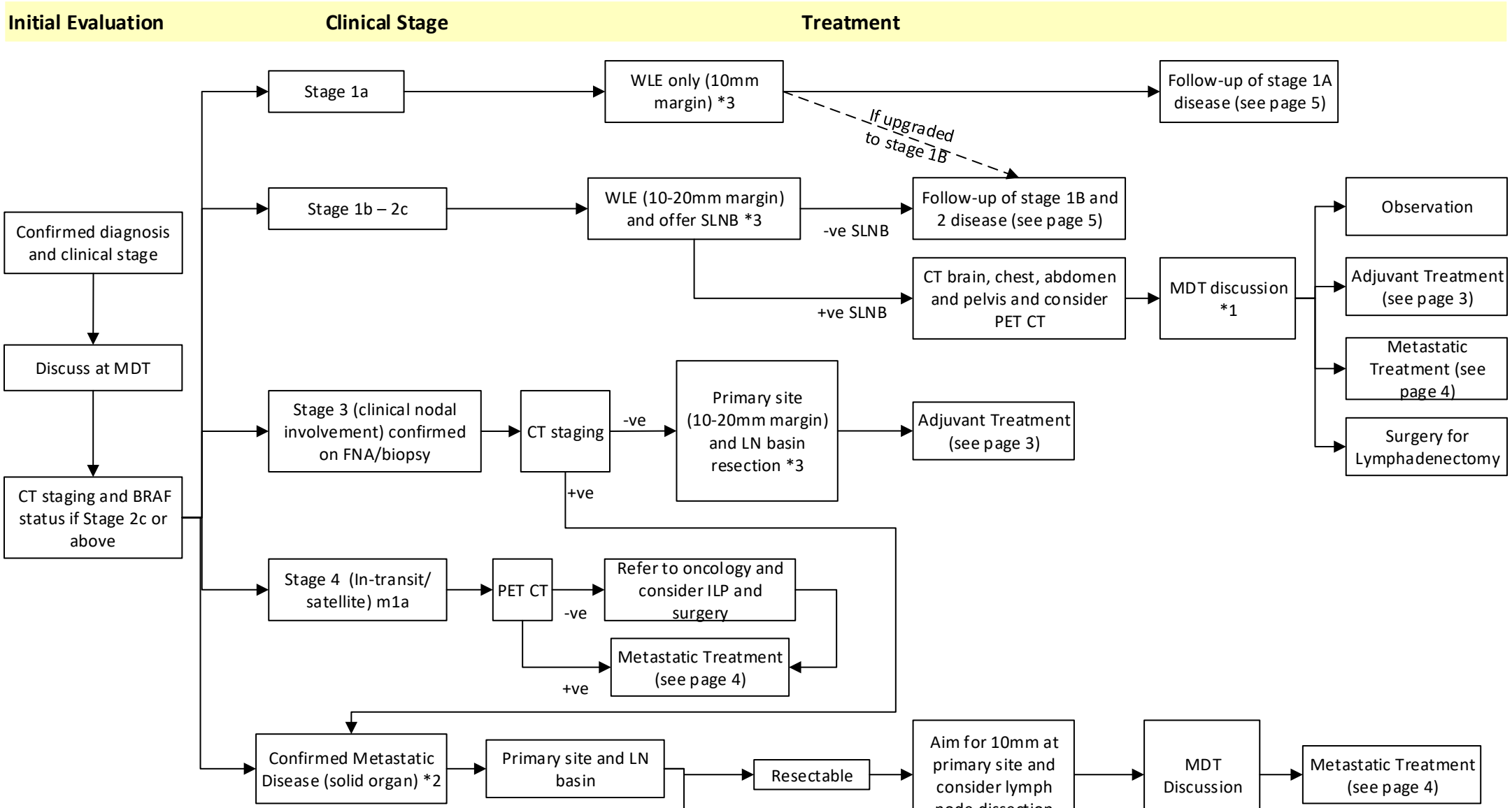


Notes

*1 Completion lymph node dissection (CLND) after a positive sentinel lymph node should not be performed routinely. If CLND is considered this should be agreed at the MDT

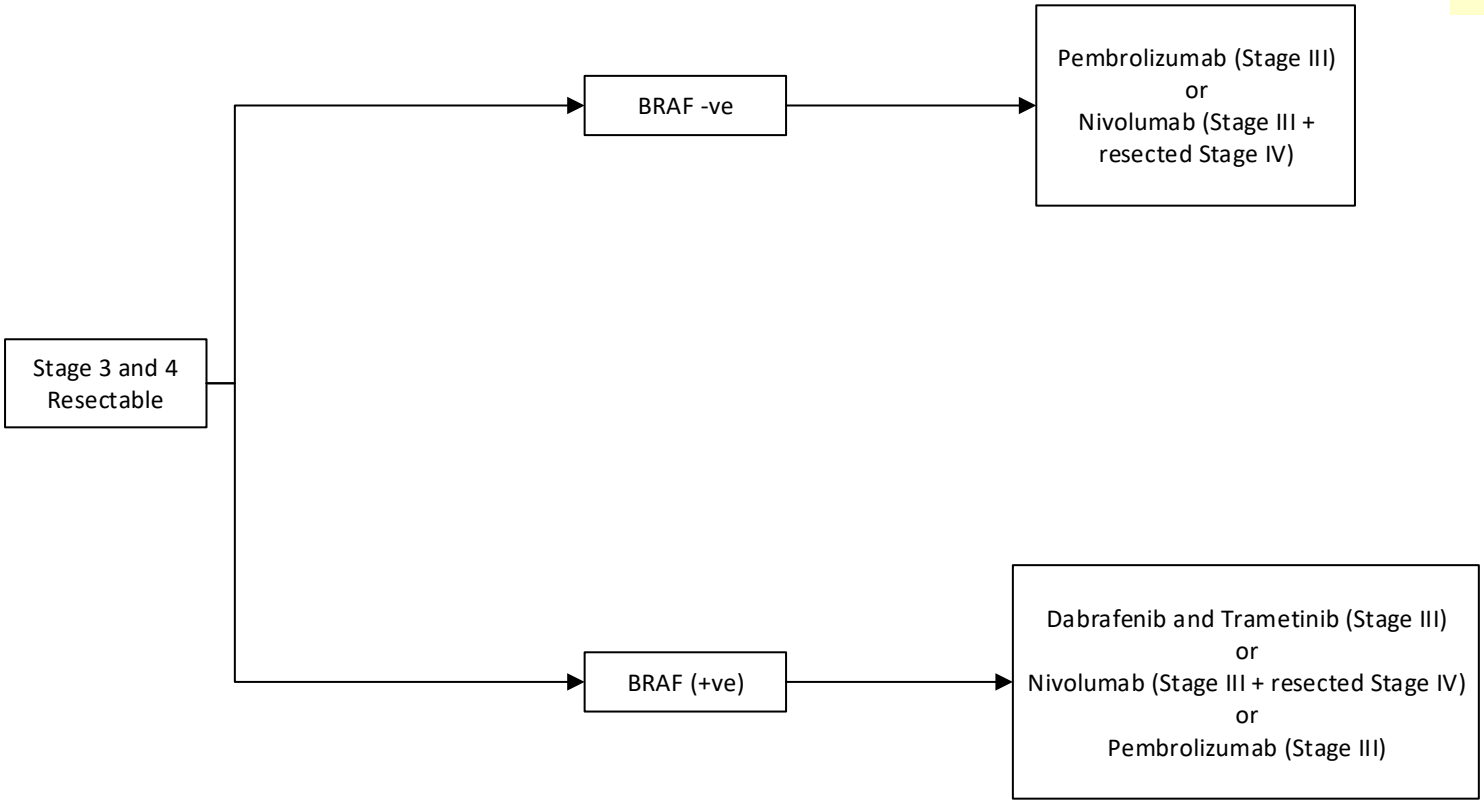
*2 Electrochemotherapy may be considered in appropriate irresectable stage 3 and 4 patients

*3 excision margins should be documented

Pathological Stage	Adjuvant Treatment

Consider referral for radiotherapy if extranodal spread or suspicion of incomplete tumour resection

All SACT regimens to be given until disease progression or toxicities up to maximum duration of 1 year.



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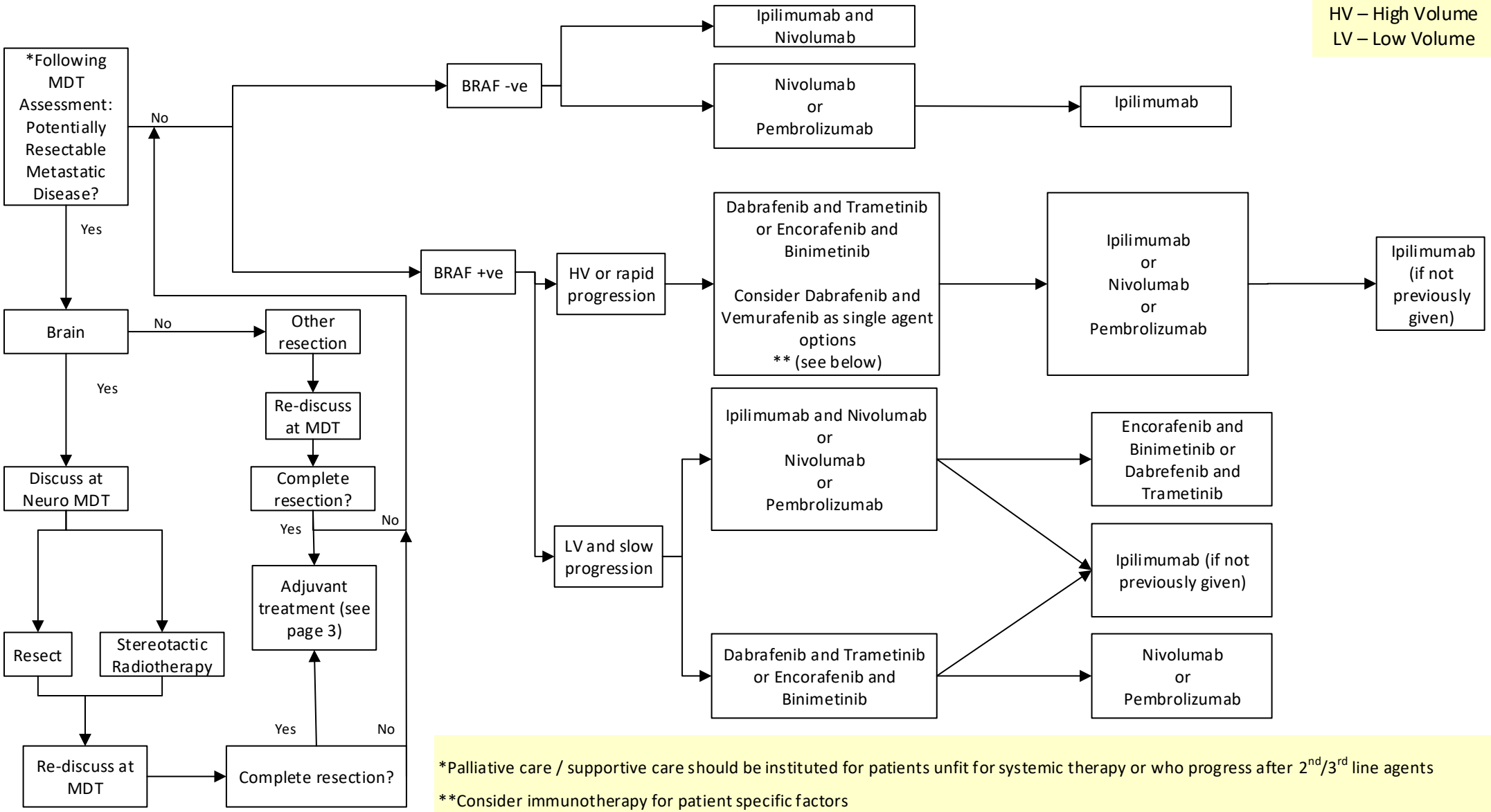
Metastatic Disease | **1st Line** | **2nd Line** | **3rd Line**

HV – High Volume
LV – Low Volume



*Palliative care / supportive care should be instituted for patients unfit for systemic therapy or who progress after 2nd/3rd line agents

**Consider immunotherapy for patient specific factors

If a patient is not suitable for immunotherapy, but would otherwise be advised cytotoxic chemotherapy can be considered (see page 6)

Follow-up and Aftercare

- There is no strong evidence to determine the exact pattern of follow-up. It should be tailored to the needs of the individual patient
- The following is provided for guidance only and is derived from SIGN, NICE & BAD/BAPRAS Guidelines.
- All patients should be given appropriate verbal and written information about the diagnosis, prognosis and management including self-examination.

Frequency of Follow-up		
Melanoma Stage	**Schedule of Care**	**Total duration of recommended Follow-up**
In situ	1 FUA then discharge	n/a
Stage 1A	3-6 monthly	12 months
Stage 1B-2C	3-6 monthly for years 1-3	5 years
Stage 3A (positive SLNB)	2 FUA/year for years 4-5	
Stage 3B	3 FUA/year for years 1-3	10 years
-Resectable	2 FUA/year for years 4-5	
Stage 4	1 FUA/year for years 6-10	
Stage 4 –Unresectable	According to clinical need and applicable clinical trials	

Follow-up model of care	
Melanoma Stage	**Guidance**
Stage 1-2	Local clinicians for continuity of care
Stage 3-4	Applicable local/regional specialist skin cancer MDT should lead the care
Melanoma Stage	**Suggested first point of contact only: in practice, shared follow-up is useful**
Stage 1	Dermatologist or Surgeon
Stage 2	Dermatologist or Surgeon
Stage 3	Surgeon
Stage 4	Oncologist

- Consider CT follow up every 6 months for asymptomatic Stage 2c and above
- Consider ultrasound scan every 3 months of nodal basin for follow-up of positive sentinel lymph node biopsy patients or stage 2 patients who do not have a sentinel lymph node biopsy

Note: Patients who are participating in a clinical trial should always be followed up according to the study protocol

SACT Regimens

Adjuvant Regimens	
BRAF mutated (+ve)	Dabrafenib and Trametinib (Stage III) Nivolumab (Stage III and resected Stage IV) Pembrolizumab (Stage III)
BRAF wild-type (-ve)	Nivolumab (Stage III and resected Stage IV) Pembrolizumab (Stage III)

Advanced Disease Regimens		
	BRAF mutated (+ve)	BRAF wild-type (-ve)
1st line	**BRAF/MEK targeted therapy** Dabrafenib + Trametinib Encorafenib + Binimetinib Dabrafenib (monotherapy) Vemurafenib (monotherapy) **Combination immunotherapy** Ipilimumab + Nivolumab for 4 doses, then Nivolumab **Anti-PD1 immunotherapy** Nivolumab Pembrolizumab	**Combination immunotherapy** Ipilimumab + Nivolumab for 4 doses, then Nivolumab **Anti-PD1 immunotherapy** Nivolumab Pembrolizumab
2nd line onwards	**If not had BRAF/MEK targeted therapy** Encorafenib + Binimetinib Dabrafenib + Trametinib **If not had immunotherapy** Nivolumab Pembrolizumab **If previously had anti-PD1 immunotherapy** Ipilimumab	Ipilimumab
Cytotoxic regimens	Dacarbazine Temozolamide Paclitaxel + carboplatin (weekly or 3-weekly regimens)	

TNM Staging for Malignant Melanoma, AJCC (8th Edition; 2017)		
Primary Tumour (T)		
pTX	Primary tumour cannot be assessed a	
pTo	No evidence of primary tumour	
pTis	Melanoma in situ (Clark level I) (atypical melanocytic hyperplasia, severe melanocytic dysplasia, not an invasive malignant lesion)	
pT1	**pT1**	Tumour 1 mm or less in thickness
	pT1a	0.8 mm or less in thickness without ulceration
	pT1b	0.8 mm in thickness with ulceration or more than 0.8 mm but no more than 1mm in thickness, with or without ulceration
pT2	**pT2**	Tumour more than 1 mm but not more than 2 mm in thickness
	pT2a	without ulceration
	Pt2b	with ulceration
pT3	**pT3**	Tumour more than 2 mm but not more than 4 mm in thickness
	pT3a	without ulceration
	pT3b	with ulceration
pT4	**pT4**	Tumour more than 4 mm in thickness
	pT4a	Without ulceration
	pT4b	With ulceration
Notes	a pTX includes shave biopsies and regressed melanomas	

TNM Staging for Malignant Melanoma, AJCC (8th Edition; 2017)		
Regional Lymph Nodes (N)		
NX	Regional lymph nodes cannot be assessed	
N0	No regional lymph node metastasis	
N1	**N1**	Metastasis in one regional lymph node or intralymphatic regional metastasis without nodal metastases
	N1a	Only microscopic metastasis (clinically occult)
	N1b	Macroscopic metastasis (clinically apparent
	N1c	Satellite or in transit metastasis without regional nodal metastasis
N2	**N2**	Metastasis in two or three regional lymph nodes or intralymphatic regional metastasis with lymph node metastases
	N2a	Only microscopic nodal metastasis
	N2b	Macroscopic nodal metastasis
	N2c	Satellite or in transit metastasis with only one regional nodal metastasis
N3	**N3**	Metastasis in four or more regional lymph nodes, or matted metastatic regional lymph nodes, or satellite(s) or in transit metastasis with metastasis in two or more regional lymph node(s)
	N3a	Only microscopic nodal metastasis
	N3b	Macroscopic nodal metastasis
	N3c	Satellite(s) or in transit metastasis with two or more regional nodal metastasi
Notes	Satellites are tumour nests or nodules (macro or microscopic) within 2 cm of the primary tumour. In transit metastasis involves skin or subcutaneous tissue more than 2 cm from the primary tumour but not beyond the regional lymph nodes	
Distant Metastasis (M)		
M0	No distant metastasis	
M1	**M1**	Distant metastasis a
	M1a	Skin, subcutaneous tissue or lymph node(s) beyond the regional lymph nodes
	M1b	Lung
	M1c	Other non-central nervous system sites
	M1d	Central nervous system
Notes	a Suffixes for M category: (0) lactic dehydrogenase (LDH) – not elevated (1) LDH – elevated so that M1a(1) is metastasis in skin, subcutaneous tissue, or lymph node(s) beyond the regional lymph nodes with elevated LDH. No suffix is used if LDH is not recorded or unspecified.	

Anatomic Stage/Prognostic Groups							
Clinical Staging				**Pathological Staging**			
Stage 0	Tis	N0	M0	0	Tis	N0	M0
Stage IA	T1a	N0	M0	IA	T1a	N0	M0
Stage IB	T1b	..	..	IB	T1b	..	..
	T2a	..	..		T2a	..	..
Stage IIA	T2b	N0	M0	IIA	T2b	M0	M0
	T3a	..	..		T3a	..	..
Stage IIB	T3b	..	..	IIB	T3b	..	..
	T4a	..	..		T4a	..	..
Stage IIC	T4b	..	..	IIC	T4b	..	..
Stage III	Any T	≥N1	M0	IIIA	T1-2a	N1a	M0
		..	..		T1-2a	N2a	..
		..	..	IIIB	T0	N1b-c	M0
		..	..		T1-2a	N1b-c	..
		..	..		T1-2a	N2b	..
		..	..		T2b-3a	N1a-2b	..
		..	..	IIIC	T0	N2b-c	M0
		..	..		T0	N2b-c	..
		..	..		T1a-3a	N2c-3c	..
		..	..		T3b-4a	Any N	..
		..	..		T4b	N1a-2c	..
		..	..	IIID	T4b	N3a-c	M0
Stage IV	Any N	Any N	M1	IV	Any T	Any N	M1

Definitions and References

Definitions

CLND	Complete Lymph Node Dissection
CT	Computerised Tomography
ILP	Isolated Limb Perfusion
LDH	Lactate Dehydrogenase
LN	Lymph Node
MDT	Multi-disciplinary Team
PACS2	Peer Approved Clinical System Tier 2
PET-CT	Positron Emission Tomography
SACT	Systemic Anti-Cancer Therapy
SLNB	Sentinel Lymph Node Biopsy
SNB	Sentinel Node Biopsy
WLE	Wide Local Excision
+ve	Positive
-ve	Negative

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