Cutaneous Malignant Melanoma (MM) Management Guidelines
There is a lack of well-conducted RCTs in this area. A number of guidelines have been published but most rely on expert opinion for the majority of recommendations. This guideline should be read in conjunction with those published previously and should be tailored to the individual patient.

Diagnosis
Patients referred with a suspicious pigmented lesion should be seen urgently in the dermatology clinic. Suspected MM should be managed in secondary care.

Management
The initial treatment for suspected primary cutaneous melanoma is complete surgical excision with a 2mm margin of clinically normal skin and a cuff of fat. A wider surgical excision is subsequently performed with margins dependant on the Breslow thickness, along with functional and cosmetic implications of the margin chosen. Incomplete removal may compromise subsequent measurements of tumour thickness, so if an incisional biopsy is performed due to the size or site of the lesion then it should be designed to minimize this risk. An elliptical incisional biopsy, through the darkest area, should be performed rather than a diagnostic punch biopsy. Suspected melanomas or suspicious melanocytic lesions should not be treated with curettage and cautery.

Surgical wider excision margins for primary melanoma

<table>
<thead>
<tr>
<th>Breslow thickness</th>
<th>Lateral excision margins</th>
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<tbody>
<tr>
<td>In situ</td>
<td>5mm</td>
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<tr>
<td>&lt;1mm</td>
<td>1cm</td>
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<tr>
<td>1.01-2mm</td>
<td>1-2cm</td>
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<tr>
<td>2.1-4mm</td>
<td>2-3cm</td>
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<tr>
<td>&gt;4mm</td>
<td>3cm</td>
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</tbody>
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In practice, wide excision margins greater than 2cm are rarely performed.

Staging
Accurate AJCC staging is important as it determines treatment and prognosis.

Investigations
Routine investigations are not required for asymptomatic patients with primary melanoma as the true positive pick up rate is low and the false positive rate high. Staging investigations for patients with metastatic disease may be ordered in light of the outcome of discussion at the skin cancer multi-disciplinary meeting.
**Sentinel Lymph Node Biopsy (SLNB)**

The role of SLNB is unclear. There is no RCT evidence to show that SLNB has any overall survival advantage. SLNB aids staging and provides some prognostic information. This is currently discussed with MM patients who have Stage IB or greater. Consultant plastic surgeons Mr Mark Butterworth, Mr Cameron Raine (St Johns) and Mr Omar Quaba (Fife) perform this procedure.

**Malignant melanoma with metastatic lymph nodes**

Treatment of clinically apparent regional lymph nodes is dependent on positive final needle aspirate cytology or positive frozen/paraffin sections of an involved lymph node.

**Malignant Melanoma with distant metastases**

Historically therapy has been palliative and includes surgery, radiotherapy, chemotherapy and immunotherapy. This may be a rapidly changing area with new molecular therapies becoming available. Close liaison with Dr Ewan Brown in Oncology and Dr Alistair Law in Radio-oncology is advised. Surgery is usually for accessible oligometastatic disease, or to prevent pain/ulceration.

**Cancer Nurse Specialist**

Patients should have access to a clinical nurse specialist for support.

**Skin cancer multi-disciplinary meeting**

All new patients with invasive MM and those with recurrent or metastatic disease should be discussed at this meeting. It takes place fortnightly on Fridays at 8.30 am with teleconferencing links at the Lauriston Building, WGH, St Johns Hospital, Fife, the BGH and Dumfries. A referral form (appendix 1) should be completed and emailed to Pam Muir MDM co-coordinator: Pam.Muir@luht.scot.nhs.uk. All staff managing skin cancer patients are welcome to attend. You are encouraged to attend if one of your patients is to be discussed. An outcome of the discussion is emailed, usually on the same day. It remains the responsibility of the Consultant in charge of the patient to arrange any further treatment and communicate timely with the patient’s GP.

**Follow up**

There is no strong evidence to determine the exact pattern of follow-up. Below is a suggestion but this should be tailored to the individual patient.

- Breslow <1mm, no ulceration, no mitoses: 3-6/12 up to 1yr then discharge
- Breslow <1mm, ulceration or >/1 mitoses: 3/12 for 3 yrs, then 6/12 to 5 yrs
- Breslow >1mm: 3/12 for 3 yrs, then 6/12 to 5 yrs
- Stage III B, III C, resected stage IV: 3/12 for 3 yrs then 6/12 to 5 yrs, then 12/12 to 10 yrs
- Stage IV unresectable seen according to need.

Patients should be given appropriate verbal and written information on their diagnosis and management.
References


3) Cutaneous Melanoma (Sign guideline no72). Available at www.sign.ac.uk/pdf/sign72.pdf

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Website: www.scan.scot.nhs.uk © South East Scotland Cancer Network (SCAN)