# Cutaneous Melanoma

## Cancer Centre of Southeastern Ontario

**Standard Management Guidelines**

**Version 1.2014**

**Revision Date: 2014/03/06**

**Lead: T Baetz**

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**Intended for use by Clinicians and Health Care Providers involved in the Management or Referral of adult patients with Cutaneous Melanoma**

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<th>Activity</th>
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</table>
| AA      | Cancer Centre Referrals | Melanoma multidisciplinary clinic | • Post-excisional biopsy or after definitive surgery/sentinel node procedure.  
• Central pathology review recommended.  
• Referral directly to medical oncology if presentation with metastatic disease.  
• Referral directly to radiation oncology if presentation with brain metastasis. | |
| A       | Diagnosis | Biopsy type, procedure | • Excisional biopsy | 1, 2 |
| B       | Pathology of diagnostic specimen | Synoptic report | • As per College of American Pathologists (CAP) guideline  
• BRAF mutational analysis if requested – standard for all metastatic melanoma  
• Other mutational analysis as clinically indicated (eg NRAS, CKit) | CAP Guideline, Melanoma Synoptic Template |
| C       | History and Physical exam | | If negative for evidence of satellites, other primaries and clinical nodal involvement go to D. **If suspicious for metastatic disease, proceed to G (investigations)** | 1, 2 |
| D       | Definitive Curative Intent Surgery (if applicable) | Wide excision with ideal margins measured clinically:  
• 1 cm for < 1.0 mm depth where possible  
• 1-2 cm > 1.0 mm < 4 mm where possible  
• 2 cm for > 4 mm where possible  

Sentinel node biopsy offered - for melanoma > 1 mm following discussion of risks and benefits | 1-4 |
### Section E: Pathology of final surgical specimen (if applicable)

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| Synoptic report content | *Wide excision specimen:* Indicate if: Remaining tumour present margins  
*Sentinel lymph node(s):* Presence/absence of melanoma  
If present:  
- Number of nodes involved  
- Measured Size of metastases  
- Presence of extranodal involvement | 1, 2 |

### Section F: Assign Post-Surgical Primary Stage

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<th>Activity Description</th>
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<td>Appendix 1</td>
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### Section G: Investigations

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| | Stage I, IIA: no further investigations unless indicated by symptoms or findings on physical exams  
All other patients: Baseline lab tests (CBC, LFT, LDH) and imaging of head and body – MRI head (CT if MRI not possible) and CT chest, abdomen and pelvis. Other imaging if patient symptomatic (e.g. bone scan)  
PET scan – only if equivocal results from baseline imaging or if excision of metastasis considered to rule out occult diffuse metastatic disease. | 1, 2, 5 |

### Section H: Post-investigation management

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| Curative intent: | Stage IA, B, IIA– routine follow up (H)  
Stage III – Complete node dissection followed by observation or high dose interferon alpha or clinical trial | 1-3, 6 |
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<tbody>
<tr>
<td>I</td>
<td>Post-investigation management</td>
<td>Advanced Disease:</td>
<td>Stage IV: If no brain metastases a. Solitary or subcutaneous (&lt;3) – consider surgical resection. PET scan may be helpful to determine absolute number and location of metastatic disease to ensure it is surgically resectable. b. Multiple metastases or not resectable</td>
<td>Cancer Care Ontario Drug Formulary</td>
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Interferon alfa only to be offered to >1 macroscopically node positive patients and/or those with tumour > 4mm deep with adequate performance status and no medical contraindications. (AJCC T4 or T1-3, N1b or higher, M0)

Adjuvant Radiation to be considered in cases of:
- Any single node size of ≥3 cm (axilla or groin) and ≥2 cm (head and neck)
- Any extracapsular extension
- Number of lymph nodes (at least one with macrometastatic deposit) ≥1 parotid node, ≥2 axillary or neck nodes, ≥3 inguinal nodes
- Resected recurrent nodal disease
- Doubt regarding adequacy of lymph node dissection

All patients meeting above criteria should be discussed at Multidisiplinary Case Conference for review.
### Systemic First Line
- If asymptomatic, may consider observation
- If symptomatic or observation not appropriate:
  - If BRAF mutated – BRAF inhibitor or MEK inhibitor or clinical trial
  - If BRAF negative or not suitable for BRAF inhibitor – DTIC or temozolomide

### Systemic Second Line
- Consider ipilimumab if suitable
- Consider BRAF inhibitor if not already exposed
- Consider DTIC or temozolomide if not already exposed
- Clinical trial

### Brain metastasis
Consider surgical resection or stereotactic radiation if possible, typically followed by whole brain radiotherapy.

If not consider for Palliative whole brain radiation.

If brain metastases are stable or resected treat as b.

If brain metastases are not stable.
- Consider temozolomide if not already exposed
- Consider clinical trial
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| J       | Follow up with no evidence of disease | Stage I-III– regular skin surveys (typically only patients with high risk stage II and III melanoma would be followed at the cancer clinic but all patients with a diagnosis of melanoma need skin surveys regularly by dermatology, family doctor, surgeon or oncologist). For those followed at the cancer centre they would be examined for new primaries and evidence recurrence of disease following resection: | Q 3 months x 4  
Q 6 months x 4  
Q 12 months x 2  
Investigations as clinically indicated |
| K       | Controversies | Therapeutic advantage of removing an involved SLN  
Completion lymph node dissection after the identification of a microscopically positive SLN  
Role of high dose interferon for T3bN0 melanoma  
Role of mitotic rate in melanoma in assigning high risk  
Role of PET scanning  
Radiation of asymptomatic incidentally identified brain metastases |
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<tr>
<td></td>
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<td>Sequence of targeted therapies versus immune treatments for metastatic disease</td>
<td>No Current Trials</td>
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<td>The role of BRAF testing in initial management of stage 1-3 melanoma</td>
<td>No Current Trials</td>
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<tr>
<td>L</td>
<td>Clinical Trials</td>
<td>Adjuvant</td>
<td>No Current Trials</td>
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<td>Metastatic</td>
<td>No Current Trials</td>
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<td>Supportive Care</td>
<td>No Current Trials</td>
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References

1. NCCN Guidelines, Melanoma Version 2.2014 (September 2013)
Appendix I – Melanoma of the Skin Staging

## Definitions

### Primary Tumor (T)

- **T1**: Primary tumor cannot be assessed (for example, unerupted or severely regressed melanoma)
- **T0**: No evidence of primary tumor
- **T1**: Melanomas 1.0 mm or less in thickness
- **T2**: Melanomas 1.01–2.0 mm
- **T3**: Melanomas 2.01–4.0 mm
- **T4**: Melanomas more than 4.0 mm

### Staging of regional lymph nodes (N)

- **N0**: No regional lymph nodes detected
- **N1**: Regional lymph nodes detected
- **N2**: Regional lymph nodes detected with involvement of in-transit lymph nodes
- **N3**: Regional lymph nodes detected with involvement of nodal metastases

### Metastasis (M)

- **M0**: No detectable evidence of distant metastases
- **M1a**: Metastases to skin, subcutaneous, or distant lymph nodes
- **M1b**: Metastases to lung
- **M1c**: Metastases to other visceral or distant sites

### Serum LDH

Serum LDH is incorporated into the M category as shown below.

### Classification

<table>
<thead>
<tr>
<th>Stage</th>
<th>Clinical Staging</th>
<th>Pathologic Staging</th>
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<tbody>
<tr>
<td>0</td>
<td>T0 N0 M0</td>
<td>T0 N0 M0</td>
</tr>
<tr>
<td>I</td>
<td>T1 N0 M0</td>
<td>T1 T2 N0 M0</td>
</tr>
<tr>
<td>II</td>
<td>T1 N1 M0</td>
<td>T1 T2 N0 M0</td>
</tr>
<tr>
<td>III</td>
<td>Any T N2 M0</td>
<td>Any T N2 M0</td>
</tr>
<tr>
<td>IV</td>
<td>Any T Any N M0</td>
<td>Any T Any N M0</td>
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### Notes

1. Histologic categories are defined as clinically detectable nodal metastases confirmed by histopathologic lymphadenectomy or when nodal metastases yield gross metastatic lesions.
2. Clinical staging includes microscopic or gross detection of the primary melanoma and clinical assessment of regional lymph nodes.
3. Histopathologic staging includes microscopic or gross detection of the primary melanoma and pathologic assessment of regional lymph nodes.
4. Histopathologic staging is equivalent for Stage IV patients when they do not require pathologic staging of the lymph nodes.