

# Summary Guidelines for Management of Cutaneous Malignant Melanoma (MM)

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## 1. Referral

- Ensure a system is in place to enable patients with suspicious lesions to be seen within 2 weeks (10 working days) of receipt of referral.

## 2. Record Keeping

- Record any history of change in the lesion, and details of the examination of the lesion, and other pigmented lesions.
- Examine the patient for lymphadenopathy and hepatomegaly if malignancy is suspected.

## 3. Treatment

- Lentigo maligna and in situ melanoma should be excised with a clear histological margin. Alternative treatments for lentigo maligna include cryotherapy and radiotherapy.
- Lesions suspect for invasive MM should be excised with a margin of 2-5 mm.
- Subsequent treatment of a melanoma is dependent on the Breslow thickness as follows:
  - Lesions less than 1 mm thick – 1 cm margin.
  - Lesions 1 – 2 mm thick – 1 – 2 cm margin.
  - Lesions 2.1 mm plus – 2 –3 cm margin.
- All patients should be managed or discussed by a Skin Cancer Multi-disciplinary Team.

## 4. Investigations

- Stage 1 – IIa, no investigations required.
- Stage IIB and over, consider chest x-ray, liver ultra sound, or CT scan chest and abdo and pelvis, for primaries on the leg.
- LFT's and full blood count.

## 5. Adjuvant Therapy

- The role of Interferon as adjuvant treatment is still controversial, enrol patients with Stage IIB, IIC or III cutaneous MM in clinical adjuvant trials where possible.

## 6. Node Negative Patients

- There is no role for elective lymph node dissection.
- Sentinel lymph node biopsy is useful for staging and is currently being used by some centres. However until evidence emerges that it can improve outcome it is not recommended as a routine procedure.

## 7. Lymph Node Involvements

- If lymph node involvement is suspected then the initial investigation should be with fine needle aspiration (FNA) and if involvement is confirmed then the patient should be referred for a formal block dissection. If FNA is negative LN excision may be necessary if clinical suspicion remains.

## 8. Cutaneous Recurrence

- This can be treated surgically or with the CO<sub>2</sub> laser.
- Isolated limb perfusion has a palliative role for disease not controllable in this way.

## 9. Distant Metastatic Disease

- Refer surgically if these can be resected.
- Refer to an Oncologist for consideration of chemotherapy/radiotherapy.

## 10. Follow Up

- Patients with in situ melanoma do not require follow up routinely, except where the patient has the atypical mole syndrome.
- Patients with lesions less than 1 mm thick should be followed up three monthly for three years and those with thicker lesions, six monthly for a further two years.

**Key to the Evidence and Recommendation gradings is in the full reference:**

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