Primary Cutaneous Malignant Melanoma Pathway

In-situ – Stg 0

Consider a total 5mm clinical WLE margin

Standard clinical FU

Breslow uncertain

Initial Narrow excision & proceed as per best available staging

MM FU as per best available staging

Breslow <0.8mm no ulcn (pT1a) - Stg IA

Breslow 0.8<1.0mm no ulc/LMI/MI<2 (pT1b) - Stg IB

Total 10mm WLE histology margin

Standard clinical MM FU

Breslow 0.8 ≤ 1mm ulc/LMI/MI<2 (pT1b) - Stg IB

Total 10mm WLE histology margin consider SNB**

Breslow 1.0(pT1b) & 1.1 -2.0mm no ulcn (pT2a) - Stg IB

Total 10mm WLE histology margin & SNB**

Breslow 1.1-2.0mm ulcn (pT2b) & 2.1-4.0mm no ulcern (pT3a) - Stg IIA

Total 20mm WLE histology margin & SNB**

Standard clinical MM FU / If SNB positive then –

1. Repeat MDT discussion
2. possible oncology treatment
3. Molecular profile
4. CT staging
5. Radiology surveillance

Breslow 2.1-4.0mm ulcern (pT3b) – Stg IIB, >4mm (all)

Total 20mm WLE & SNB**AND

Staging CT-TAP & Brain and also neck CT (for head and neck)AND

Molecular profile

Consider clinical & radiological surveillance for MM FU / If SNB pos or stage 2B/C then repeat MDT discussion & possible oncology treatment
Consider radiology surveil (RS)

Satellites/ in-transits

Staging CT-TAP & Brain and also neck CT (for head and neck), Molecular profile, consider total body PET CT scan for limbs

Consider WLE including satellites /intransits, SNB if no distant mets, and refer to Oncology
Consider radiology surveil (RS)

If distant mets refer to Oncology & consider RS

Unknown primary

Biopsy of presenting lymph node/lesion, Molecular profile, & PET CT scan consider total body for limbs

MM treatment e.g. block dissection & refer to Oncology.
Consider RS

** If SNB inconclusive / not possible then consider PET CT

Lymph node dissection should be considered for those patients who present with palpable biopsy proven node recurrence (not merely SNB pos)
CLND could be considered for those patients with features identified in their SNB that indicate a high risk of regional relapse, namely:
a. extracapsular spread
b. ≥3 involved sentinel nodes
c. Dewar criteria (multifocal or extensive)
AND
who are unsuitable for adjuvant therapy, either due to medical co-morbidities or where geographical constraints may limit access to routine follow-up at a regional cancer centre.

Follow-up for stages

0 – one visit only

IA – 1yr - Two 6mthly fu

IB – Yr 1 6mthly;
Yr 2 to 5 one yrly

IIA – Yr 1&2 6mthly;
Yr 3 to 5 one yrly

IIB/11C* – Yr 1&2 - 3mthly;
Yr 3 - 6mthly
Yr 4&5 - one yrly

III/IV resected* -
Yr1to3 - 3mthly;
Yr 4&5 – 6mthly

*Not on adjuvant Rx,trials

Radiology surveillance (RS)

Stage IIB to IIIC (CT TAP & Brain):
1st 3yrs 6mthly, Yr 4 & 5 – Annual

Stage IIID to Resected IV(CT TAP & Brain):
1st yr 3mthly, Yr 2 & 3 – 6 mthly, Yr 4 & 5 - Annual

For H&N MM add Neck CT

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