Melanoma

The following questions can be used as discussion points for peer groups or self-reflection of practice.

It is strongly recommended that the following articles are read before considering the questions:

- "**Early detection of melanoma and assessment of asymptomatic people at high risk**"
- "**Melanoma: post-treatment follow-up and surveillance**"

Early detection of melanoma and assessment of asymptomatic people at high risk

The majority of melanomas develop from uncontrolled melanocyte proliferation within the epidermis (melanoma *in situ*), which can then spread to the dermis (invasive melanoma) and in some cases, to regional lymph nodes and other tissues and organs (metastatic melanoma). Less commonly, melanomas may arise within the dermis. In very rare cases, melanomas can originate in internal tissues, such as the brain and the eye.

Lesion thickness is the strongest predictor of prognosis in patients with a primary cutaneous melanoma. Therefore, identifying and investigating suspicious lesions at the earliest possible clinical stage can improve patient outcomes. Encourage patients to report any abnormal naevi or other skin lesions and use any appropriate opportunity to assess a patient for suspicious lesions, e.g. during clinical examination for other reasons.

In many cases, the "ugly duckling" principle will prompt the initial suspicion of melanoma, with the rationale being that any lesion that is dissimilar in appearance, e.g. size, colouring and shape, to other, moles, freckles or lesions, should undergo further scrutiny. After assessing the patient's lesion of concern in the context of other lesions, determine the likelihood of melanoma. Ask about factors such as history of change, characteristics of the lesion including itching, bleeding or pain and symptom duration, family history and other risk factors, e.g. age, significant sun exposure, and work through the ABCDEFG checklist in conjunction with dermatoscopy (using the Chaos and Clues method of revised pattern analysis). Depending on the patient's risk of melanoma, the rest of the body may need to be checked for other suspicious lesions. Where dermatoscopy is not available and there is clinical concern, consider excision biopsy or refer the patient for further assessment.

A narrow complete excisional biopsy with 2 mm margins that is of sufficient depth to avoid transection at the base should be performed on suspicious lesions, otherwise, refer the patient to a dermatologist or surgeon for assessment or removal. Low concern, flat, pigmented lesions can be monitored using digital dermatoscopy over three months and then as required. Undiagnosed raised lesions (nodules) should be excised rather than monitored.

Encourage those with risk factors for melanoma to regularly examine their skin and document any changes over time. Advise patients to return to primary care for examination if changes are observed or new lesions appear. Patients at very high risk, e.g. a family and personal history of melanoma and/or multiple atypical naevi, should undergo long-term surveillance with total body photography and dermatoscopy each year.

Melanoma: post-treatment follow-up and surveillance

For patients with early-stage cutaneous melanomas that were identified and excised promptly, surgery can be essentially curative in many cases. However, melanoma has a significant metastatic capacity and can spread from relatively small primary sites to multiple locations throughout the body. Post-treatment follow-up and surveillance improves the chance that recurrence (or a new primary melanoma) will be identified early. Multiple factors including stage at diagnosis, tumour ulceration, thickness, mitotic rate and sentinel lymph node positivity, all influence the risk of local melanoma recurrence or metastasis.

In most cases, melanoma recurrence is self-detected; in addition to looking for suspicious skin lesions, patients should be aware of other features which may indicate recurrence, e.g. hardened lumps under the skin, enlarged lymph nodes or persistent and unexplained systemic symptoms. Primary care follow-up is still essential to provide a more comprehensive assessment for recurrence and/or surveillance of new lesions of concern, and to deliver ongoing education and support. Secondary care follow-up may be required for some patients with advanced disease or other medically complex needs.

The frequency and duration of follow-up is generally based on the patient's staging at diagnosis; however, it may be appropriate to individualise this schedule according to the patient's needs, objectives or other circumstances, e.g. the presence of many melanocytic naevi or atypical naevi.

Routine laboratory monitoring is not recommended for detecting recurrence in asymptomatic patients as abnormal blood findings are rarely the first sign of metastases and laboratory tests have a low level of specificity for melanoma recurrence detection. Ultrasound assessment of draining nodal basins may be appropriate for some patients, in addition to clinical examination, e.g. patients with sentinel node biopsy-positive stage III melanoma where lymphadenectomy has not been performed. Routine follow-up with cross-sectional imaging (e.g. CT, MRI) is generally only indicated for patients with stage II-C melanoma onwards, or when recurrence or metastatic disease is suspected based on clinical presentation, history or findings on ultrasound examination.

Questions to consider:

1. Thinking back to the last time you saw a patient with a lesion of concern, what steps did you take to assess the risk of melanoma? How confident are you that the risk was appropriately assessed? After reading this article, is there anything that you would now do differently?
2. Dermatoscopy is an essential skill in primary care. Does your practice have a dermatoscope and how confident are you with using one? If your practice does not have a dermatoscope, how do you assess a lesion of concern, e.g. do you refer all patients to a GPSI or equivalent, or assess with a visual inspection alone and excise?
3. A narrow complete excisional biopsy should be performed on any pigmented lesion suspicious of melanoma within two weeks of being identified. In your opinion, is this timeframe feasible? Do you often perform the excision yourself or would you refer the patient to another clinician or service? If you refer, what factors influence you to do this, e.g. skill level, time constraints, concern about lymph node involvement, body site, size of the lesion, the cosmetic result?
4. Were you surprised that evidence shows most patients detect their own melanoma recurrence? Thinking back to the last time you saw a patient with recurrent melanoma, who identified it, i.e. clinician or patient? What symptoms do patients most commonly have that indicate recurrence or a new melanoma and when do these typically appear?
5. In your experience how do you find patients cope after having treatment for melanoma and being faced with the potential for recurrence? What strategies have you found successful at improving the mental health and wellbeing of these patients? Do you have any support groups in your area that you recommend?
6. The frequency and duration of follow-up for people post-treatment for melanoma is not always clear cut. What is your approach to determine the most appropriate follow-up schedule for each patient? In your experience, do patients prefer attending more regular appointments for reassurance or do they prefer less frequent follow-up?