

# Optimal care pathway for people with melanoma

## Quick reference guide



Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for people with melanoma*.

Please note that not all patients will follow every step of the pathway.

### Step 1: Prevention and early detection

#### Prevention

When the UV index levels are 3 or above (during sun protection times), people should be encouraged to use a combination of sun protection measures to avoid relying on one form of sun protection and to minimise UV exposure. These measures include wearing long-sleeved clothing, a broad-brimmed hat and sunglasses, applying an SPF30 or higher broad-spectrum sunscreen, and seeking out shade. People should also be encouraged to avoid using solariums and to protect children from sunburn and long-term exposure to the sun.

#### Risk factors

- A personal history of melanoma or non-melanoma skin cancer
- A family history of melanoma
- Increased numbers of naevi on a total body count (> 100 of more than 2 mm)
- Increased numbers of dysplastic naevi
- Solarium use
- A fair complexion (including fair skin with poor tanning ability, light or red-coloured hair and blue or green eyes)

- A history of blistering sunburn
- Multiple solar keratoses
- High levels of intermittent sun exposure (e.g. during outdoor recreation or sunny holidays)
- Immune suppression and/or transplant recipients
- Increasing age

#### Screening

Population screening is not appropriate for melanoma. However, high-risk patients should have regular total body cutaneous examinations.

#### Managing increased risk

- Education about skin self-examination and sun protection advice
- Total skin check every six to 12 months
- Use of surveillance photography
- Sequential dermoscopic imaging
- Referral to a dermatologist or cancer geneticist for people with a family history of cancer in two first-degree relatives

#### Checklist

- Education on skin self-examination provided
- Total skin check conducted for high-risk patients
- Recent weight changes discussed and the patient's weight recorded
- Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- Physical activity recorded
- Referral to a dietitian considered
- Referral to a physiotherapist or exercise physiologist considered
- Education on being sun smart considered

### Step 2: Presentation, initial investigations and referral

**A change in one or more of the ABCDE criteria (asymmetry, border irregularity, colour, diameter of the skin, evolution) and/or the following should be investigated:**

- itching, scaling, bleeding, oozing, swelling or pain in a skin lesion
- new lesions, any changing skin lesions or lesions that do not heal or respond to treatment

- a rapidly growing skin lesion that persists after one month
- spread of pigment from a lesion to the surrounding tissue.

Note: A small percentage of cases present as a symmetrical, often non-pigmented nodule that grows progressively for over a month (EFG: elevated, firm and growing progressively).

#### Checklist

- Signs and symptoms recorded
- Biopsy conducted and tissue sent to pathologist for examination
- Patient referred to a dermatologist, skin cancer GP or surgeon, if appropriate

## Step 2: Presentation, initial investigations and referral continued

### Initial investigations

Assessments should include taking a lesion history focusing on: how long the lesion has been present; time course if it has changed; the type of change; and associated symptoms (tender, itch, bleeding).

Examinations should be undertaken with good lighting, using a dermatoscope.

Observation, with review, should only occur if there is a low level of suspicion, and only for macular (flat) lesions (to avoid monitoring a nodular melanoma), using dermatoscopic imaging.

Where there is a high level of suspicion, the practitioner should either refer to a specialist or undertake an excisional biopsy. In general, complete excision of the entire lesion with a 2 mm margin should be performed.

If referral is considered the patient should be referred to a dermatologist, skin cancer GP or surgeon who can perform the biopsy.

The following lesions should be referred to a specialist:

- high-risk melanoma (deeply invasive > 1 mm)
- metastatic melanoma
- lesions with histologic uncertainty

- incompletely excised lesions that cannot be treated definitively in primary care.

### Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

### Communication

#### The GP's responsibilities include:

- explaining the diagnosis and the prognostic implications in broad terms
- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- reassuring the patient that if the lesion is a melanoma and completely excised that a short delay to specialist review and treatment is not harmful
- informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

### Checklist continued

- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient notified of support services such as Cancer Council 13 11 20
- Referral options discussed with the patient and/or carer including cost implications

### Timeframe

If melanoma is suspected, a biopsy or excision should be done **within 2 weeks** of the initial GP consult, and results provided to the patient **within 1 week** of the biopsy.

Where appropriate, referral to a specialist should occur **within 2 weeks**. There will be some patients where management in primary care is appropriate.

## Step 3: Diagnosis, staging and treatment planning

### Diagnosis

All patients should have a complete skin check.

Most diagnoses occur in the primary care setting.

Specialist management may include complete excision (in rare instances where a punch, shave or incisional biopsy was performed pre-referral) or re-excision with recommended margins, and imaging.

### Staging

Sentinel lymph node biopsy should be considered for patients with a melanoma greater than 1 mm in thickness and for patients with a melanoma greater than 0.75 mm and other high-risk features such as ulceration; this will provide optimal staging and prognostic information. If metastatic melanoma is detected, discuss how to manage the regional lymph nodes region. The options are observation with clinical and ultrasound review or completion lymph node dissection (CLND). CLND does

not offer any survival benefit over close observation. A subset of patients who have metastatic melanoma detected in the sentinel nodes are likely to be referred to a medical oncologist to discuss the role of adjuvant systemic therapy.

### Genetic testing

Patients that may be appropriate for referral include:

- people with more than one first-degree relative with melanoma – they should be referred to a dermatologist for a clinical risk assessment
- people with three or more relatives with melanoma and/or pancreatic cancer – they should be referred to a family cancer service for a genetic risk assessment.

### Treatment planning

The multidisciplinary team should meet to discuss patients with unusual pathology, any patient where treatment may be unclear and all patients with stage III and IV disease, **within 4 weeks** of the initial diagnosis.

### Checklist

- Diagnosis and staging confirmed
- Full histology obtained
- Performance status and comorbidities measured and recorded
- Patient discussed at an MDM and decisions provided to the patient and/or carer
- Clinical trial enrolment considered
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient referred to support services (such as Cancer Council) as required

## Step 3: Diagnosis, staging and treatment planning continued

### Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <[www.australiancancertrials.gov.au](http://www.australiancancertrials.gov.au)>.

### Communication

#### The lead clinician's<sup>1</sup> responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care

- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from multidisciplinary meetings (MDMs).

### Checklist continued

- Patient referred to a familial cancer service, if appropriate
- Treatment costs discussed with the patient and/or carer

### Timeframe

Staging investigations should be completed **within 2 weeks** of the specialist's assessment.

## Step 4: Treatment

### Establish intent of treatment

- Curative
- Loco-regional control
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation

**Full skin assessment** is a preliminary treatment option to assess the risk of further melanomas, for surveillance planning and to detect synchronous primaries, and/or other keratinocytic skin cancers that may require intervention.

**Surgery** with direct primary closure can be undertaken in a primary care setting for excision biopsy and selected re-excision for in situ and early-stage melanomas. Surgery for all other excisions (including sentinel lymph node biopsy and regional lymphadenectomy) should be undertaken by a surgeon with adequate training and experience.

**Radiation therapy** may benefit in the following circumstances: definitive treatment for in situ melanoma in medically inoperable areas or for patients where a complete resection would be prohibitively morbid; adjuvant radiation therapy following surgical resection for invasive melanoma with a high risk of recurring if potentially effective systemic therapy is not available; and for palliative treatment.

**Systemic therapy** should be considered for select patients with stage III melanoma (confined to regional lymph nodes) and all patients with advanced melanoma (stage IV) given their potential improvement in progression-free survival and overall survival. Options include immunotherapy and targeted therapy.

### Palliative care:

For patients who are not responding to treatment or with very advanced disease, early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis. For more, visit the Palliative Care Australia website <[www.palliativecare.org.au](http://www.palliativecare.org.au)>.

### Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

### Checklist

- Intent of treatment established
- Advantages and disadvantages of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer and provided to the patient's GP
- Treating specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Early referral to palliative care considered
- Advance care planning discussed with the patient and/or carer

### Timeframe

**Surgery** in a primary care setting should occur **within 2 weeks** of the decision that it is necessary.

If not urgent, **radiation therapy** should begin **within 4 weeks** of the MDM.

**Systemic therapy:** as adjuvant therapy, should occur **within 12 weeks** of definitive surgery; and to treat stage IV disease, should begin as soon as clinically relevant, ideally **within 4 weeks**.

<sup>1</sup> Lead clinician – the clinician who is responsible for managing patient care. The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

## Step 5: Care after initial treatment and recovery

### Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- melanoma characteristics, specifically the primary thickness and whether ulceration is present
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided

- a follow-up schedule, including tests required and timing
- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

### Communication

#### The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP.

### Checklist

- Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- Importance of skin self-examination and sun protection discussed with the patient and/or carer
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient-reported outcome measures recorded

## Step 6: Managing recurrent, residual or metastatic disease

### Detection

Self-examination is essential for any new or changing skin lesion, cutaneous lump or persistent new symptom. Metastatic disease will be detected most commonly by the patient presenting with symptoms and less commonly via routine follow-up.

### Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

### Advance care planning

Advance care planning is important for all patients but especially those with advanced disease. It allows them to plan for their future health and personal

care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves.

### Survivorship and palliative care

Survivorship and palliative care should be addressed for patients with recurrent melanoma or melanoma that has had metastasised. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

### Communication

#### The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

### Checklist

- Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Advance care planning discussed with the patient and/or carer
- Patient referred to palliative care if appropriate
- Routine follow-up visits scheduled

## Step 7: End-of-life care

### Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

### Communication

#### The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

### Checklist

- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient referred to palliative care
- Advance care directive in place

Visit our guides to best cancer care webpage <[www.cancercareguides.org.au](http://www.cancercareguides.org.au)> for consumer guides. Visit our OCP webpage <[www.cancer.org.au/OCP](http://www.cancer.org.au/OCP)> for the optimal care pathway and instructions on how to import these guides into your GP software.