Melanoma Follow-up

This pathway is for adults with melanoma who have completed initial treatment (surgery, chemotherapy, biologics). See also:

- Established Malignant Melanoma
- Suspected Melanoma
- Melanoma referral Pathways

About melanoma follow-up

- A significant aim of follow-up is to detect recurrences or new primary skin tumours, including new primary melanomas.
- 15 to 20% of patients with melanoma develop lymph node metastases (Stage III disease) over time, and 10 to 15% of patients develop skin or visceral metastases.

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Contents

Assessment

1. Review:

- the cancer treatment summary letter.

Cancer treatment summary letter

Most importantly should include:

- risk of recurrence and intentions of treatment.
- goals and quantitative benefit of proposed treatment.
- risks of treatment.
- what the patient has been told.

Usually includes:

- diagnostic tests performed and results.
- tumour characteristics and other factors determining prognosis.
- type and date of treatments and a treatment summary.
- expectations of disease course, including expected discharge from oncology services.
- interventions and treatment plans from other health professionals.
- a process for rapid re-entry to specialist medical services for suspected recurrence.
- a list of symptoms that might need prompt investigation.
- a list of supportive care services provided and a plan for community care services, including what each service is to provide.
- contact information for key care providers.

- available disease indicators and recent investigations.

Disease indicators and recent investigations

- Survival rates by stage – improvements in prognosis from current advances are not yet reflected in these figures
- Indicators of poorer prognosis

Indicators of poorer prognosis

- Older patients
- Melanoma sited on upper arm, back, neck or scalp
- Males, Aboriginal and/or Torres Strait Islanders, Maori or Pacific Islanders

Histology:

- Worse prognosis with:
  - microsatellitosis or increased thickness or vertical spread.
  - ulceration or invasion of nerve or lymph structures. Be familiar with results of sentinel node lymph biopsy or regional lymphadenectomy if performed.
- Better prognosis with lymphocytic infiltration, regression or purely desmoplastic type.

- Imaging used in staging – optimal modality is PET scan, but appropriate modalities include PET/CT and MRI Brain. See Medicare eligibility.
- Results of general investigations:

- FBE
- Urea, electrolytes and creatinine
- Calcium and phosphate
- Serum magnesium
- Liver function tests
- BRAF mutational status

BRAF mutational status

- Ensure familiarity with the BRAF mutational status.
- BRAF status is critical in determining the management of advanced disease.
- 50% of melanomas have mutations of the BRAF gene, which may be susceptible to drugs targeting BRAF pathways, e.g., BRAF and some MEK inhibitors.[1,2]

2. Take a history asking about prevention, impact, and new symptoms.

History

Ask about:

- Preventive health:
  - A diet high in vegetables and fibre, rich in vitamin D and carotenoids, and low in alcohol[3]
  - Sun exposure and sun protection
  - Self-examination approach
- Effects of diagnosis and treatment:
  - Impact of the condition and treatment on lifestyle and well-being, including difficulty with psychosocial or sexual aspects resulting from diagnosis or treatment
  - Late side-effects, including cardiopulmonary and neurological effects
  - Visual deterioration, peripheral sensation changes, exercise tolerance, shortness of breath, and oedema
  - Unusual, changing, or bleeding skin moles – see Suspected Melanoma
- Perform a screening systems review.

See also Cancer Council – Long-term Side Effects of Cancer Treatment.

3. Perform a targeted general examination, and if immunotherapy has been used, consider retinal monitoring.

Examination

- Measure and record weight.
- Perform full skin check, optimally including dermoscopy, and photography for any suspicious pigmented or non-pigmented lesions.
- Depending on past treatment, check blood pressure and examine for cardiopulmonary and neurological late side-effects.
- Check lymph node fields and examine for lymphoedema. Examine for hepatomegaly.
- If immunotherapy has been used, consider retinal examination for melanoma related retinopathy or refer for optometry assessment or non-acute ophthalmology assessment. See also Immunotherapy Related Adverse Events.

4. Do not perform other investigations, unless there are signs or symptoms of metastases, or they are recommended by the treating team.
5. Record findings and consider a serial record with skin photography or dermoscopy.

Management

Survivorship involves careful general practitioner surveillance and attention, especially after discharge from oncology treatment.

1. Advise patient that once discharged, they can choose to have their follow-up with their general practitioner, a general practitioner with special interest, or a private specialist. Unless the treating team has recommended otherwise, review the patient for physical and skin examination every 3 to 6 months for the first 2 to 3 years, then yearly thereafter.
2. Ensure that the patient or carer has either a copy of cancer treatment summary letter or important patient centred information.

Cancer treatment summary letter

Most importantly should include:

- risk of recurrence and intentions of treatment.
- goals and quantitative benefit of proposed treatment.
- risks of treatment.
- what the patient has been told.

Usually includes:

- diagnostic tests performed and results.
- tumour characteristics and other factors determining prognosis.
- type and date of treatments and a treatment summary.
- expectations of disease course, including expected discharge from oncology services.
- interventions and treatment plans from other health professionals.
- a process for rapid re-entry to specialist medical services for suspected recurrence.
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- a list of supportive care services provided and a plan for community care services, including what each service is to provide.
- contact information for key care providers.

Patient centred information

- Diagnostic tests performed and results
- Tumour histology, markers informing treatment options
- Type and date of interventions
- Treatment plans from other health professionals
- Supportive care services and contact information for key care providers[4]

3. Manage preventive health. Encourage physical activity and a healthy diet high in vegetables and fibre, recommending foods rich in vitamin D and carotenoids, low in alcohol and refined sugar.[3] If practicable, recommend natural food over nutritional supplements, minimising supplementary sugars. Advise sun protection and provide patient education.

Patient education

It is important that the patient:

- avoids excessive sun exposure.
- understands skin surveillance and the value of photography by themselves and specialist services.
- has regular inspections to detect recurrence or new primary melanoma.
- understands the role of blood tests and imaging in melanoma, and the importance of regular follow-up.
- understands the importance of catching nodal metastases early to improve survival.

4. See Cancer Supportive Care for general advice on:

- other lifestyle changes.
- psychological needs.
- financial, legal, and practical needs.
- managing physical sequelae.
- support groups and referral services.

5. Perform excision biopsy with low threshold, for any new, growing or changing lesions, especially if features of keratoacanthoma or squamous cell carcinomas as these have increased incidence and severity after immunotherapy.

6. Add recall instruction to the patient management system for the recommended follow-up schedule, based on the patient's histology and their risk factors.

Recommended follow-up schedule[4]

- Patients at higher risk, identified by staging and tumour characteristics, will require follow-up several times annually, whereas annual check-up will suffice for those with low-risk tumours.
- If tumours < 1 mm thick, review every 4 to 6 months for 2 years, then less frequently indefinitely, depending on risk factors. If high risk, review more frequently for:
  - a second primary melanoma due to high naevus numbers
  - multiple dysplastic naevi
  - a history of melanoma in close relatives.
- If tumours > 1 mm thick, review every 3 to 4 months for 2 years, then every 6 months until 5 years, then annually.
- If stage III disease, review every 4 months for 2 years, then every 6 months until 5 years, then as clinically necessary.
- If more advanced metastatic disease, review every 1 to 4 months, indefinitely.

7. If patient has lymphoedema or high risk of lymphoedema, refer early to the appropriate service.
8. If suspected distant metastases or unexplained weight loss, fatigue, night sweats, and no primary found or cause on investigation, request non-acute oncology assessment within a week.
9. Refer within 1 to 2 weeks for non-acute dermatology assessment, non-acute plastic surgery assessment, or non-acute general surgery assessment if palliative patient with:
   - recurrence in areas affected by previous surgery.
   - suspected nodal metastases for fine needle aspiration biopsy.
   - suspected or confirmed primary melanoma, melanoma in situ (including lentigo maligna), or skin metastases.
   - large melanocytic naevi (> 20 cm) especially with suspicious changes.
10. If serious recurrence, consider arranging referral for palliative care services as early as appropriate. Early referral can improve quality of life, and in some cases, survival.
11. Provide ongoing support of patient and family throughout the course of cancer treatment and survivorship:
    - For difficulty with psychosocial or sexual aspects of cancer diagnosis and treatment, arrange counselling support.
    - Consider referral for cancer supportive care services for counselling, or if familial cancer and family distress, referral for familial genetic counselling service. Alternatively, provide Cancer Victoria support line 13-11-20.
    - Consider a GP Management Plan and team care arrangement.
    - If patient experiences hair loss, arrange referral for hair loss in cancer therapies.
    - Consider advance care planning.

Referral

Click here for Melanoma referral Pathways

- If serious recurrence, consider arranging referral for palliative care services as early as appropriate. Early referral can improve quality of life, and in some cases, survival.
- If patient has lymphoedema or high risk of lymphoedema, refer early to the appropriate service.
- If distant recurrence, e.g. unexpected weight loss or signs of hepatic, brain, or bone involvement, arrange non-acute oncology assessment within 1 week.
- Refer within 1 to 2 weeks for non-acute dermatology assessment, non-acute plastic surgery assessment or non-acute general surgery assessment if palliative patient with:

    - recurrence in areas affected by previous surgery.
    - suspected nodal metastases for fine needle aspiration biopsy.
    - suspected or confirmed primary melanoma, melanoma in situ (including lentigo maligna), or skin metastases.
    - large melanocytic naevi (> 20 cm) especially with suspicious changes.
- See Cancer Supportive Care for general advice on:
    - other lifestyle changes.
    - psychological needs.
    - financial, legal, and practical needs.
    - managing physical sequelae.
    - support groups and referral services.
- If patients struggling with psychosocial or sexual aspects of cancer diagnosis and treatment, arrange counselling support.
- Consider referral for cancer supportive care services for counselling, or if familial cancer and family distress, referral for familial genetic counselling service. Alternatively, provide Cancer Victoria support line **13-11-20**.
- If patient experiences hair loss, arrange referral for hair loss in cancer therapies.

Information

For health professionals

- Cancer Council Victoria – Optimal Cancer Care Pathway for People with Melanoma
- Cancer.net – Long-Term Side Effects of Cancer Treatment
- Cancer.org:
    - Survival Rates for Melanoma Skin Cancer
    - Targeted Therapy for Melanoma Skin Cancer
- Cancer Research Institute – Melanoma
- PubMed – Treatment of Metastatic Melanoma: An Overview

For patients

- Cancer Council – What to Expect: Melanoma
- Cancer.net – Side Effects of Radiation Therapy
- Melanoma Research Foundation – Just Diagnosed with Melanoma... Now What?

Sources

References

1. Vora NL, Vaux KK. Medscape. [place unknown]: Medscape; Melanoma and BRAF. 2016. [cited 2017 Feb 15].
2. American Cancer Society. [place unknown]: American Cancer Society; Targeted therapy for melanoma skin cancer. 2016. [cited 2017 Feb 15].
3. Millen AE, Tucker MA, Hartge P, Halpern A, Elder DE, Guerry IV D, et al. Diet and melanoma in a case-control study. Cancer Epidemiology Biomarkers and Prevention. 2004 Jun;13(6).
4. NCERG. Optimal cancer care pathway for people with melanoma. Victoria: Cancer Council Victoria; 2007.

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