Optimal cancer care pathway for people with melanoma

Quick reference guide

Step 1
Prevention and early detection

Prevention: Solar radiation is the major environmental cause of melanoma. People should be encouraged to use a combination of sun protection measures during the sun protection times.

Risk factors include:
- a personal history of 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
- fair or red hair colour

Step 2
Presentation, initial investigations and referral

Signs and symptoms:
- any changing skin lesions
- a rapidly growing skin lesion
- a change in one or more of the ABCDE criteria (asymmetry, border irregularity, colour variation, large diameter (> 6 mm), evolution)

Note: A minority of cases present as a symmetric nodule (EFG: elevated, firm and growing progressively for more than one month).

General/primary practitioner investigations:
A baseline photograph and/or measurement of the lesion should be taken before a period of observation for lesions with a low level of suspicion.

Where melanoma is highly suspected, referral to a dermatologist or surgeon, or excisional biopsy (by a general practitioner, dermatologist, or surgeon) is appropriate.

Referral: The following lesions should be referred to a specialist within two weeks:
- high-risk melanoma (deeply invasive)
- metastatic melanoma
- lesions with histologic uncertainty
- incompletely excised lesions.

Step 3
Diagnosis, staging and treatment planning

Diagnosis: The majority of diagnoses occur in the primary care setting.
Specialist management may include complete excision (in rare instances where a partial biopsy was performed pre-referral) or re-excision with recommended margins, and imaging.

Staging: Sentinel lymph node biopsy (SLNB) can be offered to assess lymph node metastases. If metastatic melanoma is detected, a complete regional lymphadenectomy (LND) can be performed.

Treatment planning: Selected patients with advanced stage melanoma, lymph node involvement or melanoma in unusual sites are best managed by multidisciplinary teams (MDTs) in a specialist facility.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:
- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

Communication – lead clinician to:
- discuss a timeframe for treatment with the patient/carer
- explain the role of the MDT in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

1 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.

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Cancer survivors should be provided with the following to guide care after initial treatment.

**Treatment summary**
- Outline diagnostic tests performed and results
- Tumour characteristics
- Type and date of treatment(s)
- Interventions and treatment plans from other health professionals
- Supportive care services provided
- Contact information for key care providers.

**Follow-up care plan**
- Outline for medical follow-up required (tests, ongoing surveillance)
- Care plans for managing the late effects of treatment
- A process for rapid re-entry to medical services for suspected recurrence.

**Communication – lead clinician to:**
- Discuss treatment options with the patient/carer including the intent of treatment as well as risks and benefits
- Discuss advance care planning with the patient/carer where appropriate
- Discuss the treatment plan with the patient's general practitioner.


**Step 4**

**Treatment:**
- Establish intent of treatment:
  - Curative
  - Anti-cancer therapy to improve quality of life and/or longevitiy without expectation of cure
  - Symptom palliation.

**Dermatological assessment:**
To assess the risk of further melanomas, surveillance planning and to detect synchronous primaries.

**Surgery**: With direct primary closure can be undertaken in a primary care setting for excision biopsy and selected re-excision. Surgery for all other excisions, SLNB and regional LND should be undertaken by a surgeon.

**Radiation treatment** may be of benefit to patients with specific types of primary melanoma or with loco-regional and distant metastatic disease.

**Chemotherapy and immunotherapy**: Should be considered for all patients with advanced melanoma given their potential for long-term improvement in patient outcome (Olszanski 2014).

**Palliative care**: Early referral can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

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

**Communication – lead clinician to:**
- Explain the treatment summary and follow-up care plan to the patient/carer
- Inform the patient/carer about secondary prevention and healthy living
- Discuss the follow-up care plan with the general practitioner.

**Step 5**

**Care after initial treatment and recovery**
Cancer survivors should be provided with the following to guide care after initial treatment.

**Treatment summary** (provide a copy to the patient/carer and general practitioner) outlining:
- Diagnostic tests performed and results
- Tumour characteristics
- Type and date of treatment(s)
- Interventions and treatment plans from other health professionals
- Supportive care services provided
- Contact information for key care providers.

**Follow-up care plan** (provide a copy to the patient/carer and general practitioner) outlining:
- Medical follow-up required (tests, ongoing surveillance)
- Care plans for managing the late effects of treatment
- A process for rapid re-entry to medical services for suspected recurrence.

**Communication – lead clinician to:**
- Explain the treatment summary and follow-up care plan to the patient/carer
- Inform the patient/carer about secondary prevention and healthy living
- Discuss the follow-up care plan with the general practitioner.

**Step 6**

**Managing recurrent, residual and metastatic disease**
Detection: Patients should be made aware that self-examination is essential for any new or changing skin lesion, cutaneous lump or persistent new symptom.

Treatment: Where possible, refer the patient to the original MDT. Treatment will depend on the location and extent of disease, previous management and the patient’s preferences.

**Palliative care**: Early referral can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

**Communication – lead clinician to:**
- Explain the treatment intent, likely outcomes and side effects to the patient/carer.

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

**Communication – lead clinician to:**
- Be open about the prognosis and discuss palliative care options with the patient/carer
- Establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

**Step 7**

**End-of-life care**
**Palliative care**: Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

**Communication – lead clinician to:**
- Be open about the prognosis and discuss palliative care options with the patient/carer
- Establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.


This work is available at: [www.cancer.org.au/ocp](http://www.cancer.org.au/ocp)