Optimal cancer care pathway for people with melanoma

Quick reference guide

Please note that not all patients will follow every step of this pathway:

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

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
- poor tanning ability
- tendency to sunburn
- multiple solar keratoses.

Management of increased risk includes:

- 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.

Early detection:

Opportunistic identification of high-risk patients with total body cutaneous examination should be practised.

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.

Communication – lead clinician to:[1]

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

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:

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

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity 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 (Olszanzki 2014).

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:

- 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.

For detailed information see http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/cp111.pdf.

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.

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.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.