### Optimal cancer care pathway for people with melanoma

**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
- **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)
- **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.

**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.

**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.

**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.

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

**Treatment summary**
- 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**
- 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.

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

**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).

**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.

**Radiation treatment** for 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.

**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.


This work is available at: www.cancer.org.au/ocp