Melanoma Treatment Guidelines 2021

Diagnosis

Biopsy for suspicious pigmented skin lesion

Evidence based recommendations

- The optimal biopsy approach for a suspicious pigmented lesion is complete excision with a 2mm peripheral clinical margin, and deep into the upper subcutis.
- Partial biopsies are not fully representative of the lesion and need to be interpreted with caution, and in light of the clinical findings, to minimise incorrect false negative diagnoses and under-staging.
- In carefully selected clinical circumstances (such as large, flat lesions, large facial or acral lesions or where the suspicion of melanoma is low) and in the hands of experienced clinicians, partial incisional, punch or shave biopsies may be appropriate.

Practice points

- It is advisable to discuss unexpected pathology results with the reporting pathologist.
- Punch biopsy should not be utilised for the routine diagnosis of suspected melanoma because this technique is associated with high rates of histopathological incorrect false negative diagnosis.
- Where a punch biopsy has been used for the diagnosis of a suspected BCC or SCC, and the diagnosis has been found to be melanocytic, then consideration should be given to excision of the entire lesion.
- The use of deep shave excision (saucerisation) should be limited to flat lesions to preserve prognostic features and optimise accurate planning of therapy.
- Consider sending a photograph of the lesion, taken before biopsy, to the pathologist with the request form, as this may assist definitive diagnosis. Also, consider using 'tissue marking ink' with a 25G needle to highlight suspicious parts of the excision biopsy, to direct the pathologist's attention.

Staging and treatment

The process of staging most melanomas that are diagnosed in primary care is simple and straightforward, as the large majority of such lesions are either in situ melanoma or thin invasive melanoma.

Please refer to the melanoma staging table and flow chart.

Melanoma in situ (MIS)

MIS is Stage 0 and does not need sentinel lymph node biopsy (SLNB).

MIS can be managed in primary care with wide local excision of 5-10mm margins (depending on location, but with a preference for 10mm).

Invasive melanoma

If the **Breslow thickness is <1mm with no ulceration and no mitoses**, there is no need to consider SLNB and wide local excision can proceed in primary care, with 10mm margin.

If the **Breslow thickness is >1mm or is >0.8mm with ulceration or mitoses**, SLNB discussion is necessary.

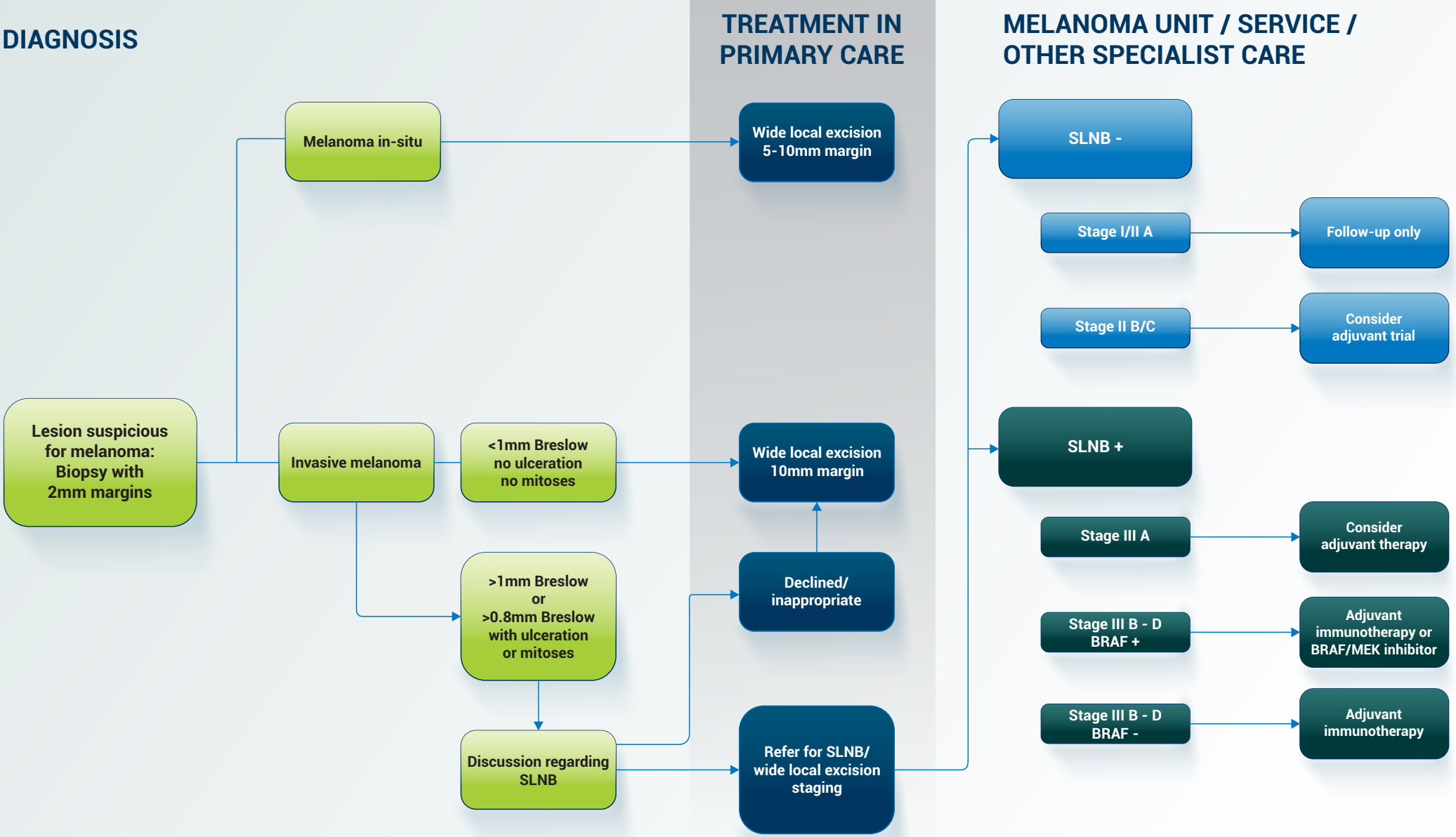
SLNB provides useful prognostic information and (very importantly) provides an access point to adjuvant therapy: all patients with positive SLNB are considered for adjuvant therapy.

If SLNB is declined or considered inappropriate (for example, very elderly or significant comorbidity, etc), wide local excision may proceed.

In most other cases, referral for SLNB and wide local excision is appropriate, and will be followed by adjuvant therapy.

Stage 1 and Stage 2 are **invasive melanomas** but with negative sentinel lymph node biopsy (SLNB). Further differentiation within Stage 1 and Stage 2 is based on both thickness and presence or absence of ulceration.

Stage 3 and Stage 4 invasive melanomas refer to SLNB positive and more distant metastases, and such staging requires hospital evaluation.



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HealthCert EDUCATION

MELANOMA STAGING		
Stage	**Classification**	**5-year survival**
Stage 0	Tis: Melanoma in situ	>98%
Stage I (A/B)	T1a: <0.8 mm and nonulcerated	97–92%
	T1b: ≥0.8 mm or <0.8 mm with ulceration	
	T2a: >1.0–2.0 mm without ulceration	
Stage II (A, B, C)	T2b: >1.0–2.0 mm with ulceration	81–53%
	T3a: >2.0–4.0 mm without ulceration	
	T3b: >2.0–4.0 mm with ulceration	
	T4a: >4.0 mm without ulceration	
	T4b: >4.0 mm with ulceration	
Stage III (A, B, C, D)	N1a: 1 clinically occult (in SLN biopsy)	78–40%
	N1b: 1 clinically detected	
	N1c: presence of in-transit, satellite, and/or microsatellite mets	
	N2a: 2–3 clinically occult (in SLN biopsy)	
	N2b: 2–3, at least 1 clinically detected	
	N2c: 1 clinically occult or detected, with in-transit, satellite, and/or microsatellite mets	
	N3a: 4 or more clinically occult (in SLN biopsy)	
	N3b: 4 or more, at least 1 of which clinically detected, or presence of any number of matted nodes	
	N3c: 2 or more clinically occult or clinically detected with in-transit, satellite, and/or microsatellite mets	
Stage IV	Distant metastasis: location and LDH levels define sub-stage	20–15%

Adapted from Gershenwald JE et al. AJCC cancer staging manual. 8th ed. Amin MB, editors. Chicago, IL: American Joint Committee on Cancer; 2017. p. 563.