

# Melanoma

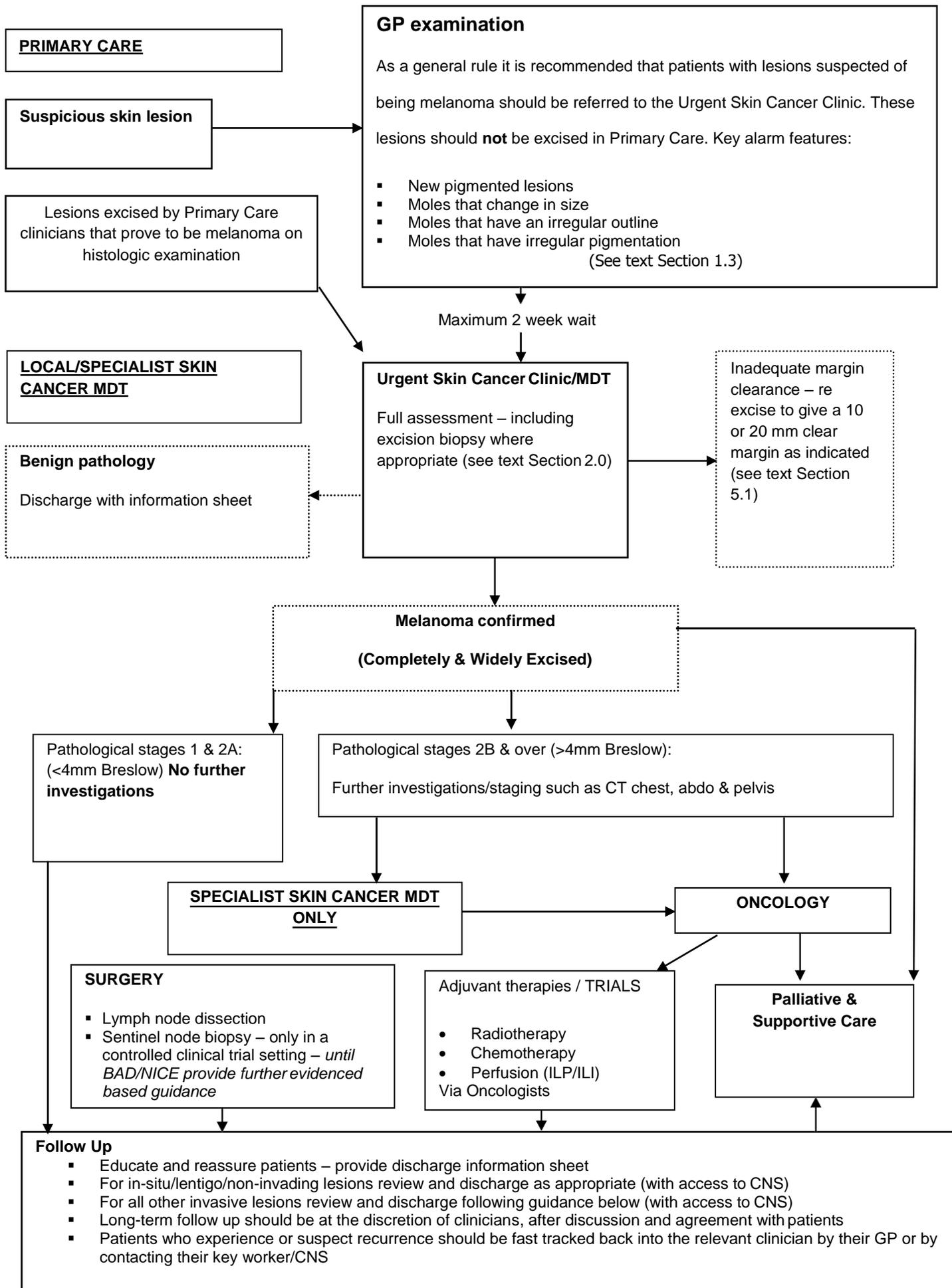
## Pathway of Care

Publication date	December 2014
Expected review date	September 2016
Version number	4.0
Version status	Final

## Contents

<b>1.0</b>	<b>Pathway Overview</b>	<b>3</b>
<b>2.0</b>	<b>Process and Terminology</b>	<b>4</b>
2.1	Scope	4
2.2	Tumours	4
2.3	Referral Guidelines and Processes	4
<b>3.0</b>	<b>Local/Specialist Skin MDTs</b>	<b>5</b>
<b>4.0</b>	<b>Cellular Pathology</b>	<b>5</b>
<b>5.0</b>	<b>Multi-Disciplinary Meeting (MDM)</b>	<b>6</b>
5.1	Data	6
<b>6.0</b>	<b>Treatment</b>	<b>7</b>
6.1	Definitive Treatment of Primary Lesion	7
<b>7.0</b>	<b>Specialist Skin Cancer MDTs</b>	<b>8</b>
7.1	Adjuvant Treatment	8
7.2	Nodal and Metastatic Disease	8
7.3	Staging Investigations	8
7.4	Sentinel Node Biopsy (SNB)	9
<b>8.0</b>	<b>Children and Young People</b>	<b>9</b>
<b>9.0</b>	<b>Oncology Provision</b>	<b>9</b>
<b>10.0</b>	<b>Supportive and Palliative Care</b>	<b>9</b>
<b>11.0</b>	<b>Follow Up</b>	<b>10</b>
<b>12.0</b>	<b>Personnel and Contact Information</b>	<b>11</b>
<b>13.0</b>	<b>Glossary</b>	<b>12</b>
<b>14.0</b>	<b>Document Administration</b>	<b>13</b>

# 1.0 Pathway Overview



## 2.0 Process and Terminology

---

### 2.1 Scope

---

This document sets out the pathway of care for patients with suspected/proven melanoma. It has been updated to ensure compliance with the 2006 NICE Improving Outcomes Guidance (IOG) for people with Skin Tumours including Melanoma (IOG), and the Peer Review Measures (2010). The IOG expects Kent & Medway to provide three levels of care for patients with skin cancer.

These are:-

1. Primary Care
2. Local hospital skin cancer MDT (LSMDT)
3. Specialist skin cancer MDT (SSMDT)

Based on the population of Kent and Medway, the Skin Cancer Tumour Site Specific Group (TSSG) is proposing that there are two skin cancer MDTs in Kent and Medway that function at both Local and Specialist level, working to one set of protocols and policies agreed by the Kent & Medway Cancer Collaborative (KMCC) Skin Cancer TSSG and its sub groups.

This document describes the process/care available at each level and is compliant with the 2006 IOG and the Peer Review Measures (2010).

### 2.2 Tumours

---

The scope of the pathway of care is confined to:-

Malignant melanoma.

### 2.3 Referral Guidelines and Processes

---

General practitioners are encouraged to refer patients with a suspected melanoma as a matter of urgency.

Patients with suspected melanoma should be referred under National cancer 2-Week Wait rules (2-WW).

The seven-point checklist of key features that should prompt and urgent referral are:-

- A mole that changes in size (increase and decrease)
- A mole that has an irregular outline
- A mole that has irregular pigmentation

Other minor features that may be suspicious are:-

- A mole 7 mm or more in diameter
- A mole that is inflamed
- A mole with any type of oozing
- A mole with changing sensation

*(MacKie RM. Malignant Melanoma: a Guide to Early Diagnosis, 1994)*

It is suggested that a combination of at least 3 out of the 4 minor features must be present in order to prompt an urgent referral. In practice, any clinically suspicious lesions or where uncertainty exists should be referred.

Patients with suspicious lesions that fulfil the above criteria should be referred directly to the Urgent Skin Cancer Clinic under the 2-WW rule.

**The melanoma sub-group recommended that lesions thought to be melanoma should not be biopsied in Primary Care.**

Lesions biopsied in Primary Care that prove to be melanomas should be referred urgently under the 2-WW rule. A copy of the histology report should either be faxed with the referral or accompany the patient to the clinic appointment. If a photograph of the pre-biopsied lesion was taken, a copy should accompany the patient if possible. These patients will be discussed at the multi-disciplinary meeting (MD) in the first instance.

### **3.0 Local/Specialist Skin MDTs**

---

Patients should be seen within 2 weeks of referral in a dedicated rapid access skin cancer clinic. Patients should be seen by a designated MDT member.

Patients will:-

- Undergo a thorough skin examination including assessment of loco-regional lymph node status where appropriate.
- Be reassured if the lesion is clinically benign.
- Have the lesion photographed if indicated.
- Have a biopsy taken or be booked for biopsy/removal as indicated.

Diagnostic biopsy – full thickness excision biopsy ensuring a 2-5 mm clinical margin of normal skin with a cuff of sub-dermal fat is recommended. Incisional/punch biopsy or curette/shave biopsy might be appropriate in certain circumstances.

The visit will be fully documented using the agreed pro-forma. The patient will receive appropriate information.

### **4.0 Cellular Pathology**

---

**It is expected that pathology departments will adhere to guidelines on specimen handling described in the Royal College of Pathology Minimum Data Set for Skin Cancer (RCP MDS).**

All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC website:-  
<http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/pathology-group/>

In order to comply with the DoH 31 day (referral to diagnosis) target, histology departments are obliged to report on pigmented lesions within 2 weeks of biopsies taken at Urgent Skin Cancer Clinics.

The Skin Cancer TSSG will jointly monitor adherence to both the guidelines set out in the RCP MDS and the 31 day target through the process of regular audit.

## 5.0 Multi-Disciplinary Meeting (MDM)

---

All patients should be discussed at multi-disciplinary meetings (MDMs).

The MDT will comply with NICE Guidelines with regard to composition and function.

These meetings will normally be held weekly.

Patients may be discussed at more than one MDM as they progress along their pathway of care.

The Skin Cancer MDT Co-ordinator will ensure that:-

- All new cases of melanoma are discussed at MDM.
- MDT decisions are communicated to GP urgently following the MDM.
- Data items described by the urgent skin cancer clinic pro-forma and RCP skin cancer pro-forma are accurately recorded.
- All patients are appropriately staged.
- MDM information is forwarded to the National Cancer Registration Service (NCRS).
- A documented initial or revised plan of care will be made at MDMs.
- The care plan will be filed in the patients notes.
- Cancer targets will be monitored and adhered to.

## 5.1 Data

---

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

Details of the Cancer Waiting Times dataset are available from:

<http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation>

Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the "Core" section of the dataset, and any additional tumour site specific sections, as applicable.

Details of the COSD are available from:

[http://www.ncin.org.uk/collecting\\_and\\_using\\_data/data\\_collection/cosd.aspx](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx)

Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by National Cancer Registration Service (NCRS).

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

Details of these datasets are available from: <http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer>

Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the DOG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, SACT, diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

## **6.0 Treatment**

---

### **6.1 Definitive Treatment of Primary Lesion**

---

Until there is proven benefit to the contrary, all melanomas will be excised with a minimum 10mm margin.

- Lentigo Maligna (LM) and other in-situ melanomas have virtually no potential for metastatic spread and therefore lesions with clear histological margins require no further treatment. Clinical margins for excision of LM are recommended as 5mm.
- Melanocytic lesions of unknown malignant potential (Melumps) will be managed as potential melanomas, but may require full surgical revision margins.

For all other melanomas:-

- 10 mm margins will be taken for lesions  $\leq$  1mm Breslow depth.
- 20 mm margins will be taken for lesions  $>$  1mm Breslow depth within cosmetic/functional considerations.
- $>$ 20 mm margins have no current proven benefit and are not recommended.

The Skin Cancer TSSG will review this recommendation as evidence becomes available.

## **7.0 Specialist Skin Cancer MDTs**

---

### **7.1 Adjuvant Treatment**

---

**Oncologists will act as “gate-keepers” for adjuvant chemotherapy.**

The Skin Cancer TSSG will only support adjuvant therapies undertaken in the context of current controlled clinical trials. Chemotherapy and limb perfusion both fall into this category.

Such treatments will only be undertaken in the context of Specialist Skin Cancer MDTs.

### **7.2 Nodal and Metastatic Disease**

---

Patients with nodal disease should undergo core biopsy prior to carrying out formal block dissection.

Axilla or groin block dissection will only be undertaken by the designated surgeon(s), who is a core MDT member.

Neck dissections will only be undertaken by designated surgeon(s), who is a core member of the Head & Neck MDT.

Radio and chemotherapy will only be given according to Kent Oncology Centre Guidelines.

### **7.3 Staging Investigations**

---

Guidelines for staging investigations are defined in KMCC Imaging Guidance. Staging scans are indicated in the following situations:

- When surgical and/or therapeutic options are being considered
- Upon clinical suspicion of relapse
- For follow up of patients with high risk melanoma defined as AJCC Stage IIB or above (see section 11.0)

(Please refer to the KMCC Imaging Guidance for further information).

**Note:** *Guidance documentation is located on the KMCC website:*

<http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/diagnostics-group/>

## 7.4 Sentinel Node Biopsy (SNB)

---

Until there is National consensus on the value of SNB in patients with melanoma, the Skin Cancer TSSG will only be able to support its continued use as:-

1. A prognostic tool in a defined sub-set of patients
2. As part of on-going data collection or research

Clinicians who undertake SNB should be core members of the Specialist Skin Cancer MDT.

The Skin Cancer TSSG will review this recommendation as evidence becomes available.

## 8.0 Children and Young People

---

Children and Young People (CYP) with Cutaneous Lymphomas will be treated in accordance with principles set out in the CPY IOG.

All children and Young People up to the age of 18 must be referred to the CYP Principle Treatment Centre, which for Kent & Medway is based in the Royal Marsden Hospital.

All Young People between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre.

Referral to a CYP Principle Treatment Centre does not necessarily mean that treatment will be undertaken at that centre shared care management protocols may allow some treatments to be undertaken locally.

## 9.0 Oncology Provision

---

The Non-Surgical Oncological management of all patients with malignant melanoma as defined by the Non-Surgical Oncology Sub Group (NOG) of the Skin Cancer TSSG is set out in the document “**The Oncological Treatment of Skin Cancer**”.

**Note:** This is located on the KMCC website:

<http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/dermatology-tssg/>

## 10.0 Supportive and Palliative Care

---

All patients with melanoma will have access to appropriate specialist palliative care and support at every stage of the patient journey.

Open and frank discussions with patients should take place at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them.

Relatives and carers will need to be supported and given information. However, in accordance with the recommendations set out in other Improving Outcomes Guidance, relatives and carers should not be given information different to that given to the patient.

Frail and terminally ill patients with melanoma should always be discussed with the specialist palliative care team.

Palliative care provision should be available for all patients who require it:-

- Hospital teams, including the Clinical Nurse Specialist for cancer patients.
- Primary Health Care Team to provide palliative care at home.
- General Practitioner should be informed within 24 hours of the diagnosis and treatment plan.

The management of symptoms, psychological, social and spiritual issues, the communication of the diagnosis and any associated problems, should be within the domain of all healthcare professionals.

Referral to specialist palliative care services should be considered when these issues have not been resolved and in particular for patients with:-

- Complex symptom management issues.
- Difficulties in adjusting to the diagnosis or disease progression.
- Psychological and family issues – such as communication problems within the family.
- Spiritual issues – such as challenging of belief system/faith/cultural values as a result of the cancer.

Consideration of specialist palliative care or support should be given throughout the patient pathway, particularly:-

- At the MDT discussion.
- When no active treatment is considered.
- After active treatment.
- At time of relapse.
- In the terminal stages of the disease.

## **11.0 Follow Up**

---

BAD guidelines exist for follow up of patients diagnosed with melanoma. *Roberts DLL et al. UK Guidelines for the management of cutaneous melanoma. BJ Dermatol 2002; 146: 7-17*

- The key purpose of follow up is patient education.
- There is good evidence that educated patients detect their own recurrence.
- Patients who do detect recurrence should be fast tracked back to the MDT.
- Patients will have access to a clinical nurse specialist for support and advice.
- Patients will have access to appropriate information and should always be given relevant “discharge” information.

Patients with in-situ/lentigo/non-invasive melanomas should be reviewed following complete excision of the primary lesion for education and advice. Routine long term follow up of these patients is not required.

In response to the 2013 Position Paper ‘Follow up of High Risk Cutaneous Melanoma in the UK’ and recent advances in the therapeutic options for patients with metastatic melanoma, the MDT recommends close clinical and radiological follow up of patients with high risk melanoma, which we define as AJCC stage IIB and above.

## Clinical Follow Up

Years 1-3 3 monthly

Years 4-5 6 monthly

Years 6-10 monthly

## Imaging

CT head/chest/abdomen/pelvis +/- neck depending on location of primary tumour

MRI head in selected cases for further investigation of abnormalities seen on CT and/or to confirm presence of solitary cerebral metastasis prior to seeking a neurosurgical opinion regarding resection

PET/CT scan in selected cases

## Frequency

Baseline

Years 1-3 6 monthly

Years 4-5 Annually

The core sub-group will review this pathway of care annually or when new evidence becomes available, whichever is soonest.

The Skin Cancer TSSG will audit adherence to this pathway of care.

## **12.0 Personnel and Contact Information**

---

A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: <http://kmcc.nhs.uk/tumour-sites/terms-of-reference/>

## 13.0 Glossary

---

Acronyms in common use throughout KMCC documentation:-

CNB	Cancer Network Board
CYP	Children and Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospital University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent and Canterbury Hospital, Canterbury (EKHUFT)
KCH	Kings College Hospital
KMCC	Kent & Medway Cancer Collaborative
KMCN	Kent and Medway Cancer Network
KMCRN	Kent and Medway Cancer Research Network
LSESN	London and South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone and Tunbridge Wells NHS Trust
NOG	Non- Surgical Oncology Group ( <i>Permanent oncologist sub group of the TSSGs with specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs</i> ).
PoC	Pathway of Care ( <i>KMCC agreed disease site specific clinical guidelines</i> )
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of Life
RAT	Research and Trials Group ( <i>Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda</i> ).
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
QVH	Queen Victoria Foundation Trust Hospital, East Grinstead
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

## 14.0 Document Administration

<b>Document Title</b>	Melanoma Pathway of Care
<b>Principle author</b>	Ashley Cooper
<b>Co-author(s)</b>	Caroline Tsatsaklas/Ian Vousden
<b>Current version number</b>	4.0
<b>Current status</b>	Final
<b>Agreed as “fit for publication” by</b>	December 2014
<b>Original publication date</b>	January 2008
<b>Expected review date</b>	November 2016

<b>Enquiries:</b>		
<b>1] Jess Jenkins</b>	01622 225103	jessicajenkins@nhs.net
<b>2] Nick Rowell</b>	01622 225 103	nrowell@nhs.net
<b>3] Natalie Aluwalia</b>	01634 33 5127	Natalie.aluwalia@nhs.net

<b>Revision History</b>			
<b>Date of Revision</b>	<b>New Version Number</b>	<b>Nature of Revision</b>	<b>Confirmation of Accuracy by</b>
Jan 2008	0.1	Draft - development	K.Ayerst
April 2008	1.0	Published - agreed	Skin DOG
Feb 2009	2.0	Published – reviewed & agreed	Skin DOG
22/12/2011	2.1	Put into new format	C.Tsatsaklas
15/02/2012	2.2	A.Cooper final version and contact details updated	A.Cooper
June 2012	2.3	Draft – updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	J.Bullass/C.Tsatsaklas
September 2012	3.0	FINAL – approved by Skin DOG 13/09/12 – agreed/published	Skin DOG/I.Vousden / A.Cooper
August 2014	3.1	Draft - Removed text relating to DOGs, PCTs, KMCN – replaced with TSSGs, CCGs, Cancer Team, updated weblinks etc	C.Tsatsaklas
November 2014	3.2	Amendments to sections 7.2/7.3 and 11 as directed by J.Jenkins	N.Aluwalia/ J.Jenkins
December 2014	4.0	Published – ratified by O&Q Group	N.Aluwalia