

## **New Zealand Guidelines on the General Management of Malignant Melanoma (2004)**

### **Discussion Document for Those Caring for Patients with Melanoma**

These guidelines were developed in 1993 following a multi-disciplinary consensus conference held at Waikato Hospital, Hamilton. The guidelines were updated following wide consultation with stake holders in 2003. These guidelines do not necessarily represent current management by all practitioners.

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Amelanotic  
melanoma



Nodular  
melanoma



Superficial spreading  
melanoma

### **Initial diagnosis**

If a pigmented lesion is thought to be a malignant melanoma or there is a high index of suspicion the lesion should either be removed by the general practitioner if he/she feels they are technically competent to do so or the patient should be referred to an appropriate specialist (eg. Dermatologist, Plastic Surgeon, General Surgeon, etc).

The ABCD criteria (**A**symmetry, **B**order, **C**olour, **D**iameter) is a useful guide to the clinical diagnosis of superficial spreading melanoma but may miss high-risk nodular melanoma (may be symmetrical and a single colour) or amelanotic melanoma (a red nodule).

Dermoscopy by a trained and experienced observer increases the accuracy of clinical diagnosis of melanoma but is not 100% reliable.

Biopsy of a suspected melanoma is not generally advised because of the risk of sampling error; multiple biopsies, however, may be of some benefit in the management of larger suspect lesions, particularly on the face.

### **Symptoms at first diagnosis**

<b>Symptoms</b>	<b>Percent of cases</b>
Change in size	30.4%
Change in colour	25.7%
Change in elevation	14.7%
Bleeding	9%
Itching	4.2%
Unspecified symptoms	7.5%
One or more symptoms	50.2%

### **Initial treatment**

Excision biopsy is the only recommended initial treatment for melanoma. Excise with a visual clear margin of 2-5 mm. Do not undermine the edge.

If you feel that primary closure will not be possible, consider referring the patient to a plastic surgeon, dermatologist or general surgeon. Curettage and diathermy is not acceptable.

All lesions removed from the skin must be examined by a histopathologist: it is negligent not to do so.

### **Histopathology reporting**

Every specimen must be sent for examination. The pathologist's report will include the following details:

- macroscopic description of lesion
- diagnosis
- depth of invasion in millimeters (Breslow thickness)
- width of margins (lateral and deep)

The following may also be included in the report: ulceration, regression, satellitosis, lymphatic invasion, radial versus vertical growth phase.

It is a legal requirement to report cases to the New Zealand National Cancer Registry.

## Age of presentation of melanoma

Age	Number of melanomas
<10 years	Very rare
10 to 19 years	0.8%
20 to 39 years	20.7%
40 to 59 years	31.9%
60 to 79 years	38.0%
>80 years	7.6%

## Definitive treatment

Definitive treatment for melanoma is determined by the depth of the lesion. A working guide to adequate treatment is a margin of 1 cm for every 1 mm depth of invasion, but anatomical site may influence this.

**Melanoma in situ or < 0.7 mm:** the initial excision may be sufficient but it is recommended that the patient be referred to a dermatologist, plastic surgeon or specialist with a particular interest, for review (patients should be seen within 3 weeks of referral if possible).

**Melanoma 0.7-1.4 mm:** if excision margin less than 0.5 cm, a re-excision of the wound with a 1 cm margin and direct closure is currently recommended. This should be down to deep fat but should not routinely include fascia. This re-excision is probably best performed by a dermatologist, plastic surgeon or surgeon with a particular interest, and should be done within 6 weeks of the initial excision if possible.

**Melanoma >1.4 mm:** if excision margin less than 1 cm, a re-excision of the wound with up to a 3 cm margin and direct closure if possible is recommended. Again this should be down to deep fat but should not routinely include fascia. A skin graft may be necessary in some areas of the body. This re-excision is best performed by a dermatologist, plastic surgeon or surgeon with a particular interest, and should be done within 6 weeks of the initial excision if possible.

**Lymph nodes:** unless clinically indicated, there is no evidence that routine regional lymph node dissection is of value. Sentinel lymph node biopsy (surgical removal of the closest draining lymph gland) is of prognostic value, particularly for melanomas >1.0 mm Breslow thickness. However, sentinel lymph node biopsy does not currently offer any survival advantage.

Definitive management of subungual melanomas, melanomas on digits and on the face is best determined on an individual basis. It is recommended that these patients be referred to a dermatologist, plastic surgeon or surgeon with a particular interest in melanoma.

Advanced melanoma with secondaries is best dealt with by a combined oncology / plastic surgery / dermatology clinic.

### Prognosis of melanoma

Depth of invasion	10 year survival rate
in situ	100%
<0.85 mm	95.7%
0.85-1.69 mm	87.1%
1.70-3.59 mm	66.5%
>3.60 mm	46.0%

### Follow-up

It is unclear as to how long patients with melanoma should be followed up and even what the value of follow-up is. The current recommendation is that the operating surgeon should follow the patient for the first 12 months and there after by a specialist/general practitioner as appropriate:

Patients that have had more than one primary melanoma or have multiple atypical naevi (funny moles), especially if there is a strong family history of melanoma, may be advised to have follow-up examinations by a specialist for life.

Depth	Follow-up intervals	Length of time
in situ	3/12	1 year
<1.4 mm	3/12 then 6/12	18 mths to the 3rd anniversary
>1.4 mm	3/12 then 6/12	18 mths to the 5th anniversary

## **What should be done at follow-up**

### **Examine:**

- For local recurrence.
- For satellite lesions (between primary site and regional lymph nodes).
- All regional lymph nodes.
- Rest of skin for new primary melanomas (occurs in 8%). Use dermoscopy if you are trained and experienced in its use.

### **Advice:**

- Sun protection advice.
- Encourage regular self examination of the skin (1 to 3 monthly). The patient should report to their medical practitioner if they are concerned especially if melanocytic naevi have grown or changed, or if new skin lesions develop. Patients who have had a melanoma have an increased risk of non-melanocytic skin cancer.

### **Routine investigations:**

- None unless clinically indicated. (eg. X-ray, blood tests). There is no current evidence that staging examinations or scanning provides any survival advantage.

## **Who should follow up the patient**

All patients should probably be seen at least once by a specialist with an interest in melanoma (e.g. dermatologist, plastic surgeon or general surgeon).

**Melanoma in situ:** after initial review by specialist, follow-up should be by the general practitioner if he/she is happy to do so using set protocols.

**Melanoma <1.4 mm:** after definitive treatment, follow-up may be by either a specialist, with an interest in melanoma, or the patient's usual general practitioner, if they wish to be involved, or both (eg. alternate visits).

**Melanoma >1.4 mm:** after definitive treatment, the specialist may enquire from the GP if they wish to be involved in shared care (eg. alternate visits) or take over the longer term follow-up.

## Examination of 1st degree relatives

Following the diagnosis of melanoma, first-degree relatives of the patient should be encouraged to have their skin examined for atypical naevi and melanoma. These relatives should be counselled about melanoma and sun protection. How frequently these patients should be reviewed is unclear and depends on risk factors (see guidelines on the management of atypical naevi). Patients should be encouraged to perform monthly self-examinations.

## Atypical (funny) naevi

Early diagnosis of melanoma in this high-risk group is possible. A degree of risk evaluation can be made using the following table:

Risk group	Presence of atypical moles	Family history of atypical moles	Personal history of melanoma	Family history of melanoma
A	+			
B	+	+		
C	+	+	+	
D	+	+	+	+

## Risk group Action

- A. Counsel patient regarding sun protection; they should be encouraged to perform regular self-examination of the skin (e.g. 1 to 3 monthly).
- B. Counsel patient regarding sun protection; they should be encouraged to perform regular self-examination of the skin (e.g. 1 to 3 monthly). Opportunistic skin checks by the general practitioner (i.e. when visiting general practitioner for other reasons).
- C. Should be seen at a specialist clinic to have baseline colour photographs taken. Whole body and close-up photographs may enable early detection of change in existing naevi, especially where dermoscopic views of individual lesions are evaluated by a trained specialist.  
Possible review in 3-6 months by specialist but then opportunistic skin checks by the general practitioner (i.e. when visiting general practitioner for other reasons). Low threshold for referral to a specialist/removal of suspicious lesions is recommended.

D. Should be followed up in a specialist clinic every 3 to 12 months with baseline colour photographs for an undetermined period of time (50% likelihood of developing further melanoma). Opportunistic skin checks by the general practitioner (i.e. when visiting general practitioner for other reasons). Low threshold for referral to a specialist/removal of suspicious lesions is recommended.

### **References/internet links**

- [NIWA Lauder](#) Discussion of ultraviolet and ozone levels in NZ.
- [2002 U.K. guidelines](#) on the management of melanoma
- [2002 American Cancer Society Guidelines](#) on the management of melanoma
- [1999 Australian National Health and Medical Research Council guidelines](#) for the management of cutaneous melanoma.

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