Algorithm for the Management of Melanoma Stage IB-III

Stage IBII or III lesion confirmed
- Patients with unresectable stage III cutaneous melanoma should follow the same treatment guidelines as unresectable stage IV cutaneous melanoma

Preliminary workup
- History and physical exam
- Complete exam of skin and nodal basin
- Document family history of melanoma
- Imaging as required to evaluate specific signs/symptoms +/- CXR tumours ≥4 mm, FNA or LN biopsy (if clinically positive nodes) LDH (optional)

Referral
- Referral to cancer centre is strongly encouraged for all patients with lesions 1 mm in thickness or greater, Clark IV or V or if ulcerated

No evidence of lymph node metastases
- Excision
  - <1.0 or 2.0 mm; 1-2 cm margin
  - 2.0-4.0 mm; 1-2 cm margin
  - >4.0 mm; 2 cm margin
  - (minimal margin distal extremities & face)

Suspicious lymph nodes
- FNA Biopsy with Imaging (as needed)

Biopsy positive?
- Positive
  - Sentinel lymph node biopsy (SNLB) - Document pathology
  - Lymph node dissection (axillary, superficial parotidectomy, inguinal, etc.)
  - ≤3 positive nodes; no EC invasion
  - >4 positive nodes; EC invasion; head & neck tumour

Follow-up and Surveillance
- History and physical examination, with emphasis on nodes and skin at least every 6 months (every 3-6 months for proven nodal metastases) for years 1-3, then every 4-12 months for years 4-5, then annually as clinically indicated
- At least annual skin examination for life by dermatologist
- Educate patient on monthly skin exam, lymph node exam, and signs of locoregional recurrence
- Patient may be seen in cancer clinic and then discharged to referring physician
- CT scan for specific signs or symptoms; additional tests as indicated

* H&P: attention to locoregional area and draining lymph nodes

Referral Letter
- Pathology reports, previous reports of skin lesions, operative reports, laboratory reports, information regarding other malignancies, imaging reports (e.g. chest x-ray)

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Accompanies Cutaneous Clinical Practice Guidelines

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