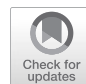

1 Management of Cutaneous Melanoma

Julie A. DiSano and Colette R. Pameijer

Algorithmic Approach

A. The history and physical examination should include risk factors for melanoma and family history. The lesion should be evaluated by the ABCDE criteria: A, asymmetry; B, borders; C, color; D, diameter; E, evolution. If the lesion meets any one of these criteria, it should be biopsied.

B. Key pathologic criteria that impact stage and treatment include depth, ulceration, mitotic rate, and satellitosis. Lesions ≤ 0.8 mm deep without ulceration or mitoses are considered low-risk lesions. These patients should undergo wide local excision (WLE) with a 1 cm margin. There is no consensus regarding high-risk features in a thin melanoma.*

C. High-risk lesions should undergo WLE with a 1–2 cm margin and sentinel lymph node biopsy. Sentinel lymph node biopsy should consist of preoperative lymphoscintigraphy and intraoperative use of gamma probe with or without vital blue dye injection, followed by meticulous pathologic exam of sentinel lymph node.

D. If the sentinel node is positive for malignancy, the patient should undergo staging workup, including either a CT of the chest, abdomen, and pelvis with IV contrast or full body PET/CT, and consider brain MRI. If there is evidence of metastasis, the patient should consider systemic therapy or a clinical trial. If there is no evidence of metastasis, the patient should be offered a completion lymphadenectomy and consider systemic therapy or a clinical trial.

E. If at the time of diagnosis there is suspicion for metastatic disease or palpable lymph nodes on exam, the patient should undergo staging imaging including either a CT chest, abdomen, pelvis with IV contrast or a full body PET/CT as well as fine needle aspiration or core biopsy of suspicious nodes. If the disease is contained in the nodes, the patient should undergo wide local excision with lymph node dissection and be considered for systemic therapy or a clinical trial postoperatively. If the disease is metastatic at the time of diagnosis, the patient should receive systemic therapy or enroll in a clinical trial. Limited metastatic disease may be resected in carefully selected patients.

F. Follow-up care: Patient should have a complete skin exam every 3–12 months for the first 5 years and at least annually for life. Imaging should be performed for signs or symptoms of metastasis in any patient and considered every 3–12 months for 3 years for stage IIB-IV. Patient should be educated about sun protection and self-examination.

*NCCN should be visited regularly for updated guidelines.

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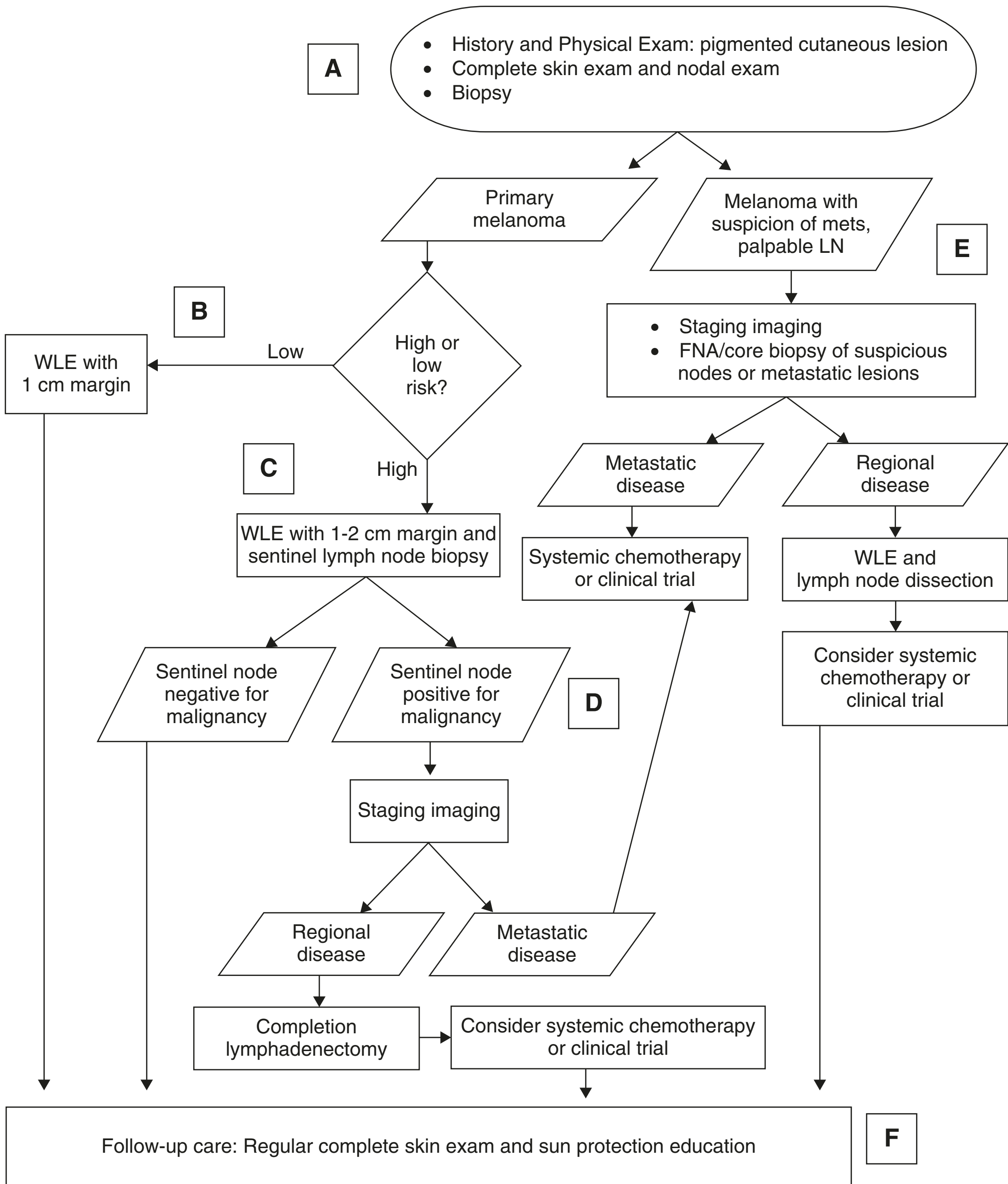

Algorithm 1.1

Suggested Reading

National Comprehensive Cancer Network. NCCN clinical practice guidelines in oncology: melanoma (version 1.2017). https://www.nccn.org/professionals/physician_gls/pdf/melanoma.pdf. Accessed 17 July 2017.