Guideline 8-7

A Quality Initiative of the Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

Follow-up of Patients with Cutaneous Melanoma who were Treated with Curative Intent


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Table of Contents

Section 1: Recommendations ................................................................. 1
Section 2: Guideline - Recommendations and Key Evidence........................ 4
Section 3: Guideline Methods Overview .................................................. 10
Section 4: Systematic Review ................................................................. 13
Section 5: Internal and External Review .................................................... 35
References................................................................................................. 40
Appendix 1: Members of the Melanoma Follow-up Guideline Development Group....... 43
Appendix 2: Literature Search Strategy ....................................................... 45
Appendix 3: AMSTAR Quality Assessment of Included Systematic Reviews .......... 47
Appendix 4: Quality Assessment of Included Studies...................................... 48
Appendix 5: Summary of Published Melanoma Follow-up CPG Recommendations ....... 50
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Section 1: Recommendations

This section is a quick reference guide and provides the guideline recommendations only. For key evidence associated with each recommendation, see Section 2.

GUIDELINE OBJECTIVES
To recommend follow-up schedules involving appropriate evaluations and timing for early detection of local-regional recurrence, distant metastases and new primary melanomas for patients with melanoma after curative-intent treatment.

TARGET POPULATION
These recommendations apply to patients with cutaneous melanoma (hereafter referred to as melanoma) after treatment with curative intent.

INTENDED USERS
Intended users of this guideline are medical oncologists and surgical oncologists specializing in melanoma, as well as dermatologists, family doctors, and surgeons involved in the follow-up care of patients with melanoma, within the province of Ontario.

RECOMMENDATIONS
In patients who have received curative-intent treatment for melanoma:

Recommendation 1
- Routine shared follow-up care with an oncologist (surgical oncologist, medical oncologist, or radiation oncologist) and a dermatologist is recommended.
  - Alternating visits should be considered.
- No evidence-based recommendation can be made with respect to appropriate follow-up schedules for patients with melanoma; however, the Melanoma Disease Site Group suggests that clinical visits, including a medical history and a physical examination, should occur at the frequency outlined below.

<table>
<thead>
<tr>
<th>Melanoma Stage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>In situ melanoma</td>
<td>Patients do not require oncologist follow-up after surgical treatment.</td>
</tr>
<tr>
<td></td>
<td>Follow-up full skin examination with a dermatologist should occur annually or as clinically indicated.</td>
</tr>
<tr>
<td>Stage I to IIA</td>
<td>Patients do not require oncologist follow-up after surgical treatment.</td>
</tr>
<tr>
<td></td>
<td>Follow-up with a dermatologist should occur every six to 12 months or as clinically indicated.</td>
</tr>
<tr>
<td>High-risk Stage IIB/C and Stage IIIA</td>
<td>Patients should receive clinical visits with an oncologist every six months in years 1 through 3, then annually until year 5. Patients may be discharged to care of dermatologist and family physician after five years if appropriate.</td>
</tr>
<tr>
<td></td>
<td>Follow-up with a dermatologist should occur every six to 12 months or as clinically indicated.</td>
</tr>
</tbody>
</table>
Section 1: Recommendations – November 3, 2015

#### Guideline 8-7

| Stage IIIB to C and resected stage IV | Patients should receive a clinical visit with an oncologist every three to six months in years 1 through 3 and every six months in years 4 to 5, or as clinically indicated. Follow-up with a dermatologist should occur every six to 12 months or as clinically indicated. |

### Qualifying Statements for Recommendation 1

- Oncologists and dermatologists have distinct skill sets and training; thus, alternating follow-up visits with both specialists is recommended.
  - Clinical follow-up with a medical, radiation, or surgical oncologist/surgeon is recommended in order to detect a local, regional, or distant melanoma recurrence and is aided by the use of imaging modalities where appropriate.
  - Clinical follow-up with a dermatologist is recommended in order to detect new primary melanomas and local recurrences of resected melanoma with the aid of specialized dermatologic imaging, full skin examinations, and photo surveillance.
- Dermatologic follow-up may also occur when patients note a new pigmented lesion, as these patients are at a 6% to 8% increased risk for primary melanoma development.
- In patients with a high mitotic rate (≥10 mitosis/mm²), ulceration, or positive lymph node involvement, a more frequent schedule may be considered.
- Patients at low risk for recurrence or death should be discharged to care of a dermatologist alone after five years.

### Recommendation 2

- For patients at high risk, the following diagnostic imaging may be appropriate.

<table>
<thead>
<tr>
<th>Diagnostic Test</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computed tomography (CT) scan</td>
<td>CT scan of the chest, abdomen, and pelvis every 12 months (or as clinically indicated) may be appropriate for patients at high risk for recurrence or death.</td>
</tr>
<tr>
<td>Chest x-ray</td>
<td>Only appropriate when CT scan cannot be performed.</td>
</tr>
<tr>
<td>CT/magnetic resonance imaging (MRI) of brain</td>
<td>Appropriate at baseline and as clinically indicated.</td>
</tr>
<tr>
<td>Bone scan</td>
<td>Not routinely recommended unless clinically indicated.</td>
</tr>
<tr>
<td>Positron emission tomography (PET) scan</td>
<td>Could be considered, as per the PEBC PET Imaging in Melanoma Recommendation Report.</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>May be appropriate for surveillance within the lymph node basin or as clinically indicated. Useful when CT scan cannot be performed.</td>
</tr>
</tbody>
</table>

### Qualifying Statements for Recommendation 2

- Diagnostic testing should only be ordered if that test will result in management decisions.
- Follow-up healthcare providers should consider the appropriateness of the diagnostic imaging coupled with the health of the patient, the potential risk of accumulated radiation exposure, and the available treatment options.
• Diagnostic imaging modalities need to be evaluated in clinical trials to assess the actual survival rate benefit.
  o Radiologic identification does not necessarily translate to a better overall survival rate.
• Patients who are considered at high risk for recurrence or death include patients with stage III and resected stage IV melanomas, as well as patients with stage IIB/C cancers with high-risk pathologic features.

**Recommendation 3**
• For high-risk patients, use of routine blood work (complete blood count [CBC] and blood chemistry, including liver function) and circulating lactate dehydrogenase (LDH) is not recommended.

**Qualifying Statements for Recommendation 3**
• Patients who are considered at high risk for recurrence or death include patients with stage III and resected stage IV melanomas, as well as patients with stage IIB/C cancers with high-risk pathologic features.

**Recommendation 4**
• In conjunction with routine follow-up, healthcare providers should provide patient education regarding skin self-examination and sun safety.
  o In particular, patients should be instructed to inspect their melanoma incision(s) and the area between their scar and the lymph node basin monthly.
  o Patients should also be instructed to watch for any new or persistent symptoms.
• New and persistent symptoms should be investigated by their healthcare provider.

**Recommendation 5**
• For patients with multiple nevi, photo surveillance, using prints or digital images, may be used by dermatologists.
  o Photos may be kept by the patient or securely at the dermatologist’s office.
  o If photos are kept at home, patients should bring the photos to scheduled follow-up visits with the dermatologist, or when visiting the patient’s family physician.
• Dermatologists, with proper training, may use dermoscopy to assess suspicious lesions.