



Follow-up of survivors of thin melanoma

Thin melanoma is defined as less than 1 mm in thickness using the Breslow method for measuring melanomas under the microscope.

GPs have an important role in caring for their patients diagnosed with melanoma. Once the patient enters the post-treatment phase, care may be partly or fully transitioned back to their GP. Of course, the timing and degree of involvement will vary depending on the patient and their stage of disease.

Five-year survival

Prognostic factors for patients with melanoma include clinical and histological factors such as tumour site, co-morbidities, tumour thickness, ulceration and mitotic rate. In Australia, over 80% of patients present with thin (less than 1 mm thick) melanoma. If treated appropriately, a diagnosis of thin melanoma is associated with very high survival rates in the order of 90–95% at five years (Green et al. 2012; AIHW & AACR 2012).

Potential issues for survivors

Survivors may experience many different issues after completing treatment: physical, emotional, psychosocial and practical.

Post-treatment survivorship care ideally addresses all of these issues. The four main aims of care during the survivorship phase, as detailed by the Institute of Medicine's report (see Hewitt et al. 2006) 'From cancer patient to cancer survivor: lost in transition', are:

- surveillance for cancer spread,

recurrence or second primary cancers and for other later effects.

- coordination between specialists and primary care providers to ensure that all of the survivor's health needs are met (incl. health promotion, immunisation, screening for cancer and non-cancerous conditions, and the care of concurrent conditions).
- intervention for consequences of cancer and its treatment (e.g. psychological distress experienced by cancer survivors and their caregivers, and concerns related to employment and insurance).
- prevention of recurrent and new cancers and of other late effects.

Surveillance for cancer spread, recurrence or second primary cancers

For the vast majority of patients with early-stage, very good prognosis melanoma, the risk of local, regional or distant recurrence is small. Most recurrences occur in the first five years after diagnosis, with local and regional recurrence usually occurring within two years. However, recurrence more than 10 years after treatment can occur. People who have been diagnosed with melanoma have nine times the risk of developing another melanoma (Bradford et al. 2010). In addition there is an increased risk of developing a non-melanoma carcinoma (i.e. basal cell carcinoma and/or squamous cell carcinoma).

As per the Australian and New Zealand clinical practice guidelines (ACN Working Party 2008), all patients who have had a melanoma should undergo regular follow-up

including at least annual full skin checks for the remainder of their lives. The frequency of skin checks will be determined by the patient's risk factors, such as their degree of sun damage, family history including genetic predispositions, and number and type of naevi. The main purpose of follow-up is to detect new skin cancers early and monitor for recurrence. Some people with recurrence may have a more favourable outcome if this is treated earlier. Also, early detection of a new melanoma will result in better chances of long-term survival.

Follow-up entails monitoring the original site of melanoma for signs of recurrence and also checking the axillary and groin lymph nodes. Follow-up should also include detection of new invasive melanomas, which occur in 2–9% of survivors. For patients with very good prognosis early melanoma, it is recommended they be reviewed at

Key messages

- Melanoma five-year survival rates are high for people whose cancer is detected early
- Management of the patient with a history of melanoma includes surveillance for recurrence/metastases and for new skin cancers
- The rate of a subsequent skin cancer is higher in patients with a past history of melanoma
- GPs play a vital role in ongoing follow-up of a melanoma survivor



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six months after initial treatment to check the wound and draining lymph node sites and again at 12 months and two years.

In Australia, 75% of melanoma patients detect their own recurrence (ACN Working Party 2008). Patients should be instructed to remain aware of changes in their skin, in particular to look for new and changing lesions on a regular basis. However, there remains a need for ongoing skin surveillance by someone with the required skill set.

Australian and New Zealand clinical practice guideline recommendations are listed below.

Recommendations for imaging

For patients with early-stage melanoma of any prognosis where there is no evidence of metastatic disease to regional lymph nodes or elsewhere, there is no indication, either at diagnosis or subsequently, for any investigations, specifically CT or PET scans. Findings based on patient history and clinical examinations that are suggestive or suspicious of recurrence or metastatic disease should be referred to a specialist clinic.

Australian and New Zealand clinical practice guidelines recommendations for self-examination and follow up are:

1. Self-examination by patients is essential and they should be taught the process. All patients should be encouraged to undertake regular self-examination using a mirror or involving a partner or carer in the process and be advised to be suspicious of new or changing lesions on the skin. They should also be taught to check their lymph nodes for lumps. Routine follow-up by the patient's preferred health professional may be appropriate to emphasise sun-smart behaviour and perform skin checks.
2. Follow-up intervals can vary according to treatment centres. Australian and New Zealand clinical practice guidelines recommend six-monthly follow-up for five years for patients with stage 1 disease, and yearly follow-up thereafter. (Refer Figure 1 for definition of stage 1 melanoma.)
3. While it is important that clinicians weigh up the advantages and disadvantages of undertaking routine

follow-up, individual patient's clinical needs must be considered before appropriate follow-up is offered.

Diagnosing melanoma: practice points

Check the entire body skin surface (including palms of hands, soles of feet and scalp). Examine suspicious lesions using a strong light, with dermoscopy (must be a appropriately trained practitioner) if possible, being mindful of clinical appearance, the patient's description of the history of the lesion and risk factors for melanoma.

The following practice points for GPs are from the Australian Cancer Network's 'Melanoma – an aide memoire to assist diagnosis' (ACN 2008).

- The history of a skin lesion is very important. A history of change in size, shape or colour is an important clue to the diagnosis of melanoma.
- Physical examination should assess the skin surface with high-quality illumination to detect lesions of which the patient is unaware.
- Not all melanomas are black – there may be variation in colour, multiple colours or amelanotic (e.g. brown, tan, pink, red, purple, of normal skin colour and areas of depigmentation).
- For suspicious lesions, depending on the skill level of the GP, excisional

Recommendations for timing of follow-up.

At times, follow-up may vary according to individual patient needs.

Recommendations for people with thin melanoma
Skin examination and surveillance at least once a year for life
Comprehensive history and physical examination with specific emphasis on regional nodes and skin performed every six months for five years and annually thereafter
Educate patient about monthly self-examination of skin and lymph nodes

The follow-up schedule may change, for example due to the detection of recurrence or the development of other illnesses. Assess symptoms fully as they arise.

Figure 1. Stage 1 melanoma

Stage 1	The melanoma has not spread beyond the skin
Stage 1 melanoma can be divided into Stage 1A and Stage 1B	
Stage 1A	The melanoma is 1 mm thick or less, without ulceration, and it has a mitotic rate of less than 1/mm ²
Stage 1B	The melanoma is 1 mm thick or less. It also has either ulceration or a mitotic rate of at least 1/mm ² OR the melanoma is between 1.01 mm and 2 mm thick, but doesn't have ulceration.

Source: Adapted from MacMillan Cancer, Support: www.macmillan.org.uk



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biopsy or referral should be considered. Partial biopsies and shave biopsies are best avoided as there may be a sampling error. They often underestimate the Breslow thickness and other clinical features important to melanoma treatment.

- For clinically doubtful pigmented skin lesions or any suspicious and particularly changing lesion, consider referral to a specialist clinic. Photography may be a useful adjunct to monitoring pigmented skin lesions.
- Locally advanced melanoma should be referred to a specialist surgeon or, where possible, to a specialist melanoma clinic.

In most cases, suspicion of melanoma is based on the ABCDE method of clinical diagnosis:

a. Asymmetry

b. Border irregularity

c. Colour variation Shades of black, brown, and tan may be present. Areas of white, grey, red, pink or blue may also be seen

d. Diameter greater than 6 mm – however melanoma can be diagnosed smaller.

e. Evolving/Elevation Lesions may enlarge and a flat lesion may become raised in a matter of a few weeks.

New symptoms: advice for survivors

Advise the survivor to contact their doctor if they notice a skin change or any other symptom that concerns them between follow-up appointments.

Advise the cancer survivor to contact you if they experience:

Late effects of thin melanoma treatment.

Late effect	Cause/association
Impaired body image	Impact of surgery (scarring, dissatisfaction with cosmetic result and change in appearance, abnormal function)
Worry about cancer coming back Anxiety	Risk of spread of disease, developing a second melanoma or a new cancer

- any suspicious or changing skin or lumps in the area of surgery.
- any suspicious new or changing skin spots on any part of the body.
- swelling in lymph nodes under arms or in the groin.

Coordination between specialists and primary care providers

Follow-up may be performed by the specialist or GP or in many cases both, often in a shared care arrangement. Guidelines included in the Victorian Government's 'Optimal cancer care pathway for people with melanoma' recommend that follow-up should be by a multidisciplinary team, although not all disciplines need to be involved in longer term follow-up. Responsibility needs to be agreed between the designated lead clinician, GP and cancer survivor, and an agreed survivorship care plan documented and shared. Survivors require education regarding self-care and attendance to follow-up appointments.

The Australian Cancer Network (2008) advises that high risk patients should be managed in consultation with appropriate specialists, and recommends referral to a dermatologist or melanoma clinic for surveillance.

Intervention for consequences of cancer and its treatment

Late effects of melanoma treatment

Note to cancer survivors: late effects from cancer treatment are generally uncommon and often rare. Do not assume that you will get a late effect if you had a treatment described here. Please speak to your doctor if you have any concerns about late effects from your cancer treatment.

Further information related to late effects

For survivors and their partners, there may be relationship effects from cancer and its treatment, including difficulties over changed roles and fear of recurrence. Some survivors may fear being a burden. Survivors who go through and beyond cancer treatment without partners or close family and friends may experience great loneliness.

Enquire about mood and whether the person feels they are coping. Assess the survivor's level of distress/depression. Psychological distress generally declines over time. Psychosocial interventions (e.g. support groups) may be effective. Support groups and/or contact with a fellow survivor through a service such as Cancer Connect (via the Cancer Council 13 11 20) or Melanoma Patients Australia (1300 88 44 50 or www.melanomapatients.org.au) may be helpful.

Prevention and detection of new cancers and recurrent cancer

People who have had melanoma and their families should be informed about skin cancer prevention including sun protection measures.

- Avoid sunburn by minimising sun exposure when the SunSmart UV Alert exceeds 3 and especially between the hours of 10 am and 4 pm, when UV levels reach their peak.
- Look and listen for UV Index levels in local weather forecasts.
- Use a combination of sun protection measures against UV radiation: never rely on just one. Seek shade; wear a hat that covers the head, neck and ears; wear sun-protective clothing and close-fitting sunglasses; and wear a SPF30+ sunscreen (i.e. 'slip, slop, slap, slide, seek').
- Do not use solariums (tanning salons). These are already banned in some states.
- People who have had melanoma may be at risk of vitamin D deficiency as a result of their ongoing sun protection measures. Refer to the Cancer Council website for advice on vitamin D. (See www.cancer.org.au/preventing-cancer/sun-protection/vitamin-d)



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General advice that can be given to all survivors

Follow-up care for all patients should include counselling about adopting healthy life-style behaviours—for example, about improved diet, maintaining a healthy weight, smoking cessation and increasing physical activity—as these may reduce the risk of subsequent cancers, as well as reducing the risk of other health problems. They may also reduce many of the psychosocial consequences of cancer treatment.

Advise survivors (unless there are health reasons that indicate otherwise) to do at least 30 minutes of moderate-intensity physical activity on most, preferably all, days. NHMRC dietary guidelines for all Australian apply equally to cancer survivors.

Where indicated, monitor survivors'

cholesterol, blood pressure, blood glucose and vitamin D levels. Survivors should have regular dental examinations.

Survivors need appropriate screening for other cancers at recommended time intervals. All women who have ever been sexually active should commence having Pap tests between the ages of 18 and 20 years, or 1 to 2 years after commencing sexual activity, whichever is later. In some cases screening for cervical cancer may be appropriate before 18 years of age. Women over 70 years of age who have had two normal Pap tests in the past five years do not require further Pap tests. If a woman over 70 years has never had a Pap test, or requests a Pap test, they should be screened. Patients over 50 years should be counselled regarding screening for bowel cancer. The National Bowel Cancer Screening

Program (NBCSP) invites Australians aged over 50 to screen for bowel cancer. Eligible people are sent a bowel screening kit (a Faecal Occult Blood Test, FOBT) by mail. Encourage those who are sent a screening test and for whom the test is clinically relevant, to participate. Assess those with a positive result and refer them for further examination as clinically indicated, for example a colonoscopy: <http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/bowel-screening-1>

Breast Screen Australia recommends women aged 50–74 undergo mammograms every two years. There is insufficient evidence for population-based screening for ovarian cancer; however, women who are at potentially high risk should be referred to a familial cancer clinic for assessment and management.

Further information

This overview was prepared with reference to:

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