Skin Cancer follow up guidelines

If **NEW serious diagnosis** given:

1. Written information to patient /GP: fax ASAP to GP & offer copy of consultation letter.
2. Free prescription information details.
3. Holistic needs assessment and named KEYWORKER contact details.
4. Self-examination should be explained. Serial photography should be considered.
5. Vitamin D levels for melanoma patients and correction following network guidelines

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Action</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Malignant Melanoma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinically suspected melanoma</td>
<td>2 mm margin excision biopsy</td>
<td>Follow up within 2 to 3 weeks for results</td>
</tr>
<tr>
<td>In situ melanoma (or lentigo maligna) - completely excised with margin &gt;5 mm</td>
<td>Refer LSMDT</td>
<td>Discharge</td>
</tr>
<tr>
<td>In situ melanoma (or lentigo maligna) - close margin (&lt;5 mm)</td>
<td>Refer LSMDT Discuss WLE to achieve 5 mm margin</td>
<td>Discharge if adequate margins</td>
</tr>
<tr>
<td>Thin melanoma &lt;1mm without mitoses or ulceration</td>
<td>Refer LSMDT Offer WLE of 1 cm</td>
<td>Follow up 1 year (review 2-4 time during year)</td>
</tr>
<tr>
<td>Thin melanoma &lt;1mm with mitoses or ulceration</td>
<td>Refer SSMDT Should be offered WLE 1 cm and consider SLNB</td>
<td>Follow up 5 years (Whole skin exam and local lymph nodes) 3 monthly for 3 years then 6 monthly for further 2 years</td>
</tr>
<tr>
<td>Intermediate thickness melanoma - 1-2 mm</td>
<td>Refer SSMDT Offer 1-2cm WLE and SLNB</td>
<td>Follow up 5 years</td>
</tr>
<tr>
<td>Intermediate thickness melanoma - 2-4 mm</td>
<td>Refer SSMDT Offer WLE 2-3 cm and SLNB</td>
<td>Follow up 5 years</td>
</tr>
</tbody>
</table>
| Thick melanoma - >4mm | Refer SSMDT  
Offer WLE 3 cm and SLNB | Follow up 5 years |
|-----------------------|-------------------------------------------------|---------------------|
| **MELANOMA**  
**Positive Sentinel nodes**  
(not head and neck) | Refer SSMDT  
Arrange CT chest abdomen and pelvis (urgent with contrast)  
FBC, U & Es, LFT and LDH  
Offer dissection of affected lymph node basin  
**Pelvic dissection if:**  
- >1 clinically palpable inguinal and/or femoral triangle LN  
- CT or ultrasound evidence of >1 inguinal and/or femoral triangle node(s), or of pelvic node involvement  
- >1 microscopically involved node at SLNB  
- A conglomerate of inguinal or femoral triangle lymph nodes  
- Microscopic or macroscopic involvement of Cloquet's node | Follow up 5 years as per guidance (ALL lymph nodes)  
Then annually for further 5 years  
See high risk melanoma imaging follow up below |
| **Melanoma**  
**Positive sentinel nodes**  
**Head and neck** | Refer SSMDT Head and Neck Consultant  
Arrange CT Chest abdomen and pelvis (urgent with contrast)  
Arrange MRI head  
FBC, U & Es, LFT and LDH  
Offer dissection of affected lymph node basin (MDT) | Follow up 5 years as per guidance (ALL lymph nodes)  
Then annually for further 5 years  
See high risk melanoma imaging follow up below |
| **Palpable lymph node** | Refer SSMDT  
FNA (consider US guided)  
Only 2 inconclusive attempts before open biopsy | Follow up 1 to 2 weeks for results or FNA  
See above for pelvic dissection decision |
| **Melanoma**  
**Radiotherapy** | Refer SSMDT  
Refer for any patient with node >3 cm axilla and 4 cm groin or >3 nodes or extracapsular spread.  
Consider surgical resection margins; if in doubt refer for radiotherapy. Due to morbidity and balance survival advantage, this may not be offered by Oncologist | Follow up 5 years (ALL lymph nodes)  
Then annually for further 5 years |
| **Relapse melanoma** | Refer SSMDT  
For MDT discussion & consider trials | Follow up 5 years (whole skin exam and ALL lymph nodes)  
Then annually for further 5 years |
| **High risk melanoma** | If palpable lymph node disease or metastatic disease  
Stage 4 or palpable melanoma proven lymphadenopathy  
Refer to SSMDT  
Consider Oncology referral | Follow up 5 years (whole skin exam and ALL lymph nodes)  
Then annually for 5 years  
AND  
CT Chest, abdomen and pelvis (+/- MRI brain) 6 monthly for 3 years then annually to 5 years  
Please notify SSMDT when these scans are performed |
|------------------------|-------------------------------------------------|-------------------------------------------------|
| **Melanoma in Pregnancy** | Primary lesions offer WLE only.  
Palpable lymph node disease for SSMDT discussion in conjunction with Obstetrician | Follow up 5 years |
| **Merkel Cell Carcinoma** | Refer SSMDT  
Plan CT staging, 3cm WLE and SLNB  
Offer post op radiotherapy to primary and lymph node basins - Early metastasis common (50%). | Close follow up  
3/12 for 5 years |
| **Squamous cell carcinoma** | In situ SCC (Bowen’s disease)  
Treat topically (e.g. Efudix, Aldara, PDT, cryotherapy, curettage etc.)  
Refer back to origin if low risk and/or biopsy proven | Moderate/Poorly differentiated SCC (dependent on histological features)  
(4 or 6 mm margin to fascia)  
Refer LSMDT  
Follow up 3 years |
| | Well differentiated SCC  
(low risk area and type)  
Excision 4 mm margin (<2 cm diameter)  
Discharge after two 6 month appointments if completely excised with >2 mm radial and deep margins in low risk area | Well differentiated SCC  
(high risk area and histology)  
6 mm margin if thicker, ulcerated or high risk area  
Refer LSMDT  
Follow up 3 years  
(3/12 for one year then 4/12 for one year then 6/12 for one year) |
| | Moderate/Poorly differentiated SCC  
(low risk area and histology)  
Refer LSMDT  
Follow up 3 years | High risk SCC with management difficulty  
Refer SSMDT  
Follow up 3 to 5 years |
| | Palpable lymph node  
FNA  
Only 2 inconclusive attempts before open biopsy  
If positive SSMDT referral | Follow up within 3 weeks for results or FNA |
| | | |
### Basal Cell Carcinoma

<table>
<thead>
<tr>
<th>Low risk site and type of BCC</th>
<th>Excision 3-4 mm radial margin</th>
<th>Discharge if completely excised</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk site and low risk BCC type</td>
<td>Consider excision 4 mm margin</td>
<td>Discharge if completely excised</td>
</tr>
</tbody>
</table>
| High risk site and type | Consider excision 10-15 mm margin  
Consider Mohs | Discharge if completely excised |
| Incompletely excised radial margin BCC (or close margins) | Offer observation or re-excision for low risk  
High risk offer re-excision, Mohs or radiotherapy | 3/12 for 1 year  
Then 6/12 for further 1 to 2 years |
| Incompletely excised BCC Deep margin | Offer wider excision, radiotherapy or Mohs | 3/12 for 1 year  
Then 6/12 for further 1 to 2 years |
| Large, multiple or inoperable BCC | Consider referral to Oncology for Vismodegib | Follow up shared on a case by case basis |
| Dermatofibrosarcoma protuberans (DFSP) | Offer wider excision 3-5 cm margin | Follow up local recurrence and lymphatic basins, late local recurrence common  
10 year follow up |

**Notes and exceptions**

1. Young people aged 16-24 years should also be referred to the TYA (Teenage and Young Adult) MDT.
2. Patients with palpable lymph nodes should not be offered SLNB.
3. Those with primary sites that have been reconstructed with a skin graft should be discussed with a nuclear medicine Consultant to consider suitability for SLNB.

**For long term follow up consider:**

1. Referral back to local Dermatology team.
2. Alternating or shared follow up.
3. Distance of patient to travel to and from follow up appointments.
4. Avoid duplicating appointments.

**ABBREVIATIONS:**

- C & C - Curettage and cautery
- FNA – Fine needle aspiration for cytology
- LSMDT – Local skin Multidisciplinary Team
- SLNB – Sentinel Lymph node biopsy
- SSMDT – Specialist Skin Multidisciplinary Team
- WLE – Wide local excision
REFERENCE (Risk definitions)

**Squamous cell carcinoma**
There is widely varying malignant behavior of tumours which fall within the histological diagnostic category of ‘primary cutaneous SCC’. *Site*
Tumour location influences prognosis: sites are listed in order of increasing metastatic potential. High risk sites are:
- SCC arising at sun-exposed sites excluding lip and ear.
- SCC of the lips and ears.
- Tumours arising in non sun-exposed sites (e.g. perineum, sacrum, sole of foot).
- SCC arising in areas of radiation or thermal injury, chronic draining sinuses, chronic ulcers, chronic inflammation or Bowen’s disease.

**Size:**
- >2cm diameter (local recurrence [15.2% v 7.4%] metastatic risk x 3 [30.3% v 9.1%])
- >4mm depth.
- Extending into or beyond subcutaneous tissue (Clark level V) are more likely to recur and metastasize (metastatic rate 45.7% v 6.7%).

**Histological differentiation and subtype**
Poorly differentiated tumours have a poorer prognosis, with more than double the local recurrence rate and triple the metastatic rate of better differentiated SCC.
- Better prognosis
  - Verrucous subtype
- Worse prognosis (more likely to metastasize)
  - Acantholytic, spindle and desmoplastic subtypes
  - Perineural involvement, lymphatic or vascular invasion

**Host immunosuppression**
- Poorer prognosis.

**Previous treatment and treatment modality**
- The risk of local recurrence depends upon the treatment modality.
- Locally recurrent disease itself is a risk factor for metastatic disease.

**Local circumstances**
Follow up in primary care may be a satisfactory option, depending on tumour risk and local circumstances.

**Basal Cell Carcinoma**
- Increasing size confers higher risk of recurrence.
- Site - lesions on the central face (the eyes, nose, lips & ears have higher recurrence risk.
- Poorly defined lesions are at higher risk of recurrence.
- Certain histological subtypes confer higher risk of recurrence; morpheic, infiltrative, micronodular and basosquamous subtypes.
- Histological features of aggression such as perineural &/or perivascular involvement confer a higher risk of recurrence.
- Recurrent lesions are at higher risk of further recurrence.
- Immunosuppression possibly confers increased risk of recurrence.
- Close margins (<0.5mm) warrant discussion with patient about observation or further surgery in some cases (e.g. can't observe due to site or poor vision).
### Table 2: Vitamin D treatment guidelines.

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Recommendations</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **Insufficiency in adults:**  
>30 to 50nmol/L  
Or >12-20ng/mL  
**Insufficiency:** Maintenance treatment likely to be required  
| There is currently a lack of evidence on the functional outcomes of populations with insufficient vitamin D concentration to justify the treatment of all patients with insufficiency.  
Assess patient holistically  
Consider prescribing if symptomatic & at risk / previously deficient/ unlikely to take supplements / breast feeding or considering pregnancy / wintertime | **Maintenance dose:**  
- Vitamin D equivalent to 800IU daily e.g. Vitamin D 400IU (10mcg) tablets. One tablet twice daily for life.  
- A range of Vitamin D tablets are available to buy from community pharmacies, health food stores or via prescription. (See Appendix 2)  
- Calcium and Vitamin D tablets e.g. Calcichew D3 Forte and Addcal D3 are licensed preparations available on prescription and can be considered for maintenance treatment  
Or where compliance may be an issue  
- Colecalciferol 20,000IU one capsule per month available via prescription | |
| **Healthy or at risk adults**  
>50-75nmol/L  
Or > 20ng/mL  
**Symptom free** | Lifestyle advice  
Can consider daily self treatment with over the counter purchased supplement of 400-800IU Vitamin D daily | Over the counter products contain amounts likely to prevent rickets/osteomalacia, but are unlikely to raise Vitamin D concentration to optimal in most people who are deficient.  
NB prevention may be needed in older people / housebound / in institution | |

| Exclude patients with hypercalcaemia or an eGFR <30mL/minute/1.73m². See Appendix 1 |
|-------------------------|-----------------|-------|
| **Deficiency in adults:**  
≤30nmol/L  
Or <12ng/mL  
**Deficiency:** high dose treatment initially, then long term maintenance treatment required  
| Most UK Guidelines suggest a loading dose of 300,000IU colecalciferol is required to replenish Vitamin D concentration. Various regimes can be considered to achieve this.  
Check Vitamin D concentration after 6 months to ensure adequate replacement and/or concordance.  
If ≥100nmol/L consider reducing dose.  
If still deficient alter dose as necessary  
If sufficient no further monitoring recommended | **Treatment Dose:**  
Due to compliance issues locally Liverpool are suggesting a loading dose is given by either:  
Colecalciferol 20,000IU orally ONE daily for 15 days  
OR  
Colecalciferol 20,000IU orally FIVE daily for 3 days  
**Maintenance dose:**  
Colecalciferol 20,000 IU ONE orally once a month  
Prescribers can prescribe from a selection of available products to give a total dose as recommended above. See Appendix 2 for further prescribing and product information | |
| **If deficiency is diagnosed in pregnancy please follow guidelines of your local maternity services provider**  
| Alfalcaldiol is not considered appropriate for community use in Vitamin D deficiency unless advised by specialists due to the risk of hypercalcaemia. See Appendix 3 | |
Definitions

Primary Tumor (T)
- TX: Primary tumor cannot be assessed (for example, excised or severely regressed melanoma)
- T0: No evidence of primary tumor
- Tis: Melanoma in situ
- T1: Melanomas 1.0 mm or less in thickness
- T2: Melanomas 1.01-2.0 mm
- T3: Melanomas 2.01-4.0 mm
- T4: Melanomas more than 4.0 mm

NOTE: a and b subcategories of T are assigned based on ulceration and number of mitoses per mm², as shown below:

<table>
<thead>
<tr>
<th>T Classifications</th>
<th>Thickness (mm)</th>
<th>Ulceration Status/Mitoses</th>
</tr>
</thead>
</table>
| T1                | ≤1.0           | a: w/o ulceration and mitosis <1/mm²  
               |                 | b: w/ ulceration or mitosis ≥1/mm²    |
| T2                | 1.01-2.0       | a: w/o ulceration          |
| T3                | 2.01-4.0       | a: w/o ulceration          |
| T4                | >4.0           | a: w/o ulceration          |

Regional Lymph Nodes (N)
- NX: Patients in whom the regional nodes cannot be assessed (for example, previously removed for another reason)
- N0: No regional metastases detected
- N1: Regional metastases based upon the number of metastatic nodes and presence or absence of intralymphatic metastases (in transit or satellite metastases)

NOTE: N1–3 and a–c subcategories assigned as shown below:

<table>
<thead>
<tr>
<th>N Classifications</th>
<th>No. of Regional Metastatic Nodes</th>
<th>Regional Metastatic Mass</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>1 node</td>
<td>a: micrometastasis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b: macrometastasis</td>
</tr>
<tr>
<td>N2</td>
<td>2-3 nodes</td>
<td>a: micrometastasis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b: macrometastasis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c: in transit metastasis(s) without metastatic nodes</td>
</tr>
<tr>
<td>N3</td>
<td>4 or more metastatic nodes, or matted nodes, or in transit metastasis(s) with metastatic nodes</td>
<td></td>
</tr>
</tbody>
</table>

Distant Metastasis (M)
- M0: No detectable evidence of distant metastases
- M1a: Metastases to skin, subcutaneous, or distant lymph nodes
- M1b: Metastases to lung
- M1c: Metastases to all other visceral sites or distant metastases to any site combined with an elevated serum LDH

NOTE: Serum LDH is incorporated into the M category as shown below:

<table>
<thead>
<tr>
<th>M Classifications</th>
<th>Site</th>
<th>Serum LDH</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1a</td>
<td>Distal skin, subcutaneous, or nodal mets</td>
<td>Normal</td>
</tr>
<tr>
<td>M1b</td>
<td>Lung metastases</td>
<td>Normal</td>
</tr>
<tr>
<td>M1c</td>
<td>All other visceral metastases</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Any distant metastasis</td>
<td>Elevated</td>
</tr>
</tbody>
</table>

ANATOMIC STAGE/PROGNOSTIC GROUPS

<table>
<thead>
<tr>
<th>Clinical Staging</th>
<th>Pathologic Staging</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 0</td>
<td>T0 N0 M0</td>
</tr>
<tr>
<td>Stage IA</td>
<td>T1a N0 M0</td>
</tr>
<tr>
<td>Stage IB</td>
<td>T1b N0 M0</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>T1b N0 M0</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>T1b N0 M0</td>
</tr>
<tr>
<td>Stage III</td>
<td>Any 1 ≥ 2.0</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Any 1 ≥ 4.0</td>
</tr>
<tr>
<td>Stage V</td>
<td>Any 1 ≥ 6.0</td>
</tr>
</tbody>
</table>

Notes
1. Micrometastases are diagnosed after sentinel lymph node biopsy and complete lymphadenectomy if performed.
2. Macrometastases are defined as clinically detectable nodal metastases confirmed by lymphadenectomy or when nodal metastasis exhibits extracapsular extension.
3. Clinical staging includes micrometastats of the primary melanoma and clinical/histologic evaluations for metastases. By convention, it should be used after complete excision of the primary melanoma with clinical assessment for regional and distant metastases.
4. Pathologic staging includes micrometastasis of the primary melanoma and pathologic information about the regional lymph nodes after partial or complete lymphadenectomy. Pathologic Stage 0 or Stage IA patients are the exceptions; they do not require pathologic evaluation of their lymph nodes.

American Joint Committee on Cancer
7th Edition Staging Posters
provided by the American Cancer Society

Copyright 2009 American Joint Committee on Cancer - Used with permission by the AJCC.