Tuesday, 17 March 2020

Advice for managing Melanoma patients during Coronavirus pandemic

These recommendations have been drawn up to guide local services manage their new and review melanoma patients. These are not evidence based, but are a peer reviewed practical policy, to cope with the expected drastically reduced clinical and surgical facilities

Diagnosis of suspected melanoma

Current diagnostic pathways should be followed, with the referral providing a clear history of the lesion and good photograph and dermoscopic image if available (see appendix 1) This will be reviewed by the MDT dermatologist/plastic surgeon and advice given on the basis of the photograph. Patients should be aware of the suspected diagnosis of melanoma. Please inform your patient at this stage that they may be sent directly for surgery to remove the lesion (following decision from the hospital) and that they then may be phoned with the results at a later date (either malignant or benign) once the pathology has been analysed.

Primary Lesion

Excision of any suspicious lesion should be with a 2mm margin and sent for histology. The excision could be provided by a GP/local/regional MDT - MDT to advise. Lesions located in a significant functional or cosmetic place are more likely to require MDT input for resection, however on the basis of a photograph, these patients could be listed straight for theatre (See & Tx). It is recognised that there could be an increased number of non-malignant lesions excised.

Further treatment could then be arranged at that point, when the impact of the Corona Virus is better known.

All pathology will be discussed at MDT, All cases of Melanoma will be staged as normal and the management plan outlined.

When phoning patients with a diagnosis of confirmed Melanoma, the next steps of WLE +/_-SNB should be followed as below

WLE & Sentinel Node Biopsy

WLE can be carried out quickly under local anaesthetic, by junior surgeons. SNBx generally requires a general anaesthetic and a senior surgeon. SNBx does provides regional control and staging, the latter impacts on current assessment for adjuvant therapy. Each regional MDT will have to assess its own current capacity for delivering SNBx and it is recognised this can change over a short period. Currently SNBx should continued to be offered to patients pT1b-pT4b, however as capacity diminishes the patient population offered SNBx shrinks too, pT2b-pT4b and finally pT2b-pT3b. This focuses the service on patients who are mostly likely to benefit from a SNBx.

It is anticipated that SNBx may have to stop all together, in which case primaries on the extremities could have a 1cm WLE with a longitudinally orientated scar and the potential for a delayed SNBx, after the pandemic has cleared. Lymphatic drainage is more predictable in the limbs and closure of these defects, is normally possible with a linear scar, which is least likely to interfere with lymphatic drainage. Head and neck and truncal primaries will have greater variability in their lymphatic drainage and delayed SNBx may not be appropriate.

Patients should be advised that they will be phoned with the results and that the results may show they have a cancer. Patients with high risk sentinel node tumour burden, need to be carefully observed for recurrent nodal disease.

Pathology

Staffing of this service is likely to be affected too, therefore workload needs to be kept to a minimum. This is relevant for the SNBx procedure, due to the work involved in processing and reporting the specimen. Local conditions will dictate the level of service available. Minimising work eg excision rather than biopsy then excision; highlighting urgent cases; defining local population to be offered SNBx; local policy on the need for double reporting of all cases.

Recurrence

The first in transit recurrent lesion should be excised with >5mm margin. Subsequent individual recurrences could be monitored on the basis that resection of these lesions, which ams to provide local control, is unlikely to prevent further lesions developing. If multiple lesions (>5) are developing over a short period of time (<2-3 months), then patients should be referred to the regional MDT for review.

Recurrent nodal disease should be referred to the regional MDT for consideration of resection. A comprehensive history for potential systemic metastases should be taken with simple staging - LDH and CXR, if CT imaging not available. Lymph node dissections provide local control and should be considered as primary treatment as adjuvant treatment may not be available. Patients can be considered for early discharge, the day of / after surgery, with a drain in.

Recurrent lesions causing significant morbidity should be prioritised - Fungating tumour, pain, involvement of critical structure or delayed surgery would lead to loss of control at that site.

Outpatient follow-up

All patients due for review should have their previous clinic letter assessed and offered the choice of a telephone consultation only or standard clinic follow up. If only a routine review then this can be done by telephone. The NHS has provide useful information around information governance

https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance).

Patients should be asked to assess:-

- The area around their primary scar
- The skin draining towards the appropriate nodal basin(s)
- The node basins themselves
- The presence of any other new lesions - photographed and emailed
- Whether they have any systemic symptoms

Patients over 70 or with relevant medical co-morbidities should be seen only if they are expected to require surgical / medical intervention / they are unable to examine the above.

Wound Care

Patients should be given written wound care advice. All wounds should be closed with an absorbable suture and a dressing, which can be removed by the patient at 10-14 days. If the would becomes red, painful, increasing discharge or smelly, then the patient should seek medical advice.

Adjuvant treatment

Systemic adjuvant treatment was approved 12 months ago. Currently stage III - resected stage IV patients are eligible for adjuvant treatment. It is time costly, is associated with significant side-effects and is of at least 12 months duration. The introduction has stretched most fully staffed medical oncology services, with an associated high demand for radiological imaging. Of note, the treatment of the immune mediated side-effects involves significant medically induced immunosuppression, which is of concern in the current environment.

The delivery of adjuvant therapy needs to be considered locally with medical oncology colleagues when determining which cohort of patients are to be offered adjuvant treatment. The current medical oncology consensus is recommending adjuvant treatment for resected stage IIIC, IIID and IV patients, but not stage IIIA or IIIB, would seem appropriate. It would seem possible, but uncomfortable, if the situation deteriorates further, to advise that no adjuvant treatment is offered to any patient with melanoma and that treatment facilities are kept for use with patients who develop defined systemic disease or who have unresectable loco-regional disease. Current medical oncology advise is being written and distributed.

Therapeutic systemic treatment

Where isolated recurrent disease has developed which is easily resectable, then day-case / overnight surgery should be offered. If surgical resection is likely to involve prolonged inpatient stay and unlikely to achieve a clear margin, then systemic treatment should be considered. This should be as per current practice.

GP blood testing and telephone follow up consultations can limit the need for hospital attendance. Most centres will have this facility, with attendance only required for administration of the treatment.

Current medical oncology advice is as follows:-

Metastatic disease - move to single agent immunotherapy for all but the highest risk patients in first-line. If giving targeted therapy, consider encorafenib/binimetinib in view of less symptoms mimicking COVID-19.

Advice is due to be published on Melanoma Focus website

https://melanomafocus.com

Conclusion

It is acknowledged that local situations will vary and this will determine local practice. However this should not be used to significantly deviate from current recognised high standards. The SSMDT should be used for advice. Attendance at the MDT meeting could be done remotely. Finally as this is a unique situation, each local skin MDT and SSMDT should document how patients are managed and their outcomes as it may provide useful information for future management strategies.

Appendix 1 - Patient advice on photographing lesions

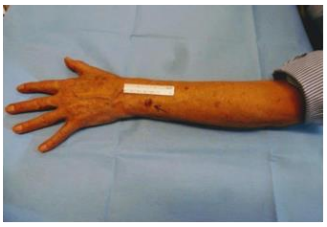
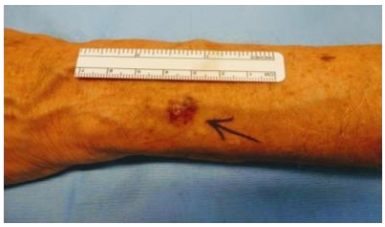
Patient advice on photographing lumps, bumps, moles or rashes

Preparation:

a. **Clearly expose the skin: remove make-up, fake-tan and ensure hair/ clothes not obscuring lesion**

b. **Ensure well lit: avoid shadows**

c. **Ideally mark the lesion with an arrow using a skin marker and add a ruler nearby (if you have one): label with a number if more than one**

VIEWS	1 OVERVIEW	2 CLOSE-UP
EXAMPLES		
AIM	Enables the doctor to identify the exact location (eg. Right or left hand, upper or lower back) and compare it to other lesions	Hopefully enables the doctor to make a diagnosis by naked-eye
TIPS	Entire limb, Head or back/chest should be visible	Lesion centrally located in the photo
	Check that the photos are in focus before sending	

Corona patient photography advice