

## Melanoma Referral Guideline

### Indications for Specialty Care Referral

- Refer provider to provider all patients with suspected or new diagnosis to either Dermatology or General Surgery.
- Melanomas > 1mm should be referred to UM – Surgical Oncology for consideration of sentinel lymph node biopsy

### Criteria for Return to Primary Care

- After initial definitive diagnosis and therapy, patients with melanoma should be followed at specialty level clinic (General Surgery, Dermatology, or Oncology) as follows:
- Patients who have undergone curative resection and with no clinically detectable metastatic disease should be followed in General Surgery or Dermatology Clinic for the first two years after initial therapy, after which time they may be followed at a primary care level.
- Detailed exam of the initial melanoma site, documentation of new or changing lesions, examination of all regional lymphatic beds, and general surveillance of other moles should take place at each visit.
- Patients with proven nodal metastases or other proven metastatic disease should be followed by an Oncologist together with the patient's primary care provider, as appropriate.

### *Diagnosis/Definition*

- Suspected or biopsy-proven malignant melanoma.

### *Initial Diagnosis and Management*

- Suspect melanoma is a pigmented lesion based on the following changing factors and remembered by the mnemonic “ABCDE”.

**A**symmetry: self-explanatory, and very important.

**B**order: irregularity of the margin of a pigmented lesion.

**C**olor: variable colors within a single pigmented lesion.

**D**iameter: lesion greater than 6mm diameter.

**E**levation/**E**volution: many melanomas have no elevation, may not be palpable, but a rapid change in elevation and the evolution of changes and symptoms in an otherwise static lesion is suspicious.

- If melanoma is strongly suspected appropriate excisional biopsy may be done or, refer directly to Dermatology or General Surgery (arranged provider to provider) prior to biopsy for initial specialty assessment.
- Because depth of the lesion is the most valuable prognostic factor, excisional biopsy is preferred on small lesions with minimal margin; for larger lesions, or

lesions in cosmetically sensitive areas, punch biopsy or saucerization shave with adequate depth of suspicious portion is essential.

- Avoid transversely oriented excisional biopsies on an extremity (a biopsy which, when completed, will result in a transverse closure).
- Entry (listing site, depth, management) into the patient's Master Problem List by the provider confirming the diagnosis.

***Ongoing Management and Objectives***

- If a melanoma is discovered by biopsy or strongly suspected, consider requesting baseline CBC, LDH, liver function panel, and chest x-ray at time of specialty consultation.