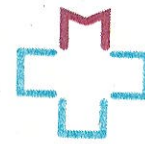


Skin Cancer Management guidelines 2023



MERSEYSIDE
& CHESHIRE
Skin Cancer Centre

Summary of Changes February 2023 (Post – Covid)

Melanoma

Updated melanoma oncology – consider referral to oncology for Stage 2b and upwards for Melanoma. Balance of risks benefit will be discussed with Oncology team.

Stage 3A melanoma should be referred to oncology for discussion.

Essentially – ANY patient with a melanoma over 4mm or greater than 2mm with ulceration should be offered systemic treatment (see NICE guidelines Melanoma 2022 update). Staging is not complete until Sentinel node biopsy is performed. For Stage 2b and above patients that decline SLNB, please continue to refer to oncology.

'Staging CT' for melanoma should include MRI head prior to referral for systemic treatment. This should be performed within 12 weeks of starting systemic treatment. For ALL stage 2b and 2c melanoma patients refer to oncology for immunotherapy discussion with imaging arranged locally and ONLY for SSMDT discussion by exception / unexpected findings after local reporting.

Under COVID action plan, some patients were not offered Sentinel Lymph node biopsy

1. For these patients regional recurrence is a greater risk and recommendation is for face to face review for the first year.
2. Ultrasound surveillance for these patients is currently not offered routinely; but 4-6 monthly for three years is recommended and should be performed locally wherever possible. More frequent scanning for the first year (particularly for those with a higher Breslow thickness/stage) should be considered. If multiple lymph node basins included; please scan all appropriate as the sentinel node is unknown.

pT1b Melanoma – only offer SLNB if ulcerated, but it may be considered if increased mitoses and perivascular invasion. For those not ulcerated for Local Skin MDT discussion only.

Maximum melanoma follow up is 5 years (NICE 2022)

Imaging recommendations in follow up for discussion April 2023 Cancer network group
US surveillance for Melanoma can be offered in keeping with MDT advice and local availability

Mini-tub trial closed

Non-melanoma skin cancer

New British Association of Dermatology BCC guidelines updated 2021

Skin Cancer Management guidelines 2023

If **NEW serious diagnosis** given:

1. Inform GP within 24 hours
2. Offer patient copy of consultation letter
3. Offer prescription exemption information if appropriate
4. Provide contact details of key worker (usually skin cancer CNS)
5. Offer holistic needs assessment (within 31 days of diagnosis)
6. Consider serial photography, particularly for melanoma patients. Encourage patients to bring own photographs on their digital devices.

NB Follow up to be discussed with patient – Back to Referrer/Local or Specialist Nurse-led clinics



DIAGNOSIS	ACTION	FOLLOW UP ACTION
<u>Malignant Melanoma</u>		
Clinically suspected melanoma	2 mm margin excision biopsy	Follow up 2 to 3 weeks for results Ensure histopathology result available
<i>In situ</i> melanoma or lentigo maligna excised ≥5mm margin	Refer LSMDT	Discharge
<i>In situ</i> melanoma or lentigo maligna close margin (<5mm)	Refer LSMDT Discuss WLE to achieve 5 mm margin	Discharge if adequate margins
<i>Severely dysplastic naevus</i>	Consider wider excision to achieve 5mm margin (ONLY for severely dysplastic)	Discharge if adequate margins
<u>Melanoma stages 1 and 2</u>		
Thin melanoma – <0.8mm Breslow (stage pT1a)	Refer LSMDT Offer WLE of 1 cm <u>including superficial fascia, down to muscle fascia wherever possible due to anatomical constraints**</u>	Follow up 1 year review 2-4 times during year Whole skin exam & local lymph nodes
Two Primary melanomas pT1a	Refer LSMDT Offer 1cm WLE <u>with superficial fascia**</u>	Follow up 5 years with local Dermatology services Whole skin exam & local lymph nodes
Primary Melanoma 0.8mm to 1mm without ulceration or lymphovascular invasion or mitoses >2 (Stage 1b)	Refer LSMDT Offer 1cm WLE <u>including superficial fascia**</u>	Follow up 5 years Whole skin exam & local lymph nodes 3 monthly for 3 years then 6 monthly for further 2 years
Melanoma ≥0.8mm with ulceration, or <0.8mm WITH ulceration or Intermediate thickness melanoma 1 to 2 mm	Refer SSMDT Offer 1-2cm WLE <u>with superficial fascia**</u> and consider SLNB Provide SLNB leaflet to aid discussion BRAF test	Follow up 5 years (see above and additional information below)
Intermediate thickness melanoma ≥2mm with ulceration or ≥ 4mm without ulceration	Refer SSMDT Offer WLE 2 cm <u>including superficial fascia**</u> and SLNB Provide SLNB leaflet and BRAF test Consider referral to oncology after staging imaging	Follow up 5 years (see above) Genetic/BRAF testing CT Chest, abdomen and pelvis and MRI or CT head

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DIAGNOSIS	ACTION	FOLLOW UP ACTIONS
Thick (>4mm) AND Ulcerated melanoma	Refer SSMDT Offer WLE 2 cm <u>including superficial fascia**</u> and SLNB (CT staging <u>prior to</u> SLNB) Refer Oncology	Follow up 5 years (see above) Consider contrast CT of Chest abdomen and pelvis every 6 months for 3 years and then annually for further 2 years (MRI or CT head if head and neck primary)
Melanoma with lymph node disease (Stage 3) [see page 13]		
Positive Sentinel nodes - not head and neck Stage 3A (Microscopic AND low burden disease)	Refer SSMDT CT scan Chest, abdomen and Pelvis with contrast MRI head Refer to oncology if high risk tumour type after SSMDT review. Scans should be up to date (<i>within 12 weeks</i> of starting oncological systemic treatment).	Follow up 5 years as per guidance (ALL lymph nodes) Consider regional Lymph node ultrasound every 3 months for 3 years. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">Mini-tub (closed trial) involved: US follow up 3-4 monthly 2 years 6/12 3-5 years, annual 6-10 years CT scan annually for 10 years</div>
Positive Sentinel nodes- not head and neck <u>AND</u> ≤2mm <u>OR</u> No Extracapsular spread	Refer SSMDT Arrange CT chest, abdomen and pelvis (urgent with contrast) and MRI brain FBC, U & Es, LFT and LDH Refer to Oncology if 1mm -2mm SLNB deposit(s) or ≥pT2b with micromets and if able to travel and performance status 0-2 BRAF test	Follow up 5 years as per guidance (ALL lymph nodes) See high risk melanoma imaging contrast CT of Head, Chest abdomen and pelvis: 6 monthly for 3 years & 12 monthly for 2 years SSMDT to consider PET scan if groin positive node SSMDT to consider Trial
Positive Sentinel nodes (not head and neck) AND >2mm Or Extracapsular spread	Refer SSMDT Arrange CT chest abdomen and pelvis (urgent with contrast) FBC, U & Es, LFT and LDH Consider lymph node dissection <u>Pelvic dissection:</u> <ul style="list-style-type: none"> ▪ >1 clinically palpable groin LN ▪ CT or ultrasound evidence of >1 groin node(s), or of pelvic node involvement ▪ >1 macroscopically involved sentinel node at SLNB >2mm metastasis ▪ A conglomerate of inguinal or femoral triangle lymph nodes ▪ Micro/macrosopic involvement of Cloquet's node 	Follow up 5 years as per guidance (ALL lymph nodes) See high risk melanoma imaging contrast MRI of Head, Chest abdomen & pelvis: 6 monthly for 3 years & 12 monthly for 2 years (See page **) Genetic/BRAF testing SSMDT to Consider PET scanning if for pelvic lymphadenopathy <u>Refer after Surgery to Oncology</u> for adjuvant therapy if able to travel and performance status 0-2

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DIAGNOSIS	ACTION	FOLLOW UP ACTIONS
Melanoma Positive sentinel nodes (any size) Head and neck	Refer SSMDT (Head and Neck Consultant) Arrange CT Chest abdomen and pelvis (urgent with contrast) Arrange MRI brain and neck FBC, U & Es, LFT and LDH Offer dissection of affected lymph node basin (SSMDT)	Follow up 5 years as per guidance (ALL lymph nodes) See high risk melanoma imaging follow up (see above and page **) Genetic/BRAF testing <u>Refer after Surgery to Oncology</u> for adjuvant therapy if able to travel and performance status 0-2
Palpable lymph node (possible melanoma)	Refer SSMDT FNA (consider US guided) Only 2 inconclusive attempts before open biopsy	Follow up 1-2 weeks for FNA results See above for pelvic dissection decision
Melanoma Radiotherapy	Refer SSMDT Refer patients with: Node ≥ 3 cm axilla, ≥ 4 cm groin or ≥ 3 nodes Extracapsular spread or Extracapsular spread for head and neck or ≥ 3 cm Consider surgical resection margins; if in doubt refer for radiotherapy. (May not be offered by Oncology due to morbidity & balance survival advantage)	Follow up 5 years (ALL lymph nodes) Then annually for further 5 years
Relapse melanoma	Refer SSMDT For MDT discussion & consider trials Refer to Oncology if \geq Stage 3b disease Staging CT Chest, abdomen and Pelvis and MRI brain	Follow up 5 years (whole skin exam and ALL lymph nodes) Then annually for 5 more years
Melanoma in younger people (less than 24)	If stage 3 disease or greater consider whole body MRI for staging (SSMDT) Refer to TYA (Teenager and Young adult) MDT	Follow up 1 year stage 1, 5 years if stage 2 and 10 years if Stages 3-4 (SSMDT to consider planning for imaging)
Palpable melanoma proven lymphadenopathy or High risk melanoma Stage 4	Refer to SSMDT Consider Surgical resection and Oncology referral (stage 4 resected)	Follow up 5 years (whole skin exam and ALL lymph nodes) Then annually for 5 years AND CT Chest, abdomen and pelvis + MRI head and neck first then 6 monthly CT (CAP) only for 3 years & 12 monthly for 2 years
Melanoma in Pregnancy	Refer SSMDT WLE & consider SLNB and Anaesthesia risks according to trimester of pregnancy. Consider risks: 1 st Trimester risks for GA Palpable lymph node disease for SSMDT discussion in conjunction with Obstetrician for early delivery or termination (see page 10)	If < 0.8 mm review until 1 year after delivery Consider risk to pregnancy for each trimester Follow up 5 years otherwise

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DIAGNOSIS	ACTION	FOLLOW UP ACTIONS
Cutaneous Squamous cell carcinoma (see page **) for reference		
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
<p><i>For invasive cSCC a full skin check is required with examination of regional lymph node basins, patient education about sun protection and skin surveillance and warned about the risk of further cSCCs.</i></p> <p><i>There is a 40% chance of further keratinocyte carcinoma within 5 years. If more than 1 previous keratinocyte carcinoma then risk is doubled to 80% within 5 years.</i></p> <p><i>After discharge if patients suspect further cSCC for referral under 2 week wait pathway via GP.</i></p>		
Low risk cSCC	No LSMDT referral needed Clinical excision 4 mm margin	Discharge if completely excised with histological ≥ 1 mm margins
High Risk cSCC	Refer LSMDT for those with close or involved pathological margins and/or more than 1 risk factor >6mm excision margin	Follow up every 4 months for 1 year If >1 risk factor for 6 monthly review in 2 nd year
Very High risk cSCC	Consider SSMDT referral for opinion or management >10mm excision margin	Follow up 3 years: Every 4 months for 2 yrs Every 6 months for final year
Scalp SCC with narrow (≤ 1mm) or incomplete deep margin	If head and neck SCC either incompletely excised or histologically narrow deep margin (< 1 mm) <u>Refer to SSMDT or Head and Neck MDT (Max fac/ENT) according to local rules</u>	Consider further treatment with WLE and/or radiotherapy Follow up 3 years
High risk SCC with management difficulty	Refer SSMDT Consider Cemiplimab	Follow up 3 years
Palpable lymph node	FNA Open biopsy if two failed attempts	Follow up ≤ 3 weeks for results If positive SSMDT referral
Metastatic SCC	Refer SSMDT Consider Oncology referral if not resectable	CT Chest and Abdomen (+/- Pelvis for lower body) + MRI Neck for Head/Neck
Primary Radiotherapy for SCC	Patient preference and MDT agreement Where cSCC primary surgery not feasible (poor functional or cosmetic outcome)	Follow up as per Risk guidance
Adjuvant radiotherapy for SCC if any of these factors:	<ul style="list-style-type: none"> Incomplete excision and further surgery not feasible High risk of local recurrence >0.1mm perineural invasion below dermis or multifocal nerve involvement Recurrent disease Immunocompromised Close peripheral margins (≤ 1 mm) pT3 tumours (with multiple risk factors including: invasion beyond fat and >6mm thick) Offer adjuvant radiotherapy following therapeutic regional lymph node dissection with high risk pathology (> 2 involved nodes, large nodes or extracapsular extension - \geq pN1) 	<p>Very high risk SCC follow up</p> <p>Consider imaging if bone/cavity involvement</p>

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DIAGNOSIS	ACTION	FOLLOW UP ACTIONS
Basal Cell Carcinoma (see page ** for reference)		
Low risk site and type of BCC	Excision 4 mm radial margin	Discharge if completely excised
High risk site and low risk BCC type	Consider excision 4 mm margin	Discharge if completely excised
High risk site and type	Consider excision with Mohs (or 10-15 mm margin)	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/ 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 Refer to SSMDT	Follow up shared on a case by case basis
Atypical Fibroxanthoma		
AFX (Although not strictly malignant)	Refer LSMDT Offer clinical 6mm WLE	If completely excised with good margins discharge (treat as per well diff SCC)
Dermatofibrosarcoma protuberans		
Dermatofibrosarcoma protuberans (DFSP)	Refer to SSMDT Offer >1cm wider excision including fascia	Follow up local recurrence and lymphatic basins, late local recurrence common 10 year follow up
Fibrosarcomatous changes within DFSP (treat as soft tissue sarcoma)	Refer Sarcoma MDT 3-5cm Wider excision including fascia 10% risk of lymph node metastasis CT staging Chest, abdomen and pelvis	Follow up local recurrence and lymphatic basins, late local recurrence common Consider Chest X-rays every 6-12 months for 5 years 10 year follow up
Merkel Cell Carcinoma		
Merkel Cell Carcinoma	Refer SSMDT Plan CT Chest, abdomen and pelvis staging, 1 to 3cm WLE including fascia and SLNB Offer post op radiotherapy to primary and lymph node basins - Early metastasis common (50%).	Close follow up High risk CT scanning protocol 3/12 for 5 years
Pleomorphic Sarcoma		
Pleomorphic Sarcoma (previously known as Malignant Fibrous Histiocytoma)	Refer Skin MDT if above fascia and less than 4cm in size; otherwise refer Sarcoma MDT. Offer Wide excision with >1cm including superficial fascia	Follow up 3 years (3/12 for one year then 4/12 for one year then 6/12 for one year) Consider CT at diagnosis (Chest, abdomen and Pelvis)

Skin Cancer Management guidelines 2023

Notes and exceptions

Young people aged 16-24 years should also be referred to the TYA (Teenage and Young Adult) MDT, consider offering MRI investigations instead of CT (caution with interpretation of chest MRI scans)

1. Patients with palpable lymph nodes should not be offered SLNB.
2. 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.
3. If SLNB declined, offer imaging in consultation with SSMDT (see NICE guidelines).

For long term follow up consider:

1. Refer patient back to local dermatology team / nurse led clinic for either alternating or shared care, avoiding duplication of appointments and consideration of distance to travel.
2. Teach patient how to perform skin self examination
3. Offer smoking cessation advice.
4. Offer HNA during treatment, once treatment is complete.
5. Offer the patient the opportunity to attend a health and well being clinic/ event within 6 months of completion of treatment.
6. Offer end of treatment summary once treatment is complete.
7. Provide information on reducing sun exposure.
8. Measure serum Vitamin D levels at diagnosis and treat accordingly using local Vitamin D guidance (page 8).

The Melanoma Major Changes from AJCC 7th Edition are:

T group	Change of T1a thickness from 1mm to 0.8mm and ulceration significant (mitoses not significant) Pathology of T to nearest 0.1mm. Tis, T0 and Tx can be used in staging
N group	Clinically occult replaces "microscopic" and "macroscopic" and clinically apparent for palpable clinical regional lymph node disease. Increased stratification of non-nodal regional disease according to number of tumour involved nodes
M group	Defined by distant anatomical sites and LDH status for each group (elevated LDH is not M1c) New M1d sub group

Notes on Sentinel lymph node biopsy from AJCC 8th Edition

1. **Not recommended** if Stage 1a and less than 0.76mm (pre-test probability of 3% of positive result)
2. For stage 1a and 0.76-1mm with no ulceration and <1mm² mitoses – **Consider** SLNB according to AJCC 8th edition (not NICE guidelines currently) as 7% pre-test probability of positive result.
For AJCC 8th edition stage 1b (0.76mm to 1mm with ulceration) **offer** SLNB as pretest probability is higher
3. After Cancer Quality Group Meeting May 2023 following NICE guidelines for SLNB only if ulcerated if under 1mm, but could be considered if High mitoses or lymphovascular invasion

ECOG PERFORMANCE STATUS	
GRADE	
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any self-care; totally confined to bed or chair
5	Dead

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Staging adapted from Melanoma of the Skin AJCC 8th Edition (2018)

Primary Tumour:

Tx	Primary tumor thickness cannot be assessed (eg, diagnosis by curettage)
T0	No evidence of primary tumor (eg, unknown primary or completely regressed melanoma)
Tis	Melanoma in situ
T1a	<0.8 mm without ulceration
T1b	0.8-1.0 mm without ulceration or <0.8mm with ulceration
T2a	>1.0-2.0 mm without ulceration
T2b	>1.0-2.0 mm with ulceration
T3a	>2.0-4.0 mm without ulceration
T3b	>2.0-4.0 mm with ulceration
T4a	>4.0mm without ulceration
T4b	>4.0mm with ulceration

Nodal status

Nx	Regional nodes not assessed (eg, sentinel lymph node [SLN] biopsy not performed, regional nodes previously removed for another reason); Exception: pathological N category is not required for T1 melanomas, use clinical N information
N0	No regional metastases detected
N1a	One clinically occult (ie, detected by SLN biopsy)
N1b	One clinically detected
N1c	No regional lymph node disease. With satellites or in-transit disease and/or microsatellite metastases
N2a	Two or 3 clinically occult (ie, detected by SLN biopsy)
N2b	Two or 3, at least one of which was clinically detected
N2c	One clinically occult or clinically detected with satellites or in-transit disease and/or microsatellite metastases
N3a	Four or more clinically occult (ie, detected by SLN biopsy)
N3b	Four or more, at least one of which was clinically detected, or the presence of any number of matted nodes
N3c	Two or more clinically occult or clinically detected and/or presence of any number of matted nodes with satellites or in-transit disease and/or microsatellite metastases

Metastases

[add (0) for Not elevated LDH and (1) for elevated LDH]

M0	No evidence of distant metastasis
M1a	Distant metastasis to skin, soft tissue including muscle, and/or nonregional lymph node
M1b	Distant metastasis to lung with or without M1a sites of disease.
M1c	Distant metastasis to non-CNS visceral sites with or without M1a or M1b sites of disease
M1d	Distant metastasis to CNS with or without M1a, M1b, or M1c sites of disease

Staging

Clinical Staging				Pathological staging			
Stage 0	Tis	N0	M0	Stage 0	Tis	N0	M0
Stage 1A	T1a	N0	M0	Stage 1A	T1	N0	M0
Stage 1B	T1b or T2a	N0	M0	Stage 1B	T2a	N0	M0
Stage 2A	T2b or T3a	N0	M0	Stage 2A	T2b or T3a	N0	M0
Stage 2B	T3b or T4a	N0	M0	Stage 2B	T3b or T4a	N0	M0
Stage 2C	T4b	N0	M0	Stage 2C	T4b	N0	M0
Stage 3	Any T, Tis	≥N1	M0	Stage 3A	T1a/b-T2a	N1a or N2a	M0
				Stage 3B	T0	N1b or N1c	M0
					T1a/b-T2a	N1b/c or N2b	M0
					T2b-T3a	N1a or N2b	M0
				Stage 3C	T0	N2b/c or N3b/c	M0
					T1a-T3a	N2c or N3a/b/c	M0
					T3b or T4a	Any N ≥ N1	M0
					T4b	N1a-N2c	M0
					T4b	N3a/b/c	M0
				Stage 3D	T4b	N3a/b/c	M0
Stage 4	Any T	Any N	M1	Stage 4	Any T	Any N	M1

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Risk stratification for cutaneous Squamous Cell Carcinoma

	Low Risk	High Risk	Very High Risk
Tumour	Tumour max. diameter ≤20mm Tumour ≤4mm thickness No Perineural invasion Well or moderate differentiation No Lymphovascular invasion (ALL factors should apply to denote low risk)	Diameter >20-40 mm (pT2) Tumour 4-6 mm thickness Invasion into subcutaneous fat Perineural invasion – dermal only (nerve diameter ≤0.1mm) Poorly differentiation Lymphovascular invasion Tumour of ear, lip or arising in area of chronic inflammation (ANY single factor denotes high risk)	Diameter >40 mm (pT3) Tumour >6 mm thickness Invasion beyond subcutaneous fat Any bone invasion Perineural invasion: named nerve, nerve diameter ≥0.1mm or nerve beyond dermis High grade subtype: Adenosquamous, desmoplastic, spindle/ sarcomatoid/ metaplastic In-transit metastasis (ANY single factor denotes very high risk)
Margin status	Clear pathological margins in all dimensions ≥1mm	One or more involved or close (<1mm) margin in a pT1 tumour Close pathological margins (<1mm) in a pT2 tumour	One or more involved or close (<1mm) pathological margin in a high risk tumour
Patient factors	Immune competent	Iatrogenic immunosuppression or biological therapies; frailty &/or comorbidities likely to cause some degree of immunocompromised; HIV infection stabilised on HAART	As for High risk especially solid organ transplant recipients, haematological malignancies, (eg CLL or myelofibrosis) other significant immunosuppression

Staging for cutaneous Squamous cell carcinoma (Tumour- Nodes- Metastasis)

T categories	
T1	<2cm in greatest dimension
T2	2 to 4cm in greatest dimension
T3	>4cm in greatest dimension or minor bone erosion or specified perineural invasion (≥0.1mm diameter and/or nerve deeper than the dermis and/or named nerve) or deep invasion (Thickness >6mm and/or beyond sub-cutaneous fat)
T4a	Tumour with gross cortical bone/marrow invasion
T4b	Tumour with skull base or axial skeleton invasion including foraminal involvement and/or vertebral foramen involvement to the epidural space
N categories (Non head and neck)	
N1	Metastasis in a single ipsilateral lymph node ≤3cm greatest diameter
N2	Metastasis in a single ipsilateral lymph node >3cm but ≤ 6cm or in multiple nodes <6cm or in multiple ipsilateral nodes with none >6cm in greatest dimension
N3	Metastasis in lymph node >6cm maximal dimension
N categories (head and neck)	
N1	Metastasis in a single ipsilateral lymph node ≤3cm greatest diameter without ENE
N2a	Metastasis in a single ipsilateral lymph node >3cm but < 6cm without ENE
N2b	Multiple metastatic ipsilateral lymph nodes, where none are >6cm greatest diameter and without ENE
N2c	Metastasis in multiple or contralateral lymph nodes, where none are >6cm greatest diameter without ENE
N3a	Metastasis in single or multiple lymph nodes >6cm in greatest dimension without ENE
N3b	Metastasis in single or multiple lymph nodes >6cm in greatest dimension with ENE
M categories	
M0	No distant Metastases
M1	Distance metastasis (excluding contralateral lymph nodes non-head and neck cSCC)

ENE = Extranodal extension (or extracapsular extension) can be clinical or pathological

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TNM 8th edition for cutaneous Squamous Cell Carcinoma

Stage	T	N	M
1	T1	N0	M0
2	T2	N0	M0
3	T3	N0	M0
	T1, T2 or T3	N1	M0
4A	T1, T2 or T3	N2 or N3	M0
	T4	Any N	M0
4B	Any T	Any N	M1

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Checklist for Completion Lymphadenectomy

Possible advantages of completion lymphadenectomy	Possible disadvantages of completion lymphadenectomy
Removing the rest of the lymph nodes before cancer develops reduces the chance of the cancer returning in the same part of the body.	Lymphoedema (long-term swelling) may develop, and is most likely if the operation is in the groin and least likely in the head and neck.
The operation is less complicated and safer than waiting until cancer develops in the remaining lymph nodes and then removing them.	In 4 out of 5 people, cancer will not develop in the remaining lymph nodes, so there is a chance that the operation will have been done unnecessarily.
People who have had the operation may be able to take part in clinical trials of new treatments to prevent future melanoma. These trials often cannot accept people who have not had this operation.	There is no evidence that people who have this operation live longer than people who do not.
	Having any operation can cause complications.

Checklist for imaging for melanoma high risk patients (Stage 3C or over)

Possible advantages of surveillance imaging (having regular scans)	Possible disadvantages of surveillance imaging (having regular scans)
If the melanoma comes back (recurrent melanoma), it is more likely to be detected sooner. It is possible that this could lead to a better outcome by allowing treatment with drugs (such as immunotherapy drugs) to start earlier.	Although early drug treatment of recurrent melanoma might improve survival, there is currently no evidence showing this.
Some people find it reassuring to have regular scans.	Some people find that having regular scans increases their anxiety.
	Scans expose the body to radiation, which can increase the risk of cancer in the future.
	Scans of the brain and neck increase the risk of developing cataracts.
	Scans of the chest cause a very small increase in the risk of thyroid cancer & increased risk of breast cancer.
	Scans may show abnormalities that are later found to be harmless, causing unnecessary investigations and anxiety.

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Imaging for high risk melanoma

- **Stage IIC:**
 - Lesions >4 mm in thickness with ulceration but no lymph node involvement (pT4bN0M0) are associated with a 5-y survival rate of **45%**
- **Stage IIIB:**
 - Patients with any-depth lesion, positive ulceration, and 1 lymph node positive for micrometastasis (pT1-4bN1aM0) or 2-3 nodes positive for micrometastasis (T1-4bN2aM0) have a 5-y survival rate of **50-53%**
 - Patients with any-depth lesion, no ulceration, and 1 lymph node positive for macrometastasis (pT1-4a, N1b, M0) or 2-3 nodes positive for macrometastasis (pT1-4aN2bM0) have a 5-y survival rate of **46-59%**
- **Stage IIIC:**
 - Patients with any-depth lesion, positive ulceration, and 1 lymph node positive for macrometastasis (T1-4bN1bM0); 2-3 nodes positive for macrometastasis (pT1-4bN2bM0); or ≥4 metastatic lymph nodes, matted lymph nodes, or in-transit met(s)/satellite(s) have a 5-y survival rate of **24-29%**

At CNG meeting on 28th March 2018, the information above was presented. Consideration for follow up CT scans was discussed. On a case by case basis the risks of radiation, anxiety and cost implications should be discussed with each patient. The approximate risk of each CT scan of Chest, abdomen and Pelvis confers a 0.05% chance of a solid organ malignancy.

Updated October 2022. Due to benefit/risk analysis of Stage 2b, stage 2c and Stage 3a melanoma, adjuvant oncology may give some benefit and referral should be considered. If referral for staging scans and braf status assessment PRIOR to referral. NICE recommended.

Adjuvant therapy for Stage 3 disease

October 2018 NICE approved treatment for braf +ve stage 3 disease treatment with combination adjuvant therapy (Dabrafenib and Trametinib) for one year. Evidence currently doesn't support treatment for those with <1mm micrometastasis. Combi-AD trial 19% reduction disease free survival DFS, but trial inclusion only if >1mm micrometastasis.

December 2018 NICE approved Pembrolizumab for braf wild type disease for 1 year treatment.

Current consensus CQG March 2019 – offer adjuvant therapy for those with >1mm micrometastasis and minimal tumour burden (i.e. have had completion dissection if high risk factors – head and neck primary, extracapsular spread and >2mm disease).

CQG meeting November 2019

Offer CT for pT4b melanoma prior to SLNB due to increased chance of other metastasis MRI brain for patients greater than stage 3b.

Melanoma in pregnancy – 1st trimester caution for any operation ,

2nd trimester – may not offer further treatment – question need for SLNB.

3rd Trimester – consider SLNB as likely able to offer completion or immunotherapy.

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Decision matrix for adjuvant therapy or further surgery for melanoma

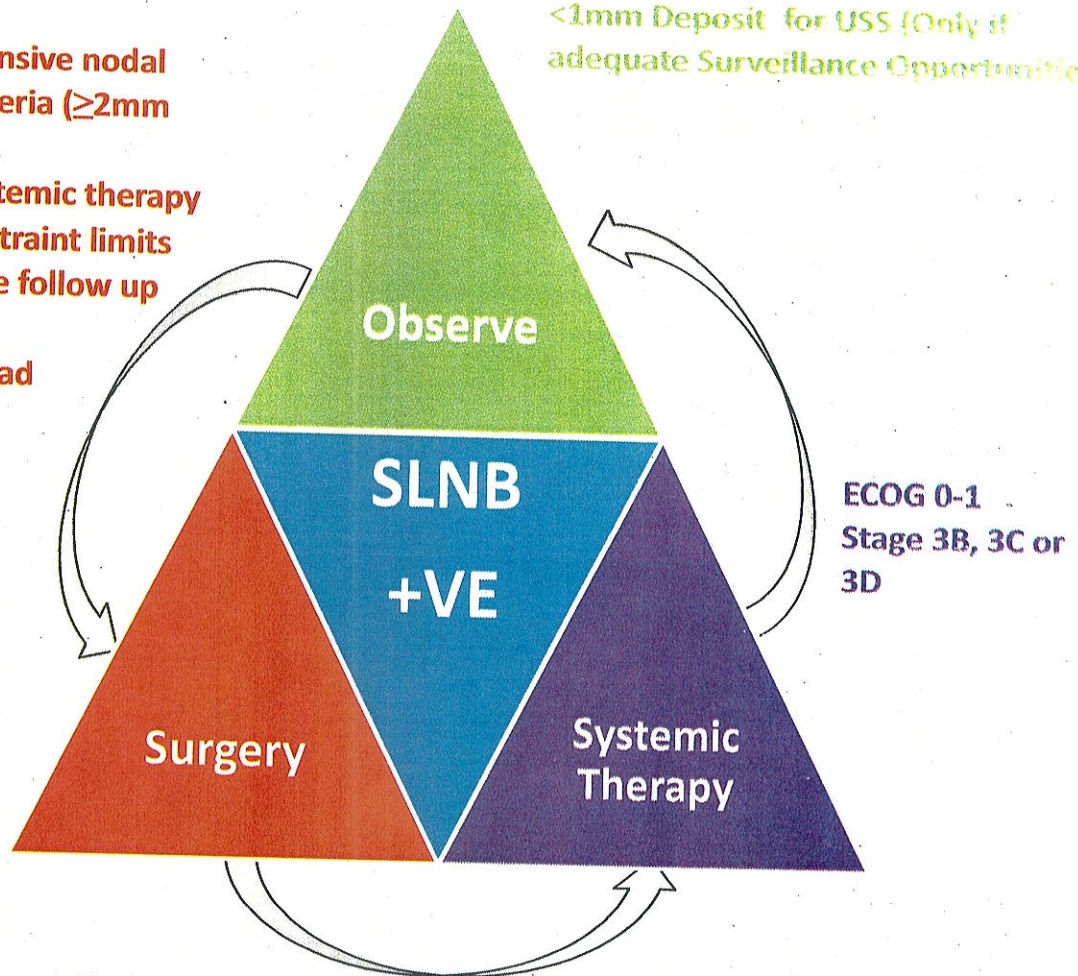
Head and neck site

And/Or

- Multifocal or extensive nodal met by Dewar criteria ($\geq 2\text{mm}$ deposit)
- Unsuitable for systemic therapy
- Geographical constraint limits access to adequate follow up therapy
- Extracapsular spread
- ≥ 3 +ve nodes

AJCC Stage 3A

<1mm Deposit for USS (Only if adequate Surveillance Opportunities)



Treatment for Stage 3

- Stage 3A
 - pT1a, pT1b and pT2a and N1a or N2a
 - Offer Minitub if eligible or USS surveillance locally.
 - Refer for adjuvant therapy if <1mm deposit in sentinel node (< 2mm primary melanoma)
- Stage 3B
 - pT0 and N1b or N1c OR pT1a/b-pT2a and N1b/c or N2b OR pT2b -pT3a and N1a or N2b
 - Offer surgical excision if immunocompromised, extracapsular spread or >2mm deposit in lymph node.
 - Refer to Oncology for adjuvant treatment if performance status 0-1 and no contra-indications
- Stage 3c
 - pT0 and N2b/c or N3b/c OR pT1a-3a and N2c or N3a/b/c OR pT3b-4a and any n \geq n1 OR pT4b and N1a-2c
 - Offer surgical excision if immunocompromised, extracapsular spread or >2mm deposit in lymph node.
 - Refer to Oncology for adjuvant treatment if performance status 0-1 and no contra-indications
- Stage 3d
 - pT4b and N3a/b/c
 - Offer surgical excision if immunocompromised, extracapsular spread or >2mm deposit in lymph node.
 - Refer to Oncology for adjuvant treatment if performance status 0-1 and no contra-indications

REFERENCE (Risk definitions)

Squamous cell carcinoma

Tumour behavior widely variable within the histological diagnostic category of 'primary cutaneous SCC'.

Site:

Tumour location influences prognosis: sites are listed in order of increasing metastatic potential.

Low risk:

- SCC arising at sun-exposed sites excluding lip and ear.

High risk:

- 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, Marjolin's ulcer
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, local circumstances and patient's wishes.

Brigham and Women's staging system (Skin Squamous Cell Carcinoma)

T1 = 0 high-risk factors

T2a = 1 high-risk factor

T2b = 2 to 3 high-risk factors

T3 = ≥ 4 high-risk factors

High-risk factors include: tumour diameter ≥ 2 cm, poorly differentiated histology, perineural invasion ≥ 0.1 mm, and tumour invasion beyond fat (excluding bone invasion, which automatically upgrades to stage T3).

Basal Cell Carcinoma

- Increasing size and poorly defined lesions confer higher risk of recurrence.
- Site – lesions on the central face (the eyes, nose, lips & ears have higher recurrence risk).
- 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 radial margins (<0.5 mm) warrant discussion with patient about observation or further surgery in some cases (e.g. can't observe due to site or poor vision). Note narrow deep margins harder to observe. Consider that could be incompletely excised if not excised with Mohs technique

Skin Cancer Management guidelines 2023

Table 2: Vitamin D treatment guidelines.

Exclude patients with hypercalcaemia or an eGFR <30mL/minute/1.73m². See Appendix 1

Patient Characteristics	Recommendations	Notes
Deficiency in adults: ≤30nmol/L Or <12ng/mL Deficiency: high dose treatment initially, then long term maintenance treatment required If deficiency is diagnosed in pregnancy please follow guidelines of your local maternity services provider	<p>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.</p> <p>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</p>	<p>Treatment Dose: Due to compliance issues locally Liverpool are suggesting a loading dose is given by either:</p> <p>Colecalciferol 20,000IU orally ONE daily for 15 days</p> <p style="text-align: center;">OR</p> <p>Colecalciferol 20,000IU orally FIVE daily for 3 days</p> <p>Maintenance dose: Colecalciferol 20,000 IU ONE orally once a month</p> <p><i>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</i></p>
<p>Alfacalcidol is not considered appropriate for community use in Vitamin D deficiency unless advised by specialists due to the risk of hypercalcaemia. See Appendix 3</p>		

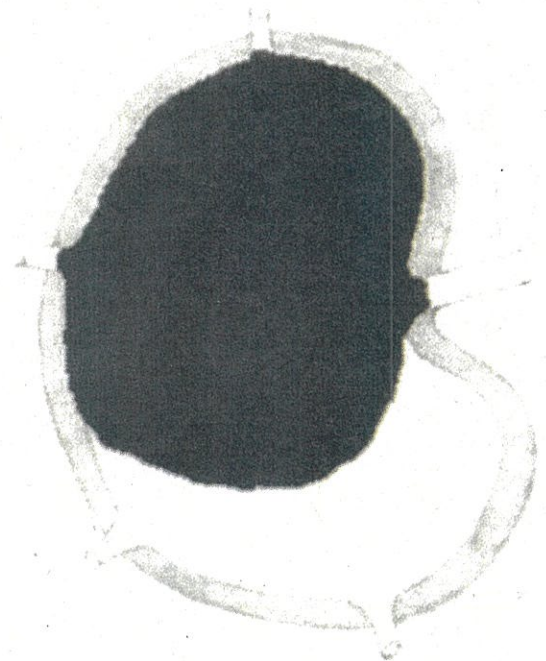
Table 2: Vitamin D treatment guidelines.

Patient Characteristics	Recommendations	Notes
Insufficiency in adults: >30 to 50nmol/L Or >12-20ng/mL Insufficiency: Maintenance treatment likely to be required	<p>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.</p> <p>Assess patient holistically Consider prescribing if symptomatic & at risk / previously deficient/ unlikely to take supplements / breast feeding or considering pregnancy / wintertime</p>	<p>Maintenance dose:</p> <ul style="list-style-type: none"> 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 Adcal D3 are licensed preparations available on prescription and can be considered for maintenance treatment <p>Or where compliance may be an issue</p> <ul style="list-style-type: none"> Colecalciferol 20,000IU one capsule per month available via prescription
Healthy or at risk adults >50-75nmol/L Or > 20ng/mL Symptom free	<p>Lifestyle advice</p> <p>Can consider daily self treatment with over the counter purchased supplement of 400-800IU Vitamin D daily</p>	<p>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.</p> <p>NB prevention may be needed in older people / housebound / in institution</p>

Dewar Criteria for lymph node metastases:



Multifocal metastases



Extensive nodal metastasis

Dewar et al 2004 JCO

ABBREVIATIONS:

AJCC – American Joint Cancer Committee	SLNB – Sentinel Lymph node biopsy
C & C – Curettage and cautery	SSMDT – Specialist Skin Multidisciplinary Team
ENE – Extranodal extension	TYA – Teenage and Young Adult
FNA – Fine needle aspiration for cytology	WLE – Wide local excision
HAART – Highly active antiretroviral therapy	
LSMDT – Local skin Multidisciplinary Team	
NICE – National Institute for Health and Care Excellence	