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Prevention and Early Detection 1

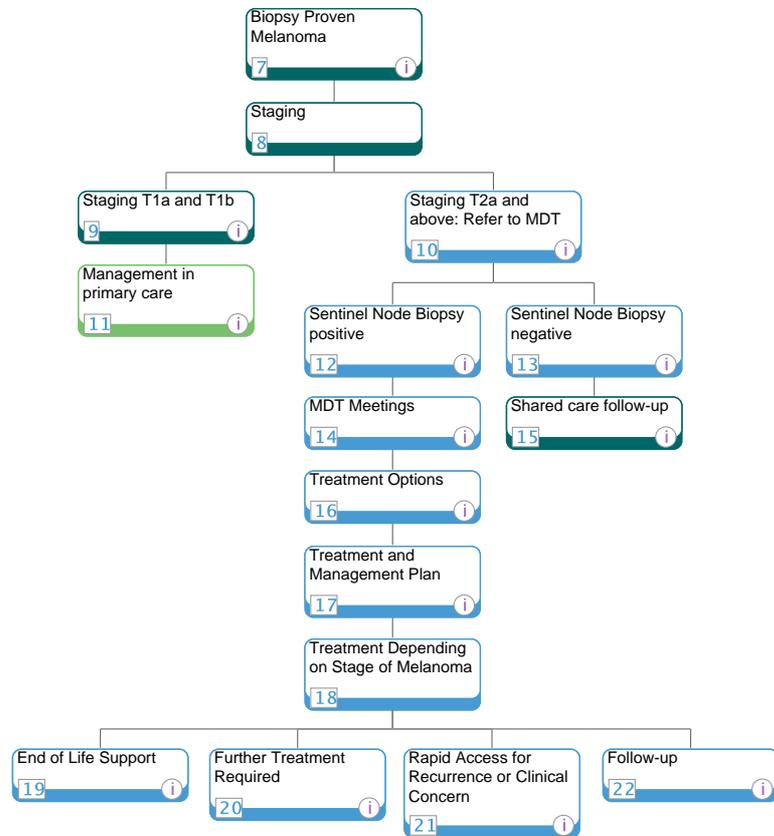
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Melanoma

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1 Prevention and Early Detection

Quick info:

Those at risk of melanoma in New Zealand should be informed that:

- sunburn should be avoided and ultra violet protection (primarily physical methods complemented by sunscreen) adopted
- the use of artificial tanning devices (sunbeds/tanning units) should be strongly discouraged. According to the Australia/New Zealand Solaria Standard, those under the age of 18 years and those with Skin Phototype 1 are prohibited from using sunbeds. Those 18 years and over should be informed of the risks and lack of evidence for any health benefits

All adults, particularly those 50 years of age and over, should be advised to:

- regularly examine their skin (including skin not normally exposed to the sun) so that they can be aware of any changes
- get someone else to check areas difficult to see, such as their back
- seek advice from a doctor about suspicious lesions
- consider personal photographic record

Information aimed at reducing melanoma deaths should focus on:

- all adults, particularly males 50 years and over
- raising awareness of melanoma in Maori and other ethnic minorities including the specific features of nodular and acral lentiginous melanoma

Clinician Information:

- all primary care clinicians should be knowledgeable about the risks and types of melanoma
- all clinicians should be alert for skin lesions with malignant features in the context of physical examinations performed for other reasons
- all relevant allied health professionals who come into contact with people's skin should have access to training to recognise skin changes suggestive of melanoma and to advise patients with suspicious lesions to see a doctor
- the practice of skin check (sometimes referred to as spot check) programmes/clinics outside of established medical practice has not been evaluated
- there is no evidence to support population-based skin screening as to its effectiveness in reducing mortality

Individuals with two or more first-degree relatives with a history of melanoma below the age of 40 years should be examined carefully and those found to have melanoma and/or multiple atypical naevi:

- should be under the long-term care of a melanoma specialist
- may meet criteria for referral to Regional Clinical Genetics Services for further assessment, genetic counselling and discussion regarding criteria for genetic testing (rarely indicated)
- may require baseline total body photography and high-quality sequential digital dermoscopic imaging at 6 to 12-month intervals to detect new and changing lesions, particularly those with more than 50 melanocytic naevi and with multiple atypical naevi

Patients with large congenital melanotic naevi (CMN) (> 20 cm) should be under lifetime surveillance by a dermatologist or other clinician experienced with CNM.

2 Care Map Information

Quick info:

Latest data from 2009 shows that there were:

- 2212 new diagnoses of invasive melanoma
- 2040 melanoma in situ
- 326 deaths
- in that year melanoma was the fourth most commonly registered invasive cancer and the sixth most common cause of death from cancer in New Zealand

The incidence of melanoma increases with age, with the median age at diagnosis of 56 in men and 62 in women in 2008/2009. However, melanoma is one of the more common malignancies in younger age groups with significant numbers diagnosed between 19 and 39 years of age. Melanoma is the commonest cause of cancer death in this age group.

For melanoma, the thickness of the lesion at diagnosis is the strongest predictor of prognosis; in general, the thinner the lesion, the better the outcome.

There are five classifications of melanoma

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[Link to dermnet website for classifications of Melanoma](#)

Malignant melanoma is a tumour arising from melanocytes.

Superficial spreading/radial growth phase melanoma (SSM):

- most common type of melanoma characterised by:
 - asymmetrical pigmented lesion with irregular borders
 - irregular pigmentation
 - irregular outline
 - patient may notice growth, change in sensation and/or colour, crusting, bleeding, or inflammation
 - duration of symptoms varies from months to years
- tend to occur on sun-exposed skin

Nodular/vertical growth phase melanoma (NM):

- usually has a shorter history:
 - greater tendency to bleed and/or ulcerate
- may occur on skin not habitually exposed to sun

Lentigo maligna melanoma (LMM):

- most often occurs in sun damaged skin on the head and neck of older patients

Acral lentiginous melanoma (ALM):

- occurs on sites including the palms, soles, and beneath the nails

Desmoplastic melanoma

Incidence and prevalence:

- melanoma of the skin is an increasingly common tumour
- NM is the second most common type of melanoma
- ALM is an uncommon melanoma

3 Information resources for patients and carers

Quick info:

[Melanoma guide](#) from Cancer Society

[NZGG \(2008\) Pamphlet on melanoma](#)

[Health Pathways \(Nov 2010\) Sun smart behaviour leaflet](#)

[Health Pathways \(Nov 2010\) Looking after your skin surgery wound](#)

[Advanced cancer](#)

[Cancer in the family](#)

[Eating well during cancer treatment](#)

[Emotions and cancer](#)

[Sexuality and cancer](#)

[Understanding grief](#)

[Cancer Society Support services](#)

[Melanoma Foundation of New Zealand](#)

4 Updates to this care map

Quick info:

Date of draft publication: September 2014.

Updated: January 2015

Next update due: January 2016

This care map has been developed in line with consideration to evidenced based guidelines.

For further information on contributors and references please see the care map's Provenance.

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NB: This information appears on each page of this care map.

5 Hauora Maori

Quick info:

Maori are a diverse people and whilst there is no single Maori identity, it is vital practitioners offer culturally appropriate care when working with Maori whanau. It is important for practitioners to have a baseline understanding of the issues surrounding Maori health. This knowledge can be actualised by (not in any order of priority):

- clinicians acknowledging [Te Whare Tapa Wha](#) (Maori model of health) when working with Maori whanau
- asking Maori clients if they would like their whanau or significant others to be involved in assessment and treatment
- asking Maori clients about any particular cultural beliefs they or their whanau have that might impact on assessment and treatment of the particular health issues
- consider the importance of introductions and mihimihi ('whanaungatanga') - a process that enables the exchange of information to support interaction and meaningful connections. This means taking a little time to ask where this person is from or where they have significant connections to. This information is reciprocated; i.e. the health professional also shares where they are from
- knowledge of the [Hawke's Bay health sector's strategies and initiatives](#) for improving Maori health and wellbeing
- having a historical overview of legislation that has impacted on Maori well-being

Training is available through the Hawke's Bay DHB to assist you to better understand Maori culture and to better engage with Maori patients. Contact the coordinator (education@hbdhb.govt.nz) to request details of the next courses.

For more information on the regional and national Maori Health Strategies go to:

- **Mai** Maori Health Strategy 2014-2019- [Full file](#) or [Summary diagramme](#)
- **He Korowai Oranga:** Maori Health Strategy - sets the [Government's overarching framework](#) to achieving the best health outcomes for Maori

Hawke's Bay District Health Board contracts Maori Providers to deliver some screening, and mobile nursing services. A referral to one of these providers may assist Maori patients to feel more comfortable about receiving these services.

Central Hawke's Bay:

- Central Health - <http://www.centralhealth.co.nz/>

Hastings:

- Te Taiwhenua o Heretaunga - <http://www.ttoh.iwi.nz/>
- Kahungunu Health Services (Choices) - <http://www.choices.maori.nz/>

Napier:

- Te Kupenga Hauora - <http://www.tkh.org.nz/>

Wairoa:

- Kahungunu Executive - <http://www.familyservices.govt.nz/directory/viewprovider.htm?id=5352&back=searchprovideralphabetical.htm?letter=K&providerId>

6 Pacific

Quick info:

Pacific people value their culture, language, families, education and their health and wellbeing. Many Pacific families have a religious affiliation to a local church group.

The Pacific people are a diverse and dynamic population:

- more than 22 nations represented in New Zealand
- each with their own unique culture, language, history, and health status
- share many similarities which we have shared with you here in order to help you work with Pacific patients more effectively
- for many families language, cost and access to care are barriers

Pacific ethnic groups in Hawke's Bay include Samoa, Cook Islands, Fiji, Tonga, Niue, Tokelau, Kiribati and Tuvalu. Samoan and Cook Island groups are the largest and make up 2/3rds of the total Pacific population. There is a growing trend of inter-ethnic relationships and New Zealand born Pacific populations.

Acknowledge [The FonoFale Model](#) (Pacific model of health) when working with Pacific peoples and families.

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General guidelines when working with Pacific peoples and families (information developed by Central PHO, Manawatu):

- [Cultural protocols and greetings](#)
- [Building relationships](#) with your Pacific patients
- [Involving family support and religion](#) during assessments and in the hospital
- [Home visits](#)

Hawke's Bay-based resources:

- [HBDHB interpreting service](#) 06 8788 109 ext 5805 (no charge for hospital patients; charges apply for community-based translations)
- Tim Hutchins - Pacific Navigation Services LTD 027 9719199
- Services to assist Pacific peoples to access healthcare ([SIA](#))
- [Improving the Health of Pacific People in Hawke's Bay](#) – Pacific Health Action Plan

Ministry of Health resources:

- [Ala Mo'ui](#) - Pathways to Pacific Health and Wellbeing 2014-2018
- [Primary care for Pacific people](#): a Pacific and health systems approach
- Health education resources in [Pacific languages](#) (links to a webpage where you can download resources)

7 Biopsy Proven Melanoma

Quick info:

Patient receives results:

- diagnosis
- education
- management plan

Timely access to services - faster cancer treatment guidelines:

Patient MUST have a first specialist assessment (FSA) at the next clinic (within 14 days of referral).

Patients with histologically confirmed diagnosis of Melanoma must receive their recommended cancer treatment (surgery, radiotherapy, systemic therapy or palliative care) within 31 days of decision to treat.

The time from receipt of referral to the commencement of cancer treatment should not exceed 62 days.

9 Staging T1a and T1b

Quick info:

Histologically confirmed melanomas require re-excision with margins determined by Breslow thickness:

- in-situ melanomas – 5mm margins
- melanomas <1mm – 10mm margins
- melanomas 1-2mm – 10-20mm margins
- melanomas 2-4mm – 20mm margins
- melanomas >4mm – 20mm or greater margins

[American Joint Committee of Cancer poster on staging](#)

10 Staging T2a and above: Refer to MDT

Quick info:

Histologically confirmed melanomas require re-excision with margins determined by Breslow thickness:

- in-situ melanomas – 5mm margins.
- melanomas <1mm – 10mm margins
- melanomas 1-2mm – 10-20mm margins
- melanomas 2-4mm – 20mm margins

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- melanomas >4mm – 20mm or greater margins

[American Joint Committee of Cancer poster on staging](#)

Lesions meeting histological staging American Joint Committee on Cancer (AJCC) **T1b or higher** will be referred to a specialist for sentinel node biopsy at the time of the excision.

11 Management in primary care

Quick info:

The purpose of follow up is to:

- detect recurrence early
- detect new primary melanoma
- provide on-going patient education regarding self-examination and safe sun exposure
- provide psycho-social support

Follow up:

- 6 monthly for 5 years, then lifetime annual checks.

Staging T1a and below [Primary Care Management as per Melanoma Standards](#) OR referral to appropriate health professional for management.

[American Joint Committee of Cancer poster on staging](#)

See "Information resources for patients and carers" node at the top of this pathway for material and handouts and the "Supportive Care" node for local support agencies.

12 Sentinel Node Biopsy positive

Quick info:

Effective management of Stage III melanoma results in better regional control, potential survival benefits and recruitment into clinical trials. Surgeons and units experienced in lymphadenectomy improve outcomes for patients:

- all Stage IIIb patients should have imaging with whole body positron emission tomography-computed tomography (PET-CT) prior to surgery
- lymphadenectomy should be performed by surgeons trained and experienced in the procedures
- operation notes should fully describe the anatomical boundaries of the lymphadenectomy and lymph node levels removed
- a therapeutic axillary lymph node dissection includes levels I-III
- a therapeutic neck dissection needs to be tailored to the individual patient's metastatic disease and may include radical, modified radical or selective neck dissections plus/minus a parotidectomy
- a therapeutic inguinal dissection should involve skeletonisation of the femoral vessels; removal of pudendal nodes, nodes anterior to the external oblique and "Cloquet's" nodes in the femoral canal
- patients with palpable inguinal node metastases or greater than 3 positive nodes below the inguinal ligament will be considered for clearance of the iliac and obturator nodes in the pelvis
- patients with staging evidence of pathological intrapelvic nodes will undergo an iliac and obturator dissection plus/minus an inguinal dissection
- all Stage III melanoma will be discussed at a multidisciplinary team and be considered for adjuvant radiotherapy or enrolment in clinical trials
- patients should have access to a lymphoedema specialist (physiotherapist), to fit compression garments and provide education about post-operative lymphoedema management

13 Sentinel Node Biopsy negative

Quick info:

Follow-up is carried out by a clinician experienced in melanoma diagnosis and management.

14 MDT Meetings

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Quick info:

Multi-disciplinary Team Meetings (MDT):

Patient presentation includes:

- melanoma patients with stage IIa- IV level of disease/ desmoplastic/ non-cutaneous/ < 18 years of age
- patients may represent for discussion at any stage of their journey for further management//treatment

This needs input from SMOs involved in care in Hawkes Bay.

15 Shared care follow-up

Quick info:

[American Joint Committee on Cancer \(AJCC\) staging poster](#)

- Stage I melanoma should be assessed annually until the 10th anniversary
- Stage IIA, 6 monthly for 2 years and then annually until the 10th anniversary
- Stage IIB-IIC 4-monthly for 2 years, 6 monthly in the third year and annually thereafter until the 10th anniversary
- Stage III, 3 monthly for year 1, 4 monthly for year 2, 6 monthly until year 5, then annually thereafter until the 10th anniversary
- Stage IV, as for Stage III with additional visits as per clinical requirements [Ref 1 - Standard 8.1]

Patient self-examination is taught and is an integral part of melanoma follow-up [Ref 1 - Standard 8.2].

See "Information resources for patients and carers" node at the top of this pathway for material and handouts.

16 Treatment Options

Quick info:

The national tumor standards describe the level of service that a person with cancer should have access to in New Zealand.

[Refer to melanoma standards for the appropriate staging and treatment.](#)

The standards cover:

- timely access to services
- communication and referral
- data collection
- investigations, staging and diagnosis
- multidisciplinary care
- lifestyle factors and recommendations
- care coordination
- palliative care
- anti-cancer treatment
- follow up

17 Treatment and Management Plan

Quick info:

Formalise and discuss an appropriate Treatment and Management Plan with patient.

19 End of Life Support

Quick info:

[Cranford Hospice](#)

- 300 Knight Street
- Hastings, 4122

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- Phone: (06) 878 3799
- Fax: (06) 878 3799

Patients with Stage 4 melanoma will likely die from their disease. Many will experience a high symptom burden, this may be related to the disease or the treatment and emphasises the importance of palliative care. Palliative care interventions are known to improve the quality of life for patients:

- a Skin Cancer Clinical Nurse Specialist (SK-CNS) should be included in the multidisciplinary treatment team to:
 - provide assistance with symptom control
 - support patients and their families
 - when necessary, coordinate care of patients between settings
 - assist in clarifying goals of care
- patients should be screened for palliative care needs at their initial visit, at appropriate intervals, and as clinically indicated
- access to palliative care is available for all people based on need and is independent of current health status, diagnosis, age, cultural background or geography
- patients and their families/whanau with complex needs including physical, psychosocial and spiritual domains are referred to a specialist palliative care team at any stage during the illness
- cultural and spiritual support should be made available if required
- supportive and palliative care of the patient should be provided by general and specialist palliative care providers
- screening for palliative care needs, comprehensive assessment and care planning should be undertaken at appropriate intervals to meet the needs and wishes of the patient and their family/whanau
- access to palliative care, decision making and care planning should be based on a respect for the uniqueness of the patient and their family/whanau independent of their current health status, diagnosis, age, gender, cultural background or geography. Their needs and wishes should guide the decision making and care planning
- provider organisations should ensure that patients and their family/whanau have easy access to a range of high quality information materials about cancer and palliative care services. These materials should be free, culturally and educationally appropriate and in a variety of formats
- systems should be in place to ensure the views of patients and their family/whanau are taken into account when developing and evaluating cancer and palliative care services. All such services should support them to participate in their own care by offering a range of informal opportunities such as self-help activities and peer support schemes with community settings
- formal mechanisms should be in place to ensure that the patient, their carers and family/whanau have access to bereavement care, information and support services
- practitioners should assess dying patients in a timely manner and discuss with patients and their family/whanau about advance care planning and end of life goals of care using end of life care pathways, such as the Liverpool Care Pathway . This pathway should be implemented in hospitals, hospices and other health care settings

20 Further Treatment Required

Quick info:

Patients with loco-regional recurrent, locally advanced and stage IV melanoma are seen or discussed by melanoma specialists experienced in the care of melanoma patients and part of a multidisciplinary meeting, including:

- surgical oncologists
- radiation oncologists
- medical oncologists

[Refer to melanoma standard 7.5 for the management of advanced melanoma.](#)

Refer to [Standards of Service provision for Melanoma Patients in New Zealand - provisional](#)

21 Rapid Access for Recurrence or Clinical Concern

Quick info:

Must be seen within 14 days.

Urgent referral from GP/Specialist or CNS equivalent.

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22 Follow-up

Quick info:

Stage I: Annually for 10 years

Stage IIA: 6 monthly for 2 years then annually

Stage IIB - IIC: 4 monthly for 2 years then 6 monthly for 3 years, then annually thereafter until 10th anniversary

Stage III: 3 monthly for 1 year, 4 monthly for 2 years, 6 monthly for 5 years, then annually thereafter until 10th anniversary

Melanoma Provenance Certificate

Overview

This document describes the provenance of Hawke's Bay's District Health Board's Melanoma Pathway. It was developed in November 2013 and first published in September 2014. A review of the Pathway is due in January 2016.

The Collaborative Clinical Pathways programme is one initiative stemming from the *Transform and Sustain* agenda. The main aims of CCP are to:

- Identify opportunities to improve how health and disability care is planned and delivered within the district to improve patient access to a wider range of health services that are both closer to home and reduce avoidable hospital admissions.
- Provide health professionals throughout the Hawke's Bay district with best practice, evidence-based clinical pathways that are available at the point of care.

Outcomes we expect to achieve include faster access to definitive care, improved health equity and outcomes, better value from publically-funded resources, and better patient experience through clear expectations, improved access and greater health literacy. These outcomes are clearly aligned to the NZ healthcare *Triple Aim* and *Better, Sooner, More Convenient* policy directions.

Editorial methodology

This Pathway was based on high-quality information and known Best Practice guidelines from New Zealand and around the world including Map of Medicine editorial methodology. It was developed by individuals with front-line clinical experience (see Contributors section of this document) and has undergone consultation to gain feedback and input from the wider clinical community.

Map of Medicine Pathways are constantly updated in response to new evidence. Continuous evidence searching means that Pathways can be updated rapidly in response to any change in the information landscape. Indexed and grey literature is monitored for new evidence, and feedback is collected from users year-round. The information is triaged so that important changes to the information landscape are incorporated into the Pathways through the quarterly publication cycle.

An update to this Pathway is scheduled for 12 months after first publication. However, feedback is welcomed at any time, with important updates added at the earliest opportunity within the Map of Medicine publishing schedule (the third Friday of each month).

References

This Pathway has been developed according to the Map of Medicine editorial methodology. Its content is based on high-quality guidelines and practice-based knowledge provided by contributors with front-line clinical experience. Feedback on this Pathway was received from stakeholders during a consultation process.

- 1 Royal College of Physicians (RCP). The prevention, diagnosis, referral and management of melanoma of the skin. London: RCP; 2007.

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Disclaimers

Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay

It is not the function of the Clinical Pathways Steering Group, Hawke's Bay DHB and Health Hawke's Bay – Te Oranga Hawke's Bay to substitute for the role of the clinician, but to support the clinician in enabling access to know-how and knowledge. Users of the Map of Medicine are therefore urged to use their own professional judgement to ensure that the patient receives the best possible care. Whilst reasonable efforts have been made to ensure the accuracy of the information on this online clinical knowledge resource, we cannot guarantee its correctness and completeness. The information on the Map of Medicine is subject to change and we cannot guarantee that it is up-to-date.