Ontario Health
Cancer Care Ontario

Guideline 8-7 v2

A Quality Initiative of the Program in Evidence-Based Care (PEBC), Ontario Health (Cancer Care Ontario)

Surveillance of Patients with Stage I, II, III, or Resectable IV Melanoma Who Were Treated with Curative Intent

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Guideline Report History

GUIDELINE VERSION	SYSTEMATIC REVIEW Search Dates	SYSTEMATIC REVIEW Data	PUBLICATIONS	NOTES AND KEY CHANGES
Original version October 2015	1966 - 2015	Full Report	Web publication	NA
Version 2 March 2023	2015-2022	New data in Section 4	Updated Web publication Journal publications	Revised recommendations in Sections 1 and 2

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PUBLICATIONS FROM THIS REPORT

1. Rajagopal S, Yao X, Abadir W, Baetz TD, Easson A, Knight G, et al. Surveillance evaluations in patients with stage I, II, III, or resectable IV melanoma who were treated with curative intent: a systematic review. Surgical Oncol. 2024;54:102077.
2. Rajagopal S, Yao X, Abadir W, Baetz TD, Easson A, Knight G, et al. An Ontario Health (Cancer Care Ontario) clinical practice guideline: Surveillance strategies in patients with stage I, II, III, or resectable IV melanoma who were treated with curative intent. Clin Oncol. 2024;36:243-53.

Surveillance of Patients with Stage I, II, III, or Resectable IV Melanoma Who Were Treated with Curative Intent

Recommendations

This section is a quick reference guide and provides the guideline recommendations only. For key evidence associated with each recommendation, see Section 2.

GUIDELINE OBJECTIVES

To update the 2015 guideline of the Program in Evidence-Based Care (PEBC) Ontario Health (Cancer Care Ontario) to provide guidance for managing surveillance of patients with stage I, II, III, or resectable IV melanoma who are clinically disease-free after treatment with curative intent (following the definition of American Joint Committee on Cancer [AJCC] Pathological Prognostic Stage Groups in the 2017 Cancer Staging Manual, the 8th edition).

TARGET POPULATION

These recommendations apply to patients with stage I, II, III, or resectable IV melanoma who are clinically disease-free after treatment with curative intent. Pathological staging is according to the 8th edition AJCC staging system (Appendix 1) [1].

INTENDED USERS

Intended users of this guideline are medical oncologists, dermatologists, surgical oncologists, radiation oncologists, family doctors, and other clinicians who are involved in the follow-up care of patients with melanoma in the province of Ontario.

RECOMMENDATIONS

The strength of recommendations for this guideline includes three categories: Recommendation, Weak Recommendation, and No Recommendation (definitions and corresponding verb wording are provided in Appendix 2).

Recommendation 1

For patients with stage IA, IB, or IIA melanoma who are clinically disease-free after receiving curative-intent treatment:

1.1 Clinical follow-up with history and physical examination with full skin and lymph node examination by a dermatologist (with photo-surveillance and dermoscopy if indicated), and/or a surgeon, family physician, cancer nurse specialists should occur every six to 12 months for three years, then annually for two years or as clinically indicated. **[Strength: Recommendation]**

1.2 Routine biomarker or blood tests and imaging evaluations to screen for asymptomatic recurrence or metastatic disease are not recommended. **[Strength: Recommendation]**

1.3 In conjunction with routine follow-up, healthcare providers should provide education to patients and patients' caregivers who are involved in decision-making regarding skin self-examination (SSE) and sun safety. **[Strength: Recommendation]**

Qualifying Statements for Recommendation 1

1.4 For details of SSE, refer to Skin Cancer Self-exam on the Canadian Dermatology Association website https://dermatology.ca/public-patients/skin/melanoma/.

Recommendation 2

For patients with stage IIB, or IIC melanoma:

2.1 Clinical follow-up with history and physical examination with full skin and lymph node examination by a dermatologist (with photo-surveillance and dermoscopy if indicated), and/or a surgeon, medical oncologist, cancer nurse specialist should occur every three to six months in years 1 to 3, then every six months in years 4 to 5, or as clinically indicated. **[Strength: Recommendation]**

2.2 Routine biomarker or blood tests to screen for asymptomatic recurrence or metastatic disease are not recommended. **[Strength: Recommendation]**

2.3 Computed tomography (CT) or positron emission tomography (PET)/CT scans every six to 12 months should be considered to screen for asymptomatic recurrence or metastatic disease in years 1 to 3, then annually in years 4 to 5. **[Strength: Recommendation]**

2.4 Annual brain magnetic resonance imaging (MRI) can be considered for years 1 to 5. MRI (no radiation) of the brain is preferred for routine screening where available; otherwise, head CT may be considered after discussing with patients. **[Strength: Weak Recommendation]**

In conjunction with routine follow-up, healthcare providers should provide education to patients and patients' caregivers who were involved in decision-making regarding SSE and sun safety. **[Strength: Recommendation]**

Qualifying Statements for Recommendation 2

2.5 For the details of SSE, refer to Skin Cancer Self-exam on the Canadian Dermatology Association website https://dermatology.ca/public-patients/skin/melanoma/.

Recommendation 3

For patients with stage IIIA, IIIB, IIIC, IIID, or resected IV melanoma:

3.1 Clinical follow-up with history and physical examination with full skin and lymph node examination by a dermatologist (with photo-surveillance and dermoscopy if indicated), and/or a surgeon, medical oncologist, or cancer nurse specialist should occur every three to six months in years 1 to 3, then every six months in years 4 to 5, or as clinically indicated. **[Strength: Recommendation]**

3.2 Routine biomarker or blood tests to screen for asymptomatic recurrence or metastatic disease are not recommended. **[Strength: Recommendation]**

3.3 CT or PET/CT scans every six to 12 months should be considered to screen for asymptomatic recurrence or metastatic disease in years 1 to 3, then annually in years 4 to 5. **[Strength: Recommendation]**

3.4 Annual brain MRI can be considered for years 1 to 5. MRI (no radiation) of the brain is preferred for routine screening where available, otherwise, head CT may be considered after discussing with patients. **[Strength: Weak Recommendation]**

3.5 For patients with a positive sentinel lymph node, ultrasound scans of the draining nodal basin should be done every four to six months for years 1 to 3, and then every six months

for years 4 to 5, if no complete lymph node dissection is performed. **[Strength: Recommendation]**

3.6 In conjunction with routine follow-up, healthcare providers should provide education to patients and patients' caregivers who were involved in decision-making regarding SSE and sun safety. **[Strength: Recommendation]**

Qualifying Statements for Recommendation 3

3.7 In patients with positive sentinel lymph nodes, ultrasound screening should take place following recommendations in the CCO Guideline "8-6 Surgical Management of Patients with Lymph Node Metastases from Cutaneous Melanoma of the Trunk or Extremities".

3.8 For the details of SSE, refer to Skin Cancer Self-exam on the Canadian Dermatology Association website https://dermatology.ca/public-patients/skin/melanoma/.

3.9 There are no studies specifically addressing patients with resected stage IV melanoma;, this subgroup of patients is included with the stage III group of patients because of their similar clinical characteristics.

Recommendation 4

4.1 Patients may be transitioned to a primary care physician who has had training in melanoma care for follow-up after five years depending on the stages of the disease and clinical risk factors. Annual follow-up with a dermatologist should continue as clinically indicated. **[Strength: Weak Recommendation]**

Qualifying Statements for Recommendation 4

4.2 Patients should have access to return to the dermatology, surgery, or medical oncology clinic if clinically needed.