Executive summary

- In 2002 reporting of melanoma to cancer registries in Australia and New Zealand revealed it to be the fourth most common cancer and ninth most common cancer causing death in Australia and New Zealand. These registries reported melanoma incidence rates in males and females that were substantially above those from all other reporting registries worldwide[1]
- Increasing mortality from melanoma in Australian and New Zealand men is a disturbing trend
- Exposure to ultraviolet (UV) radiation in sunlight is the primary cause of most melanoma
- Intermittent pattern of sun exposure is most frequently associated with melanoma
- Sun bed and tanning bed exposure is associated with a small increase in melanoma risk and may be more significant when exposure occurs before 35 years of age
- Brief periods of sun exposure are needed to maintain vitamin D levels
- In the absence of any substantial evidence as to its effectiveness in reducing mortality population-based screening cannot be recommended
- It is important for practicing clinicians to be aware of high-risk groups in the population and that those in such groups also be aware of their status and establish a surveillance program
- Early detection and diagnosis of melanoma is clearly important in sound management
- Doubt in diagnosis or where melanoma is highly suspected, referral to a specialist or biopsy is appropriate. A 2mm margin for the biopsy is adequate. Prophylactic excision of benign naevi is not recommended
- Diagnosis may be enhanced by clinicians trained in dermoscopy
- It is imperative that all biopsy material be submitted for histopathological examination
- Management of involved lymph nodes should be undertaken in specialist centres
- Following diagnosis of metastatic melanoma, no further investigations are required unless surgery is planned and the detection of additional sites of distant disease would result in a change in management
- Communication skills training should help promote patient-centred care, shared decision-making, empathy and support where desired
- Timing of referral for palliative care relates to the needs of the patient and family, not just the stage of the disease
- In treating specific populations, it is important to recognise cultural differences, particularly the final disposal of body parts after surgical removal in Māori and Pacific peoples. It is also good practice in physical examination to ensure that skin areas examined include periungual and subungual skin and soles of feet
- Patients with high risk primary melanoma, lymph node involvement and melanoma in unusual sites (eg. mucosal and disseminated melanoma) are best managed by multidisciplinary teams in a specialist or melanoma facility

- These evidence-based guidelines have been developed by a multidisciplinary volunteer working party. They are aimed at encouraging improved management through evidence-based decision-making
- Guidelines are guides not rules and they are not prescriptive in any way. A good approach is to be fully aware of appropriate guidelines before making final management decisions

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Reference

1. Australian Cancer Network Melanoma Guidelines Revision Working Party. Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand. The Cancer Council Australia and Australian Cancer Network, Sydney and New Zealand Guidelines Group, Wellington (2008).