- National Comprehensive Cancer Network (NCCN) guidelines on melanoma
- Higgins II, W. et al. Melanoma in situ Part II. Histopathology, treatment, and clinical management. J Am Acad Dermatol, Volume 73, Number 2. August 2015, 193-203
- Debloom J. et al. The Invasive Growth Potential of Residual Melanoma and Melanoma In Situ. Dermatologic Surgery. 36:8: August 2010, 1251-1257
- Kallini JR, Jain SK, Khachemoune A. Lentigo maligna: review of salient characteristics and management. Am J Clin Dermatol. 2013 Dec;14(6):473-80
- McKenna JK, Florell SR, Goldman GD, Bowen GM. Lentigo maligna/lentigo maligna melanoma: current state of diagnosis and treatment. Dermatol Surg. 2006 Apr;32(4):493-504

National Comprehensive Cancer Network (NCCN) categories of evidence and consensus

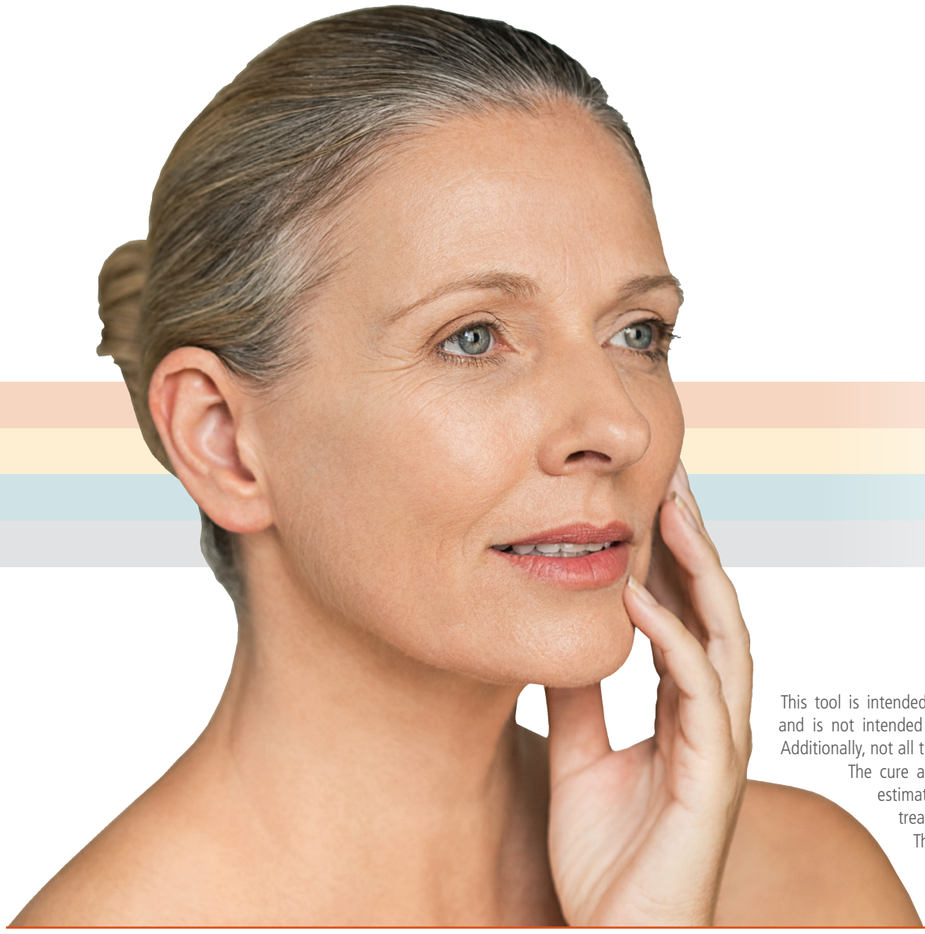
- **Category 1 -** based on high-level evidence, there is uniform NCCN consensus that intervention is appropriate
- **Category 2A -** based on lower-level evidence, there is uniform NCCN consensus that intervention is appropriate
- **Category 2B -** based on lower-level evidence, there is NCCN consensus that intervention is appropriate
- **Category 3 -** based on any level of evidence, there is major NCCN disagreement that intervention is appropriate

Reference - *NCCN Categories of Evidence and Consensus*

What is the frequency of physician visits?	Recovery Time	What are the costs to the healthcare system? (Individual insurance plans will vary)
2-3 year	N/A	Office visits $
3-4 visits for the first year follow-up every 3-12 months, depending on risk of recurrence or another melanoma, with full history and physical exam and close attention to skin and regional lymph node exam	Depending on extent of surgery - Average 1 to 2 weeks with continued improvement over 1 year	Depends on local rates / insurance coverage
3-4 visits for the first year follow-up every 3-12 months, depending on risk of recurrence or another melanoma, with full history and physical exam and close attention to skin and regional lymph node exam	Initial redness and skin breakdown will improve after stopping within 6 to 8 weeks – may have persistent redness May have skin discoloration	Depends on local rates / insurance coverage
Depends on dose and type of radiation. (Can be multiple visits a week during treatment) follow-up every 3-12 months, depending on risk of recurrence or another melanoma, with full history and physical exam and close attention to skin and regional lymph node exam	Initial redness and skin breakdown will improve after stopping within 6 to 8 weeks May have skin discoloration	Depends on local rates / insurance coverage

DECISION AID

To help patients compare different treatment options for **MELANOMA IN SITU** of the head and neck in **patients 65 and older**



This tool is intended to be used by a patient with their physician and is not intended to be the sole guide of an individual's care. Additionally, not all treatment options are appropriate for all tumors. The cure and recurrence rates provided in this table are estimates and ranges. Additionally, tumors that recur after treatment require more lengthy and detailed discussion. This tool is to be used with your physician to discuss specific details of your treatment, and is not intended to replace a physician consultation.

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

DECISION:

How should I treat melanoma in situ skin cancer on sun-damaged skin (lentigo maligna) on the head and neck (over age 65)?

WHAT IS LENTIGO MALIGNA?

Lentigo maligna is a form of melanoma in situ skin cancer that occurs on sun damaged skin mainly on the head and neck. Since it is a type of melanoma there is a risk that it can continue to grow wider and deeper into the skin and has even been shown to metastasize (spread through the body). Surgery is typically recommended for this however since the amount of margins needed to clear this type of melanoma may be larger there are other options that can be considered when surgery is not an option or not preferred.

- Patients may consider non-surgical management when
  - contraindications for surgery such or other significant comorbidities or conditions
  - very large lesions can lead to deforming surgery and reconstruction
  - patients may have problematic reconstruction following excision due to location or size

It is important to understand that lesions of melanoma in situ may have invasive components within it, which can potentially lead to spread

LEGEND

ACTIVE SURVEILLANCE

SURGERY - NCCN LEVEL 2A

IMIQUIMOD 5% - OFF LABEL INDICATION - NCCN LEVEL 3

RADIATION - NCCN CATEGORY 2 B

A range of 5 to 29% of melanoma in situ lesions were found to contain an invasive component upon surgical removal.

Higgins II, W. et al. Melanoma in situ Part II. Histopathology, treatment, and clinical management. J Am Acad Dermatol, Volume 73, Number 2. August 2015, 193-203

Also inadequately treated melanoma can recur – in a study of 108 recurrent melanomas, of the 84 lesions initially treated as MIS, 19 (22.6%) recurred marginally with a histologically invasive component and a mean depth of 0.94 mm.

Debloom J. et al. The Invasive Growth Potential of Residual Melanoma and Melanoma In Situ. Dermatologic Surgery. 36:8: August 2010, 1251-1257

THINGS I MIGHT CONSIDER IN MY DECISION:

My lifestyle is:	My current health:	My social factors:	My concern for scar:	Concerns or questions about surgery:	Are you worried about the risk of the melanoma spreading?
☐ Active	☐ Few medical problems	☐ Able to care for myself	☐ Yes	☐ Yes	☐ Yes
☐ Sedentary	☐ Many medical problems	☐ Need help caring for myself	☐ No	☐ No	☐ No

PATIENT QUESTIONS:

How effective is the treatment?	What does this treatment involve?	What are advantages?	What are the goals of treatment?	What are the adverse effects?
N/A	Monitoring by patient and dermatologist for signs of continued growth, change, or symptoms such as pain or bleeding	Nontraumatic	Deferring treatment until lesions require therapy based on physician and patient judgment	Continue tumor growth – possible invasion and metastatic spread Risk of death / distant spread if invasive
Approximately 94% for early in situ disease. Recurrence and cure rates depend on final staging after excision and pathology.	Surgical removal of the lesion with possible repair	Detects invasive disease and checks margins Shorter treatment time	Clear surgical margins and complete removal of tumor	Complications of surgery include: • scar • Infection • Bleeding • Wound separation • Risk of death / distant spread if invasive
Approximately 76% clearance rate *May not completely treat invasive disease leading to persistent disease, recurrence, and potential spread	Application of a topical cream daily x 12 weeks Skin will become red, irritated, tender, and breakdown	Non-surgical treatment - no cutting or reconstruction	Clearance of lesion without recurrence *If no response noted may need to be treated by different modality	Redness , skin breakdown, flu like symptoms, lighting or darkening of skin color Scarring Not effective – continued growth of melanoma and may not treat invasive melanoma Risk of death / distant spread if invasive
70%to 90% depending on type used Recurrence ~ 11.5% (range 0%-31.3%) May not completely treat invasive disease leading to persistent disease, recurrence, and potential spread	Use of external beam radiation to treat melanoma Skin will become red, tender, and skin will breakdown Number of treatments and length of treatment depends on radiation dose and type	Non-surgical treatment - no cutting or reconstruction	Clearance of lesion without recurrence	Reddness, skin breakdown, erosion, lightening or darkening of skin color, blood vessel growth after, possible new skin cancers Scarring Not effective – continued growth of melanoma and may not treat invasive melanoma Risk of death / distant spread if invasive