Malignant Melanoma Guideline

Draft Scope Stakeholder Workshop: Group Notes

Group 1

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Dr Maureen Walsh

Proposed membership of the GDG

The group seemed happy with the proposed GDG membership. Additional comments made were:

GP – this should possible include someone with experience to inform a discussion about follow-up for melanoma patients.

Surgeon - this should include surgeons who are part of the MDT.

Scope

3 Clinical need for the guideline

3.1 Epidemiology

No comments were made on this section

3.2 Current Practice

No comments were made on this section

4.1 Population

4.1.1 Groups that will be covered

It was noted that children should be included in the populations to be covered, whilst melanoma was rare in children and treatment not covered by clinical trials it was felt that the treatment of children and young people with melanoma should be the same.

4.1.2 Groups that will not be covered

It was noted that children should be covered.

There was agreement amongst the group that people with primary ocular melanoma and people with melanoma arising in mucosal sites are excluded from the scope.

4.2 Healthcare settings

It was noted that there was a need for information for GP's in primary care for people that had received treatment in secondary/tertiary care, and felt that forwarding written information to GPs with clinical letters to GPs would supply information which would allow GPs to better to support their patients.

4.3 Clinical Management

4.3.1 Key clinical issues that will be covered

Topic A

The group discussed that this topic needed to cover, access to information, how information is given, who gives the information and they felt that there was also a need for consistency of information by stage of the disease.

Topic B

The group discussed this topic and agreed that it was a key issue as there is variation and inconsistencies in practice. Tumour sampling was discussed, and the need to excise all lesions in their entirety to allow proper histological assessment of the lesions. The need to avoid incisional, punch or curettage biopsies raised the issue of who performs the excision.

Topic C

The group agreed that this was an important topic with potential cost implications. The group discussed *BRAF* testing of tumours, the delays in receiving results from tumour samples, and the issues with the retention and storage of specimens.

Topic D

The group agreed that this was a key topic and agreed that the main issue is what does sentinel lymph node biopsy give in terms of terms of cost and clinical efficacy. The group also commented that the question of imaging should include ultrasound.

Topic E

The group thought that this was a particularly low priority area in terms of topics, but agreed that re-enforcement of margins excisions should be covered.

Topic F

The group agreed that the main issue surrounding this topic was who performs the surgery in that outcomes were predicted to be better where the surgery is carried out by those carrying out the same procedures regularly.

Topic G

The group agreed that there is marked variation of use and this is therefore an important topic

Topic H

The group agreed that this was an important topic for a small number of people, as access to treatment is variable.

Topic I

The group agreed that the issues surrounding this topic include first, when and how radiotherapy is done e.g. stereotactic versus whole brain radiotherapy. Second what the role of surgical excision of oligometastatic disease.

Topic J

The group agreed that this topic should be made broader to cover other chemotherapy regimens.

Topic K

The group discussed this topic and agreed that the issues regarding follow-up were relevant, and agreed that there currently are issues around the frequency of imaging and where follow up should take place.

Topic L

The group agreed that the approach to this topic can be variable and are happy with it being a topic in the scope

Topic M

The group were happy with this question.

Additional topics

The group agreed that the scope should cover the risk associated with concurrent drug treatment such as metformin.

4.3.2 Clinical issues that will not be covered

The group were happy with this section.

Group 2

Andrew Champion
Claire Turner
Anthony Hubbard
Barry Powell
Catriona Henderson
Howard Peach
Stephen Kownacki
Susan O'Connell
Dr Christine Parkinson
Dr David Slater
Joanne Bird
Dr Max Summerhayes
Rachel Ellis
Ruby Saharan

Title:

- The group suggested that the word 'malignant' could be deleted from the title as there are no 'non-malignant' melanomas.

Epidemiology:

- The group strongly disagreed with the use of the term 'intermittent sun exposure' as they felt that this implied that this was the only factor and left potential for the assumption that sun bed use, prolonged exposure etc were not risk factors.
- In section 3.2a the group asked for more information on routes of presentation to be included for the 60% of melanomas that are not diagnosed via the 2-week wait.

Current Practice

- The group felt that the section on current practice needed to be revised to more accurately reflect the role of the pathologist /pathology in the diagnosis of melanoma. It was felt that there was a general pathology 'theme' running through the topics which was not represented in the information on current practice.
- There was some discussion around the definition of current waiting time targets with the group suggesting that some comment should be made on the fact that historically the clock gets reset following excision biopsy.

Population

- The group felt that the population should also include children: the reason for this was related to equal access to skin specialists with melanoma experience.
- In section 4.1.1b 'genital' should be better defined as 'vulval and penile'

Healthcare setting:

- All settings should be included, including the LSMDT and SSMDT

Topic A

- Add an extra group 'suspected melanoma' in the review question
- Change 'for those considering palliative care' to 'after treatment' which will cover palliative options
- Check what is covered in the NICE Palliative and Supportive Care guideline to see if any of it is relevant to this guideline.

Topic B

- The group highlighted that there are large cost implications to ensure everyone who carries out dermoscopy are fully trained and accredited.
- There is an argument for recommendations around record keeping and data collection for audit purposes.
- There are other technologies available which could be used in place of dermoscopy (e.g. confocal microscopy).
- The group suggested that the use of teledermatology should be included as a specific review question

Topic C

- There were discussions surrounding whether gene testing should be done only in one location or in a number of locations. There are currently 3 locations in the UK where gene testing is carried out.
- The group discussed how gene testing should be carried out (for example, Next Generation Sequencing) and is panel testing more cost effective?
- It was uncertain whether all the review questions related to only BRAF mutations?
- The group felt that although the review questions for this topic were currently the questions of interest, they were very specific and may be difficult to answer. The GDG will need to remain flexible and potentially change the questions during development as things are changing rapidly in this field and those questions listed in the scope may not remain the relevant/important issues.

Topic D

- Everyone was happy for SLNB to be included as it was considered the most important topic. However the group felt a better question would be 'should SLNB be available to all patients' and that the most important aspect was related to cost effectiveness.
- Ultrasound and fine needle biopsy should be added to the list of imaging techniques
- SLNB for head and neck was discussed as being an specific subgroup of interest

Topic E&F

- For stage I-II melanoma the primary area of concern for the group was related to excision margins.
- For stage III melanoma the main area of concern within the group was who should be doing the surgery.
- Moh's surgery for lentigo melanoma was raised as a specific issue
- The number of surgical dissections performed was considered an important issue – the IOG currently recommends a minimum of 15 for skin cancer
- Indications for pelvic clearance was considered a potentially important question to investigate as there is considerable variation in practice across the UK.

Topic G&H&I

- There were no major discussion on these topics and all were considered to be valid for inclusion in the scope by the group.

Topic J

- The group agreed that this was a valid topic for inclusion however they noted there would be very few data available on temozolomide.

Topic K

- The group agreed that this was a valid topic with several potential review questions that could be looked at including:
    - Frequency and duration
    - The role of imaging (particularly for brain metastases -should it be done and if so should CT or MRI be used))
    - Who should see the patient
    - Setting

Topic L

- The group agreed this was a valid topic for inclusion.

Topic M

- The group agreed this topic should be included however they felt the question should concentrate on surgery versus Imiquimod versus surgery + Imiquimod.
- The group also felt that the indications for use prior to surgery and as adjuvant treatment should be investigated.

Group 3

John Graham
Lily Huajie Jin
Clair McGarr
Dr Clive Mulatero
Dr Stephen Keohane
Dr Ivan Bristow
Nathan Bromham
Anna Bianconi
Dr Bav Shergill
Dr Jonathan Botting
Pat Ackerman

Suggested GDG membership

GDG membership list

The group were in general agreement with the list. They did not believe that a GP with a commissioning role would be a useful member – instead they suggested splitting this role into a commissioner and a G.P. with a special interest.

For the expert advisor "molecular biologist" the group discussed whether this should be clinical geneticist or molecular pathologist instead.

4.1 Population

4.1.1 Groups that will be covered

a)

Agreed with age groups, although there are some cases of melanoma in children there will be little evidence. The group suggested that we can extrapolate the recommendations from adults to children.

The group commented that melanoma patients could be referred from health care settings other than primary care. So they suggested to remove "from primary care" from 4.1.1.a

b)

The group discussed whether genital melanoma might need extra explanation – but agreed that it was not needed since 4.1.2.d states mucosal sites are excluded.

4.1.2 Groups that will not be covered

Remove "from primary care" from 4.1.2.a

Group discussed whether *in situ* disease should be mentioned in this section.

4.2 Healthcare setting

The group suggested adding "primary care" here, since follow-up might take place in primary care. Other management of melanoma might take place in the community under the governance of the skin cancer MDT.

4.3 Clinical management

4.3.1 Key clinical issues that will be covered

Topic a

The group suggested changing 4.3.1.a to “during and after treatment and follow-up”. Palliative care could be removed as it is part of treatment

Topic b

The group suggested removing “secondary care” since diagnosis might take place in other places (such as primary care under supervision of secondary care).

Topic c

Some group members wanted to expand this topic to include:

- the ongoing restaging of people with melanoma.
- The timing and frequency of staging melanoma
- Clinical staging

Consequently some group members suggested to change the topic to ‘When and how to stage melanoma?’

Topic d

The group felt that this topic could be of economic importance, because there is uncertainty over the cost-effectiveness of sentinel lymph node biopsy. And the group suggested that the economic model need to examine the eligibility criteria and frequency of using sentinel lymph node biopsy.

Topic g

Medical oncologist discussed the possible issue of adjuvant interferon – but was not particularly enthusiastic about including it.

Topic i

Some group members felt that this topic is about the role of local treatment, not only radiotherapy. However the group acknowledged that there are not many local treatments currently in use other than radiotherapy. Group suggested removing “stereotactic” – the issue is the definitive local treatment of metastases.

Topic j

The group expressed general frustration with the interface between Technology Assessments and guidelines. Some suggested removing drug names and replacing with “cytotoxic chemotherapy”

Topic k

The group raised the issue of identifying high risk individuals and secondary prevention in this group. It was also suggested to include the duration, frequency and tools of follow-up in this topic.

Topic m

The group felt that this was the least important of all the proposed topics because:

- Imiquimod is not licensed for the use of treating melanoma in the U.K at the moment (although the group mentioned that some clinicians might still use imiquimod to treat melanoma)
- Not many people are using imiquimod.

They mentioned that imiquimod was used in stage 0 disease, in-transit disease or as palliation where comorbidity prevented other therapies.

4.4 Main Outcomes

j) Number and severity of adverse events

One group member mentioned that number of attendances at hospital post diagnosis is a relevant outcome.

4.5 Review Questions

a)

Three key points at which information/support is needed: diagnosis of localised melanoma, diagnosis of metastatic disease and the end of treatment.

Mentioned that palliative care can occur during treatment.

The group noted that the availability of clinical nurse specialists was a key issue here: many are expected to provide information and support to an unmanageable number of patients.

A possible clinical question was suggested “what is the best use of a skin cancer clinical nurse specialist?”

c)

The group suggested this question should cover anyone involved in primary diagnosis