

Individualizing Care for Melanoma Patients



Melanoma is unpredictable, making patient visits and communications complicated. Following the initial diagnosis, individualized patient care is key. Methods for discussing the diagnosis, treatment, and health upkeep with patients are explained.

Lorraine L. Rosamilia, MD

What does your patient need to know at the first visit?

Melanoma patient visits and communications are complicated. When possible, you can preview the surgical and prognostic expectations with the patient when you see the lesion clinically for the first time, especially for a lesion that you're sure is melanoma before it even hits the specimen cup. Sometimes you have to convey important biopsy and treatment information over the telephone, or sometimes you have the luxury of an extra clinic visit to discuss it with the patient and perhaps a family member in person.

During the first set of conversations, I explain the things that are tangible: the depth of the lesion, the relationship it has to prognosis, surgical options based on staging, further testing/referrals, and known risk factors. Then I wait. The digestion phase is critical before you hang up and schedule a surgery.

Probably the most important thing I tell patients is that melanoma is unpredictable. Not everyone has the same kind of "surgery," we don't say "remission," we don't have a certain "chemo" that we know will be best, and not everyone will need "CAT scans." I tell patients that they're stuck with me. Skin examinations, talk of sun protection, photography of nevi, upkeep of health maintenance visits with other specialists (eg, primary care physician, optometry/ophthalmology, gynecology, dentistry), and education of family members on melanoma risk factors will be the norm.

What are your go-to treatments?

In the past, surgical management was perhaps streamlined, but as we learn more about melanoma tumor biology, the less we can form generalizable guidelines for surgery, margin control, and lymph node perusal. Wide local excision is paramount, but the evidence that guidelines for 0.5-cm, 1-cm, and 2-cm margins or greater fit for all types of tumors is lacking, and many have challenged the recommended margins, particularly for lentigo maligna subtypes (Kunishige et al).

The 0.75-mm Breslow depth threshold guides my sentinel lymph node (SLN) discussion, with upstaging based on primary tumor mitotic index and/or ulceration. But SLN biopsy is always still a discussion and not a foregone conclusion because the risk-benefit ratio and prognostic/survival data are very difficult to dissect for some cases. Certainly, mention of SLN biopsy morbidity, including lymphedema, is warranted before the patient consents. Then there is further explanation that more invasive lymphadenectomy could occur based on SLN findings. If applicable in advanced cases, options for imaging and adjuvant therapy are introduced by us but then primarily led by oncologists.

Patients are generally pleased that the approach to melanoma surgery, reconstruction, SLN biopsy, and oncologic care is increasingly becoming (almost) harmoniously multidisciplinary. Larger institutions have streamlined their melanoma providers into shared clinics or at least regional networks—dermatologists, plastic/otolaryngology/oncologic surgeons, oncologists, and radiation oncologists, for instance—and simplified patient access based on individual tumor treatment plans. Dr. Christopher J. Miller at Penn Medicine (Philadelphia, Pennsylvania) is excelling at a collaborative surgical approach for melanoma between dermatologic surgery and specialties such as otolaryngology

Dr. Rosamilia is Staff Dermatologist, Department of Dermatology, Geisinger Health System Scenery Park, State College, Pennsylvania. Dr. Rosamilia reports no conflict of interest.
Correspondence: Lorraine L. Rosamilia, MD, 200 Scenery Dr, 56-02, State College, PA 16801 (lrosamilia@geisinger.edu).

and also spearheading the Mohs micrographic surgery approach for primary melanoma as possible standard of care for some cases (Etzkorn et al).

Also evolving is the access to clinical trials and care coordination regarding the most novel metastatic melanoma therapies, which can now be a short drive away for most patients as the National Cancer Institute broadens its clinical trial reach.

After the diagnosis of melanoma is made, care is becoming much more individualized for surgery and beyond, but true morbidity and mortality benefit for the more complicated regimens has become anybody's guess as this research field grossly and rapidly swells. Then these discussions with the patient become longer and more open-ended.

How do you keep patients compliant with treatment?

Initial surgery and multidisciplinary management requires meticulous communication between providers to ensure that pathology reports, surgical findings, imaging, wound care, and follow-up are transparent. The easier it is for patients to navigate the medical system(s), the more likely they are to comply. Voicemail, e-mails, text messages, and/or mailings are standard for different offices for reminders, but an old-fashioned telephone call goes a long way for a patient who has melanoma on his/her mind. Adherence to sun protection, health maintenance, and skin examination appointments is then the challenge.

Sun protection strategies were well-represented in the *Cutis* July issue's Practical Pearls featuring Dr. Vincent A. DeLeo. My script for sunscreen-averse patients as I leave the room is "Take a mosey through the sunscreen aisle. You may be surprised at what you find." And sporting goods stores are chock full of UPF (UV protection factor) clothing options. I'm not a scolder, but I do utilize the power of repetition/the squeaky wheel.

Patient delay or cancellation of skin checks requires other types of surveillance. Here at Geisinger Health System (State College, Pennsylvania), when melanoma patients check out, they are placed in a "priority appointment" slot, meaning that if they cancel, their names are automatically put on an electronic list that is compiled weekly by our schedulers to ensure that patients are called for another appointment. To avert telephone tag and delay of care, melanoma patients also get our direct nurses station extension and are encouraged to use our chart e-mail system to communicate with us if they notice a new or changing skin lesion.

What do you do if they refuse treatment?

Initial consent and compliance with melanoma wide local excision are rarely challenged by a

well-informed patient, but what I find more common is delay in treatment and nonadherence to periodic skin examinations.

What resources do you recommend to patients for more information?

The National Comprehensive Cancer Network clinical practice guideline resource in oncology (melanoma) is the place to start, as their Web site is easily navigable for patients and providers (<http://www.nccn.org>).

The American Academy of Dermatology (<http://www.aad.org>) and Skin Cancer Foundation (<http://www.skincancer.org>) Web sites also provide useful information, and there are always copies of their key melanoma and nevi surveillance pamphlets in our office.

Most recently, my melanoma patients have been inspired by another local patient and her cause: a 28-year-old woman with metastatic melanoma on a National Cancer Institute BRAF inhibitor clinical trial who plans to run an Ironman race this year (Thomason, Ames). Her motivation to maintain her baseline health and fitness while still reaching for this further remarkable goal gives fellow melanoma patients a source for enthusiasm and hope.

Inspiration and adherence come in all shapes and sizes for patients with melanoma. I find you need to throw multiple resources and strategies at them and see what sticks.

SUGGESTED READINGS

Ames C. Local runner fights cancer. WeAreCentralPA Web site. <http://www.wearecentralpa.com/news/local-runner-fights-cancer#.VZw92-pJ2AU.mailto>. Published June 30, 2015. Accessed August 14, 2015.

DeLeo VA. Patient compliance with photoprotection. *Cutis*. 2015;96:13-14.

Etzkorn JR, Sobanko JF, Elenitsas R, et al. Low recurrence rates for in situ and invasive melanomas using Mohs micrographic surgery with melanoma antigen recognized by T cells 1 (MART-1) immunostaining: tissue processing methodology to optimize pathologic staging and margin assessment. *J Am Acad Dermatol*. 2015;72:840-850.

Kunishige JH, Brodland DG, Zitelli JA. Larger surgical margins are required for lentigo maligna and other melanoma in situ. *J Am Acad Dermatol*. 2012;67:1069-1071.

NCCN clinical practice guidelines in oncology: melanoma. National Comprehensive Cancer Network Web site. http://www.nccn.org/professionals/physician_gls/pdf/melanoma.pdf. Updated March 11, 2015. Accessed August 14, 2015.

Thomason M. My story: April Salinas. Live In Our Skin! Blog. <http://blog.uvskinz.com/2015/01/30/my-story-april-salinas/#sthash.yvSRVgLT.YGLDn95T.dpbs>. Published January 30, 2015. Accessed August 14, 2015.