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

**What is the frequency of physician visits?**

- **2-3 year follow-up**
  - N/A
  - Office visits $ 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**
  - Depending on extent of surgery - Average 1 to 2 weeks with continued improvement over 1 year
  - 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

- **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**
  - 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

**What are the costs to the healthcare system?**

- (Individual insurance plans will vary)

**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

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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.
**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 as 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

**THINGS I MIGHT CONSIDER IN MY DECISION:**

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

**PATIENT QUESTIONS:**

**What are advantages?**

- Monitoring by patient and dermatologist for signs of continued growth, change, or symptoms such as pain or bleeding
- Surgical removal of the lesion with possible repair
- Application of topical cream daily x 12 weeks
- Clear surgical margins and complete removal of tumor
- Non-surgical treatment - no cutting or reconstruction
- Clearance of lesion without recurrence
- Deferring treatment until lesions require therapy based on physician and patient judgment
- Nontraumatic
- Shorter treatment time

**What are the goals of treatment?**

- Continue tumor growth – possible invasion and metastatic spread
- Risk of death / distant spread if invasive
- Complications of surgery include:
  - scar
  - Infection
  - Bleeding
  - Wound separation
  - Risk of death / distant spread if invasive

**What are the adverse effects?**

- Risk of death / distant spread if invasive
- Not effective – continued growth of melanoma and may not treat invasive melanoma
- 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
- Redness, skin breakdown, erosion, lightening or darkening of skin color, blood vessel growth after, possible new skin cancers
- Scarring
- Risk of death / distant spread if invasive

**LEGEND**

- ACTIVE SURVEILLANCE
- SURGERY - NCCN LEVEL 2A
- IMIQUIMOD 5% - OFF LABEL INDICATION - NCCN LEVEL 3
- RADIATION - NCCN CATEGORY 2 B

**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.


Aloa 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.