# MELANOMDA EVRELEME VE İZLEM

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III. DERMATOONKOLOJİ GÜNDEMİ

BAKÜ, 2014

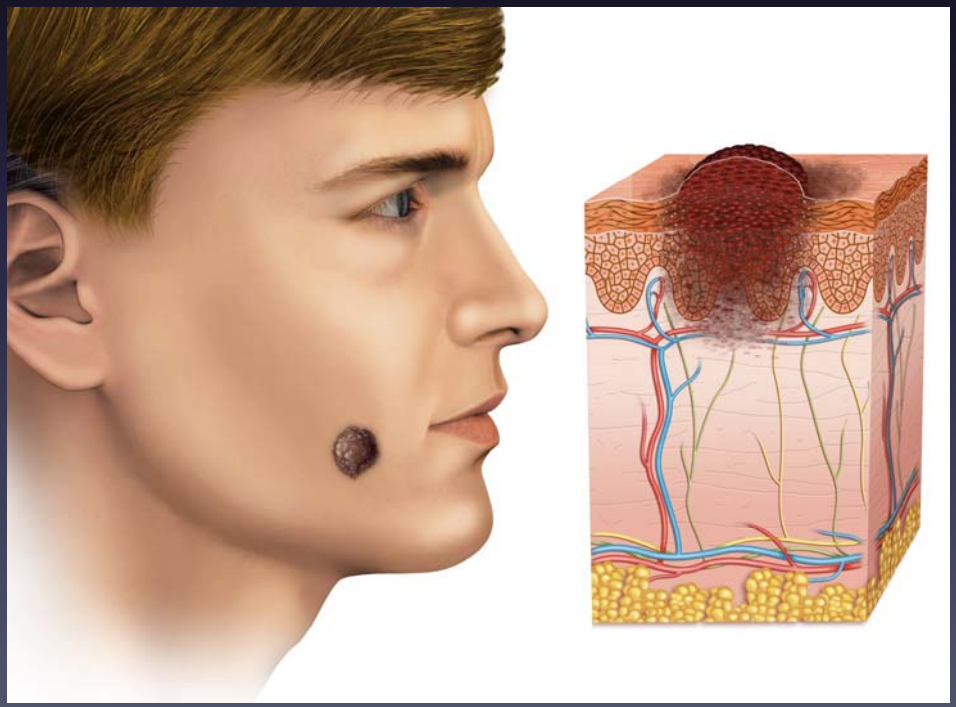
# EVRELEME

- Prognostik Öngörü
- Tedavi Stratejisi Belirleme
- Klinik Çalışma Dizaynı

*Prognostik faktörlerin idantifikasyonu ve analizi*

Wallace H. CLARK 1969

Alexander BRESLOW 1970



# PROGNOSTİK FAKTÖRLER

- Primer tumor;
  - BRESLOW Tumor kalınlığı
  - Mitoz oranı
  - Ulserasyon
  - CLARK seviyesi
  - Anatomik bölge
- Lenf Nodu;
  - LN sayısı
  - Mikroskobik
  - Makroskobik
- Metastaz;
  - Uzak
  - Kutan, subkutan
  - Akc met
- Yaş
- Cins
- Immun yetmezlik

**Table 4**
**Multivariate Cox regression analysis of prognostic factors in 10,233 patients with localized cutaneous melanoma (stage I and II)**

| Variable | Chi-Square Value (1 df) | *P* | HR | 95% CI |
|---|---|---|---|---|
| Tumor thickness | 84.6 | <.0001 | 1.25 | 1.19–1.31 |
| Mitotic rate | 79.1 | <.0001 | 1.26 | 1.20–1.32 |
| Ulceration | 47.2 | <.0001 | 1.56 | 1.38–1.78 |
| Age | 40.8 | <.0001 | 1.16 | 1.11–1.22 |
| Gender | 32.4 | <.0001 | 0.70 | 0.62–0.79 |
| Site | 29.1 | <.0001 | 1.38 | 1.23–1.54 |
| Clark level | 8.2 | .0041 | 1.15 | 1.04–1.26 |

# AJCC

## AMERICAN JOINT COMMITTEE ON CANCER
## MELANOMA STAGİNG GUİDELİNES

- 1998
- 2002; TNM sistemi
- 2009; Son versiyon

**Table 3**
**Differences between the sixth edition (2002) and the seventh edition (2009) of the melanoma staging system**

| Factor | Sixth Edition Criteria | Seventh Edition Criteria | Comments |
|---|---|---|---|
| Thickness | Primary determinant of T staging | Same | Thresholds of 1.0, 2.0, and 4.0 mm |
| Level of invasion | Used only for defining T1 melanomas | Same | Used as a default criterion only if mitotic rate cannot be determined |
| Ulceration | Included as a secondary determinant of T and N staging | Same | Signifies a locally advanced lesion; dominant prognostic factor for grouping stages I, II, and III |
| Mitotic rate per $mm^2$ | Not used | Used for categorizing T1 melanoma | Mitosis $\geq 1/mm^2$ used as a primary criterion for defining T1b melanoma |
| Satellite metastases | In N category | Same | Merged with in transit lesions |
| Immunohistochemical detection of nodal metastases | Not included | Included | Must include at least 1 melanoma-associated marker (eg, HMB-45, Melan-A, MART-1) unless diagnostic cellular morphology is present |
| 0.2 mm threshold of defined N+ | Implied | No lower threshold of staging N+ disease | Isolated tumor cells or tumor deposits <0.1 mm meeting the criteria for histologic or immunohistochemical detection of melanoma should be scored as N+ |
| Number of nodal metastases | Primary determinant of N staging | Same | Thresholds of 1 vs 2–3 vs 4+ nodes |
| Metastatic volume | Included as a second determinant of N staging | Same | Clinically occult (microscopic) nodes are diagnosed at sentinel node biopsy vs clinically apparent (macroscopic) nodes diagnosed by palpation or imaging studies, or by the finding of gross (not microscopic) extracapsular extension in a clinically occult node |
| Lung metastases | Separate category as M1b | Same | Has a better prognosis than other visceral metastases |
| Increased serum LDH level | Included as a second determinant of M staging | Same | Recommend a second confirmatory LDH level if increased |
| Clinical vs pathologic staging | Sentinel node results incorporated into definition of pathologic staging | Same | Large variability in outcome between clinical and pathologic staging; sentinel node staging encouraged for standard patient care, should be required before entry into clinical trials |

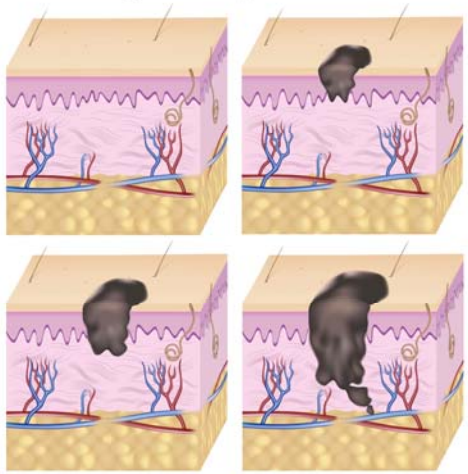
**Table 6**
**Multivariate Cox regression analysis of pathologic factors by T category for stage I and II melanoma**

| | Tumor Thickness | | Ulceration | | Mitotic Rate | | Clark Level | |
|---|---|---|---|---|---|---|---|---|
| T Category | $\chi^2$ | *P* | $\chi^2$ | *P* | $\chi^2$ | *P* | $\chi^2$ | *P* |
| T1 | 12.8 | .0003 | 3.8 | .05 | 20.8 | <.0001 | 1.9 | .17 |
| T2 | 4.9 | .03 | 16.2 | <.0001 | 15.9 | <.0001 | 0.2 | .65 |
| T3 | 4.1 | .04 | 15.4 | <.0001 | 12.2 | .0005 | 1.4 | .24 |
| T4 | 0.2 | .69 | 14.2 | .0002 | 9.1 | .003 | 2.7 | .10 |

Table 1
TNM staging categories for cutaneous melanoma

| T | Thickness (mm) | Ulceration Status and Mitoses |
|---|---|---|
| T is | Not applicable | Not applicable |
| T1 | ≤1.00 | T1a: without ulceration and mitoses <1/mm$^2$<br>T1b: with ulceration or mitoses ≥1/mm$^2$ |
| T2 | 1.01–2.00 | T2a: without ulceration<br>T2b: with ulceration |
| T3 | 2.01–4.00 | T3a: without ulceration<br>T3b: with ulceration |
| T4 | ≥4.01 | T4a: without ulceration<br>T4b: with ulceration |
| N | No. of Metastatic Nodes | Nodal Me… |

The stages of malignant melanoma



# TUMOR

- Kalınlık
- Mitoz
- Ulserasyon

## Kalınlık

**T1** ≤ 1 mm

a. Uls. yok ve Mitoz < 1 / mm2

b. Uls. var veya Mitoz ≥ 1 / mm2

**T2** 1.01-2.00

a. Uls. Yok

b. Uls. var

**T3** 2.00-4.00

a. Uls. Yok

b. Uls. var

**T4** ≥ 4.00 mm

a. Uls. Yok

b. Uls. var

# KALINLIK

Intraokuler mikrometre

Granüler tabaka üst seviyesinden en alttaki tumor hücresine dek

Ulserasyon varsa; ulser tabanından.....

1 mm. ye dek; İnce / 1-4mm ; Orta / 4mm. üstü ; Kalın

# ULSERASYON

Travma & cerrahi olmaksızın;

Epidermisin tüm kalınlığındaki defekt... ( T; a...b'ye)

Ulserasyon yüzdesi; Tumor çapı ve ulserasyon çapı ölçülür.

% 5 den az ulserasyon varsa yaşam şansı daha yüksektir.

# DERMAL MİTOZ

Hot spot ;Dermiste en çok mitotik figürün görüldüğü alan.

'Hot spot'ta mitoz sayılır.

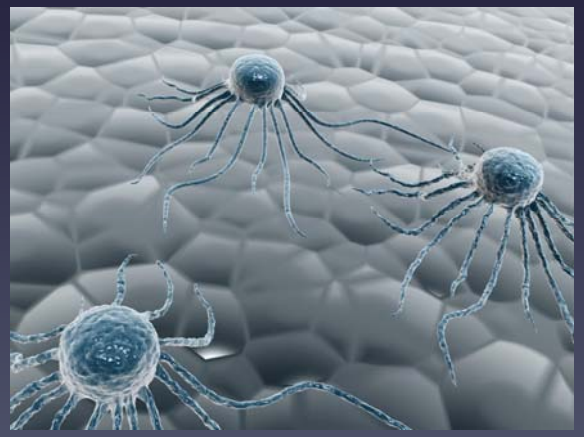
Sayım 1 mm2 lik alana genişletilir.

1 /mm2 ; Mitojenik

0 / mm2; Nonmitojenik

**Table 7**
**2008 AJCC melanoma staging database data on mitotic rate and survival**

| Number of Mitoses/mm² | n | Survival Rate ± SE | |
|---|---|---|---|
| | | 5 y | 10 y |
| 0–0.99 | 3312 | 0.973 ± 0.004 | 0.927 ± 0.007 |
| 1.00–1.99 | 2117 | 0.920 ± 0.007 | 0.842 ± 0.012 |
| 2.00–4.99 | 3254 | 0.869 ± 0.007 | 0.754 ± 0.012 |
| 5.00–10.99 | 2049 | 0.781 ± 0.011 | 0.680 ± 0.018 |
| 11.00–19.99 | 673 | 0.695 ± 0.022 | 0.576 ± 0.027 |
| ≥20.0 | 259 | 0.594 ± 0.039 | 0.476 ± 0.050 |
| Total | 11,664[a] | | |



Ki 67

Antifosfohiston H3; Anti- PHH3

# DERMAL MİTOZ

1. Prognostik bilgi
2. Cerrahi sınır genişliği planlaması

Mitotik aktivite yüksekliği; SLN pozitifliği ( ≥1 /mm2 ise SLN biyopsisi ince melanomda bile önerilmektedir)

**Table 7**
**2008 AJCC melanoma staging database data on mitotic rate and survival**

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| Total | 11,664[a] | | |

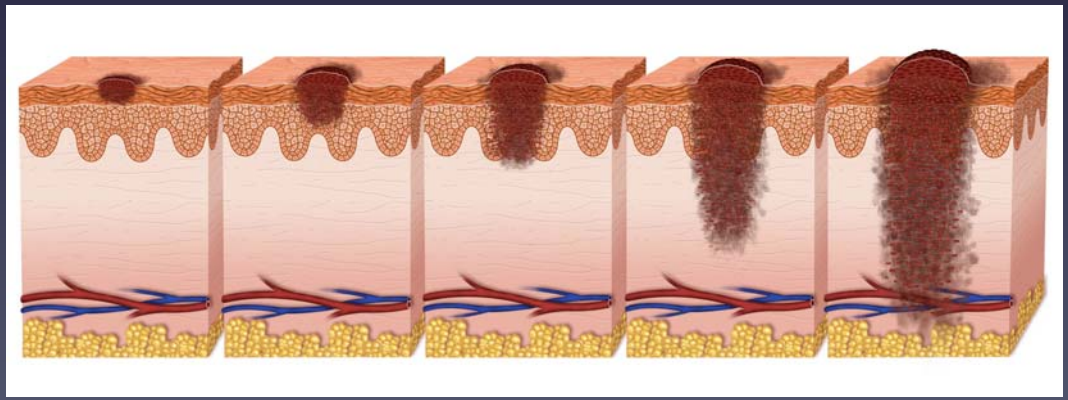
# CLARK SEVİYESİ

Mitotik hızın belirlenemediği durumlarda

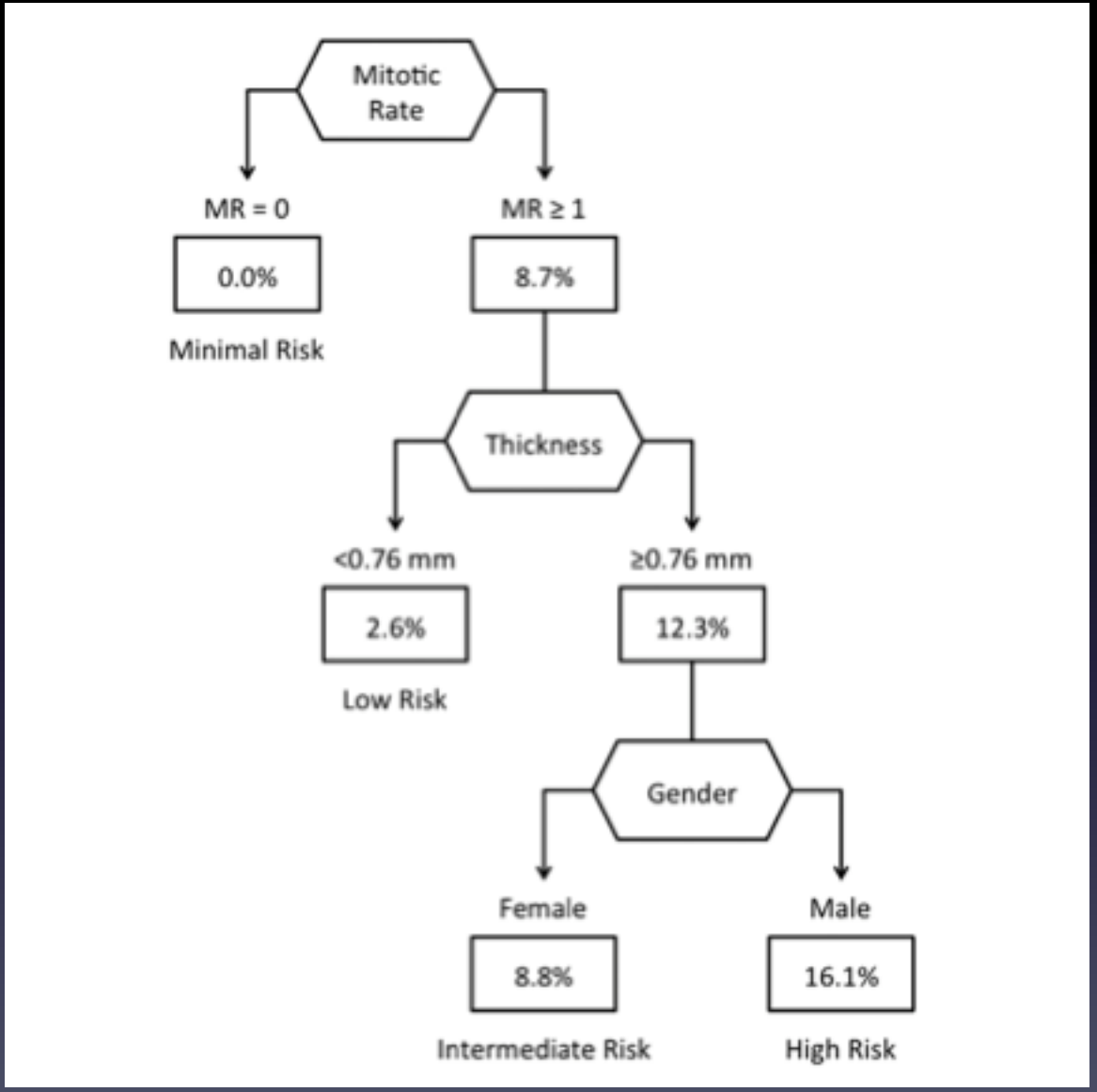
**Table 5**
**Clark levels of invasion**

| | |
|---|---|
| I | Tumor confined to the epidermis |
| II | Tumor invading into the upper papillary dermis |
| III | Tumor filling the papillary dermis with no extension into the reticular dermis |
| IV | Tumor invading into the reticular dermis |
| V | Tumor invading into the subcutaneous tissue |

CLARK IV ve V; Tumor 1mm altında bile olsa T1 üzerine çıkar



# Risk Belirleme



# LENF NODU

- Sayı
- Mikrometastaz
- Makrometastaz

Table 1
TNM staging

| T | | |
|---|---|---|
| T is | | |
| T1 | | |
| T2 | | |
| T3 | | |
| T4 | | |
| **N** | | |
| N0 | 0 | Not applicable |
| N1 | 1 | N1a: micrometastasis[a]<br>N1b: macrometastasis[b] |
| N2 | 2–3 | N2a: micrometastasis[a]<br>N2b: macrometastasis[b]<br>N2c: in transit metastases/satellites without metastatic nodes |
| N3 | 4+ metastatic nodes, or matted nodes, or in transit metastases/ satellites with metastatic nodes | |
| **M** | **Site** | **Serum Lactate Dehydrogenase** |
| M0 | No distant metastases | Not applicable |
| M1a | Distant skin, subcutaneous, or nodal metastases | Normal |
| M1b | Lung metastases | Normal |
| M1c | All other visceral metastases | Normal |
| | Any distant metastasis | Increased |

[a] Micrometastases are diagnosed after sentinel lymph node biopsy.
[b] Macrometastases are defined as clinically detectable nodal metastases confirmed pathologically.
*Data from* Edge SB, Byrd DR, Compton CC, et al, editors. AJCC cancer staging manual. 7th edition. Chicago: Springer; 2009. p. 332.

## Sayı

**N1** 1

a. Mikrometastaz

b. Makrometastaz

**N2** 2-3

a. Mikrometastaz

b. Makrometastaz

c. In-transit metastaz/ Satellit (LN yok)

**N3** 4

4 den fazla lenf nodu veya in-transit metastaz/ satellit (LN var)

**Table 9**
**Multivariate Cox regression analysis of prognostic factors in 1338 stage III patients in the 2008 melanoma staging database**

| | Chi-Square Values (1 df) | | |
|---|---|---|---|
| Variable | All Patients with Stage III (n = 1338) | Patients with Micrometastasis (n = 1070) | Patients with Macrometastasis (n = 268) |
| Number of positive nodes | 27.4 | 27.8 | 5.0 |
| Ulceration | 17.5 | 13.5 | 2.1 |
| Tumor thickness | 9.1 | 9.4 | 1.1 |
| Tumor burden (micro vs macro) | 4.7 | — | — |
| Mitotic rate | 4.4 | 12.7 | 0.2 |
| Age | 24.8 | 15.8 | 7.1 |
| Site | 4.3 | 4.7 | 0.4 |
| Gender | 0.5 | 0.4 | 0.2 |
| Clark level | 0.l | 0.0 | 0.2 |

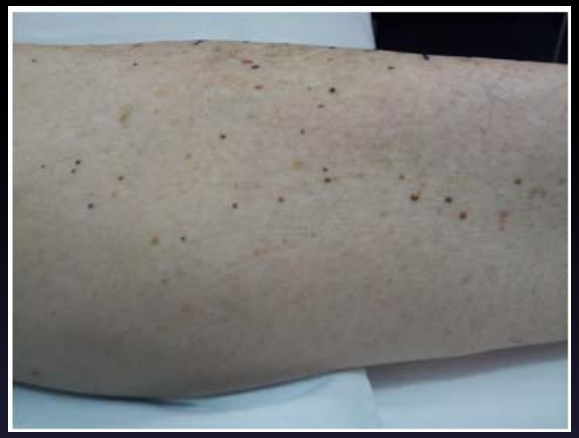
*Adapted from* Balch CM, Gershenwald JE, Soong SJ, et al. Melanoma of the skin. In: Edge SB, Byrd DR, Compton CC, et al, editors. AJCC staging manual. 7th edition. New York: Springer; 2010. p. 325–44; with permission.

# İNTRALENFATİK METASTAZ

- Satellit
  - Mikrosatellit

    Melanom hücre grupları

    - 0.05mm den büyük
    - Tumor kitlesinden en az 0.3 mm uzakta
  - Klinik satellit
    - Primer lezyondan 5 cm



Beraberinde lenf nodu yoksa N2c……Lenf nodu varsa N3

# İNTRALENFATİK METASTAZ

- In-transit metastaz
  - 5 cm.den uzaktaki lezyonlar
  - Lenf drenajının proksimali

Beraberinde lenf nodu yoksa N2c.....Lenf nodu varsa N3

# SENTINEL LENF NODU METASTAZI

- Klinik olarak gizli lenf nodu metastazı
- Lenfatik drenaj paterni
- Isosulfan blue dye, Technetium-99m

# Roterdam Kriteleri

Lenf nodunda tumorun boyutu

- < 0.1 mm
- 0.1- 1.0 mm
- > 1.0 mm

# Dewar Kriteleri

## Lenf nodunda tumorun lokalizasyonu

- Subkapsüler
- Parankimal
- Multifokal
- Kombine
- Yaygın
- Bilinmeyen

0.1 altında tumor boyutunda;
Subkapsüler tutulum; %95
Non subkapsüler tutulum; % 88

# Lenf nodu patolojisi;

## İmmunohistokimyasal inceleme

- Melanom Marker

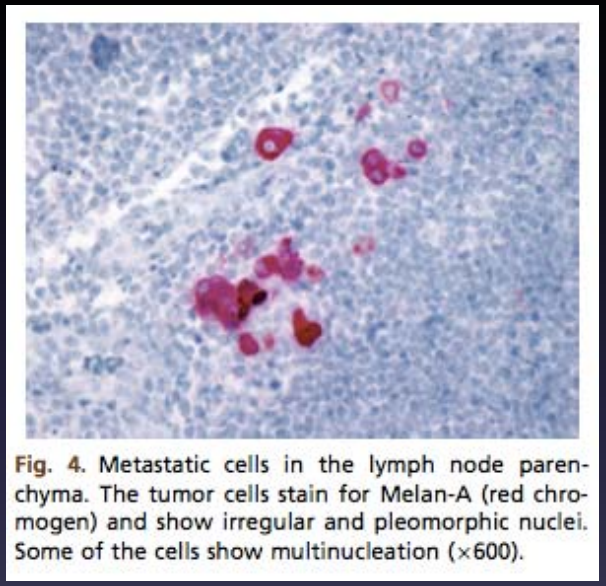


Fig. 4. Metastatic cells in the lymph node parenchyma. The tumor cells stain for Melan-A (red chromogen) and show irregular and pleomorphic nuclei. Some of the cells show multinucleation (×600).

- S 100
- Melanoma antigen; **Melan A**
- Melanoma antigen recognized by T cells; **MART-1**
- Human Melanoma Black 45; HMB 45
- Microphtalmia- associated transcription factor; MITF

0.1 mm.den daha az boyuttaki mikrometastazlar saptanabilir.

# METASTAZ

- Yeri
- LDH

Table 1
TNM staging

| | | |
|---|---|---|
| T | | |
| T is | | |
| T1 | | |
| T2 | | |
| T3 | | |
| T4 | | |
| N | | |
| N0 | | |
| N1 | | |
| N2 | | |
| N3 | | |
| M | | |
| M0 | No distant metastases | Not applicable |
| M1a | Distant skin, subcutaneous, or nodal metastases | Normal |
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| | Any distant metastasis | Increased |

[a] Micrometastases are diagnosed after sentinel lymph node biopsy.
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*Data from* Edge SB, Byrd DR, Compton CC, et al, editors. AJCC cancer staging manual. 7th edition. Chicago: Springer; 2009. p. 332.

## Yeri

**M1 a**

Uzak Kutan / Subkutan veya

Nodal metastaz / LDH normal

**M1 b**

Akciğer metastazı/ LDH normal

**M1 c**

Diğer organ metastazı

LDH Yüksekliği

Herhangi bir uzak metastaz

Metastaz sayısı da önemli; Evrelemede yok

# Metastazlar

- Deri
- Yumuşak Doku
- Akciğer
- Beyin
- Kemik
- GIS

LDH yüksekse metastaz yeri önemli değil, yaşam şansı azalır

**Table 10**
**Impact of serum LDH on median survival by site of disease**

| | LDH <200 U/L | | | LDH >200 U/L | | | |
|---|---|---|---|---|---|---|---|
| Site of Disease | Number of Patients | Number of Deaths | Median Survival | Number of Patients | Number of Deaths | Median Survival | *P* Value |
| Skin/subcutaneous/ distant nodal | 49 | 32 | 16 (13–21) | 5 | 5 | 9 (2–n/r) | .10 |
| Lung | 83 | 71 | 14 (12–17) | 15 | 12 | 9 (4–17) | .008 |
| Other viscera | 114 | 91 | 9 (7–10) | 105 | 95 | 5 (4–7) | .003 |

*Adapted from* Neuman HB, Patel A, Ishill M. A single-institution validation of the AJCC staging system for stage IV melanoma. Ann Surg Oncol 2008;15:2034–41; with permission.

**Table 1**
**TNM staging categories for cutaneous melanoma**

| T | Thickness (mm) | Ulceration Status and Mitoses |
|---|---|---|
| T is | Not applicable | Not applicable |
| T1 | ≤1.00 | T1a: without ulceration and mitoses <1/mm$^2$<br>T1b: with ulceration or mitoses ≥1/mm$^2$ |
| T2 | 1.01–2.00 | T2a: without ulceration<br>T2b: with ulceration |
| T3 | 2.01–4.00 | T3a: without ulceration<br>T3b: with ulceration |
| T4 | ≥4.01 | T4a: without ulceration<br>T4b: with ulceration |
| **N** | **No. of Metastatic Nodes** | **Nodal Metastatic Burden** |
| N0 | 0 | Not applicable |
| N1 | 1 | N1a: micrometastasis[a]<br>N1b: macrometastasis[b] |
| N2 | 2–3 | N2a: micrometastasis[a]<br>N2b: macrometastasis[b]<br>N2c: in transit metastases/satellites without metastatic nodes |
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**Table 2**
**TNM melanoma staging**

| | Clinical Staging[a] | | | | Pathologic Stagingt[b] | | |
|---|---|---|---|---|---|---|---|
| | T | N | M | | T | N | M |
| 0 | Tis | N0 | M0 | 0 | Tis | N0 | M0 |
| IA | T1a | N0 | M0 | IA | T1a | N0 | M0 |
| IB | T1b | N0 | M0 | IB | T1b | N0 | M0 |
| | T2a | N0 | M0 | | T2a | N0 | M0 |
| IIA | T2b | N0 | M0 | IIA | T2b | N0 | M0 |
| | T3a | N0 | M0 | | T3a | N0 | M0 |
| IIB | T3b | N0 | M0 | IIB | T3b | N0 | M0 |
| | T4a | N0 | M0 | | T4a | N0 | M0 |
| IIC | T4b | N0 | M0 | IIC | T4b | N0 | M0 |
| III | Any T | N > N0 | M0 | IIIA | T14a | N1a | M0 |
| | | | | | T14a | N2a | M0 |
| | | | | IIIB | T14b | N1a | M0 |
| | | | | | T14b | N2a | M0 |
| | | | | | T14a | N1b | M0 |
| | | | | | T1-4a | N2b | M0 |
| | | | | | T14a | N2c | M0 |
| | | | | IIIC | T1-4b | N1b | M0 |
| | | | | | T14b | N2b | M0 |
| | | | | | T14b | N2c | M0 |
| | | | | | Any T | N3 | M0 |
| IV | Any T | Any N | M1 | IV | Any T | Any N | M1 |

# Patolojik Evreleme

- Tumor kalınlığı
- Ulserasyon
- Mitoz hızı
- Sınırların durumu
- Clark seviyesi
- Mikrosatellitler

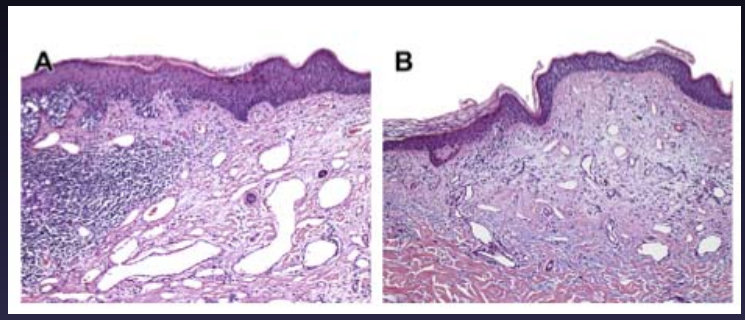
**Mutlak Bakılmalıdır !**

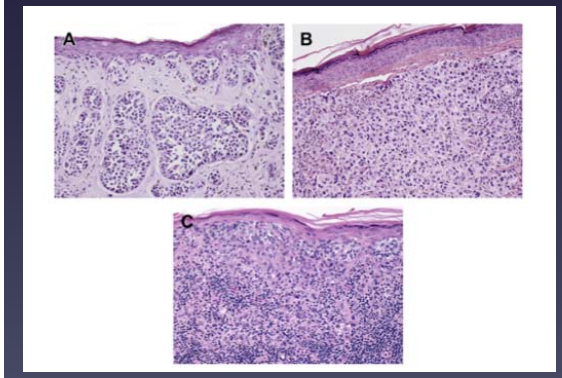
# Patolojik Evreleme

- Anjiolenfatik

  (Lenfovaskuler)invazyon
- Histolojik subtip
- Nörotrofizm
- Regresyon
- İnfiltre lenfositler (Sitotoksik T hüc)
- Vertikal büyüme fazı

REGRESYON




INFILTRE LENFOSITLER

Opsiyonel

**Table 11**
**Optional melanoma histologic features with prognostic value found in the dermatopathology report**

| Histologic Feature | Description | Impact on Prognosis |
|---|---|---|
| Angiolymphatic Invasion | Presence of tumor cells within a vessel lumen | Potential marker for hematologic/lymphatic spread of melanoma cells, but there is a high potential for misinterpretation in the presence of torturous vessels; Prognostic power overlaps with angiotropism |
| Histologic Subtype | SSM<br>NM<br>LMM<br>ALM | LMM and SSM have been found to have a better prognosis than NM and ALM, but when controlling for tumor thickness, studies have not consistently found a significant difference between the subtypes<br>There is also significant variance in categorization criteria among dermatopathologists |
| Neurotropism | Neoplastic infiltration of nerve fibers | Found to increase risk for local recurrence with an unclear role in metastatic disease, but there is limited data reported in the literature |
| Regression | Partial or complete absence of tumor cells in both the dermis and epidermis found within a melanoma; There is a residual variable combination of fibrosis, degenerative melanoma cells, melanophages, lymphocytes, and telangiectasia.<br>Thought to be caused by interaction between the host immune response and the tumor cells | Unclear prognostic value because of inconsistencies in definition and measurement and lack of control of other histologic variables<br>Several studies have shown that severe regression correlates with a worsening DFS, whereas other studies have found that regression in thin melanomas had a decreased metastatic risk |
| Angiotropism | Melanoma cells cuffing the external surface of vessels | Potential source for hematologic spread of melanoma cells, but there is limited data to evaluate whether angiotropism is an independent risk factor for metastasis or survival |
| Tumor Infiltrating Lymphocytes | Brisk: diffuse infiltrate of lymphocytes throughout the dermal tumor cells or the presence of lymphocytes along 90% of the circumference of the lesion base<br>Non-Brisk: focal infiltrate of lymphocytes<br>Absent: no lymphocytes are admixed with melanoma cells, but may be present perivascularly | Presence of a host inflammatory response is generally associated with a better prognosis, but prognostic power is limited because of the inconsistency in controlling for other prognostic features in previous studies<br>There is lack of research on the functional status of lymphocytic infiltrates to determine whether they are operating as an active vs anergic immune response |
| Vertical Growth Phase | Presence of aggregates of tumor cells in the dermis with at least one nest in the dermis being larger than the largest intraepidermal nest, or the presence of mitoses | Indicates a worse prognosis, but its value as an independent risk factor has not been consistently validated; confounding factors are Breslow thickness and mitotic rate, with significant controversy in thin melanomas |

*Abbreviations:* ALM, acral-lentiginous melanoma; LMM, lentigo maligna melanoma; NM, nodular melanoma; SSM, superficial spreading melanoma.
*Data from* Payette MJ, Katz M, Grant-Kels JM. Melanoma prognostic factors found in the dermatopathology report. J Clin Dermatol 2009;27:53–74.

| STAGE | PATHOLOGIC STAGE GROUPING | 10-YEAR SURVIVAL RATE | |
|---|---|---|---|
| | | 2002 | 2010 |
| **Stage 0** | Tis N0 M0 | | |
| **Stage IA** | T1a N0 M0 | 88 | 94 |
| **Stage IB** | T1b–T2a N0 M0 | 80 | 85 |
| **Stage IIA** | T2b–T3a N0 M0 | 64 | 67 |
| **Stage IIB** | T3b–4a N0 M0 | 52 | 56 |
| **Stage IIC** | T4b N0 M0 | 32 | 40 |
| **Stage III** | Stage IIIA T1–4a N1a/N2a M0 | 60 | 68 |
| | Stage IIIB T1b–T4b N1a/N2a M0 | 42 | 44 |
| | • T1a–T4a N1b/N2b M0 | 40 | 44 |
| | • T1a–T4a/b N2c M0 | | 52 |
| | Stage IIIC T1–T4b N1b/2b M0 | 20 | 30 |
| | • T1a–T4b N3 M0 | 18 | 26 |
| | • Any T N3 M0 | | |
| **Stage IV** | Any T Any N M1 | 2.5–10 | 2.5–5 |

Abbreviations: is=*in situ*

Adapted from Balch CM, Gershenwald JE, Soong S, Thompson JF, Atkins MB, Byrd DR, et al. Final Version of 2009 AJCC Melanoma Staging Guidelines. *J Clin Oncol.* 2009;27(61):6199-6206.

# İZLEM

- Rekurrens
- Metastaz
- Yeni primer tumor

(İkinci yeni melanom için yaşam boyu risk; %4-8)

# İZLEM

- NCCN; National Comprehensive Cancer Network
- ESMO; European Society for Medical Oncology
- AAD; American Academy of Dermatology
- BAD; British Association of Dermatologists
- Swiss Melanoma Guidelines
- German Cancer Society and German Dermatologic Society
- Guidelines for the Management of Melanoma in Australia and New Zealand

Evre

NCCN
BAD
Swiss Guideline
German Guideline
Australia- New Zaeland Guideline

AAD
ESMO

Bireysel risk

| | PROVIDER OR SPECIALTY | BASIS OF FOLLOW-UP GUIDELINES | FOLLOW-UP GUIDELINES | | | |
|---|---|---|---|---|---|---|
| | | | STAGE/ BRESLOW THICKNESS | H&P | IMAGING/ LABORATORY EVALUATION | COMMENTS |
| NCCN | Not discussed | Stage specific | Stage 0 | H&P annually for life | None | • Lifelong clinical exams<br>• Routine blood tests not recommended<br>• Frequency of H&P given in ranges and should be adjusted based on risk factors<br>• Self-skin exams should include self-lymph node exams |
| | | | Stage IA–IIA | H&P every 3–12 months for 5 years and then annually as clinically indicated | Not recommended | |
| | | | Stage IIB–IV | H&P every 3–6 months for 2 years and then every 3–12 months for 3 years and then annually as clinically indicated | Consider CXR, CT+/-PET every 3–12 months and annual MRI of brain. No imaging in asymptomatic patients after 5 years | |
| ESMO | Not discussed | Risk | Low risk/ thin melanomas | No specific recommendations | Not recommended | • Emphasis on patient education and lifelong regular self-exams |
| | | | High risk | No specific recommendations | CT +/- PET recommended | |

| | | | | | | |
|---|---|---|---|---|---|---|
| AAD | Not discussed | General recommendations | NA | H&P at least annually, possibly every 3–12 months | • Not recommended in asymptomatic patients<br>• Directed imaging and lab work not recommended after 5 years in high-risk patients | • Lifelong clinical exams<br>• Follow-up should be based on individual risk factors<br>• Not stage-specific recommendations |
| BAD | Specialist skin cancer multidisciplinary teams | Stage specific | *in situ*<br>Stage IA | Self-exam<br>H&P 2–4 times for 12 months | No specific recommendations | No follow-up required for MIS |
| | | | Stage IB–IIIA | H&P every 3 months for 3 years then every 6 months for 2 years | No specific recommendations | — |
| | | | Stage IIIB–IV (resected) | H&P every 3 months for 3 years, every 6 months for the next 2 years and then annually for the next 5 years | Consider CT | — |
| | | | Stage IV (unresected) | Per patient need | No specific recommendations | Not discussed |

Bireysel kontrol

NCCN
BAD
Swiss Guideline
German Guideline
Australia- New Zaeland Guideline

## Optimal izlem süresi

1 yıl.....yaşam boyu

## İzlem sıklığı

3 ay.....12 ay

BAD

İnsitu; yok
IA; 1 yıl
IB-IIIA; 5 yıl
IIIB-IV; 10 yıl

GERMAN

Tüm evrelerde;
10 yıl

| | PROVIDER OR SPECIALTY | BASIS OF FOLLOW-UP GUIDELINES | FOLLOW-UP GUIDELINES | | | |
|---|---|---|---|---|---|---|
| | | | STAGE/ BRESLOW THICKNESS | H&P | IMAGING/ LABORATORY EVALUATION | COMMENTS |
| German Cancer Society and German Dermatologic Society | Not discussed | Stage and Breslow thickness | Stage I <1mm | H&P every 6 months for years 1–5 then every 6–12 months for years 6-10 | No imaging or blood work | • Limit clinical exams to 10 years<br>• Use of LNS, S100β levels emphasized |
| | | | Stage I, II >1mm | H&P every 3 months for years 1–5 then every 6–12 months for years 6–10 | LNS every 6 months for years 1–5 | |
| | | | Stage III | H&P every 3 months for years 1–5 then every 6 months for years 6–10 | S100β level every 3–6 months for years 1–5<br>No additional imaging studies<br>LNS every 3–6 months for years 1–5 | |
| | | | Stage IV | | S100β level every 3–6 months for years 1–5<br>Abdominal sonography and CXR or CT, MRI, or PET every 6 months for years 1–5 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Swiss Guidelines | Not discussed | Stage specific | Stage I (≤T1N0) | H&P every 6 months for years 1–3 then annually from years 6-10 | None | • Lifelong clinical surveillance is recommended<br>• Use of LNS emphasized<br>• Abdominal sonography and CXR on individual basis for Stage I (T2N0)–IV melanomas |
| | | | Stage I (T2N0)–IIB | H&P every 3 months for years 1–3, every 6 months for years 4-5, then every 6–12 months for years 6–10 | LNS and S100 every 6–12 months for years 1–5 | |
| | | | Stage IIC–III | H&P every 3 months for years 1–5 then every 6 months for years 6–10 | LNS and S100 every 6 months for years 1–5<br>CT, MRI, PET or PET-CT every 6–12 months for years 1–5 | |
| | | | Stage IV | Individual | Individual | |
| Guidelines for Management of Melanoma in Australia and New Zealand | Patients themselves and/or preferred health professional | Stage specific | Stage I | H&P every 6 months for 5 years | • Ultrasound may be used in conjunction with clinical examination only in patients with more advanced primary disease<br>• No lab tests are recommended | • Self examinations are essential and all patients should be properly educated on how to perform them<br>• Individual patient's needs must be considered before appropriate follow-up is offered |
| | | | Stage II, III | H&P every 3–4 months for 5 years then annually thereafter | | |
| | | | Stage IV | Not discussed | | |

NCCN
AAD
SWISS

Yaşam Boyu

EVRE I
5 yıl

Diğer;
Yaşam boyu

# Risk Faktörleri Değerlendirilmeli

Evre

Breslow kalınlığı

Açık ten

Atipik nevus varlığı

Aile öyküsü

Entellektüel düzey

Psikolojik durum, anksiyete

İlk 5 yıl önemli
Yılda 2 kez
Yaşam boyu

# Kim ?

a. Dermatolog

b. Onkolog

c. Plastik Cerrah

d. Genel Cerrah

# Kim ?

a. Dermatolog

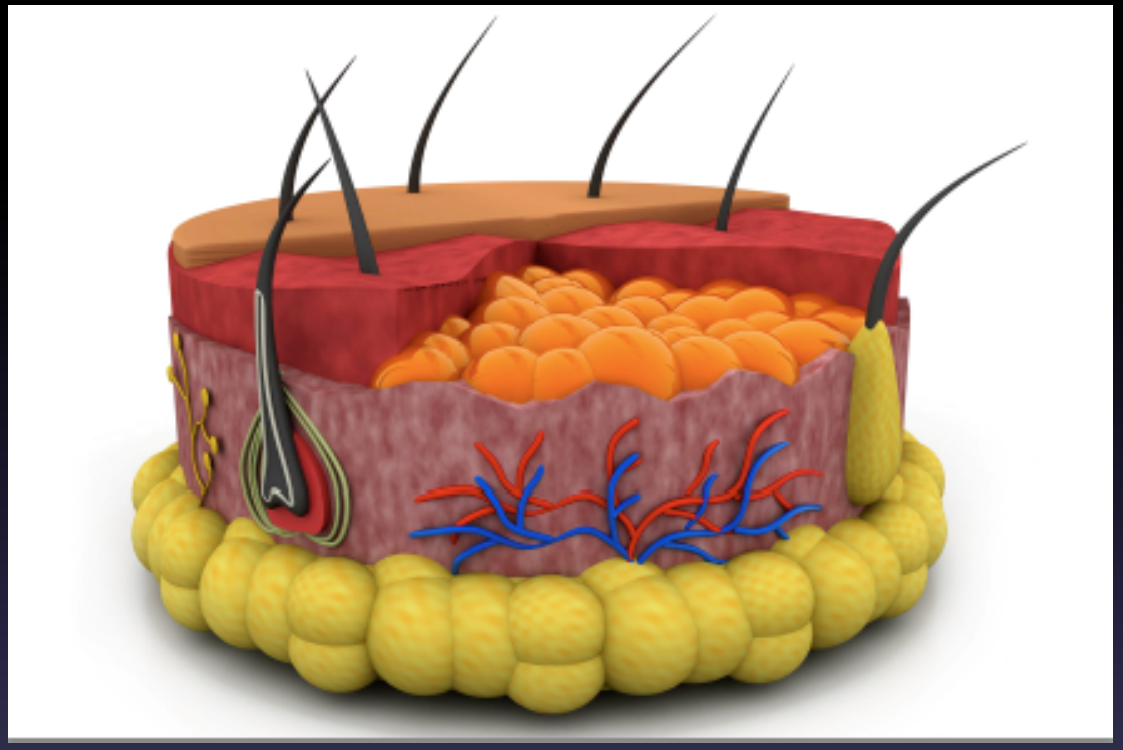
b. Onkolog

c. Plastik Cerrah

d. Genel Cerrah

McKenna ve ark. Br J Dermatol 2004

**a. Dermatolog**



Saygılarımla.....