Cutaneous Melanoma

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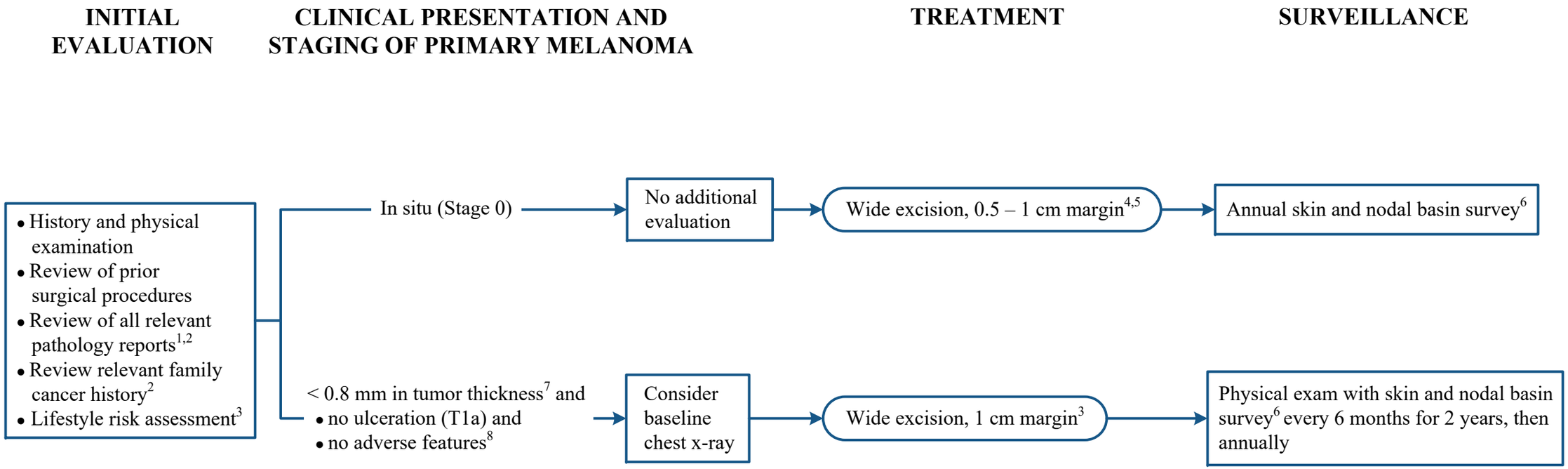
CNS = central nervous system

Cutaneous Melanoma

Note: Consider Clinical Trials as treatment options for eligible patients.



[1] Refer to Review of Outside Pathology Material Policy (#CLN0605) as indicated
[2] Guidelines for germline testing to assess genetic predisposition for melanoma are rapidly evolving. At a minimum, patients with a history of three invasive cutaneous melanomas and/or high risk family history (multiple cutaneous melanomas, pancreatic, renal and/or breast cancer; astrocytoma; uveal melanoma and/or mesothelioma) should be offered genetic counseling (refer to Genetic Counseling algorithm).
[3] See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[4] Consider function and cosmesis
[5] Margins larger than 0.5 cm may be necessary for some, particularly large melanoma in situ, lentigo maligna type, lesions
[6] For patients with multiple complex nevi, history of multiple primary cutaneous melanomas or multiple non-melanoma skin cancers, Dermatology follow up is strongly recommended
[7] Per AJCC 8th edition, the convention for rounding decimal values in the hundredth's place is to round down those ending in 1 to 4 and to round up those ending in 5 to 9. For example, a melanoma measuring 0.75 mm in thickness would be recorded as 0.8 mm in thickness (*i.e.*, T1b), and those measuring from 0.95 to 1.04 mm would be rounded to 1 mm (*i.e.*, T1b).
[8] Adverse features include: positive deep margins, lymphovascular invasion, young age or ≥ 2 mitoses/mm^2

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Cutaneous Melanoma

Note: Consider Clinical Trials as treatment options for eligible patients.

INITIAL EVALUATION

- History and physical examination
- Consider additional diagnostic biopsy if significant residual (primary cutaneous) lesion
- Review of prior surgical procedures
- Review of all relevant pathology reports[1,2]
- Review relevant family cancer history[2]
- Lifestyle risk assessment[3]
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[4]

CLINICAL PRESENTATION AND STAGING OF PRIMARY MELANOMA

< 0.8 mm in tumor thickness[5] and
- ulceration (clinical T1b) and/or
- with adverse features[6]

→ Consider baseline chest x-ray

≥ 0.8 mm in tumor thickness[4] and clinical N0M0 → See Page 4

TREATMENT

- Wide excision, 1 cm margin[7]
- Consider LM/SLNB (obtain preoperative lymphoscintigraphy if ambiguous lymphatic drainage or at the discretion of surgeon)

Sentinel node(s) negative **or** LM/SLNB not performed → Physical exam with skin and nodal basin survey[8] every 6 months for 2 years, then annually

Sentinel node(s) positive →

- Staging:
  - CT chest, abdomen, and pelvis with IV/PO contrast or PET-CT (with IV/PO contrast)
  - CNS imaging (MRI brain with IV contrast)
- Tumor mutation testing[9]
- Nodal observation and nodal ultrasound generally recommended
  - CLND not routinely recommended but can be considered on selective basis[10]

→
- Clinical trial
- Nivolumab
- Pembrolizumab
- Dabrafenib with trametinib (*BRAF* V600E/K mutations)
- Observation

SURVEILLANCE

- Physical exam with skin and nodal basin survey[8] **and** CT chest, abdomen, pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) **and** ultrasound of involved nodal basin every 3-4 months for 2 years, then every 6 months for 3 years, then annually
- MRI brain with IV contrast at least annually and/or as clinically indicated

CNS = central nervous system
CLND = completion lymph node dissection
SLN = sentinel lymph node
LM = lymphatic mapping
SLNB = sentinel lymph node biopsy

[1] Refer to Review of Outside Pathology Material Policy (#CLN0605) as indicated

[2] Guidelines for germline testing to assess genetic predisposition for melanoma are rapidly evolving. At a minimum, patients with a history of three invasive cutaneous melanomas and/or high risk family history (multiple cutaneous melanomas, pancreatic, renal and/or breast cancer; astrocytoma; uveal melanoma and/or mesothelioma) should be offered genetic counseling (refer to Genetic Counseling algorithm).

[3] See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

[4] GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

[5] Per AJCC 8th edition, the convention for rounding decimal values in the hundredth's place is to round down those ending in 1 to 4 and to round up those ending in 5 to 9. For example, a melanoma measuring 0.75 mm in thickness would be recorded as 0.8 mm in thickness (*i.e.*, T1b), and those measuring from 0.95 to 1.04 mm would be rounded to 1 mm (*i.e.*, T1b).

[6] Adverse features include: positive deep margins, lymphovascular invasion, young age or ≥ 2 mitoses/mm^2

[7] Consider function and cosmesis

[8] For patients with multiple complex nevi, history of multiple primary cutaneous melanomas or multiple non-melanoma skin cancers, Dermatology follow up is strongly recommended

[9] Tumor mutation analysis includes at a minimum *BRAF*, *NRAS* and *KIT*

[10] Randomized trials have failed to demonstrate survival benefit for routine CLND following a positive SLN. Although CLND is associated with improved regional control and in a minority of patients upstaging might impact clinical decision-making, post-hoc forest plot analyses of MSLT-2 have not definitely identified any subgroups of patients likely to derive a survival benefit; therefore, the vast majority of patients are no longer routinely offered CLND. One rare possible exception to this approach is for patients with limited access to follow-up.

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Note: Consider Clinical Trials as treatment options for eligible patients.

CLINICAL PRESENTATION AND STAGING OF PRIMARY MELANOMA

≥ 0.8 mm in tumor thickness[1] and clinical N0M0

- Consider preoperative ultrasound of regional nodal basin(s) if primary tumor greater than 4 mm or for ambiguous/equivocal regional basin(s) physical examination
- Baseline chest x-ray
- Consider cross-sectional imaging as clinically indicated for symptoms or T3b or T4 primary

TREATMENT

- Wide excision with the following margins[2] based on tumor thickness[1]
  - ≤ 1 mm: 1 cm margin
  - > 1-2 mm: 1-2 cm margin
  - > 2 mm: 2 cm margin
- LM/SLNB (obtain preoperative lymphoscintigraphy if ambiguous lymphatic drainage or at the discretion of surgeon)
- Multidisciplinary discussion for consideration of primary site adjuvant radiation therapy for high risk primaries[3]

Sentinel node(s) negative → Consider pembrolizumab or nivolumab for Stage IIB or IIC

Sentinel node(s) positive →

- Staging (if not already performed prior to surgery):
  - CT chest, abdomen, and pelvis with IV/PO contrast or PET-CT (with IV/PO contrast)
  - CNS imaging (MRI brain with IV contrast)
- Tumor mutation testing[5]
- Nodal observation and nodal ultrasound generally recommended
  - CLND not routinely recommended but can be considered on selective basis[6]

→

- Clinical trial
- Nivolumab
- Pembrolizumab
- Dabrafenib with trametinib (*BRAF* V600E/K mutations)
- Observation

SURVEILLANCE

- SLN-negative melanomas 0.8-1 mm
  - Physical exam with skin and nodal basin survey[3] every 6 months for 2 years, then annually
- SLN-negative melanomas > 1 mm
  - Physical exam with skin and nodal basin survey[4] every 3-4 months for 2 years, then every 6 months for 3 years, then annually
  - Consider chest x-ray, interval CT chest, abdomen, and pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) and MRI brain with IV contrast, as clinically indicated

- Physical exam with skin and nodal basin survey[4] **and** CT chest, abdomen, pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) **and** ultrasound of involved nodal basin every 3-4 months for 2 years, then every 6 months for 3 years, then annually
- MRI brain with IV contrast at least annually and/or, as clinically indicated

CNS = central nervous system
CLND = completion lymph node dissection
LM = lymphatic mapping
SLN = sentinel lymph node
SLNB = sentinel lymph node biopsy

[1] Per AJCC 8th edition, the convention for rounding decimal values in the hundredth's place is to round down those ending in 1 to 4 and to round up those ending in 5 to 9. For example, a melanoma measuring 0.75 mm in thickness would be recorded as 0.8 mm in thickness (*i.e.*, T1b), and those measuring from 0.95 to 1.04 mm would be rounded to 1 mm (*i.e.*, T1b).

[2] Consider function and cosmesis

[3] High risk primaries include those with microsatellitosis, positive margins, or a combination of factors increasing the risk of local recurrence such as perineural invasion (PNI), > 4 mm thickness or an anatomically challenging area (*e.g.,* head and neck)

[4] For patients with multiple complex nevi, history of multiple primary cutaneous melanomas or multiple non-melanoma skin cancers, Dermatology follow up is strongly recommended

[5] Tumor mutation analysis includes at a minimum *BRAF*, *NRAS* and *KIT*

[6] Randomized trials have failed to demonstrate survival benefit for routine CLND following a positive SLN. Although CLND is associated with improved regional control and in a minority of patients upstaging might impact clinical decision-making, post-hoc forest plot analyses of MSLT-2 have not definitely identified any subgroups of patients likely to derive a survival benefit; therefore, the vast majority of patients are no longer routinely offered CLND. One rare possible exception to this approach is for patients with limited access to follow-up.

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Note: Consider Clinical Trials as treatment options for eligible patients.

CLINICAL PRESENTATION/STAGING

Local recurrence, unknown primary melanoma (presenting as dermal, subcutaneous or nodal disease) or in-transit metastasis[1,2]

- Review of all relevant pathology reports[2,3]
- Review relevant family cancer history[2]
- CT chest, abdomen, pelvis with IV/PO contrast or PET-CT (with IV/PO contrast)
- CNS imaging (MRI brain with IV contrast)
- Tumor mutation testing[4]
- CBC with differential, comprehensive metabolic panel, LDH
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[5]

TREATMENT

Inadequately treated primary (local persistence or margin positive resection) → Refer to Pages 2-4 for clinical presentation, staging, and treatment of primary melanoma

Resectable (isolated or limited) non-nodal locoregional metastasis[6]

- Consider clinical trial of neoadjuvant therapy **or**
- Local excision, negative margin
- Consider LM with SLNB
- Consider local postoperative adjuvant radiation therapy

→ **A**

Clinical nodal with or without clinical non-nodal locoregional metastasis, see Page 6

Multiple and/or unresectable satellite and/or in-transit metastases with or without clinical regional nodal disease, see Page 7

Distant metastasis, see Pages 8-10

A

- Consider staging/re-staging as clinically indicated:
  - CT chest, abdomen, and pelvis with IV/PO contrast or PET-CT (with IV/PO contrast)
  - CNS imaging (MRI brain with IV contrast)

If SLNB performed and positive sentinel nodes:

- Nodal observation and nodal ultrasound generally recommended
  - CLND not routinely recommended but can be considered on selective basis[7]

For either positive or negative sentinel nodes **or** if SLNB not performed, consider the following:

- Clinical trial
- Nivolumab
- Pembrolizumab
- Dabrafenib with trametinib (*BRAF* V600E/K mutations)
- Observation
- Ipilimumab or ipilimumab with nivolumab if refractory to anti-PD-1 based therapy

SURVEILLANCE

- Physical exam with skin and nodal basin survey[8] **and** chest x-ray **and** if SLNB positive, ultrasound of involved nodal basin every 3-4 months for 2 years, then every 6 months for 3 years, then annually
- CT chest, abdomen and pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) and MRI brain with IV contrast at scheduled follow-up visits and/or, as clinically indicated

CLND = completion lymph node dissection LM = lymphatic mapping
CNS = central nervous system SLN = sentinel lymph node SLNB = sentinel lymph node biopsy

[1] If patient presents with clinically suspicious lymph node or nodule, and/or history of melanoma[2], consider fine needle aspiration and/or core needle biopsy to establish the diagnosis prior to excision to facilitate definitive treatment planning

[2] Guidelines for germline testing to assess genetic predisposition for melanoma are rapidly evolving. At a minimum, patients with a history of three invasive cutaneous melanomas and/or high risk family history (multiple cutaneous melanomas, pancreatic, renal and/or breast cancer; astrocytoma; uveal melanoma and/or mesothelioma) should be offered genetic counseling (refer to Genetic Counseling algorithm).

[3] Refer to Review of Outside Pathology Material Policy (#CLN0605) as indicated

[4] Tumor mutation analysis includes at a minimum *BRAF*, *NRAS* and *KIT*

[5] GCC should be initiated by the Primary Oncologist. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

[6] Includes local recurrence, in-transit and/or satellite metastasis

[7] Randomized trials have failed to demonstrate survival benefit for routine CLND following a positive SLN. Although CLND is associated with improved regional control and in a minority of patients upstaging might impact clinical decision-making, post-hoc forest plot analyses of MSLT-2 have not definitely identified any subgroups of patients likely to derive a survival benefit; therefore, the vast majority of patients are no longer routinely offered CLND. One possible exception to this approach is for patients with limited access to follow-up. Overall, this remains an area of active investigation and dialogue.

[8] For patients with multiple complex nevi, history of multiple primary cutaneous melanomas or multiple non-melanoma skin cancers, Dermatology follow up is strongly recommended

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CLINICAL PRESENTATION/STAGING

Clinical nodal with or without clinical non-nodal locoregional metastasis

- Review of all relevant pathology reports[1,2]
- Review relevant family cancer history[2]
- CT chest, abdomen, pelvis with IV/PO contrast or PET-CT (with IV/PO contrast)
- CNS imaging (MRI brain with IV contrast)
- Tumor mutation testing[3]
- CBC with differential, comprehensive metabolic panel, LDH
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[4]

TREATMENT

Resectable clinical regional nodal metastasis with or without resectable (isolated or limited) non-nodal locoregional metastasis[5]

- Clinical trial
- Neoadjuvant therapy, (immune checkpoint blockade [ICB] or ICB/ intralesional talimogene laherparepvec [T-VEC] or targeted therapy)
- Lymph node dissection (LND)
  - Consider parotidectomy if head/neck primary tumor
  - Consider adjuvant radiation therapy for high risk features[6] (with pretreatment dental consult if head/neck radiation therapy planned)
- Consider adjuvant therapy (see Box A on Page 5)

Note: If recurrence on prior adjuvant therapy, consider switching agents

Multiple and/or unresectable satellite and/or in-transit metastases with or without clinical regional nodal disease, see Page 7

Distant metastasis, see Pages 8-10

SURVEILLANCE

- Physical exam with skin and nodal basin survey[7] **and** CT chest, abdomen, pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) every 3-4 months for 2 years, then every 6 months for 3 years, then annually
- MRI brain with IV contrast at least annually and/or, as clinically indicated

CNS = central nervous system

[1] Refer to Review of Outside Pathology Material Policy (#CLN0605) as indicated

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[5] Includes local recurrence, in-transit and/or satellite metastasis

[6] High-risk nodal features include:
- Lymph node number: 1+ parotid, 2+ other head and neck, 3+ axillary or inguinal **or**
- Lymph node deposit size: 3 cm+ head and neck, 4 cm+ axillary or inguinal **or**
- Extracapsular extension

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Cutaneous Melanoma

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CLINICAL PRESENTATION/STAGING

Multiple and/or unresectable satellite and/or in-transit metastases with or without clinical regional nodal disease

- Review of all relevant pathology reports[1,2]
- Review relevant family cancer history[2]
- CT chest, abdomen, pelvis with IV/PO contrast or PET-CT (with IV/PO contrast)
- CNS imaging (MRI brain with IV contrast)
- Tumor mutation testing[3]
- CBC with differential, comprehensive metabolic panel, LDH
- Discuss Goal Concordant Care (GCC) with patient or if clinically indicated, with Patient Representative[4]

TREATMENT

- Consider clinical trial
- Systemic therapy as recommended on Pages 9-11
- Intralesional injection with talimogene laherparepvec (T-VEC) with or without immune checkpoint blockade
- Consider isolated limb infusion (ILI) for symptomatic patients refractory to other treatment modalities

Distant metastasis, see Pages 8-10

SURVEILLANCE

- Physical exam with skin and nodal basin survey[5] **and** CT chest, abdomen, pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) every 3-4 months for 2 years, then every 6 months for 3 years, then annually
- MRI brain with IV contrast at least annually and/or as clinically indicated

CNS = central nervous system

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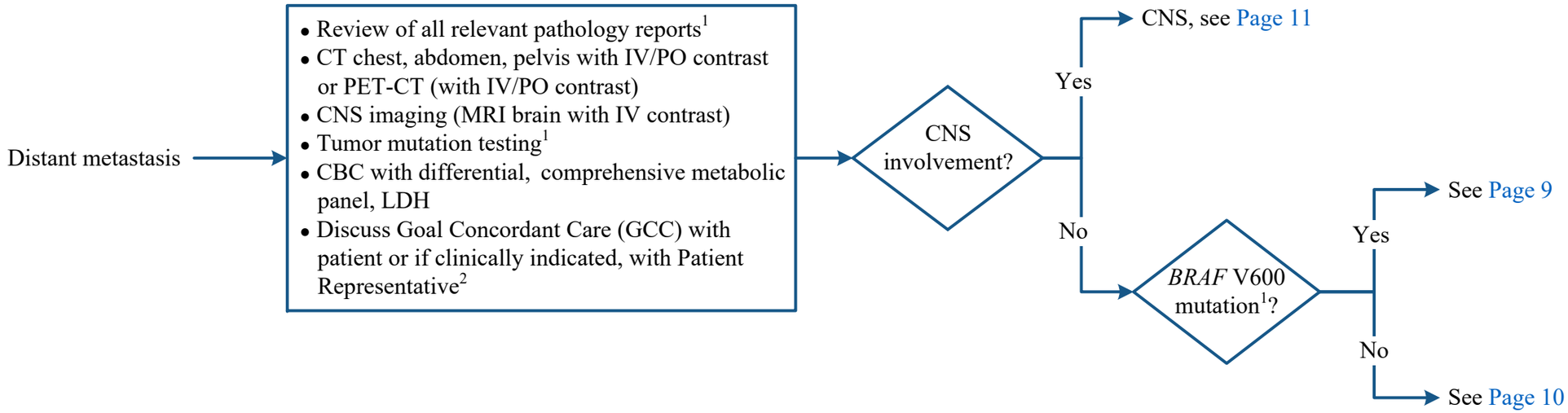
CLINICAL PRESENTATION/STAGING

TREATMENT



CNS = central nervous system

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CLINICAL PRESENTATION/ STAGING	TREATMENT	SURVEILLANCE
Patient **with** *BRAF* V600 mutation[1] and non-CNS distant metastasis/ unresectable locoregional metastasis	**First-line therapies:** • Clinical trial • Anti-PD-1 monotherapy (nivolumab or pembrolizumab) • Ipilimumab with nivolumab • Nivolumab and relatlimab-rmbw • *BRAF* inhibitor with MEK inhibitor[2] • Atezolizumab with vemurafenib and cobimetinib • Intralesional injection with talimogene laherparepvec (T-VEC) with or without immune checkpoint blockade • Consider surgery for resectable (isolated or limited) distant metastasis with or without post-operative adjuvant therapy **Second/subsequent-line therapies:** • Clinical trial • *BRAF* inhibitor with MEK inhibitor if refractory to anti-PD-1 based therapy • Anti-PD-1 or ipilimumab with nivolumab if refractory to *BRAF* inhibitor with MEK inhibitor • Ipilimumab or ipilimumab with nivolumab if refractory to anti-PD-1 based therapy • Consider TIL harvest for standard of care or investigational TIL trials • Consolidative local therapy (including surgery and/or radiation therapy) after response to systemic therapy • Surgical and/or regional therapy for limited and/or symptomatic disease (*e.g.,* surgery, infusional therapy, radiation therapy, or liver-directed therapy) • Intralesional injection with T-VEC with or without immune checkpoint blockade • Chemotherapy[3] or biochemotherapy[4]	Follow-up evaluation at least every 3 months and/or as clinically indicated, and includes periodic CT chest, abdomen, and pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) and MRI brain with IV contrast

CNS = central nervous system
TIL = tumor-infiltrating lymphocytes

[1] Tumor mutation analysis includes at a minimum *BRAF*, *NRAS* and *KIT*
[2] Regimens: dabrafenib with trametinib **or** vemurafenib with cobimetinib **or** encorafenib with binimetinib
[3] Chemotherapy: CVD (cisplatin, vinblastine, dacarbazine), carboplatin in combination with paclitaxel, nab-placlitaxel, dacarbazine or temozolomide
[4] Biochemotherapy: CVD plus interleukin-2 and interferon alpha

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Note: Consider Clinical Trials as treatment options for eligible patients.

CLINICAL PRESENTATION/ STAGING	TREATMENT	SURVEILLANCE
Patient **without** *BRAF* V600 mutation[1] and non-CNS distant metastasis/ unresectable locoregional metastasis	**First-line therapies:** • Clinical trial • Anti-PD-1 monotherapy (nivolumab or pembrolizumab) • Ipilimumab with nivolumab • Nivolumab and relatlimab-rmbw • Intralesional injection with talimogene laherparepvec (T-VEC) with or without immune checkpoint blockade • Consider surgery for resectable (isolated or limited) distant metastasis with or without post-operative adjuvant therapy **Second/subsequent-line therapies:** • Clinical trial • Ipilimumab or ipilimumab with nivolumab if refractory to anti-PD-1 based therapy • FDA-approved *KIT* inhibitor for patients with targetable *KIT* mutation • Consider TIL harvest for standard of care or investigational TIL trials • Consolidative local therapy (including surgery and/or radiation therapy) after response to systemic therapy • Surgical and/or regional therapy for limited and/or symptomatic disease (*e.g.,* surgery, infusional therapy, radiation therapy, or liver-directed therapy) • Intralesional injection with T-VEC with or without immune checkpoint blockade • Chemotherapy[2] or biochemotherapy[3]	Follow-up evaluation at least every 3 months and/or as clinically indicated and includes periodic CT chest, abdomen, and pelvis with IV/PO contrast or PET-CT (with IV/PO contrast) and MRI brain with IV contrast

CNS = central nervous system
TIL = tumor-infiltrating lymphocytes

[1] Tumor mutation analysis includes at a minimum *BRAF*, *NRAS* and *KIT*
[2] Chemotherapy: CVD (cisplatin, vinblastine, dacarbazine), carboplatin in combination with paclitaxel, nab-placlitaxel, dacarbazine or temozolomide
[3] Biochemotherapy: CVD plus interleukin-2 and interferon alpha

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CLINICAL PRESENTATION/ STAGING

Brain metastasis (with or without extracranial disease) → *BRAF* V600 mutation[1]?

- Yes → **TREATMENT**:
  - Consider multidisciplinary MD Anderson Brain Metastasis Clinic **or**
  - Clinical trial **or**
  - Ipilimumab with nivolumab, unless contraindicated[2] **or**
  - *BRAF* inhibitor with MEK inhibitor[3] **or**
  - Anti-PD-1 monotherapy (nivolumab or pembrolizumab) **or**
  - Relatlimab with nivolumab **or**
  - Chemotherapy (temozolomide) **or**
  - Surgery +/- adjuvant radiation therapy if resectable **and/or**
  - Stereotactic radiation therapy +/- immunotherapy **or**
  - Whole brain radiation therapy +/- immunotherapy
- No → CNS metastasis (with or without extracranial disease) → Is there evidence of LMD?
  - Yes → LMD with or without brain metastasis (with or without extracranial disease)[4] → *BRAF* V600 mutation[1]?
    - Yes → **TREATMENT**:
      - Clinical trial **or**
      - Ipilimumab with nivolumab, unless contraindicated[2] **or**
      - *BRAF* inhibitor with MEK inhibitor[3] **or**
      - Relatlimab with nivolumab **or**
      - Intrathecal nivolumab with systemic nivolumab, with or without concurrent BRAF inhibitor with MEK inhibitor **or**
      - Chemotherapy (temozolomide) **or**
      - Whole brain radiation therapy and/or focal radiation to the spine as indicated based on LMD location and symptoms
    - No → **TREATMENT**:
      - Clinical trial **or**
      - Ipilimumab with nivolumab, unless contraindicated[2] **or**
      - Relatlimab with nivolumab **or**
      - Intrathecal (IT) nivolumab with systemic (IV) nivolumab **or**
      - Chemotherapy (temozolomide) **or**
      - Whole brain radiation therapy and/or focal radiation to the spine as indicated based on LMD location and symptoms
  - No → **TREATMENT**:
    - Consider multidisciplinary MD Anderson Brain Metastasis Clinic **or**
    - Clinical trial **or**
    - Ipilimumab with nivolumab, unless contraindicated[2] **or**
    - Anti-PD-1 monotherapy (nivolumab or pembrolizumab) **or**
    - Relatlimab with nivolumab **or**
    - Chemotherapy (temozolomide) **or**
    - Surgery +/- adjuvant radiation therapy if resectable **and/or**
    - Stereotactic radiation therapy +/- immunotherapy **or**
    - Whole brain radiation therapy +/- immunotherapy

SURVEILLANCE

Follow-up evaluation at least every 3 months and/or as clinically indicated, and includes periodic MRI brain with IV contrast

CNS = central nervous system
LMD = leptomeningeal disease

[1] Tumor mutation analysis includes at a minimum *BRAF*, *NRAS* and *KIT*
[2] Contraindications: receiving corticosteroids (at least dexamethasone 4 mg daily or equivalent) or is symptomatic requiring intervention
[3] Regimens: Dabrafenib with trametinib **or** Vemurafenib with cobimetinib **or** Encorafenib with binimetinib
[4] Refer to the Solid Tumor Leptomeningeal Metastases algorithm

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SUGGESTED READINGS

STAGING

Aloia, T. A., Gershenwald, J. E., Andtbacka, R. H., Johnson, M. M., Schacherer, C. W., Ng, C. S., . . . Mansfield, P. F. (2006). Utility of computed tomography and magnetic resonance imaging staging before completion in lymphadenectomy in patients with sentinel lymph node-positive melanoma. *Journal of Clinical Oncology, 24*(18), 2858-2865. https://doi.org/10.1200/JCO.2006.05.6176

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INTRATUMORAL THERAPY

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TUMOR INFILTRATING LYMPHOCYTES

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GENERAL

MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

MD Anderson Institutional Policy #CLN0604 – Review of Outside Pathology Material Policy

DEVELOPMENT CREDITS

This practice algorithm is based on the majority expert opinion of the Melanoma Center providers at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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