

key points

SELECTED BY

Dr Peter Saul

GP, Wrexham and associate GP Dean for North Wales

Melanoma affects 15 to 20 per 100, 000 in the UK.

Common cancers such as breast, and prostate are around ten times more common than melanoma. It is the most common cancer between the age of 20 and 35 years in Caucasians but the incidence of melanoma is still very low in that age group.

Melanoma has different clinical presentations with

different outcomes and management. The most common form of melanoma is superficial spreading melanoma (SSM) which in its early stages will be a flat lesion often originating from a flat junctional naevus. In nodular melanoma, the lesion may present as a very small black nodule, growing over weeks or months. These lesions have a vertical growth phase from the onset and are usually more aggressive. Lentigo maligna are melanoma seen in older subjects on chronically sun-exposed sites, often on the face. Melanoma can also appear on the palms and soles or under the nail and on those sites may present as a vascular non-pigmented lesion which may cause diagnostic problems.

Subjects with fair skin and hair are at increased risk

of melanoma but the magnitude of the risk is only two-fold. The most consistent risk factor for melanoma in Caucasians is the number of naevi especially atypical naevi (lesions >5 mm in diameter with hazy borders and often irregular pigmentation). The presence of >100 naevi with atypical naevi can increase the risk of melanoma five-to ten-fold. The atypical mole syndrome phenotype is defined as >100 naevi with two or more atypical naevi and/or naevi on unusual sites such as the breasts in women, buttocks, feet and scalp. In the presence of the atypical mole syndrome phenotype and a positive family history, the risk is further increased and these patients should be followed up by a dermatologist. A family history of other cancers is also important.

Melanomas grow over weeks or months and the lesions

will most often have changed in terms of size, shape and colour. They may grow from a pre-existing naevus but also from normal skin. There are many features which differentiate a melanoma from a benign naevus. Melanoma borders are more likely to be geographical for SSM, the pigment distribution in the lesion is often irregular and asymmetrical, they are generally >5 mm and usually contain different shades. Any new mole in a subject over 40 should be regarded as suspicious.

All suspicious pigmented lesions should be referred to

secondary care via the two-week wait pathway. The diagnosis of melanoma can only be confirmed with a full excision biopsy of the lesion. This should be carried out by a specialist. Melanomas with thickness greater than 2 mm have a poor prognosis but most melanomas are now picked up below 1 mm in thickness and have a much better outcome. More than 80% of melanoma patients have surgery alone and survive their disease with no other treatments. No adjuvant therapy has been shown to provide a survival advantage.