

Resource for Management Options of Melanoma During COVID-19

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SSO supports the need for treatment decisions to be made on a case-by-case basis. The surgeon's knowledge and understanding of the biology of each cancer, alternative treatment options, and the institution's policies at the time the patient will be scheduled for surgery all need to be taken into consideration.

The information below is based on the opinions of individuals who are experts within the field of melanoma and are members of the Society's Melanoma Disease Site Work Group.

- Delay wide local excision of in-situ disease for 3 months and, as resources become scarce, all lesions with negative margins on initial biopsy. Efforts should be made to perform procedures in an outpatient setting to limit use of OR resources. If significant delay of definite excision is anticipated, the precise location of the biopsy site should be carefully documented (eg photography, marking of site by patient or caregiver) to facilitate identification at later time.
- Surgical management of T3/T4 melanomas (>2 mm thickness) should take priority over T1/T2 melanomas (\leq 2 mm thickness). The exception is any melanoma that is partially/incompletely biopsied in which large clinical residual lesion is evident. Gross complete resection is recommended in this case.
- Sentinel Lymph Node biopsy is reserved for patients with lesions > 1mm and, as resources become scarce, set aside for 3 months.
- Manage clinical Stage III disease with neoadjuvant systemic therapy. If resources permit and patient is not suitable for systemic therapy, consider resection of clinical disease in an outpatient setting.
- Metastatic resections (stages III and IV) should be placed on hold unless the patient is critical/symptomatic or unresponsive to systemic therapies (assuming surgical resources are available). Single dose palliative radiation may be considered for bulky disease to alleviate symptoms if OR capacity is limited.