March 2018

Dear Colleague

Please find to follow guidelines for referral to the WA Kirkbride Melanoma Advisory Service for your patients with intermediate thickness melanoma. You may be aware that there has been considerable controversy about the sentinel node procedure with respect to its application for intermediate thickness melanomas and we have, therefore, provided guidelines for clinicians who treat melanoma to help determine which patients may be suitable for the procedure should they wish to have it discussed with clinicians who perform sentinel node biopsy. **Please note that this is not a directive but merely indicates which patients you may wish to refer for further information.** Not all patients who are referred will be offered sentinel node biopsy; however the procedure, its risks and potential benefits applicable to each patient will be discussed with the patients, should they be referred.

Please note that, as always, the WA Kirkbride Melanoma Advisory Service is a free service to patients, whether they have private insurance or not. We will make arrangements to provide sentinel node biopsy surgery to them, either in the public or private system by surgeons who work in the Advisory Service, if you would like us to do so. If you would prefer to refer the patients yourself then please let us know when they are referred and we will not arrange for the surgery. Please note also that if patients are subsequently treated through the private hospital system, that out-of-pocket expenses may apply.

Please do not hesitate to contact us should you require further information.

Kind regards

Mr Mark Hanikeri
Director

Sentinel Lymph Node Biopsy for Melanoma
Guidelines for Referral to WAKMAS

Indications for SLN biopsy (SLNB) include the following:

SLNB should be considered for all suitable patients with a clinically negative nodal basin and/or absence of systemic metastases and a primary melanoma where the Breslow thickness is 0.8mm in depth or more. In addition, SLNB may be considered for melanoma <0.8mm in thickness with ulceration.

If indicated, SLNB should generally be performed at the time of wide local excision.

Contraindications for SLNB include the following:

Patients who present with known lymph node or systemic disease do not need SLNB.

Fine-needle aspiration cytology is preferable to SLNB when a clinically evident node is present.

SLNB should generally not be performed after a wide local excision; however it may be acceptable if extensive reconstruction has not been performed. This depends on the context of the lesion in the affected patient. Increasing distance from the primary melanoma increases the likelihood of a false negative result. Advice from an expert in the field is recommended in this circumstance.

No definitive recommendations exist for repeat SLNB after a prior SLNB. Advice from an expert in the field is recommended in this circumstance.

Completion Lymphadenectomy

Completion lymph node dissection (CLND) may or may not be recommended for patients with a positive sentinel lymph node biopsy. Patients with a positive SLNB should have discussion at the MDT to determine whether CLND is appropriate.

These guidelines have been constructed by a panel of clinicians and cutaneous histopathologists from WAKMAS. They have been formulated through a comprehensive review of the clinical and pathology literature pertaining to the indications for SLNB in malignant melanoma and applied in the context of acceptable local practice in Western Australia.