

STAGE 1A MELANOMA

WHAT ARE THE AIMS OF THIS LEAFLET?

This leaflet provides you with information about stage 1A melanoma. The following information tells you what a stage 1A melanoma is, what will be the investigations/treatments and where to find out more information. It has been prepared in response to some of the questions people with melanoma often ask.

WHAT IS MELANOMA?

Melanoma is a type of skin cancer, which arises from the pigment cells (melanocytes) in the skin. One of the main causes of melanoma is exposure to too much ultraviolet light in sunlight. The use of artificial sources of ultraviolet light, such as sunbeds, also increases the risk of getting a melanoma.

Melanocytes make a brown/black pigment (known as melanin), and often the first sign of a melanoma developing is a previous mole changing in colour or a new brown/black spot developing on the skin. Most frequently there is darkening in colour but occasionally there is loss of pigmentation with pale areas or red areas developing. Occasionally melanomas have no pigment and appear just a pink/red colour. The development of this melanoma on the skin is known as the primary melanoma.

Melanoma is considered to be the most serious type of skin cancer. This is because it is more likely to spread (metastasise) from the skin to other parts of the body than other types of skin cancer. If melanoma has spread to other parts of the body, those deposits are known as secondary melanoma

(secondaries/metastases). Although a diagnosis of melanoma can be serious, most melanomas are diagnosed at an early stage and so do not cause any further problems. If lesions are not removed at the early stages, then there is a higher risk of the melanoma spreading, which can reduce life expectancy.

HOW IS MELANOMA DIAGNOSED?

The clinical diagnosis of melanoma is usually made by a specialist (normally a dermatologist or plastic surgeon) by looking at the skin. The initial treatment for a suspected melanoma is to cut out (excise) all of the melanoma cells. Usually this is a minor operation done under a local anaesthetic (via an injection to numb the skin). When the lesion is first removed, although your specialist may feel that it is likely to be a melanoma, the diagnosis needs to be confirmed by examining the tissue removed under a microscope, so the excision is usually done with narrow margins (a thin rim of normal skin around the suspected melanoma). The specimen that is cut out from the skin is sent to a laboratory, so that a pathologist can examine it under the microscope and then confirm if it is a melanoma or not.

If you have been given this leaflet by your doctor, you will have probably had this initial minor operation and had your diagnosis of melanoma confirmed by the pathologist.

WHAT IS STAGE 1A MELANOMA?

Doctors use a staging system for melanoma to indicate both the likely outcome and the best treatment. The AJCC (American Joint Committee on Cancer) system is currently used in the UK to stage

melanoma from 1 to 4. Stage 1 is the earliest melanoma and stage 4 is the most advanced.

The staging system takes into account the thickness of melanoma and if there has been any spread of melanoma from the skin to other parts of the body. Stage 1 and 2 melanomas are present in the skin only and have not spread elsewhere in the body. Stage 3 have spread towards or have reached the draining lymph glands (nodes) and Stage 4 melanomas are those that have spread beyond the closest draining lymph glands to other parts of the body.

The pathologist will look under the microscope to assess certain features of the melanoma. The most important of all of these is the thickness of the melanoma (called Breslow thickness), which measures how deep the melanoma cells have grown down into the layers of skin. The pathologist uses this measure and some other additional features such as ulceration of the melanoma (seen down the microscope) to create a histology report on your melanoma and we can then work out the AJCC stage.

Stage 1 melanomas can be split into stage 1A and stage 1B. A stage 1A melanoma is less than 0.8mm in thickness with no evidence of ulceration. You can discuss your staging in more detail with the medical team looking after you if you would like to know more.

WHAT HAPPENS NEXT?

A multidisciplinary team (MDT) of experts will meet to discuss the best treatment option(s) for you. The MDT is made up of dermatologists, surgeons, pathologists, oncologists, radiologists, and specialist nurses. A member of the MDT will explain your treatment options to you, and you may also meet a melanoma/skin cancer clinical nurse specialist (CNS) who would be a point of contact for you and advise you accordingly.

HOW IS STAGE 1A MELANOMA TREATED?

Removing the melanoma from the skin by surgery offers the best chance of a complete cure, and this treatment alone is usually successful in stage 1 melanoma. Most patients do NOT need either radiotherapy or chemotherapy.

After the melanoma is initially removed for histological diagnosis, you will usually be offered a second surgical procedure to remove more skin from around and beneath the melanoma scar. This second procedure typically removes a further 1cm margin of skin around the first scar site. It is called a Wide Local Excision (WLE) and is usually also carried out under local anaesthetic. The purpose of this further surgery is to try and make sure that no cancer cells are left behind in the nearby skin and to minimise the risk of the melanoma recurring (coming back).

WHAT SCAR(S) CAN I EXPECT FOLLOWING A WIDE LOCAL EXCISION?

The type of scar(s) will depend on location and the type of surgical technique required. The WLE might result in a scar similar in shape but bigger in size than the one that was left by cutting out the original melanoma. Some scars can be more complex in shape because a "flap" or skin graft was required. Further information on flaps and grafts can be found via the website links given at the end of the leaflet. Occasionally, lumpy scars called "keloids" may result and this is more common on the upper arms and chest over the breast bone. Scars can feel hard and itchy at first but usually will fade and soften with time. Stopping smoking after any surgery can improve wound healing.

WHAT IS THE RISK OF STAGE 1A MELANOMA RECURRING?



A diagnosis of stage 1A melanoma means it has been caught early and most patients don't have further recurrence of their melanoma once treated. There are statistics available on the likelihood of melanoma recurrence for each stage. If you want to know more precisely the chances of your melanoma recurring, talk to your dermatologist and/or your clinical nurse specialist (CNS). It may be difficult to take everything in that the doctor tells you during the consultation. This leaflet is designed to add to the information that the doctor gives you, but your own doctor and their team remain the best source of information for you.

AFTER TREATMENT, WHY AM I FOLLOWED UP?

Patients are routinely followed up in the out-patient clinics after the completion of the WLE for three reasons:

- To check that the melanoma has not come back or spread.
- To detect new melanomas or other skin cancers.
- To provide support, information and education.

HOW OFTEN AND FOR HOW LONG WILL I BE FOLLOWED UP?

The follow-up plan should be agreed between you and your dermatologist and/or the surgeon who did the WLE. You will most likely see your medical team on a couple of occasions over a year after diagnosis of a Stage 1A melanoma. It is common for your follow up to be shared between the different doctors, and/or a CNS, involved in your care.

HOW WILL A RECURRENCE OF THE MELANOMA OR A NEW MELANOMA BE DETECTED?

Your doctor will want to examine the area of your melanoma scar and also check your lymph glands. They will also ask to examine your entire skin to make sure there are no signs of any new melanomas.

Photographs might be taken to help compare the way your moles look now with how they looked before and will be kept in your notes if you agree. If a new or recurrent melanoma is suspected then, as before, it will most likely be removed surgically.

WHAT MAKES SOMEBODY MORE AT RISK OF DEVELOPING A NEW MELANOMA?

One of the biggest risk factors is a strong family history of melanoma. (if there are 3 or more of your family members affected by melanoma then your medical team would discuss genetic counselling with you). The following are also risk factors for developing melanoma:

- A large number of moles, and moles, which are large and irregular in colour and shape ('atypical' moles).
- Having fair skin that burns easily in the sun, freckles and/or red hair.
- A history of severe sunburn, especially sunburn that caused blisters, occurring in childhood.
- A "weaker" family history of melanoma, i.e. only 1 or 2 other family members affected.
- Having a very large dark birthmark (a giant congenital mole)
- Having already had a melanoma.
- A weakened immune system (for example, because of treatment with immunosuppressive drugs).

SELF-CARE (WHAT CAN I DO?)

Normally, your CNS will discuss the following with you after treatment:

You can examine your skin

Most people do not develop further melanomas; however, some do, and they may also develop other forms of skin cancer. The best way to detect skin cancer is to check all your skin every month (please see Patient Information Leaflet on [early detection](#)). Essentially, you are looking



for changes in the size, shape or colour of any moles, a new mole, or a mole that looks different to the others. There are patient information web-packages, which outline how to look after your moles (please see the web links at the end of this leaflet).

Reduce the risk of further melanomas

The best way you can reduce risk is to not let your skin burn in the sun. You do not have to hide during sunny days, but you do need to be careful to avoid turning pink and this applies also to any children you have as they are likely to have a similar skin type to you. Information on the best methods of sun protection can be found on the website links provided at the end of this leaflet (see Patient Information Leaflet on prevention).

Top sun safety tips:

- Protect your skin with clothing, and don't forget to wear a hat that protects your face, neck and ears, and a pair of UV protective sunglasses.
- Spend time in the shade between 11 am and 3 pm when it's sunny. Step out of the sun before your skin has a chance to redden or burn.
- When choosing a sunscreen look for a high protection SPF (SPF 30 or more) to protect against UVB, and the UVA circle logo and/or 4 or 5 UVA stars to protect against UVA. Apply plenty of sunscreen 15 to 30 minutes before going out in the sun and reapply every two hours and straight after swimming and towel-drying.
- Keep babies and young children out of direct sunlight.
- The British Association of Dermatologists recommends that you tell your doctor about any changes to a mole or patch of skin. If your GP is concerned about your skin, make sure you see a Consultant Dermatologist – an expert in

diagnosing skin cancer. Your doctor can refer you for free through the NHS.

- Sunscreens should not be used as an alternative to clothing and shade, rather they offer additional protection. Sunscreens do not provide 100% protection.

Having had a melanoma may impact on future applications for life or health insurance, particularly for the first five years after diagnosis. Equally you may be able to make a claim against any critical illness insurance you may have taken out prior to the diagnosis of melanoma. If you have particular concerns about this, you should seek financial advice.

WHERE CAN I GET MORE ADVICE, SUPPORT & INFORMATION ABOUT MELANOMA?

When you have been diagnosed with melanoma you might experience a range of emotions including worry, confusion or even feeling unable to cope. It will probably help if you discuss and share your thoughts and feelings with someone close. This might be a family member or friend. It could also be your doctor, cancer nurse specialist or another member of the team looking after you.

When you are diagnosed with melanoma, you will be given a lot of information. All this information at once can be hard to take in. If you are not clear about anything during your treatment, please don't be afraid to ask.

Web links to detailed leaflets:

British Association of Dermatologists

- Early detection and prevention
<https://www.skinhealthinfo.org.uk/symptoms-treatments/skin-cancer/>
- Sun safety
<https://www.skinhealthinfo.org.uk/sun-awareness/the-sunscreen-fact-sheet/>



<https://www.skinhealthinfo.org.uk/sun-awareness/sun-advice-for-skin-of-colour/>

<https://www.skinhealthinfo.org.uk/sun-awareness/sun-protection-advice-for-children-and-babies/>

- Vitamin D
<https://www.skinhealthinfo.org.uk/sun-awareness/vitamin-d-information/>

Cancer Research UK (CRUK)

- Melanoma
<https://www.cancerresearchuk.org/about-cancer/melanoma>
- Sun safety
<https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/sun-uv-and-cancer>

The Melanoma Genetics Consortium

- Looking after moles and vitamin D
<http://genomel.org/info-for-patients/%EF%BF%BCsun-protection-and-vitamin-d-after-a-diagnosis/>

Macmillan Cancer Support

- Melanoma
www.macmillan.org.uk/Cancerinformation/Cancertypes/Melanoma/Melanoma.aspx
- Flaps/grrafts
www.macmillan.org.uk/Cancerinformation/Cancertypes/Melanoma/Treating%20melanoma/Surgery/Surgery.aspx
- Financial support
<http://www.macmillan.org.uk/HowWeCanHelp/FinancialSupport/Financialguidance/Financialguidance.aspx>

National Cancer Action Team (NCAT)/ NHS Choices

- Vitamin D
www.nhs.uk/Conditions/vitamins-minerals/Pages/Vitamin-D.aspx

Vitamin D advice

The evidence relating to the health effects of serum Vitamin D levels, sunlight exposure and Vitamin D intake remains inconclusive. Avoiding all sunlight exposure if you suffer from light sensitivity, or to reduce the risk of melanoma and other skin cancers, may be associated with Vitamin D deficiency. Individuals avoiding all sun exposure should consider having their serum Vitamin D measured. If levels are reduced or deficient, they may wish to consider taking supplementary vitamin D3, 10-25 micrograms per day, and increasing their intake of foods high in Vitamin D such as oily fish, eggs, meat, fortified margarines, and cereals. Vitamin D3 supplements are widely available from health food shops.

For details of source materials used please contact the Clinical Standards Unit (clinicalstandards@bad.org.uk).

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

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