



Guideline 8-7 Version 2

**A Quality Initiative of the
Program in Evidence-Based Care (PEBC), Ontario Health (Cancer Care
Ontario)**

Surveillance of Patients with Stage I, II, III, or Resectable IV Melanoma Who Were Treated with Curative Intent

S. Rajagopal, X. Yao, W. Abadir, T. Baetz, A. Easson, G. Knight, E. McWhirter, C. Nessim, C.F. Rosen, A. Sun, F.C. Wright, T. Petrella, *the Melanoma Surveillance Guideline Development Group*

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An assessment conducted in December 2025 deferred the review of Guideline 8-7 Version 2. This means that the document remains current until it is assessed again next year. The PEBC has a formal and standardized process to ensure the currency of each document. ([PEBC Assessment & Review Protocol](#))

Guideline 8-7 Version 2 is comprised of 5 sections. You can access the summary and full report here:

<https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/31776>

- Section 1: Recommendations
- Section 2: Guideline - Recommendations and Key Evidence
- Section 3: Guideline Methods Overview
- Section 4: Systematic Review
- Section 5: Internal and External Review

For information about this document, please contact S. Rajagopal and T. Petrella, through the PEBC at:

Phone: 905-527-4322 ext. 42822 Fax: 905-526-6775 E-mail: ccopgi@mcmaster.ca

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Phone: 905-527-4322 ext. 42822 Fax: 905-526-6775 E-mail: ccopgi@mcmaster.ca

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PUBLICATIONS FROM THIS REPORT

1. Rajagopal S, Yao X, Abadir W, Baetz TD, Easson A, Knight G, et al. Surveillance evaluations in patients with stage I, II, III, or resectable IV melanoma who were treated with curative intent: a systematic review. *Surgical Oncol.* 2024;54:102077.
2. Rajagopal S, Yao X, Abadir W, Baetz TD, Easson A, Knight G, et al. An Ontario Health (Cancer Care Ontario) clinical practice guideline: Surveillance strategies in patients with stage I, II, III, or resectable IV melanoma who were treated with curative intent. *Clin Oncol.* 2024;36:243-53.

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Surveillance of Patients with Stage I, II, III, or Resectable IV Melanoma Who Were Treated with Curative Intent

Section 1: Recommendations

This section is a quick reference guide and provides the guideline recommendations only. For key evidence associated with each recommendation, the systematic review, and the guideline development process, see the Full Report.

GUIDELINE OBJECTIVES

To update the 2015 guideline of the Program in Evidence-Based Care (PEBC) Ontario Health (Cancer Care Ontario) to provide guidance for managing surveillance of patients with stage I, II, III, or resectable IV melanoma who are clinically disease-free after treatment with curative intent (following the definition of American Joint Committee on Cancer [AJCC] Pathological Prognostic Stage Groups in the 2017 Cancer Staging Manual, the 8th edition).

TARGET POPULATION

These recommendations apply to patients with stage I, II, III, or resectable IV melanoma who are clinically disease-free after treatment with curative intent. Pathological staging is according to the 8th edition AJCC staging system (Appendix 1) [1].

INTENDED USERS

Intended users of this guideline are medical oncologists, dermatologists, surgical oncologists, radiation oncologists, family doctors, and other clinicians who are involved in the follow-up care of patients with melanoma in the province of Ontario.

RECOMMENDATIONS, KEY EVIDENCE, AND JUSTIFICATION

The strength of recommendations for this guideline includes three categories: Recommendation, Weak Recommendation, and No Recommendation (definitions and corresponding verb wording are provided in Appendix 2).

Recommendation 1
For patients with stage IA, IB, or IIA melanoma who are clinically disease-free after receiving curative-intent treatment: 1.1 Clinical follow-up with history and physical examination with full skin and lymph node examination by a dermatologist (with photo-surveillance and dermoscopy if indicated), and/or a surgeon, family physician, cancer nurse specialists should occur every six to 12 months for three years, then annually for two years or as clinically indicated. [Strength: Recommendation] 1.2 Routine biomarker or blood tests and imaging evaluations to screen for asymptomatic recurrence or metastatic disease are not recommended. [Strength: Recommendation] 1.3 In conjunction with routine follow-up, healthcare providers should provide education to patients and patients' caregivers who are involved in decision-making regarding skin self-examination (SSE) and sun safety. [Strength: Recommendation]
Qualifying Statements for Recommendation 1
1.4 For details of SSE, refer to Skin Cancer Self-exam on the Canadian Dermatology Association website https://dermatology.ca/public-patients/skin/melanoma/ .

Recommendation 2
For patients with stage IIB, or IIC melanoma:

2.1 Clinical follow-up with history and physical examination with full skin and lymph node examination by a dermatologist (with photo-surveillance and dermoscopy if indicated), and/or a surgeon, medical oncologist, cancer nurse specialist should occur every three to six months in years 1 to 3, then every six months in years 4 to 5, or as clinically indicated. [Strength: **Recommendation**]

2.2 Routine biomarker or blood tests to screen for asymptomatic recurrence or metastatic disease are not recommended. [Strength: **Recommendation**]

2.3 Computed tomography (CT) or positron emission tomography (PET)/CT scans every six to 12 months should be considered to screen for asymptomatic recurrence or metastatic disease in years 1 to 3, then annually in years 4 to 5. [Strength: **Recommendation**]

2.4 Annual brain magnetic resonance imaging (MRI) can be considered for years 1 to 5. MRI (no radiation) of the brain is preferred for routine screening where available; otherwise, head CT may be considered after discussing with patients. [Strength: **Weak Recommendation**]

2.5 In conjunction with routine follow-up, healthcare providers should provide education to patients and patients' caregivers who were involved in decision-making regarding SSE and sun safety. [Strength: **Recommendation**]

Qualifying Statements for Recommendation 2

2.6 For the details of SSE, refer to Skin Cancer Self-exam on the Canadian Dermatology Association website <https://dermatology.ca/public-patients/skin/melanoma/>.

Recommendation 3

For patients with stage IIIA, IIIB, IIIC, IIID, or resected IV melanoma:

3.1 Clinical follow-up with history and physical examination with full skin and lymph node examination by a dermatologist (with photo-surveillance and dermoscopy if indicated), and/or a surgeon, medical oncologist, or cancer nurse specialist should occur every three to six months in years 1 to 3, then every six months in years 4 to 5, or as clinically indicated. [Strength: **Recommendation**]

3.2 Routine biomarker or blood tests to screen for asymptomatic recurrence or metastatic disease are not recommended. [Strength: **Recommendation**]

3.3 CT or PET/CT scans every six to 12 months should be considered to screen for asymptomatic recurrence or metastatic disease in years 1 to 3, then annually in years 4 to 5. [Strength: **Recommendation**]

3.4 Annual brain MRI can be considered for years 1 to 5. MRI (no radiation) of the brain is preferred for routine screening where available, otherwise, head CT may be considered after discussing with patients. [Strength: **Weak Recommendation**]

3.5 For patients with a positive sentinel lymph node, ultrasound scans of the draining nodal basin should be done every four to six months for years 1 to 3, and then every six months for years 4 to 5, if no complete lymph node dissection is performed. [Strength: **Recommendation**]

3.6 In conjunction with routine follow-up, healthcare providers should provide education to patients and patients' caregivers who were involved in decision-making regarding SSE and sun safety. [Strength: **Recommendation**]

Qualifying Statements for Recommendation 3

3.7 In patients with positive sentinel lymph nodes, ultrasound screening should take place following recommendations in the CCO Guideline “8-6 [Surgical Management of Patients with Lymph Node Metastases from Cutaneous Melanoma of the Trunk or Extremities](#)”.

3.8 For the details of SSE, refer to Skin Cancer Self-exam on the Canadian Dermatology Association website <https://dermatology.ca/public-patients/skin/melanoma/>.

3.9 There are no studies specifically addressing patients with resected stage IV melanoma; this subgroup of patients is included with the stage III group of patients because of their similar clinical characteristics.

Recommendation 4

4.1 Patients may be transitioned to a primary care physician who has had training in melanoma care for follow-up after five years depending on the stages of the disease and clinical risk factors. Annual follow-up with a dermatologist should continue as clinically indicated. [Strength: Weak Recommendation]

Qualifying Statements for Recommendation 4

4.2 Patients should have access to return to the dermatology, surgery, or medical oncology clinic if clinically needed.