4.7 Skin Cancer of the Head and Neck (lip, ear and face)

For more detail on the management of malignant melanoma, see the *Cancer Care Nova Scotia "Guidelines for the Management of Malignant Melanoma*" (2008).

All skin cancers (basal cell (BCC), squamous cell (SCC) and malignant melanoma) are common on the head and neck. BCC is the most common skin cancer and 85% are found on the head and neck. Melanoma on the face most often takes the form of an in situ (Hutchinson's melanotic freckle or lentigo maligna) or thin invasive lesion.

Prognosis

BCC rarely metastasizes but can cause significant morbidity, particularly when invasion is around areas such as the eye, nose or skull.

SCC is locally aggressive with ability to metastasize.

Melanomas diagnosed at an early stage are highly curable but the median survival for metastatic melanoma is poor.

Referral Information

Delay, misdiagnosis or mismanagement of malignant melanoma can have a serious effect on patients' chances of survival. Therefore these patients need to be urgently referred to and managed by a hospital-based multidisciplinary team with specialist skills.

Local Recurrence (Melanoma)

Local recurrence in a patient with malignant melanoma is an ominous clinical event and is almost always associated with the development of systemic metastases.

Complete surgical resection with primary wound closure is the most straightforward means of treating single recurrent lesions **or** multiple subcutaneous metastases grouped within a single site with skin grafting or flap closure as necessary for wound coverage. Radiotherapy may be considered where surgery is undesirable because of functional or cosmetic concerns.

Metastatic Disease (Melanoma)

Melanoma is the third most common cause of metastases to the central nervous system. About 2/3 of these are multiple; the other third are solitary metastases.

The management of the patient with distant metastatic melanoma must take into account several important factors. Modalities include chemotherapy, immunotherapy and combined with varied results. Because of the limited efficacy, careful consideration of these therapies must be assessed on an individualized basis. The aims of therapy in stage IV melanoma must be clearly defined and generally include one or more of the following: (1) to relieve symptoms of a life-threatening problem, (2) to increase length of survival and (3) to evaluate new therapies.

Recommended Treatment:

Refer to palliative care.

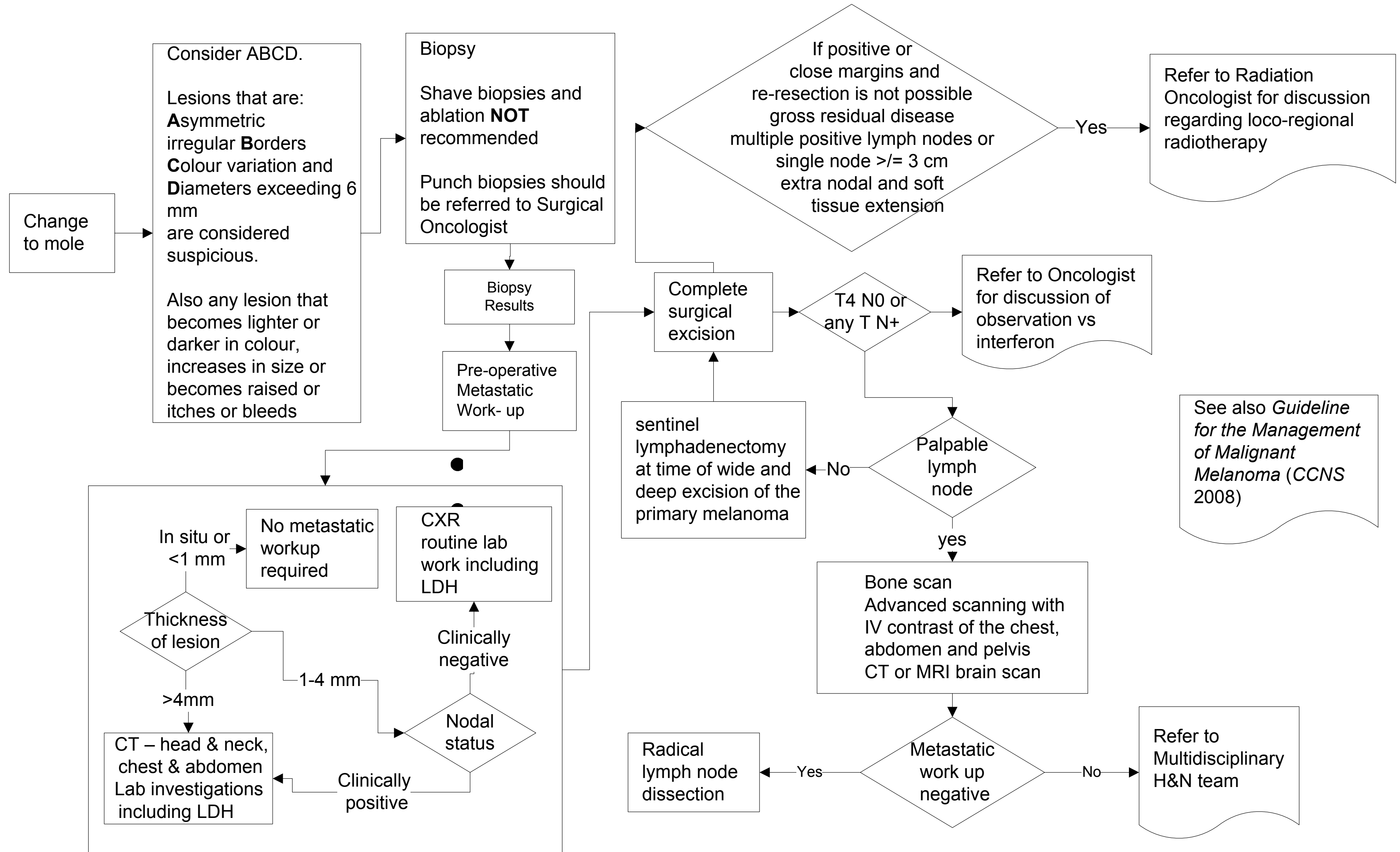
<u>Resectable disease</u> – resect with appropriate margins with observation or interferon alfa 2B

<u>Unresectable disease:</u>

1. Dacarbazine or temozolomide
2. Radiation remains the primary treatment modality for symptomatic bone metastases.
3. Radiotherapy where appropriate (i.e. brain mets, advanced axillary or groin disease and extensive cutaneous lesions not amenable to surgery or for functional or cosmetic reasons)
4. Consider clinical trial

- Cisplatin as second line chemotherapy if Performance Status is 0-2

Practice Pathway for Malignant Melanoma of the Head and Neck



Information and Supportive/Psychosocial Care services are available to patients throughout the continuum of care (see Part 5 p48)

Practice Pathway for the Management of Non-melanoma Skin Cancer (Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC)