

NICE Guideline [NG14] Last dated 27 July 2022 re reduction in PET Scans

IIA	<ul style="list-style-type: none"> • Years 1 and 2: Offer 2 clinic appointments each year, and consider adding 2 ultrasound scans of the draining nodal basin each year if SLNB was considered but not done • Year 3: Offer 1 clinic appointment, and consider adding 1 ultrasound scan of the draining nodal basin if SLNB was considered but not done • Years 4 and 5: Offer 1 clinic appointment each year. Discharge at the end of year 5
IIB	<ul style="list-style-type: none"> • Years 1 and 2: Offer 4 clinic appointments each year, and consider 2 whole-body and brain contrast-enhanced CT (CE-CT) scans each year. Consider adding 2 ultrasound scans of the draining nodal basin each year if SLNB was considered but not done • Year 3: Offer 2 clinic appointments and consider 2 whole-body and brain CE-CT scans. Consider adding 2 ultrasound scans of the draining nodal basin if SLNB was considered but not done • Years 4 and 5: Offer 1 clinic appointment each year and consider 1 whole-body and brain CE-CT scan each year. Discharge at the end of year 5
IIC	<ul style="list-style-type: none"> • Years 1 and 2: Offer 4 clinic appointments and 2 whole-body and brain CE CT scans each year. Consider adding 2 ultrasound scans of the draining nodal basin each year if SLNB was considered but not done • Year 3: Offer 2 clinic appointments and 2 whole-body and brain CE-CT scans. Consider adding 2 ultrasound scans of the draining nodal basin if SLNB was considered but not done • Years 4 and 5: Offer 1 clinic appointment and 1 whole-body and brain CE-CT scan each year. Discharge at the end of year 5
IIIA to IIIC not currently having adjuvant therapy	<ul style="list-style-type: none"> • Years 1 to 3: Offer 4 clinic appointments and 2 whole-body and brain CE-CT scans each year. Consider adding 2 ultrasound scans of the draining nodal basin each year if the person has a positive sentinel lymph node

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	<ul style="list-style-type: none">• Years 4 and 5: Offer 2 clinic appointments and 1 whole-body and brain CE-CT scan each year. Discharge at the end of year 5
IIID and resected IV not currently having adjuvant therapy	<ul style="list-style-type: none">• Years 1 to 3: Offer 4 clinic appointments and 4 whole-body and brain CE-CT scans each year• Years 4 and 5: Offer 2 clinic appointments and 2 whole-body and brain CE-CT scans each year. Discharge at the end of year 5
IIIA to IIIC, IIID and resected IV having adjuvant therapy	<ul style="list-style-type: none">• During adjuvant therapy, base follow-up on therapeutic requirements

Whole body CE-CT scans will routinely include the thorax, abdomen and pelvis. However, other sites such as the neck may need including based on the person's individual needs and circumstances (for example, when there is an increased risk of the melanoma spreading or for people who are exempt from routine follow-up).

This table sets out routine follow-up. Offer personalised follow-up to people with unresectable stage III or IV melanoma, people at increased risk of further primary melanomas, children and young adults, and women who are pregnant, in line with recommendations 1.9.5 to 1.9.10.

Web Address: www.nice.org.uk/guidance/NG14/chapter/Recommendations

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For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on follow-up after treatment for melanoma](#).

Full details of the evidence and the committee's discussion are in [evidence review G: follow-up of people with melanoma](#).

Why the committee made the recommendations

Information and support for people who have had melanoma

The committee agreed, based on their experience, that the information given to people after treatment for melanoma varies, and that it is particularly important to give people details of a specialist skin cancer service that they can contact if they have questions or concerns after treatment. The committee agreed to retain the 2015 recommendation to provide psychosocial support and to include provision of advice in local follow-up policies. The committee noted the lack of evidence on the views of people who have had melanoma and made a [recommendation for research on survivorship](#).

Exceptions to routine follow-up

Based on their experience, the committee agreed that people who have completed treatment for stage 0 melanoma can be discharged after a clinic visit for advice. They also identified groups who should be offered personalised follow-up, including people with unresectable melanoma and those at increased risk of further primary melanomas.

The committee also identified groups for whom MRI should be considered, as a substitute for CE-CT. See the [rationale section on imaging during follow-up](#).

Frequency of follow-up

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The committee sought to find a frequency of clinical follow-up that would balance the need for prompt identification of recurrence or progression with the need to reduce the burden of follow-up appointments for people with melanoma and avoid the costs of unnecessary follow-up.

Evidence showed that for stage IB to IIC disease, a lower frequency of follow-up visits did not increase mortality or cancer recurrence, or worsen quality of life. The committee therefore agreed to reduce the frequency of follow-up visits. They agreed to retain 4 visits per year for the first 2 years after stages IIB to IIC melanoma to coincide with their recommended imaging frequency, but to reduce this to 2 visits in year 3. Recommendations for clinic visits after resected stage III to IV disease were made to allow for a clinic visit after each imaging scan.

Imaging during follow-up

The committee agreed that CT scanning during follow-up after all stages of melanoma should include the head because of the frequency of brain metastases developing during follow-up. The committee considered that the radiation risk from exposure to ionising radiation during CE-CT scans was not serious. However, the committee agreed that brain MRI could be considered instead of CE-CT, if it is more suitable (for example, when there are high-risk factors associated with brain metastases or when MRI has been used in staging). This will reduce radiation exposure and potentially increase accuracy of assessing brain metastases. They noted that this should be after a discussion with the specialist skin cancer multidisciplinary team. The committee acknowledged the logistical difficulties and increased burden on MRI capacity of arranging separate CE-CT and MRI scans.

Evidence on stage III melanoma suggested that while PET-CT is more sensitive for detecting metastases compared with CE-CT it was not cost effective. The committee agreed that frequent imaging with CE-CT, particularly in the first 2 to 3 years when rates of recurrence are highest, will ensure timely identification of recurrences. The committee therefore agreed to recommend twice yearly imaging with CE-CT in the first 3 years, then once yearly in years 4 and 5. There was no evidence on CE-CT after stages IIB and IIC melanoma, but there was evidence suggesting a high risk of recurrence, particularly in stage IIC melanoma, that was worse than the risk of recurrence after stage IIIA disease. Based on this, the committee agreed that CE-CT imaging should be considered after stage IIB, and offered after stage IIC, at the same frequency as stage III.

The committee agreed that MRI should be offered for children and young adults having follow-up because of the cumulative risk of radiation associated with CE-CT scanning, and during pregnancy when CE-CT is undesirable.

Ultrasound scanning was shown by the evidence to be more sensitive than clinical examination and alternative imaging modalities (particularly CE-CT) for detecting local lymph node metastases. The committee agreed, based on their experience, that CE-CT alone can miss or delay detection of lymph node recurrences. However, there was no good quality evidence to show that ultrasound reduces mortality or time to

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recurrence in people with positive sentinel lymph nodes. Moreover, in current practice people with positive sentinel lymph nodes are offered frequent cross-sectional imaging and it is unclear whether ultrasound offers practical benefit above and beyond this imaging. This guideline does not recommend routine completion lymph node dissection, based on evidence comparing it with ultrasound scanning. However, there is no randomised controlled trial evidence comparing completion lymph node dissection with surveillance alone (with no ultrasound scanning). In addition, evidence suggested that most nodal recurrences develop within the first few years of diagnosis. The committee noted that nodal status is unknown in people who have not had an SNLB, and thus their staging is incomplete. Based on this, the committee agreed to recommend ultrasound surveillance for 3 years for people with a positive sentinel lymph node and those who were considered for but did not have an SLNB.

The committee acknowledged the practical implications of ultrasound imaging during follow-up, such as the capacity to provide increased numbers of scans and the variable experience of healthcare professionals involved in follow-up. They noted the need for more evidence to inform future guidance on follow-up after melanoma and made a [recommendation for research on surveillance strategies](#).

How the recommendations might affect practice

Current practice varies and it is expected that these recommendations will help to standardise practice across centres. Clinic visits for people with stages I to IIC melanoma may be reduced, especially for people with stage IA melanoma. It is therefore important that people are given contact details for the specialist skin cancer multidisciplinary team. The use of ultrasound, CE-CT or MRI scanning is expected to increase, but the use of PET-CT is expected to decrease.

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