

Madigan Army Medical Center

Referral Guidelines

Suspicious Moles (Melanocytic Nevi)

Diagnosis/Definition

Melanoma is rapidly increasing in incidence and is best treated by early recognition and excision. Early excision can give cure rates of 99% but this is highly dependent on the education of patients and physicians in early detection. The following guidelines in detection are aimed at early diagnosis of melanoma.

Initial Diagnosis and Management

- Consider RISK FACTORS - Family and/or personal history of melanoma, light complexion, UV tanning bed use, tendency to freckle and/or burn easily, >50 acquired nevi and clinically atypical pigmented lesions or previously biopsied dysplastic nevi
- Clinical HISTORY - Change in size, shape or height of pigmented lesion especially if acute. Change in color of lesion: lightening, darkening, redness, shades of blue, gray or black. Symptoms of itching, crusting, bleeding, erosion and ulceration.
- Physical EXAM - Examine all pigmented or questionable lesions using ABCDE criteria: (A) Asymmetry (B) Border irregularity - notching, protrusions (C) Color variegation-generally gray to blue-black, but may have white, shades of red and brown (D) Diameter - most melanomas are greater than 6 mm in diameter at time of diagnosis but this is not exclusionary (E) Evolution – a small amount of growth or elevation over time is normal, but rapid changes in size, color, elevation or border should be evaluated. Remember to examine overlooked areas such as the scalp, palms and soles, nail folds, nail beds, conjunctiva and oral cavity for suspicious lesions.
- Palpate regional lymph nodes for clinical evidence of metastases.

Ongoing Management and Objectives

Diagnostic Tests

- Dermatoscopy is a valuable in-vivo tool that MAMC Dermatologists have incorporated into their screening armamentarium.
- Biopsy remains the diagnostic "gold standard" for lesions that are felt by experienced screeners to be suspicious for melanoma.
- As management and prognosis is dependent on primary tumor thickness, the biopsy technique of choice is a total excisional biopsy with narrow margins. A punch biopsy, unless for an extremely small lesion, usually leaves part of the lesion behind and can make pathologic diagnosis difficult. It should be avoided in suspicious moles.

Indications for Specialty Care Referral

Referral to dermatology is recommended for all suspicious lesions based on above guidelines. If melanoma is strongly suspected, refer directly (arrange provider-to-provider) prior to biopsy for initial specialty assessment. If the referring physician feels confident in the diagnosis and is credentialed in the procedure, they may perform an excisional biopsy for diagnosis. We recommend that all patients with

melanoma be referred to Dermatology or General Surgery for counseling, therapy, discussion of treatment options including sentinel lymph node biopsy and initial monitoring.

Criteria for Return to Primary Care

After appropriate evaluation, diagnostic procedures, treatment, and follow-up, the patient will continue monthly self-examinations as directed, and receive further screening annually at dermatology.

Pictures of [Moles](#) from NZ DermNet - New Zealand Dermatological Society

Last Review for this Guideline: **October 2009**

Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division
Clinical Practice and Referral Guidelines Administrator