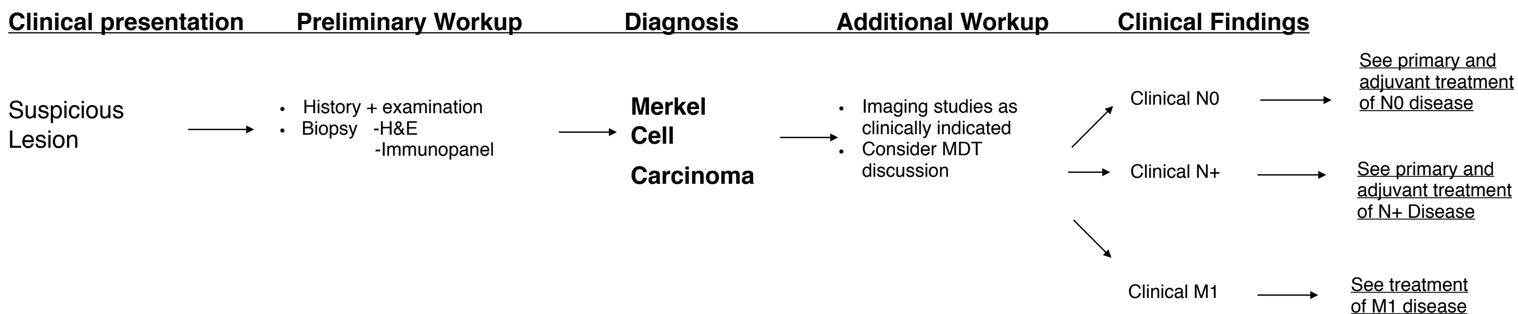
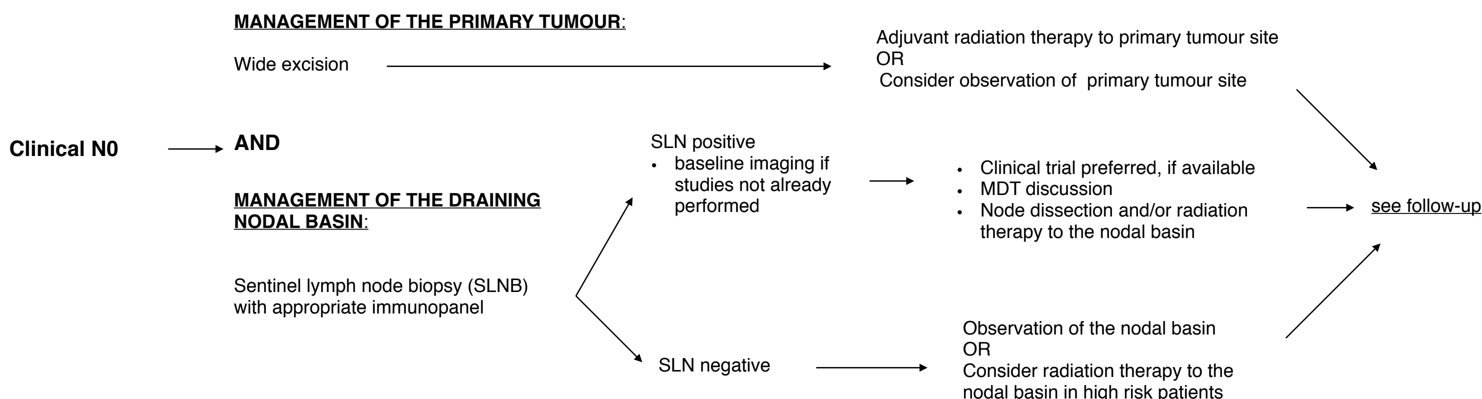
Royal Devon and Exeter Hospital

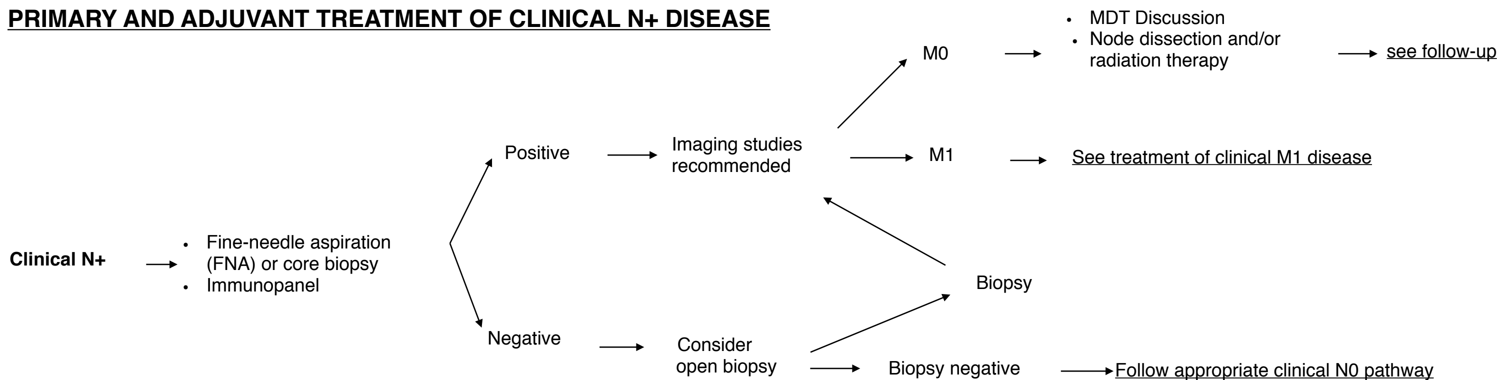
Merkel Cell Carcinoma Management Guidelines 2019



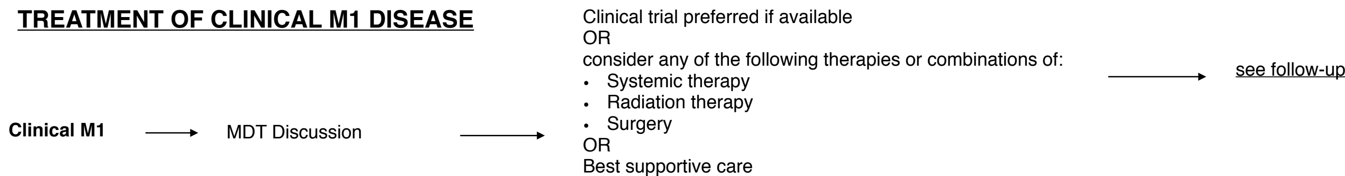
PRIMARY AND ADJUVANT TREATMENT OF CLINICAL N0 DISEASE



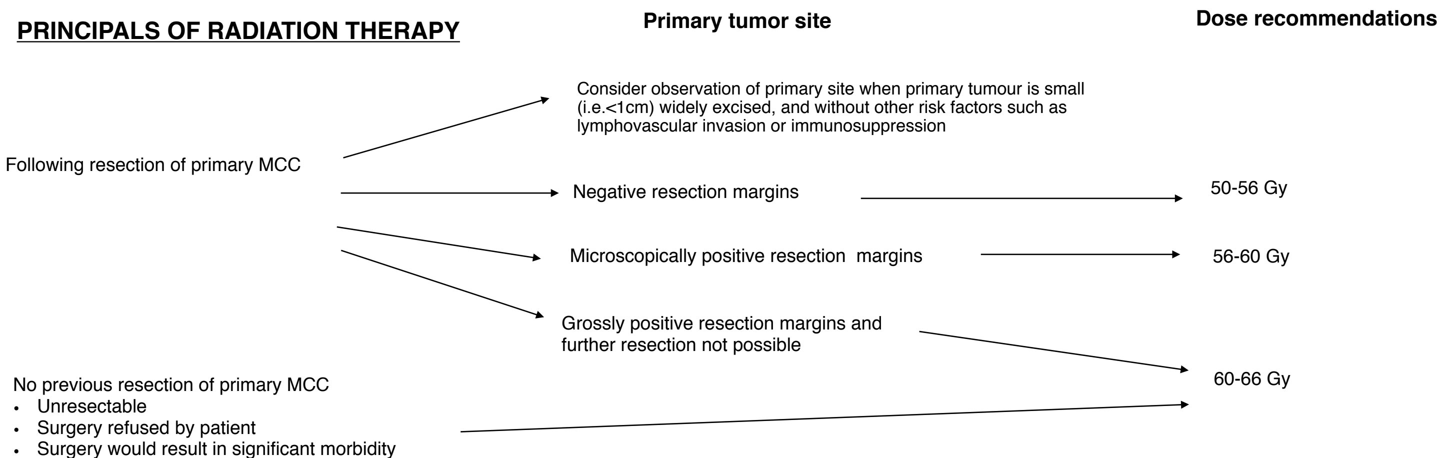
PRIMARY AND ADJUVANT TREATMENT OF CLINICAL N+ DISEASE



TREATMENT OF CLINICAL M1 DISEASE



PRINCIPALS OF RADIATION THERAPY



Principles of Wide Excision
Aim for 1-2 cm margin, unless functional consideration for anatomical site: balance with morbidity of surgery
Consider 1 cm margin for tumours < 2cm
Consider observe 1ry site if <1cm well excised primary + no adverse risk factors eg LVI, immunosuppression
In cases in which complete surgical excision is either not possible, refused by the patient or which would result in considerable morbidity , radiation monotherapy may be considered.

Clinical Imaging
Consider in all cases as clinically indicated. Encouraged when positive SLNB , metastatic disease or unresectable. Whole body PET/CT or MRI brain (+ contrast) and CT Neck/TAP (+ contrast)

SLNB
Important staging tool for regional control but impact on overall survival unclear
Head and neck lesions have increased risk of false negative
If SLNB not performed or unsuccessful consider irradiating nodal beds for subclinical disease

Radiotherapy Expeditious commencement after surgery is preferred.
Wide (5cm) margins should be used, if possible , around primary site.
Consider observe 1ry site if <1cm well excised primary, no adverse risk factors eg LVI / immunosuppression
Consider Radiotherapy to Primary tumour site and nodal basin (even if SLNB negative) in all cases with significant immunosuppression
Consider a less protracted fractionation schedule (eg 30 Gy in 10 fractions) for Palliation

Clinical Follow Up
Recommended 3-6 monthly for 3 years, then 6 monthly for up to 5 years
Imaging studies as clinically indicated. Consider routine imaging for high risk patients

Adjuvant Chemotherapy
Not recommended for Local disease. Clinical trial preferred. Consider in select clinical circumstances eg disseminated disease: however available retrospective studies do not suggest survival benefit for adjuvant chemotherapy in loco-regional disease

AJCC TNM Staging 2016

Stage	Primary Tumour	Regional Lymph Node	Metastasis	5 year survival
I	T1	N0	M0	79%
IIA	T2-3	N0	M0	54%
IIB	T4	N0	M0	49%
IIIA	T1-4	N1a	M0	40%
IIIB	T1-4	N1b-N3	M0	27%
IV	T0-4	Any	M1	13.5%

AJCC TNM staging categories for stage groupings
Primary Tumour Maximum Diameter
Tx Tumour cannot be assessed eg curetted
T0 no evidence of primary tumour
Tis in situ, confined to epidermis
T1 max diam < 2cm
T2 max diam >2 cm to <5.0
T3 max diam >5 cm
T4 tumour invading bone, muscle fascia or cartilage
Nodes
Nx Nodes cannot be assessed eg body habitus
N0 no lymph node involvement
N1 regional lymph node metastasis
N1a occult lymph node
N1b palpable lymph nodes
N2 in transit metastasis without lymph node metastasis
N3 in transit metastasis with lymph node metastasis
Metastases
M0 no distant metastases
M1 metastasis beyond regional lymph nodes
M1a metastasis to distant skin, subcutaneous tissue or lymph nodes
M1b metastasis to lung
M1c metastasis to visceral sites

References
NCCN Guidelines:Merkel Cell Carcinoma.Version1.2018.J Natl Compr Canc Netw 2018;16(6):742–774 doi:10.6004/jnccn.2018.0055
AJCC Cancer staging manual 8th edition Springer International Publishing AG. 30 Mar. 2017 ISBN-10: 3319406175