**Care pathway: Uveal melanoma**

**DIAGNOSIS OF UVEAL MELANOMA**

- Use ophthalmoscopy, fundus photography and conventional ocular ultrasound

- If ciliary body image with Ultrasound Biomicroscopy (UBM) or anterior segment Optical coherence Tomography (OCT)

**YES**

**STAGING**

- Should not delay primary treatment

**TREATMENT OF PRIMARY TUMOUR**

- Consider the following options depending on size and location of the tumour and the possible complications:

**TREATMENT OPTIONS**

- Systemic immune checkpoint inhibitors – weigh up the potential benefit and risk of toxicity in deciding between single agent and combination ICI

**PROGNOSIS BIOPSY**

- Discuss with patient including:
  - Enable prognostication and allow tailored follow-up
  - Allow recruitment into adjuvant trials
  - Risks of having the biopsy
  - Limitations of the investigation
  - Effects of prognostication information on quality of life.

**ADJUVANT THERAPY**

- Only use adjuvant systemic therapy in a clinical trial

- Consider adjuvant radiation therapy for patients deemed to be at high risk of local relapse (e.g. greater than 5mm tumour extra-ocular extension in enucleation samples). Patients should be counselled on the benefits and risks of radiation therapy.

**SURVEILLANCE TO BE UPDATED IN 2022**

- Discuss at MDT the surgical and radiotherapy options

**MACROSCOPIC ORBITAL RECURRENCE**

- Assess the burden of liver disease by contrast enhanced diffusion weighted MRI scan

- Stage extrahepatic disease using contrast-enhanced CT of chest, abdomen and pelvis and/or PET/CT scan should be used to stage extrahepatic disease.

- Do not carry out brain imaging in the absence of symptoms.

- Offer a bone scan to patients who have symptomatic bony pain.

- Collect minimum data set for all patients with systemic disease (Stage IV) for future validation.

- A biopsy should be performed to confirm the diagnosis of metastatic uveal melanoma unless contraindicated.

**STAGING & PROGNOSTICATION**

- Suitable clinical trials, should be the first option with patient agreement.

- A patient may prefer to receive supportive care and systemic treatment locally with involvement of Specialist centres.

- If a clinical trial is not possible or desirable, offer systemic treatments to patients with good performance status (PS 0-2). Options include:
  - Screening fit patients for HLA-A*02:01 to identify those who may benefit from tebentafusp. pending licencing
  - Systemic immune checkpoint inhibitors – weigh up the potential benefit and risk of toxicity in deciding between single agent and combination ICI
  - Only consider chemotherapy in the absence of other options and with full discussion of risks and impact on quality of life
  - Use targeted therapy only in the context of a clinical trial

**SYSTEMIC THERAPY**

- For patients with technically resectable disease, assessment for hepatic resection should be offered where complete macroscopic clearance (R0) can be achieved.

- Patient selection should consider these criteria:
  - The extent of liver involved with tumour
  - Absence of or no more than one site of extra-hepatic disease which is either stable or with an alternative treatment strategy for that site
  - ECOG PS <= 1
  - Absence of functionally significant underlying liver disease
  - Liver directed and/or systemic treatments should be considered in selected patients with liver dominant disease where resection is not suitable.

- Patients treated with curative intent should be followed with regular (3-4 monthly) hepatic MRI and CT of chest, abdomen and pelvis.

- Patient outcomes for this selected group should be collected centrally and prospectively.

Black sections are based on 2021 guidance, blue sections are 2015 guidance

**LOCO-REGIONAL MANAGEMENT OF LIVER PREDOMINANT DISEASE**

- Patients treated with curative intent should be followed with regular (3-4 monthly) hepatic MRI and CT of chest, abdomen and pelvis.

- Patient outcomes for this selected group should be collected centrally and prospectively.