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**Dr Susan Seifried, General Surgeon**
**Chair, National Melanoma Working Group**
**melnet@melnet.org.nz.**

**NEW ZEALAND MELANOMA CLINICAL GUIDELINES**

Te Whare Piki Ora o Māhutonga – the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Aotearoa New Zealand and Australia. Our mission is '*To improve access, equity, quality and delivery of surgical care that meets the needs of our diverse communities'*. Health advocacy is a central competency of a surgeon, and a core value of this College.

We welcome your request to review the proposed changes to the *Quality Statements to Guide Melanoma Diagnosis and Treatment in New Zealand,* now renamed as the *New Zealand Melanoma Clinical Guidelines.*

RACS commends the National Melanoma Working Group on producing well-researched, referenced and practical melanoma guidelines which will hopefully improve the care provided for melanoma in Aotearoa New Zealand. The inclusion of Key Performance Indicators for some stages allows progress towards these targets to be measured.

We strongly recommend using Aotearoa New Zealand rather than just New Zealand. Te reo Māori is an official language of Aotearoa New Zealand. Our Māori population has poorer melanoma health outcomes, and we must work to reverse this inequity. Māori often feel disenfranchised by our healthcare system and are less likely to seek help at earlier stages.

We also recommend adding "data sovereignty" to the last sentence of the Rationale on page 19 as this is an important issue for Māori considering the use of artificial intelligence.

Highlighting this poorer outcome and inequity presents an opportunity to champion cultural safety and competency, which is a core competency for all clinicians and key to improving patient care.

In relation to Supportive Care (page 78, 7.1.4), can Māori also access Rongoā Māori traditional Māori health practitioners? In relation to Care Coordination (page 82) the Meihana model is referenced as a needs assessment tool, whereas it was developed and is intended as a consultation framework rather than for needs assessment.

The section on Sentinel node biopsy technique (page 45) makes no reference to the use of indocyanine green fluorescence imaging for sentinel node biopsy detection. Although this is a newer technique studies are showing its increasing utility and its inclusion as an option is recommended.

We also recommend some minor and editorial changes, as overleaf.

If you have any questions or would like to discuss this submission, please contact Dr Sarah Rennie FRACS, Surgical Advisor with RACS at sarah.rennie@surgeons.org. We would be pleased to contribute to further work in this area.

**Nāku noa, nā**

**Ros Pochin**
**Chair, Aotearoa New Zealand National Committee**

**RACS represents more than 8300 surgeons and 1300 surgical Trainees and Specialist International Medical Graduates across Aotearoa New Zealand and Australia. We are the accredited training provider in nine surgical specialities. Surgeons are also required by RACS and Te Kaunihera Rata o Aotearoa - Medical Council of Aotearoa, to continue with surgical education and review of their practice throughout their surgical careers.**

Committed to
Indigenous health

**Recommended minor and editorial changes**

1. Title page and throughout the document, use Aotearoa New Zealand, as discussed above.
2. The movement of the glossary to the end of the document is supported – however it means the first incidence of many abbreviated words is in the main text is an abbreviation without the word being written out in full:

   Page 12: UVR should be written in full before being abbreviated.

   Page 19: FAMM, CMN, AI and TGA should be written in full before being abbreviated.

   Page 21: FSA, FNA, and FCT should be written in full before being abbreviated.

   Page 23: CNS should be written in full before being abbreviated.

   Consider adding CNC – referred to on pages 37, 38 and 81.

   MDM should be written in full before being abbreviated.

   Page 25: SNB should be written in full before being abbreviated.

   Page 26: The abbreviation SLNB is used and not written in full first and not consistent with use of SNB as an abbreviation – ensure consistency.

   SLNB is only found here and in the glossary of terms which doesn't include SNB.

   MIS should be written in full before being abbreviated.

   Page 27: AJCC, TNM, NZCR should be written in full before being abbreviated.

   Page 28: AJCC, ADD, NCCN and RCPA should be written in full before being abbreviated.

   Page 31: MIA, IHC and MDM should be written in full before being abbreviated.

   Page 38: MDT should be written in full before being abbreviated.

   Page 39: SLN should be written in full before being abbreviated.

   RCTs should be written in full before being abbreviated – it is written in full after used abbreviated.

   Page 56: ILI should be written in full before being abbreviated.

   Page 68: ABCDEFG rule should be explained before being abbreviated

   SCAN rule should be explained before being abbreviated

   Glossary: Includes CLND, FAMMM, GPEP, PPE, UPF and UVI, but these terms are not used within the document.

   RFS is called relapse-free survival on page 45 and recurrence free survival in the glossary.

3. Page 5. States the Guidelines' aim to reduce the incidence rates which will occur mainly through prevention strategies. However, the document only discusses access and delivery of care, not prevention. Suggest modifying:

   - "The guidelines aim to reduce New Zealand's world-leading melanoma incidence rates and improve outcomes for all melanoma patients by informing work aimed at ensuring national consistency in the access and delivery of quality melanoma care."
   - to: *"The guidelines aim to firstly reduce Aotearoa New Zealand's world-leading melanoma incidence rates by ensuring national consistency of health promotion and secondly improve outcomes for all melanoma patients by informing work aimed at ensuring uniform access and delivery of quality melanoma care across the Motu."*

4. Page 5: Consider a less wordy paragraph than:

   - "The guidelines comprise evidence-based statements that describe good-quality care and are reflective of global best practice. Where there was a lack of evidence, development was informed by expert opinion, which was arrived at by consensus. While it is acknowledged that the resources and protocols of individual centres may differ, the guidelines are intended to outline best practice and function as the evidence base for quality-improvement activities."

- For example: "*The guidelines comprise evidence-based statements describing good-quality care and are reflective of global best practice. Where there was a lack of evidence, development was informed by expert opinion, arrived at by consensus. While it is acknowledged the resources and protocols of individual centres may differ, the guidelines are intended to outline best practice and function as the evidence base for quality-improvement activities.*"

5. Ensure consistency in the references:
   a. Use the same referencing convention for articles with more than three authors as the majority of references sited which list the first three authors and then *et al.*
      - Page 18: *Friche P, et al. 2024. Training Family Medicine Residents in Dermoscopy Using an e learning Based Educational Tool. JMIR Formative Research 8(1): e56005.*
      - Page 56: *Garbe C et al. 2025. European consensus-based interdisciplinary guideline for melanoma. Part 2: Treatment – Update 2024. Eur J Cancer: 215; 115-153*
   b. Either list the DOI for all references where available or for none.
   c. Page 29: This was published in 2024 so issue number and page numbers should now be available and should be used.

      Blank, CU, Lucas MW, Scolyer RA, et al. 2024. Neoadjuvant Nivolumab and Ipilimumab in Resectable Stage III Melanoma. The New England journal of medicine. Advance online publication.
   d. Page 42: Volume number appearing in bold is not consistent with other references.

      Moncrieff, M.D., Gyorki, D., Saw, R. et al. 2018. 1 Versus 2-cm Excision Margins for pT2-pT4 Primary Cutaneous Melanoma (MelMarT): A Feasibility Study. Ann Surg Oncol. **25**: 2541–2549.
   e. Page 42: Year published placement is not consistent with the other references.

      Zitelli JA, Brown C, Hanusa BH. Mohs micrographic surgery for the treatment of primary cutaneous melanoma. J Am Acad Dermatol. 1997 37(2 Pt 1):236-45.
   f. What are the words in bold - are these necessary?
      - Long GV, Hauschild A, Santinami M, et al. 2024. Final Results for Adjuvant Dabrafenib plus Trametinib in Stage III Melanoma. N Engl J Med. Nov 7;391(18):1709-1720. **(COMBI-AD)**
      - Wolchok JD, Chiarion-Sileni V, Gonzalez R, et al. 2022. Long-Term Outcomes With Nivolumab Plus Ipilimumab or Nivolumab Alone Versus Ipilimumab in Patients With Advanced Melanoma. J Clin Oncol. Jan 10;40(2):127-137**(Checkmate)**.

6. Page 51: 5.4.10 End of first sentence ? accidental inclusion of 5.4.9? or should this be broken up and the next 2 sentences be 5.4.11 with renumbering of the rest of the section?

7. Page 71: Third paragraph. Add a space between the first and second sentences.
   - "Regarding salvage curative surgery, radiotherapy or emerging systemic therapies, there is some evidence that treatments are more effective in the setting of low tumour volume, making early detection of recurrence and/or distant metastatic disease relevant (Ibrahim et al 2020, Freeman et al 2019; Joseph et al 2018, Leon-Ferre et al 2017)."