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Melanoma - Treatment Options [1]

This section has been reviewed and approved by the [Cancer.Net Editorial Board](#) [2], 09/2015

ON THIS PAGE: You will learn about the different ways doctors use to treat people with this type of cancer. To see other pages, use the menu on the side of your screen.

This section outlines treatments that are the standard of care (the best known treatments available) for this specific type of cancer. When making treatment plan decisions, patients are also encouraged to consider clinical trials as an option. A clinical trial is a research study to test a new approach to treatment to evaluate whether it is safe, effective, and possibly better than the standard treatment. Clinical trials may test such approaches as a new drug, a new combination of standard treatments, or new doses of current therapies. Your doctor can help you review all treatment options. For more information, see the [About Clinical Trials](#) [3] and [Latest Research](#) [4] sections.

The cancer care team

In cancer care, different types of doctors often work together to create a patient's overall treatment plan that combines different types of treatments. This is called a [multidisciplinary team](#) [5]. For a person with melanoma, doctors on this team may include a:

- Dermatologist: a doctor who specializes in diseases and conditions of the skin
- Surgical oncologist: a doctor who specializes in treating cancer with surgery
- Medical oncologist: a doctor who specializes in treating cancer with medication

- Radiation oncologist: a doctor who specializes in treating cancer with radiation therapy
- Pathologist: a doctor who specializes in interpreting laboratory tests and evaluating cells, tissues, and organs to diagnose disease

Cancer care teams also include a variety of other health care professionals, including physician assistants, nurse practitioners, oncology nurses, social workers, pharmacists, counselors, dietitians, and others.

Treatment overview

Treatment recommendations depend on many factors, including the thickness of the primary melanoma, whether the cancer has spread, the stage of the melanoma, the presence of specific genetic changes in melanoma cells, rate of melanoma growth, and the patient's other medical conditions. Other factors used in treatment decision making include possible side effects, as well as the patient's preferences and overall health. Therefore, the following is meant to be an overview and not used as treatment recommendations for specific patients.

Descriptions of the most common treatment options for melanoma are listed below according to the [stage of melanoma](#) [6]. Your care plan may also include treatment for symptoms and side effects, an important part of cancer care. Take time to learn about all of your treatment options and be sure to ask questions about things that are unclear. Also, talk about the goals of each treatment with your doctor and what you can expect while receiving the treatment. Learn more about [making treatment decisions](#) [7].

Surgery

Surgery is the removal of the tumor and some surrounding healthy tissue during an operation. This procedure is usually performed by a surgical oncologist.

Surgery is the primary treatment for people with local melanoma and most patients with regional melanoma. For some people with metastatic melanoma, surgery may also be considered. In recommending a specific treatment plan, doctors will consider the stage of the disease, as well as the person's individual risk of recurrence.

Types of surgery used to treat local and regional melanoma are:

- **Wide excision.** The primary treatment for melanoma is excision, or surgical removal, of the primary melanoma on the skin. The extent of the surgery depends on the thickness of the melanoma. Most melanomas are found when they are less than 1.0 mm thick, and outpatient surgery is often the only treatment needed. A doctor removes the tumor, tissue found under the skin, and some surrounding healthy tissue, called a margin, so that no

cancer cells remain.

If the melanoma is staged as in situ (stage 0), the doctor may remove a margin of skin at least 0.5 cm around the cancer. Overall, the width of the margin increases with the thickness of the melanoma, ranging from a 1.0 cm margin for melanoma measuring up to 1.0 mm to a 2.0 cm margin for melanoma measuring over 2.01 mm.

Depending on the site and extent of the surgery, a skin flap or a skin graft may be necessary. A skin flap is created when nearby tissue is moved around to cover the area removed during surgery. A skin graft uses skin from another part of the body to close the wound and reduce scarring.

- **Lymphatic mapping and sentinel lymph node biopsy.** These surgical procedures help the doctor figure out whether the melanoma has spread to the lymph nodes. During these procedures, the doctor removes one or more lymph nodes near the tumor, called sentinel lymph nodes, to check for melanoma cells. If melanoma cancer cells are not found in the sentinel lymph node(s), no further lymph node surgery is required. If the sentinel lymph nodes contain melanoma, this may be called a positive sentinel lymph node biopsy result. This means the disease has started to spread, and lymph node dissection (see below) is typically recommended.

These procedures are usually recommended for people with a melanoma that is more than 1.0 mm thick or has ulceration. However, a sentinel lymph node biopsy may also be recommended by a surgical oncologist for some other melanomas that are less than 1.0 mm thick.

For non-ulcerated melanomas less than 1.0 mm thick, the likelihood that the cancer has spread to the lymph nodes is so low that, in most cases, sentinel lymph node mapping is not necessary. However, sometimes the doctor will recommend this procedure for a person with a thin melanoma if there are other signs the melanoma is more aggressive, such as ulceration or higher mitotic rate (see the [Diagnosis \[8\]](#) section). If the melanoma is less than 1.0 mm, your doctor will discuss whether this approach is recommended based on other features of the primary melanoma and other factors.

Sentinel lymph node mapping should be performed during the same operative procedure as the wide excision because such surgery can change the lymphatic drainage pattern, which may affect the reliability of the procedure in some situations.

- **Lymph node dissection.** If melanoma is found in the sentinel lymph nodes, doctors usually recommend removing the remaining lymph nodes in that area with surgery. The number of lymph nodes removed depends on the area of the body. However, research has shown that people who have a complete lymph node dissection after a positive sentinel lymph node biopsy live for the same amount of time as those who are closely watched for

signs of cancer. As a result, some people decide not to have a complete lymph node dissection. People who have had a lymph node dissection around an arm or leg have higher risk for fluid build-up in that limb, a side effect called [lymphedema](#) [9].

Sometimes a lymph node is found to be enlarged during a physical exam, after a scan, or during an ultrasound. If this happens, doctors usually recommend having a lymph node dissection. Doctors generally agree it is important to remove all lymph nodes in these situations.

Talk with your health care team about the possible side effect that may occur based on the specific type of surgery. Learn more about the [basics of cancer surgery](#) [10].

Radiation therapy

Radiation therapy is the use of high-energy x-rays or other particles to destroy cancer cells. A doctor who specializes in giving radiation therapy to treat cancer is called a radiation oncologist.

The most common type of radiation treatment is called external-beam radiation therapy, which is radiation given from a machine outside the body. The radiation beam produced by this machine can be pointed in different directions and blocked using special techniques to help decrease side effects. The radiation oncologist will recommend a specific radiation therapy regimen (schedule) with a total number of treatments and dose of radiation.

General side effects of radiation therapy include skin irritation and fatigue. These usually get better a few weeks after adjuvant radiation therapy is finished. Adjuvant therapy is treatment after the first treatment, usually surgery (see below.) However, topical corticosteroid creams and antibiotics may be used to help prevent and treat radiation-induced skin reactions.

Depending on the area of the body being treated with radiation therapy, other side effects may develop. For example, after treatment to the head and/or neck region, temporary irritation of the mouth or difficulty swallowing can occur. If treatment was directed at the armpit or groin area, the person may have higher risk of fluid build-up in that limb, a side effect called [lymphedema](#) [9]. Lymphedema can be a long-term, ongoing side effect. Talk with the radiation oncologist to learn more about the possible side effects you may experience and how they can be managed.

Learn more about the [basics of radiation therapy](#) [11].

Adjuvant therapy for stage II and stage III melanoma

After surgery, the surgeon or medical oncologist may recommend adjuvant therapy for patients who are at higher risk for recurrence. Adjuvant therapy is treatment given after the initial treatment to reduce the risk of the melanoma coming back.

Adjuvant treatment options may include radiation therapy, immunotherapy, or joining a clinical

trial researching new drug treatments (see below and the [Latest Research](#) [4] section.)

Adjuvant radiation therapy

Sometimes, radiation therapy is considered after surgery to prevent recurrence. Research has shown that, although this may reduce the risk of the melanoma coming back, it does not increase the amount of time a person lives.

People who receive adjuvant radiation therapy experience side effects depending on the area treated (see above). In general, a person's overall quality of life is similar to people who do not receive it, according to the results of recent clinical trials. However, some symptoms in the first year were worse for patients receiving adjuvant radiation therapy in those studies.

Adjuvant immunotherapy

Immunotherapy is designed to boost the body's natural defenses to fight the cancer. It uses materials made either by the body or in a laboratory to improve, target, or restore immune system function. Learn more about the [basics of immunotherapy](#) [12].

The one FDA-approved adjuvant immunotherapy for this stage of melanoma is high-dose interferon alfa-2b. High-dose interferon alfa-2b given over a year has been shown to delay recurrences for some patients. However, it has not been shown to lengthen how long people live. There are substantial and common side effects to this treatment, including flu-like symptoms, such as fatigue, fever, chills, nausea, vomiting, and headache; rashes; hair thinning; and depression. Because of the side effects and lack of a survival benefit, many doctors do not recommend using high dose interferon.

New adjuvant drug treatments

There are many clinical trials underway testing targeted therapies and other immunotherapies after surgery. These include ipilimumab (Yervoy), anti-PD1 antibodies, and inhibitors of the mutated BRAF protein. See below (under Stage IV options) and the [Latest Research](#) [4] section for more information about these treatment options that may be open for those with Stage II or Stage III disease.

Systemic treatment options for stage IV melanoma

If melanoma has spread to other parts of the body, it is called stage IV or metastatic melanoma. The most common distant places melanoma spreads include the lung, liver, and brain. People with this diagnosis are encouraged to talk with doctors who are experienced in treating this stage of cancer because there can be different opinions about the best treatment plan. Learn more about getting a [second opinion](#) [13] before starting treatment, so you are comfortable with the treatment plan chosen. This discussion usually includes [clinical trials](#) [14], which are the preferred option for certain patients with stage IV melanoma.

Treatment recommendations for people with stage IV melanoma depends on a number of factors, including the person's age and overall health, the locations and number of metastases, how fast the disease is spreading, the presence of specific genetic mutations in the tumor, and the patient's preferences.

Since 2011, a number of new drugs have become available for metastatic melanoma. These drugs help shrink melanoma for 12% to 60% of patients and help them live longer. These new drugs are generally divided into two groups: immunotherapy and targeted therapy. Immunotherapy, targeted therapy, and other common treatment options for stage IV melanoma are described below. Some of these treatments are currently available only through clinical trials. See the [Latest Research](#) [15] section for more information

For most patients, a diagnosis of metastatic cancer is very stressful and, at times, difficult to bear. Patients and their families are encouraged to talk about the way they are feeling with doctors, nurses, social workers, or other members of the health care team. It may also be helpful to talk with other patients, including through a support group.

Stage IV: Immunotherapy

As explained above, immunotherapy helps boosts the body's natural defenses to fight the cancer. In recent years, there have been major advances in treating stage IV melanoma with immunotherapy. Current options for patients include:

- **Anti-CTLA4 antibody.** Ipilimumab is a [monoclonal antibody](#) [12] approved by the FDA for the treatment of stage IV melanoma, as well as stage III melanoma that cannot be surgically removed, called unresectable melanoma. Ipilimumab targets a molecule called cytotoxic T-lymphocyte associated molecule-4 (CTLA4). It works by taking the brakes off the immune system.

Two clinical trials showed that people taking ipilimumab had a better chance of survival than people who only received traditional chemotherapy (see below). Some people with melanoma may benefit from ipilimumab treatment for years. Complete disappearance of melanoma has been observed in some patients, and it seems to be permanent.

Because this drug activates the immune system, it can trigger "autoimmune" side effects in which the patient's own immune system attacks healthy cells in the body. These side effects can be serious and even life-threatening. These side effects include significant colon inflammation (colitis), liver problems, skin reactions, nerve and hormone gland inflammation, and eye problems. Patients are also closely monitored for diarrhea, rashes, itching, and other side effects. Learn more about this medication and its side effects in this [Cancer.Net podcast](#) [16].

Before treatment begins, be sure to talk to your doctor about potential side effects, and let your doctor know right away about any side effects you experience during treatment. It is

also important to tell your doctor about all other medications you are taking, including over-the-counter drugs and dietary or herbal supplements, to avoid possible side effects from drug interactions with ipilimumab.

Ipilimumab and other anti-CTLA4 antibodies continue to be evaluated in clinical trials. See the [Latest Research](#) [4] section for more information.

- **Anti-PD-1 antibodies.** Two monoclonal antibodies that block a protein called PD-1 (programmed death-1) have been FDA-approved: nivolumab (Opdivo) and pembrolizumab (Keytruda). PD-1 is found on the surface of T-cells, which are a type of white blood cell that directly helps body's immune system fight disease. This protein keeps the immune system from destroying the cancer. Because these drugs stop PD-1 from working, the immune system is able to better target melanoma cells. New anti-PD1 and anti-PD-L1 antibodies are currently being developed.

Both nivolumab and pembrolizumab have been shown to shrink melanoma for 30% to 40% of patients. They also cause fewer side effects than ipilimumab. Because of this nivolumab and pembrolizumab are now being recommended as a first treatment option for people after being diagnosed with metastatic melanoma.

- **Combining anti-PD1 and anti-CTLA4 antibodies.** Researchers have been studying combining ipilimumab with nivolumab. This combination appears to produce a higher response rate than either drug alone. However, combining these drugs causes far more side effects. Doctors and researchers do not know yet whether the combination results in better overall survival. In September 2015, the FDA approved the immunotherapy combination of ipilimumab and nivolumab for patients whose melanoma has a BRAF V600 wild-type mutation (see below) who have metastatic melanoma or unresectable melanoma. However, there is no evidence that a BRAF V600 mutation is necessary for patients to respond to this treatment.
- **Interleukin-2 (IL-2, aldesleukin, Proleukin).** This is a drug that activates T-cells and is sometimes given to patients with metastatic melanoma. However, response rates are quite low, with less than 10% of patients experiencing a complete response. A complete response is defined as the disappearance of all signs of cancer as a result of treatment.

The most common side effects of IL-2 are low blood pressure, fever, chills, and a condition known as capillary leak syndrome. Capillary leak syndrome occurs when fluids and proteins leak from blood vessels, which can cause very low blood pressure and other dangerous effects. Patients being treated with high dose IL-2 require intensive monitoring by the health care team, and IL-2 should be given by an experienced health care team familiar with the side effects of IL-2 treatment.

Stage IV: Targeted therapy

Targeted therapy is a treatment that targets the cancer's specific genes, proteins, or the tissue environment that contributes to cancer growth and survival. This type of treatment blocks the growth and spread of cancer cells while limiting damage to healthy cells. Learn more about the [basics of targeted therapy](#) [17].

As explained above and in the [Diagnosis](#) [18] section, ongoing research has identified several key pathways and genes involved in the growth and spread of melanoma. These advances now allow doctors to tailor or personalize a patient's treatment plan based on the melanoma's genetic abnormalities or mutations.

A major research focus is the development of new drugs that block specific biochemical pathways that melanoma cells need to grow. Currently, targeted therapy for melanoma includes:

- **BRAF inhibitors.** The discovery that approximately 50% of melanomas have a mutated or activated *BRAF* gene has provided an important new direction in the treatment of melanoma. Two drugs that inhibit *BRAF*, dabrafenib (Tafinlar) and vemurafenib (Zelboraf), have been approved for people with both stage IV and stage III melanoma that cannot be surgically removed. These drugs, which are taken as a pill, are specifically used when the melanoma tumors have a V600E or V600K mutation in the *BRAF* gene (see the [Diagnosis](#) [18] section). These drugs should not be used by patients without the mutation because it can actually be harmful for them.

In clinical trials for patients with metastatic melanoma having the mutated *BRAF* gene, both drugs resulted in tumor shrinkage in the majority of those patients. Vemurafenib was shown to extend patients' survival by nearly a year, on average. Dabrafenib's effect on overall survival was not formally tested. Based on these trials, both drugs are approved for standard use for patients with locally advanced stage III melanoma that cannot be removed by surgery or for patients with stage IV melanoma, if the melanoma has the mutated *BRAF* gene.

Side effects of vemurafenib included skin problems, including rashes, hair thinning, thick or dry skin, sun sensitivity, and a less aggressive form of skin cancer called [squamous cell carcinoma](#) [19] that can often be treated with minor surgery. Other side effects included joint pain, fatigue, nausea, fever, and hair thinning and curling. Talk with your doctor about what side effects may occur before treatment begins. Dabrafenib seems to have fewer side effects like thick or dry skin and hair thinning, and it almost never causes sun sensitivity.

- **MEK inhibitors.** In May 2013, the FDA approved trametinib (Mekinist) for patients with melanoma having a *BRAF* V600E or V600K mutation who have been diagnosed with unresectable or metastatic melanoma. This drug, which is taken as a tablet, specifically

targets the MEK protein, which is involved in cancer growth and survival. Trametinib was approved based on the results of a clinical study that showed patients with Stage IIIC or IV melanoma who took this targeted therapy lived longer without the cancer getting worse than those who received chemotherapy. The side effects of trametinib include an acne-like rash, nail inflammation, itching, dry skin, and diarrhea.

- **Combining BRAF and MEK inhibitors.** In May 2014, the FDA approved the combination of trametinib with dabrafenib (see above) for melanoma that cannot be surgically removed or metastatic melanoma with a *BRAF* V600E or V600K mutation. In one clinical trial, this combination had a slightly higher response rate than dabrafenib alone (69% versus 53%). These responses also lasted slightly longer (13 months versus 11 months) and helped patients live longer. Two years after starting treatment with the combination, 51% of patients were alive compared with 42% of patients who took dabrafenib alone.

The most common side effects of treatment with trametinib with dabrafenib include fever, chills, tiredness, rash, nausea, vomiting, diarrhea, abdominal pain, swelling in the hands and feet, cough, headache, joint pain, night sweats, decreased appetite, constipation, and muscle pain.

- **KIT inhibitors.** Researchers are also focusing on the development of treatments that target the *KIT* gene, which is mutated or present in increased numbers (extra copies of the gene) in certain subtypes of melanoma, including lentigo maligna melanoma, mucosal melanoma, and acral lentiginous melanoma. Drugs currently being tested in clinical trials for patients with stage IV, mutated *KIT* melanoma include dasatinib (Sprycel), imatinib (Gleevec), and nilotinib (Tasigna).

Stage IV: Intralesional therapy

During intralesional therapy, talimogene laherparepvec (TVEC) is injected directly into one or more melanoma tumors. TVEC is a herpes virus designed in a laboratory to make an immune-stimulating hormone. This virus can infect and destroy melanoma cells. TVEC also helps stimulate the immune system to destroy other melanoma tumors.

In one clinical trial, 26% of patients treated with TVEC had melanoma tumors that shrank. For 47% of the participants, the tumors that were injected completely disappeared. Some tumors that were not injected also were eliminated, although this occurred less often. More clinical trials are currently ongoing.

Stage IV: Chemotherapy

Chemotherapy is the use of drugs to destroy cancer cells, usually by stopping the cancer cells'

ability to grow and divide. Chemotherapy is given by a medical oncologist, a doctor who specializes in treating cancer with medication.

Traditional types of chemotherapy are still used to treat melanoma although they are usually no longer used as first-line therapy. First-line therapy is the initial treatment recommended after a cancer diagnosis.

Some types of chemotherapy are given intravenously through an IV tube or catheter placed into a vein. Other types of chemotherapy can be given as a pill or capsule that is swallowed (orally).

A chemotherapy regimen usually consists of a set number of cycles given over a specific time. A patient may receive one drug at a time or combinations of different drugs at the same time. Common drugs used for melanoma include dacarbazine (DTIC-Dome), which is the only FDA-approved chemotherapy for melanoma. Temozolomide (Methazolastone, Temodar) is essentially an oral version of DTIC, and it is used for the treatment of stage IV melanoma.

Both DTIC and temozolomide have been shown to shrink melanoma for approximately 12% to 15% of patients. However, no clinical trials have tested whether these drugs increase the length of time people with melanoma live after treatment. Both DTIC and temozolomide have a limited number of side effects. Talk with your doctor about possible side effects of these drugs.

Other chemotherapies used to treat melanoma include cisplatin (Platinol), fotemustine (Muphoran), lomustine (CeeNU), the taxanes (a group of drugs that includes docetaxel [Taxotere] and paclitaxel [Taxol]), and vinblastine (Velban, Velsar). Combinations of chemotherapy drugs, such as paclitaxel plus carboplatin or cisplatin combined with vinblastine and DTIC may be used. Some chemotherapy drug combinations may have a higher chance of causing melanoma to shrink, but they also cause more side effects.

The side effects of chemotherapy depend on the individual and the dose used but they can include fatigue, risk of infection, nausea and vomiting, hair loss, nail changes, loss of appetite, diarrhea, some nerve damage causing changes in sensation, and hair loss. These side effects usually go away once treatment is finished.

Learn more about the [basics of chemotherapy](#) [20] and [preparing for treatment](#) [21]. The medications used to treat cancer are continually being evaluated. Talking with your doctor is often the best way to learn about the medications prescribed for you, their purpose, and their potential side effects or interactions with other medications. Learn more about your prescriptions by using [searchable drug databases](#) [22].

Stage IV: Radiation therapy

As described above, radiation therapy is the use of high-energy x-rays or other particles to destroy cancer cells. Radiation therapy may be used to treat melanoma that has spread in several ways.

Sometimes melanoma that has spread causes symptoms, such as bone pain or headaches, that radiation therapy can help relieve. This is called palliative radiation therapy. For some patients, palliative radiation therapy is given to an entire organ with several small doses of radiation, such as to the entire brain using whole-brain radiation therapy. Other times, one or just a few high doses of radiation therapy are given using a linear accelerator (or "linac" for short), Gamma Knife, CyberKnife, or TomoTherapy units. This is called stereotactic radiosurgery, stereotactic ablative radiation therapy, or stereotactic body radiation therapy and usually works best for just one or a few tumors in the brain or elsewhere in the body.

Radiation therapy may be used when cancer has extensive spread to the lymph nodes, following a lymph node dissection (see above, under Adjuvant therapy). Radiation therapy may sometimes be used when the amount of melanoma that can be removed with surgery is limited by the location of the tumor. In addition, researchers are testing the effectiveness of chemoradiation, a combination of radiation therapy and chemotherapy.

The side effects of radiation therapy depend on the type of radiation therapy given and the area of the body that is being treated. Radiation therapy to the brain can cause fatigue, hair loss, headaches, and nausea. Radiation therapy directed at other parts of the body can cause other specific side effects, such as skin irritation. See the Adjuvant radiation therapy section above and talk with your radiation oncologist for more information.

Stage IV: Surgery

If the melanoma has spread to a single or a few distant parts of the body or has come back after treatment, the surgical removal of cancer may help control the disease.

Stage IV: Isolated limb infusion therapy

Sometimes melanoma may cause a number of tumors to develop in one leg or arm. In these situations, there are too many tumors for surgery to be feasible or helpful. A doctor may recommend isolated limb infusion with chemotherapy.

During this treatment, a tourniquet is placed on the arm or leg before high doses of chemotherapy are given. The tourniquet keeps the chemotherapy in the arm or leg and prevents it from being transported throughout the body. Approximately 50% to 80% of tumors respond to this type of treatment. Tumor shrinkage is usually temporary; however, melanoma may be controlled for a year or more in some patients.

Stage IV: Treating brain metastases

The brain is one of the most common places melanoma spreads. Unfortunately, the presence of brain metastases is linked with a very poor prognosis. Less than 50% of people with melanoma that has spread to the brain live 6 months. Because of this poor prognosis, and because of the perceived difficulty in getting chemotherapy drugs into brain tissue (called the blood-brain

barrier), people with melanoma that has spread to the brain have traditionally been excluded from clinical trials. Fortunately, this is beginning to change, and there are clinical trials for patients with melanoma and brain metastases.

Currently, the following treatments may be recommended for melanoma that has spread to the brain:

- **Radiation therapy.** High-dose radiation therapy given using stereotactic techniques (see above) is often used when there are only a few metastatic tumors in the brain. These techniques are highly effective for getting rid of existing tumors but do not prevent new tumors from developing. The entire brain can be treated with radiation therapy, called whole-brain radiation therapy. However, because the dose of radiation used to treat the entire brain is lower, this type of treatment usually does not cause tumors to shrink.
- **BRAF inhibitors.** For people with melanoma that has a *BRAF* mutation, drugs such as dabrafenib and vemurafenib may be recommended. These drugs easily penetrate into the brain. Clinical trials have shown that melanoma tumors in the brain respond approximately 40% to 50% of the time.
- **Immunotherapy.** Ipilimumab, nivolumab, and pembrolizumab are currently being used in clinical trials to treat people with melanoma that has spread to the brain.

Getting care for symptoms and side effects

Cancer and its treatment often cause side effects. In addition to treatment to slow, stop, or eliminate the cancer, an important part of cancer care is relieving a person's symptoms and side effects. This approach is called palliative or supportive care, and it includes supporting the patient with his or her physical, emotional, and social needs.

Palliative care is any treatment that focuses on reducing symptoms, improving quality of life, and supporting patients and their families. Any person, regardless of age or type and stage of cancer, may receive palliative care. It works best when palliative care is started as early as needed in the cancer treatment process.

People often receive treatment for the cancer and treatment to ease side effects at the same time. In fact, patients who receive both often have less severe symptoms, better quality of life, and report they are more satisfied with treatment.

Palliative treatments vary widely and often include medication, nutritional changes, relaxation techniques, emotional support, and other therapies. You may also receive palliative treatments similar to those meant to eliminate the cancer, such as chemotherapy, surgery, or radiation therapy. Talk with your doctor about the goals of each treatment in your treatment plan.

Before treatment begins, talk with your health care team about the possible side effects of your specific treatment plan and palliative care options. And during and after treatment, be sure to tell your doctor or another health care team member if you are experiencing a problem, so it can be addressed as quickly as possible. Learn more about [palliative care](#) [23].

Remission and the chance of recurrence

A remission is when cancer cannot be detected in the body and there are no symptoms. This may also be called having “no evidence of disease” or NED.

A remission may be temporary or permanent. This uncertainty causes many people to worry that the cancer will come back. While many remissions are permanent, it’s important to talk with your doctor about the possibility of the cancer returning. Understanding your risk of recurrence and the treatment options may help you feel more prepared if the cancer does return. Learn more about [coping with the fear of recurrence](#) [24].

If the melanoma does return after the original treatment, it is called recurrent cancer. It may come back in the same place (called a local recurrence), nearby (regional recurrence), or in another part of the body (distant recurrence).

When this occurs, a cycle of testing will begin to learn as much as possible about the recurrence. After testing is done, you and your doctor will talk about your treatment options. Often the treatment plan will include the treatments described above, such as surgery, chemotherapy, immunotherapy, targeted therapy, and radiation therapy, but they may be used in a different combination or given at a different pace. Your doctor may also suggest clinical trials that are studying new ways to treat this type of recurrent cancer. Whichever treatment plan you choose, palliative care will be important for relieving symptoms and side effects.

People with recurrent cancer often experience emotions such as disbelief or fear. Patients are encouraged to talk with their health care team about these feelings and ask about support services to help them cope. Learn more about [dealing with cancer recurrence](#) [25].

If treatment fails

Recovery from cancer is not always possible. If the cancer cannot be cured or controlled, the disease may be called advanced or terminal.

This diagnosis is stressful, and advanced cancer is difficult to discuss for many people. However, it is important to have open and honest conversations with your doctor and health care team to express your feelings, preferences, and concerns. The health care team is there to help, and many team members have special skills, experience, and knowledge to support patients and their families. Making sure a person is physically comfortable and free from pain is extremely important.

Patients who have advanced cancer and who are expected to live less than six months may

want to consider a type of palliative care called hospice care. Hospice care is designed to provide the best possible quality of life for people who are near the end of life. You and your family are encouraged to think about where you would be most comfortable: at home, in the hospital, or in a hospice environment. Nursing care and special equipment can make staying at home a workable alternative for many families. Learn more about [advanced cancer care planning](#) [26].

After the death of a loved one, many people need support to help them cope with the loss. Learn more about [grief and loss](#) [27].

The [next section in this guide is About Clinical Trials](#) [3], and it offers more information about research studies that are focused on finding better ways to care for people with cancer. Or, use the menu on the side of your screen to choose another section to continue reading this guide.

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