

Melanoma - Treatment Options [1]

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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 [Clinical Trials](#) [3] and [Latest Research](#) [4] sections.

Treatment overview

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, this team may include a dermatologist, a doctor who specializes in diseases and conditions of the skin; a surgical oncologist, a doctor who specializes in treating cancer with surgery; a medical oncologist, a doctor who specializes in treating cancer with medication; a radiation oncologist, a doctor who specializes in giving radiation therapy to treat cancer; and a pathologist. See the [Diagnosis](#) [6] section for more information.

Treatment recommendations depend on many considerations 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](#) [7]. 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](#) [8].

Surgery

Surgery is the removal of the tumor and surrounding 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. In some patients 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 patient's individual risk of recurrence.

Types of surgery for local and regional melanoma are:

Wide excision. The primary treatment for melanoma is excision (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 thin (less than 1.0 mm), 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, to ensure 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 both close the wound and reduce scarring.

Lymphatic mapping and sentinel lymph node biopsy. This surgical procedure helps determine whether the melanoma has spread to regional lymph nodes. It is generally used for patients with melanomas that are more than 1.0 mm thick or have ulceration; however, it 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 indications the melanoma is more aggressive, such as ulceration or higher mitotic rate (see the [Diagnosis](#) [6] 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.

During the procedure, the doctor removes one or a few sentinel lymph nodes to check for melanoma cancer cells. A sentinel lymph node is the first node into which the lymphatic system drains from the primary melanoma site. If melanoma cancer cells are not detected in the sentinel lymph node, no further lymph node surgery is required. However, if the sentinel lymph node does

contain melanoma, the disease has spread to regional lymph nodes, and lymph node dissection (see below) is typically recommended. In general, the risk of spread to areas of the body beyond the regional lymph nodes is greater for patients who have lymph nodes containing melanoma than when lymph nodes do not contain disease.

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 has spread to nearby lymph nodes, surgical removal of the remaining lymph nodes in that area is usually recommended. The number of lymph nodes removed depends on the area of the body. However, it is still unclear whether removing these additional lymph nodes improves the chance of long-term survival. The only randomized clinical trial that has looked into the value of this procedure for people with stage I or II melanoma found that people who had a complete lymph node dissection after a positive sentinel lymph node biopsy had the same overall survival as those who were closely observed after the biopsy. As a result, some patients 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].

Talk with your health care team about the possible side effect that may develop based on the specific type of surgery. Learn more about [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 fatigue and skin irritation or infections. These usually get better a few weeks after adjuvant radiation therapy is finished. However, topical corticosteroid creams and antibiotics may also be used to treat and prevent radiation-induced skin reactions. Depending on the area of the body being treated with radiation therapy, other side effects may occur. For example, after treatment of the head and/or neck area, temporary irritation of the mouth or difficulty swallowing could 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 [radiation therapy](#) [11].

Adjuvant therapy (stage II and stage III)

After surgery, the surgeon or medical oncologist may also recommend adjuvant therapy for patients who are at higher risk for recurrence of melanoma. Adjuvant therapy is treatment given after the initial treatment to reduce the risk of melanoma recurrence. People who might consider adjuvant therapy are those whose melanomas are more than 4.0 mm thick (stage IIB or IIC) or have spread to regional lymph nodes (stage III). Adjuvant treatment options may include immunotherapy, radiation therapy, participation in a clinical trial (see [Latest Research](#) [4] section), or observation/active surveillance, which includes regular check-ups with your doctor.

On the other hand, if the melanoma is thinner and no lymph nodes are involved, your doctor may not recommend adjuvant therapy.

Adjuvant radiation therapy

Sometimes, radiation therapy is considered after surgery to prevent recurrence. A recent randomized trial showed that, although this can slightly decrease the risk of the melanoma coming back after treatment at or near the same place, it does not increase the amount of time a person lives. Patients who received adjuvant radiation therapy experienced side effects; however, their overall quality of life was the same as patients who did not receive it.

Adjuvant immunotherapy

Immunotherapy, also called biologic therapy, 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 [immunotherapy](#) [12].

Interferon. 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 in some patients; however, it has not been shown to increase overall survival. 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. High dose interferon is not used everywhere in the United States.

Vaccines. Vaccines that may improve the specific immune response to melanoma have been the focus of multiple clinical trials and are currently being explored as adjuvant therapy for melanoma. See the [Latest Research](#) [4] section for additional details. However, to date, vaccines must still be considered experimental as none have shown clinical benefit in patients. Learn more about [cancer vaccines](#) [13].

New drug treatments

With a number of new drugs available for stage IV melanoma and stage III melanoma that cannot be removed with surgery, there are many clinical trials underway looking at using targeted therapies and other immunotherapies after surgery. These include ipilimumab (Yervoy) and inhibitors of the mutated BRAF protein. See [Stage IV: Immunotherapy](#) (below) and the [Latest Research](#) [4] section for more information about these treatment options.

Systemic treatment options for stage IV melanoma

If melanoma has spread through the bloodstream, it is considered stage IV or metastatic melanoma. The most common sites of distant spread include the lung, liver, and brain. Patients 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 seeking a [second opinion](#) [14] before starting treatment, so you are comfortable with the treatment plan chosen. This discussion usually includes [clinical trials](#) [3], which are the preferred option for certain patients with stage IV melanoma.

Treatment recommendations for patients with stage IV melanoma depends on multiple factors, including the patient'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. Treatment options include immunotherapy, targeted therapy, chemotherapy, biochemotherapy (the combination of immunotherapy with chemotherapy), radiation therapy, surgery for isolated and/or limited metastases, and participation in a clinical trial. For patients with brain metastases, surgery or radiation therapy (see below) may be considered based upon symptoms, number and size of lesions, and location of metastases in the brain. Supportive care will also be important to help relieve symptoms and side effects.

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.

Common treatment options for stage IV melanoma are described below. Some of these treatments are currently available only through clinical trials.

Stage IV: Immunotherapy

As explained above, immunotherapy is aimed at boosting 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 antibodies. Ipilimumab is a monoclonal antibody 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 cytotoxic T-lymphocyte associated molecule-4 (CTLA-4) and 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 chemotherapy. 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 normal cells in their body. These side effects can be serious, even life-threatening. Such side effects can include significant colon inflammation (colitis), liver problems, skin reactions, nerve and hormone gland inflammation, and eye

problems. Due to these potentially significant side effects, the drug's manufacturer has created an [FDA-approved wallet card for patients \(PDF\)](#) [15] being given this therapy to carry with them for emergency reference. 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-CTLA-4 antibodies continue to be evaluated in clinical trials. See the [Latest Research](#) [4] section for more information.

PD-1/PDL-1 pathway inhibitors. Drugs that block interactions between a protein called PD-1 (programmed death-1) on T-cells and PD-L1 on tumor cells have shown promise in clinical trials. 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, and keeps the immune system from destroying the cancer. Because these drugs stop PD-1 from working, the immune system is able to better fight against the cancer.

In September 2014, the FDA approved pembrolizumab (Keytruda) as a treatment for patients with unresectable or metastatic melanoma whose disease has progressed after ipilimumab and a BRAF inhibitor (if the tumor was BRAF V600 mutation positive). Research of PD-1 and PD-L1 inhibitors alone and in combination continues, especially for patients with later-stage melanoma, and other anti-PD-1 antibodies are expected to be approved by the FDA in the near future.

Interleukin-2 (IL-2, aldesleukin, Proleukin). This is a drug that activates T-cells and is sometimes given to patients with this stage of melanoma. The current FDA-approved IL-2 regimen consists of two five-day courses of IL-2, separated by a rest period of seven to 10 days. Typically, two or three courses are given when the melanoma responds well to treatment. 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 in response to treatment.

The most common side effects 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.

Combination therapies. Doctors are also looking into combining immunotherapy and chemotherapy as a way to treat metastatic melanoma. This approach is called biochemotherapy. However, there are many side effects, and evidence has not yet shown survival benefit over standard treatment. Another approach is to combine immunotherapy with targeted therapy (see below).

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.

As explained above and in the [Diagnosis \[6\]](#) section, ongoing research has identified several key pathways and genes involved in melanoma. These advances now allow doctors to begin to classify melanoma into specific subtypes based upon the melanoma's genetic abnormalities or mutations. As a result, a patient's treatment plan can be tailored or personalized based upon each subtype of melanoma.

A major research focus is the development of new drugs that target specific molecular pathways and genes that are abnormal or activated in melanoma. Currently there are two specific types of targeted therapy for melanoma:

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 by patients with melanoma whose tumors have a V600E or V600K mutation in the *BRAF* gene (see the [Diagnosis \[6\]](#) section). These drugs should not be used by patients without the mutation as it can actually be harmful for them.

In randomized clinical trials for patients with metastatic melanoma whose tumors had the mutated *BRAF* gene, both drugs resulted in tumor shrinkage in the majority of those patients [17]. 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, thick or dry skin, sun sensitivity, and a less aggressive form of skin cancer called [squamous cell carcinoma \[18\]](#) 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 and almost never causes sun sensitivity.

MEK inhibitors. In May 2013, the FDA approved trametinib (Mekinist) for patients with 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 III C or IV melanoma who took this targeted therapy lived longer without the cancer getting worse than those who received chemotherapy. However, trametinib is rarely used alone for the treatment of BRAF-mutated melanoma. The side effects of trametinib include an acne-like rash, nail inflammation, dry skin, diarrhea, and lymphedema.

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. However, a more recent phase III study showed the combination provided only a minor benefit in overall survival. The most common side effects of this combination therapy 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. Because of the side effects and cost, the dabrafenib + trametinib combination is not universally accepted. More research into combining BRAF and MEK inhibitors is ongoing.

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).

Other targeted therapies. There are many targeted therapies being researched in clinical trials for melanoma, both alone and in combination. See the [Latest Research \[4\]](#) section for more information.

Learn more about [targeted therapy \[19\]](#).

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, 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.

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 and infections. See the Adjuvant radiation therapy section above and talk with your radiation oncologist for more information.

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

Stage IV: Surgery

If the melanoma has spread to a single or a few distant organs (stage IV) or has come back after treatment, the surgical removal of cancer that has spread to an internal organ may help control the disease.

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.

Systemic chemotherapy is delivered through the bloodstream to reach cancer cells throughout the body. Common ways to give chemotherapy include an intravenous (IV) tube placed into a vein using a needle or in 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. Other chemotherapies used to treat melanoma include carmustine (BiCNU), 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, also may be given to patients with stage IV melanoma. Combinations of new drugs that may reduce melanoma's resistance to chemotherapy are being researched in clinical trials.

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 [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].

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 can help a person at any stage of illness. 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, and other therapies. You may also receive palliative treatments similar to those meant to eliminate the cancer, such as chemotherapy, surgery, and 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 supportive 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 is 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 "no evidence of disease" or NED.

A remission can be temporary or permanent. This uncertainty leads to many survivors feeling worried or anxious 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 the 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 again to learn as much as possible about the recurrence, including whether the cancer's stage has changed. After testing is done, you and your doctor will talk about your treatment options. Often the treatment plan will include the therapies 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.

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 treatment is not successful, the disease may be called advanced or terminal cancer.

This diagnosis is stressful, and this 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 helps explain clinical trials, which are research studies. Use the menu on the side of your screen to select About Clinical Trials, or you can select another section, to continue reading this guide.

Links:

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- [2] <http://www.cancer.net/about-us>
- [3] <http://www.cancer.net/node/19260>
- [4] <http://www.cancer.net/node/19263>
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