Survivorship – Uveal Melanoma after Enucleation

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ELIGIBILITY

Ocular cancer ≥ 2-3 years post-enucleation and stable[1]

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

Every 5-6 months for the first 1-2 years, **then** every 9-12 months for 10-15 years **or** consider transition to local primary care provider (PCP):

- Ocular history and physical exam
- Orbital imaging for high-risk histopathological features (microscopic extra ocular extension noted on pathology)
  - MRI orbits with and without contrast every 6 months for the first year and then annually
- Systemic imaging surveillance with Melanoma Medical Oncology
  - CT chest, abdomen, pelvis with and without contrast every 3-12 months for 10-15 years or as determined by Melanoma Medical Oncology

Suspected new primary or recurrent disease?

- Yes → Return to primary treating physician
  - **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[2]
- No → Continue survivorship monitoring

MONITORING FOR LONGTERM EFFECTS

Assess eye socket for:

- Contracture
- Ptosis
- Facial cosmesis (facial asymmetry)
- Giant papillary conjunctivitis
- Infection[3]
- Implant exposure
- Lower lid laxity (ectropion)
- Prosthesis functionality
- Supportive care for socket flare-ups (*e.g.,* discharge, redness, tenderness)
- Assess socket for signs of recurrent mass (inability to maintain prosthesis)
- Visit with Ocularist annually as clinically indicated
- Monocular precautions (*i.e.,* functional vision in one eye only):
  - Emphasize the importance of taking all necessary precautions and safety measures to avoid placing the remaining eye at risk for injury or damage
    - Recommend the patient to wear an impact resistant eyeglass frame (Z-frame) with polycarbonate (shatterproof) lens material. It should be worn full-time or as often as possible, regardless of refractive status and especially in situations that place the eye or head at risk for injury.
    - Patients will have reduced ability to accurately judge distances and depths. Extra precaution should be taken during daily activities (*e.g.,* driving, navigating unfamiliar environments, stairwells, etc.)

→ Refer or consult as indicated

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

CHRONIC HEALTH MAINTENANCE

→ See Page 2

DISPOSITION

[1] Stable visual activity in contralateral eye, no eye socket issues and no active disease

[2] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only)

[3] Periorbital/orbital cellulitis, bright red blood from socket

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ELIGIBILITY

Ocular cancer ≥ 2-3 years post-enucleation and stable[1]
(continued from previous page)

CONCURRENT COMPONENTS OF VISIT

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[2]
- Palpate thyroid for thyroid cancer assessment
- Flu/COVID-19 testing as needed when symptomatic
- Loss of appetite or unexplained weight loss
- Cancer screening[3]
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
- Consider cardiovascular screening (see Survivorship - Adult Cardiovascular Screening algorithm)
- Vaccinations[4] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)
  - Shingles vaccination after age 50 years old

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Anxiety/depression
- Financial stressors
- Social support/withdrawal
- Psychological well-being
- Access to local general ophthalmic care
- Driving and occupational health information for monocular patients
- Facial disfigurement

CHRONIC HEALTH MAINTENANCE

- Confirm primary care provider (PCP) or recommend establishing care with a local PCP
- PCP responsible for assessment and management of non-cancer chronic health conditions (hyperlipidemia, diabetes, hypertension, *etc.*) or refer as indicated
- Refraction eye exam annually

DISPOSITION

Refer or consult as indicated

TSH = thyroid-stimulating hormone

[1] Stable visual activity in contralateral eye, no eye socket issues and no active disease
[2] See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation Treatment algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[3] Includes breast, colorectal, liver, lung, pancreatic, and skin cancer screening
[4] Based on American Society of Clinical Oncology (ASCO) guidelines and Centers for Disease Control and Prevention (CDC) guidelines

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UT MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

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DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Ocular Oncology Survivorship workgroup at The University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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