

Melanoma Excision Margins — Quick Reference

For daily practice.

To see more comprehensive documents on this topic please follow this link [“Clinical and Histological Margins in Melanoma” and its “Evidence Supplement”](#)

Radial (Clinical) Margins

Lesion	Radial margin
Initial diagnostic biopsy	2 mm
Melanoma in situ (MIS)	5–10 mm (see criteria below)
Invasive, Breslow $\leq$ 1.0 mm	10 mm
Invasive, Breslow 1.1–2.0 mm	10–20 mm
Invasive, Breslow $>$ 2.0 mm	20 mm (evidence limited beyond 10 mm)

Note: where the prescribed margin risks significant functional or cosmetic harm, consider border mapping, sequential excisions, or referral for Mohs surgery — to remove no more tissue than needed for clear margins.

MIS Margin Selection — Which Width?

5 mm may suffice if all of the following	10 mm considered if any of the following	10–15 mm may be required if all of the following
• Well-circumscribed • $<$ 1 cm diameter • Non-CSD skin (trunk, proximal limbs) • No solar elastosis on biopsy (not LM)	• Ill-defined lesion • $>$ 1 cm diameter • Chronically sun-exposed (head/neck, distal limbs) • LM on biopsy • Acral site	• Very large lesion ($>$ 3 cm) • Chronically sun-exposed skin • Head and neck location

Deep Margin

- Excise down to, but not including, the deep fascia — unless the fascia is involved by tumour. Evidence: two retrospective studies found no outcome benefit from routinely excising the fascia, even in melanomas $>$ 1mm or $>$ 2mm thick.
- If the subcutis is unusually deep and fascia is hard to reach (e.g. obese abdomen): excising to a depth equal to the radial margin is acceptable, without continuing to fascia.

Lentigo Maligna (Head/Neck)

- Often needs $>$ 10 mm clinical margin to achieve adequate histological clearance.
- Mohs / slow Mohs preferred where available; otherwise serial excision or border mapping.
- Confirm histologic clearance before complex reconstruction.
- Nonsurgical options (imiquimod, radiotherapy) for frail patients or where excision is cosmetically/functionally unacceptable — no RCT evidence. Imiquimod: $\sim$ 76% histologic clearance; recurrence 0–21%.

Rare Subtypes

- Desmoplastic melanoma: wider margins recommended. Pure DM ($\geq$ 90%) — metastasis risk comparable to or lower than conventional melanoma; mixed DM — similar to or higher.
- Mucosal, Spitzoid, Volar: often more aggressive — consider SLNB and adjuvant therapy.

“Clear Histological Margin” — Reference Values

Lesion	Floor value	Basis
MIS	$>$ 3 mm	Moura 2020: 3% LR ($>$ 3mm) vs 13% LR ($\leq$ 3mm)
Invasive	$>$ 6 mm	Reverse-engineered floor: 10 mm minimum clinical margin $\times$ 40% shrinkage (deliberately conservative — measured shrinkage in melanoma-specific studies is typically 12-15%)