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Медицинские новости Грузии

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Abstract.

Dilemmas in the diagnosis and treatment of cutaneous melanoma, concerning the prognosis of patients, are far from finding an adequate or optimal solution at the moment.

The issues are multifaceted and encompass a number of key points such as: 1) the choice of resection field, 2) the choice between a one-stage and a two-stage model of surgical removal of the tumor lesion, 3) the removal (or not) of the so-called sentinel lymph node, 4) the time intervals between the two surgical sessions, 5) the need or not for reciprocity between the clinically measured and the histologically established postoperatively resection field, and a number of others.

The likelihood that the key to successful treatment/no recurrence of cutaneous melanoma lies in one or more of the above points is high.

We present and analyze two patients with histopathologically established intermediate-thickness cutaneous melanomas, treated: 1) one of them: with a two-stage approach according to the generally accepted AJCC/EJC recommendations, and the other with 2) a single-stage procedure/ one step melanoma surgery (OSMS) with a resection margin of surgical security of 2 cm and no detection/removal of the so-called draining lymph node (at his request). The first patient developed progression and lethality within 2 years, and the second patient remained progression-free 6 years later. Conclusions based on these observations, although speculative, could be as follows: Strict adherence to the guidelines does not insure patients against progression and lethality (patient 1), but an individualized/personalised/modified approach, as well as deviations from the official recommendations of the generally accepted guidelines (AJCC/EJC) - could ensure (sometimes) the absence of such progression (patient 2).

In practice, the reason for the successful treatment of cutaneous melanomas and the lack of progression, could also be due to (or associated with) the differences in the therapeutic approaches applied by clinicians. These could be seen as a good starting point for deeper analysis.

The reason for the lack of progression could probably be sought in the fusion of the surgical sessions or in the application of the one step melanoma surgery (OSMS). In practice, the total resection field in one-stage and two-stage melanoma surgery is the same, but in the one-step melanoma surgery (OSMS) approach it is achieved within only one surgical session. This fusion of surgical sessions provides a number of advantages for patients that are currently not well studied from a scientific/prognostic point of view.

Another key, even strange point, is the non-performance of a sentinel/draining lymph node. According to common beliefs, detection and removal of the draining lymph node is advisable, but it has more diagnostic, clarifying rather than a therapeutic value. The lack of its localization and removal in the described patient could also be related/associated with the lack of progression (although unlikely): and this fact is evident not only in the data presented in this publication, but also in other cases described in the scientific literature. And would probably benefit from further careful analysis.

The lack of progression in intermediate-thickness melanomas in certain patients could be related to the following 2 interesting, concurrent, and currently unclear events: 1) the consolidation of the 2-in-1 surgical sessions (i.e., in the application of a one-step model of surgical behaviour / OSMS/ one step melanoma surgery), and 2) the failure (probably) to perform a sentinel lymph node detection and removal.

Whether this is a sporadic finding-or whether there is a definite correlation-would need to be verified by observing a larger number of patients at different clinical centers. The likelihood that other factors influence the presence or absence of this progression remains quite possible.

Key words. One step melanoma surgery, novel surgical margin, sentinel lymph node, innovations in melanoma surgery.

Introduction.

The extent of the resection margins in the surgical treatment of cutaneous melanoma (the distance of the resection line from the tumor tissue) has been the subject of lively debate for decades, with the proposed approaches containing at times divergent, and sometimes (for a number of colleagues), possibly vague, insufficiently well-founded, or contradictory information [1]. Nevertheless, some of the guiding factors concerning the prognosis of affected patients remain 1) tumor thickness and 2) the location of the primary lesion itself and 3) the choice of the individual surgical approach/relevant resection surgical field [2-4].

We present two patients with intermediate-thickness cutaneous melanomas (between 1-4mm tumor thickness) who were operated on- one following the AJCC- EJC recommendations and the other: using a single-stage/modified surgical approach, comparing individual survival and the tendency to develop recurrence.

Case 1.

We report a 33-year-old female patient who visited the dermatology and venereology outpatient clinic for a new-onset pigmented lesion located dorsoventrally in the right thigh/ hamstring fossa area, approximately 3 cm from the flexion of the knee joint (Figure 1a). The age of the lesion was unclear according to history. There was no evidence of comorbidities, medication intake, or positive family history of skin cancer. There is also no information about painful sunburns in the past.

The dermatological examination revealed a lesion clinically and dermatoscopically suggestive of nodular melanoma (Figure 1a). Surgical removal of the lesion was undertaken with a...
surgical margin of safety of no more than 0.5 cm in all directions, and the resulting defect was closed using an expandable flap and single skin sutures (1a-d). The histopathological findings were suggestive of nodular melanoma with a tumour thickness of just under 2 mm, and there was no evidence of locoregional or distant recurrence/medium-thick cutaneous melanoma/within the screening performed. According to the AJCC/ EJC rules for two-stage treatment/ surgical removal of melanomas according to the AJCC/ EJC guidelines, the patient was referred for re-excision with a surgical margin of safety of 0.5 cm and parallel detection/removal of a draining lymph node to another specialized oncology unit. Reexcision of the primary cicatrix was performed with a corresponding additional resection field (Figures 1e,1f), as well as the simultaneous removal of a draining lymph node / sentinel lymph nodes in the right inguinal region / (Figure 1f). Histopathological verification was without evidence of tumor cells in the removed lymph nodes.

At follow-up, the patient developed locoregional and distal (central nervous system) metastases over a period of approximately 2.5 years, followed by a lethal outcome.

Case 2.

We report a 67-year-old patient who attended the outpatient clinic regarding an altered mole that had grown in size and started bleeding over the last 2 years. The date of presence of the mole was from childhood and the changes found secondary occurred last 2-3 years as per history. Data for several painful sunburns were available and dates back 40-45 years. No familial burden of skin cancer in the family. Clinical and dermatoscopic evidence of melanocytic lesion with an abnormal melanocytic network, relatively clearly demarcated from healthy tissue, was present, and a nodular, achromatic formation was found in the area around 14:00, which was bleeding at the time of examination (Figure 2a,2b). Due to suspicion of nodular melanoma based on a congenital melanocytic nevus, it was suggested that the lesion be surgically removed.

Surgical removal of the lesion was undertaken and the standard two-stage management approach for this type of manipulation was explained in the pre-operative discussion according to the international AJCC/EJC recommendations and national guidelines.

It was explained that during the second operation the anaesthesia would be general/intubation and the so-called draining lymph nodes would probably have to be removed. The patient categorically refused a second operation and, due to the fact that there were no lymph nodes currently involved, also refused their removal (sentinel lymph nodes), regardless of whether this would be carried out within the first or second surgical session. After lengthy discussions with the patient's relatives and general agreement, it was decided by consensus that the manipulation would be one and that it would meet (in terms of the size of the total resection field) either the 2 cm, AJCC/EJC recommendations, but without undergoing general anaesthesia. A one-stage surgical removal of the lesion/OSMS, which was suspicious for nodular cutaneous melanoma, developed on the basis of a medium-sized congenital melanocytic nevus with a resection field of 2 cm in all directions (Figures. 2c-f). The histopathological findings were comparable to those of the previous patient: medium-thickness nodular melanoma (Breslow 2.2 mm) based on a medium-sized congenital melanocytic nevus. Screening was without evidence of metastasis. The patient was referred to the regional oncology hospital for follow-up as 6 years after manipulation he was free of evidence of metastasis.

Discussion.

The standard or commonly used global guidelines for the surgical treatment of cutaneous melanoma according to the AJCC/EJC guidelines always suggest a two-stage model of clinical/surgical management [3,4], whereas modern, innovative guidelines suggest a one-stage model - OSMS/One step melanoma surgery [1,2,5].

The two-stage model of surgical management is always based on the tumor thickness found after the first surgical session (postoperatively) [3,4], whereas the personalized approach / OSMS, is based on the preoperative analysis of certain morphological characteristics such as: 1) clinical findings, 2) dermatoscopic findings and possibly 3) specialized specific instrumental findings-echographic/confocal microscopy or others [1,2,5].

The modern combined devices are currently able to determine preoperatively (non-invasively) on the one hand the tumor thickness of the lesion below 1 mm, and on the other hand the morphology of the lesion itself, its dignity [6].

This undoubtedly supports the thesis that "a single operation is more favourable as a worldwide event", compared to multiple operations for which the patient "may not show up"?

So-called virtual biopsy is on its way to categorically and definitively turning two-stage melanoma treatment into a single-stage/one step treatment [7].
Detailed knowledge of the surgical guidelines/different options underlying the two types of guidelines for the surgical treatment of melanomas is an essential aid for clinicians and at the same time a guarantor in making the best possible decision (for the benefit of patients) [3,4].

The fact that the two types of guideline (standard/innovative) could be combined and benefit both patients and clinicians should not be overlooked. The prerequisites for this optimization to become a reality are 2: 1) the availability of trained staff (familiar with both types of guidelines), working with a specialized ultrasound head (to determine the tumor thickness preoperatively), and 2) a dermatologist/dermatologic surgeon and a surgeon in a team to perform the complex dermatosurgical manipulation.

The confrontation of the two types of guidelines is undesirable but seems inevitable and is already a reality. This reality is not in favor of the two-step model for the surgical treatment of melanomas, on the contrary. Unfortunately, progress and the benefits of innovation are not always perceived as "clean coin" and the time to rethink the therapeutic strategy lasts longer than expected.

It should be noted that in the different countries, the dermatosurgical societies have different recommendations regarding the width of surgical resection margins in patients with cutaneous melanoma, but in general the primary resection margin at the first surgical intervention does not exceed a distance of 0.5 cm from the tumor/melanoma tissue [1-4]. Proceeding from the fact that all final total or aggregate resection fields are strictly defined or the same (1 to 2 cm/with or without sentinel), then 1) achieving them within a single surgical session is more than desirable and 2) ensures the minimization to complete absence of a number of gaps. Gaps that would only and primarily be possible when applying/following the two-stage model for the surgical treatment of melanomas, such as: 1) lack of imaging regarding the primary resection field, 2) lack of imaging regarding the secondary resection field, 3) delay (as a time factor) for the second surgical intervention, 4) conducting an incomplete second intervention/variability of choice such as-no sentinel lymph node 5) failure of the patient to appear for the second surgical intervention, etc.

The merging of the two surgical sessions into one "destroys" in practice these 5 problems-categorically and definitively.

The French dermatosurgical school was one of the first to focus scientific attention on preoperative ultrasonographic measurement of tumor thickness to reduce the number of surgical sessions [5]. Moreover, their results are more than indicative [5]. This effectively opens the door to a much more liberating individual/personalised approach to the diagnosis and treatment of cutaneous melanomas: an approach that does not follow conventional guidelines and an approach that provides a number of advantages for patients [5]. One of the supposed advantages of this approach is the lack of progression, similar to the patient we presented.

The Bulgarian school of dermatologic surgery also remains "revolutionary on the subject" and is one of the pioneers worldwide in the application of single-stage personalized melanoma surgery/OSMS [1,2,9-11].

The presented cases (relatively equal in tumor thickness) are indicative of the following: 1) that following the current AJCC/EJC guidelines is no guarantee for avoiding short-term tumor progression followed by lethality. And this is not rare (case 1). As well as 2) that not following the guidelines could be a guarantee of success (case 2), especially if the surgical session is one and the patient has not undergone sentinel lymph node removal (recommended for patients with medium-thick melanomas or those with tumor thickness between 1 and 4 mm).

Interestingly, other cases from the world literature are indicative of the same: the absence of a sentinel lymph node removal within the second surgical session was subsequently accompanied by a very good 6-year survival rate in patients with thick and medium-thick melanomas, (with surgical treatment within 2 surgical sessions, for example) [9,10].

Starting from these cases, there is practically nothing to obstruct 1) the two sessions to be combined into one (as in the patient we described) and 2) the draining lymph node "relatively neglected"?

This is exactly what we observed in the second patient we presented: no progression/evolution of melanoma after combining the surgical sessions into one and not performing a sentinel lymph node (due to patient refusal). And we observed similar to what was shared in other patients-lack of progression.

Whether either of these two revolutionary proposals (deviations from standard guidelines) influenced prognosis (or lack of recurrence at all) is unclear, but not impossible to speculate because:
1) The therapeutic role of the so-called draining/sentinel lymph node in melanoma is, according to expert opinion, becoming increasingly irrelevant to absolutely negligible. At present, its conduct is more of a diagnostic nature (rare cases of therapeutic character where the melanoma cells have been removed within it) and is mainly related to staging and the choice/decision of subsequent adjuvant therapy.

2) The fusion of two sessions into one has been repeatedly described in the literature in thin melanomas, and its relevance and benefits are definite and without any doubt [1,2]. The performance of this type of surgery has also been described within the removal of thick melanomas (with simultaneous lymph node or sentinel lymph node removal) [12,13], and perhaps prognostic significance there is rather controversial and should not be sought due to the generally available unfavorable prognosis in those affected (because micrometastases probably already available).

It remains puzzling that although it has not even been introduced as an option in the official AJCC/EJC guidelines for surgical treatment of cutaneous melanoma (despite the advantages it provides), personalized one-stage melanoma surgery (OSMS) is a reality and is practiced daily all over the world [14].

Conclusions.

The two-stage model for the surgical treatment of melanomas should be debated and updated at least several times each year in order to more rapidly adopt innovations and provide the most adequate care to those affected. The lack of this "receptivity" creates serious prerequisites for the progression of the disease and the expenditure of considerable financial resources in attempts to control it.

It is the duty and responsibility of every health-conscious clinician to express his scientific, and hence social, position on the subjects to which he has devoted himself, because of the responsibility he assumed when he completed his medical education to follow the postulates of Hippocrates.

The lack of this very important position within the murderous haste of globalization, the loss of one's own scientific identity under the heavy mantle of conformity, the social depersonalization and consumerism of our surroundings (encompassing in their steely paws the scientific intellect and progress), precisely all of them as a sum of negatives, forcibly close our eyes to the path leading to objective truth and true medicine - evidence based medicine.

REFERENCES