

# GEORGIAN MEDICAL NEWS

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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии  
საქართველოს სამედიცინო სიახლენი

## GEORGIAN MEDICAL NEWS

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**GMN: Georgian Medical News** is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

**GMN: Медицинские новости Грузии** - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

**GMN: Georgian Medical News** – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

### WEBSITE

[www.geomednews.com](http://www.geomednews.com)

## К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman (Кириллица)**, для текста на грузинском языке следует использовать **AcadNusx**. Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - <http://www.spinesurgery.ru/files/publish.pdf> и [http://www.nlm.nih.gov/bsd/uniform\\_requirements.html](http://www.nlm.nih.gov/bsd/uniform_requirements.html) В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректур авторам не высылаются, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

**При нарушении указанных правил статьи не рассматриваются.**

## REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or computer-printed on a single side of standard typing paper, with the left margin of 3 centimeters width, and 1.5 spacing between the lines, typeface - **Times New Roman (Cyrillic)**, print size - 12 (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: [http://www.nlm.nih.gov/bsd/uniform\\_requirements.html](http://www.nlm.nih.gov/bsd/uniform_requirements.html)  
[http://www.icmje.org/urm\\_full.pdf](http://www.icmje.org/urm_full.pdf)

In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

**Articles that Fail to Meet the Aforementioned  
Requirements are not Assigned to be Reviewed.**

## ავტორთა საქურაღებოლ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დაიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx**. შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შედეგის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფხიხლებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

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## CONTROVERSIES AND PARADOXES IN MELANOMA SURGERY: CONSOLIDATING TWO SURGICAL SESSIONS INTO ONE AND SPARING THE SENTINEL LYMPH NODE- A POSSIBLE GUARANTEE OF RECURRENCE-FREE SURVIVAL

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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 /2 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 are available and dates back 40-45 years. No familial burden of skin cancer in the family. Clinical and dermatoscopic evidence of a 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



**Figure 1.** *1a:* Nodular melanoma suspected lesion in a young lady, *1b:* Surgical removal of the lesion under local anesthesia, *1c:* Postoperative clinical findings after defect closure, *1d:* One day after the first surgical session has been performed, *1e:* Reexcision of the primary lesion area within the second surgical session, *1f:* Sentinel lymph node removal within the second surgical session under general anesthesia.

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].



**Figure 2.** 2a: Patient with nevus associated melanoma on the back, 2b: Surgical margins preoperatively, 2c-e: Resection of the melanoma suspected lesion with a primary security surgical margin of 2 cm in all direction, 2f: Postoperative clinical findings after defect closure.

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 dermatological 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-stage 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 dermatological 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 dermatological 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/personalized 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 dermatological 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 critical thought of representatives of the Dermatological Society in Sofia, Bulgaria, the daily debates regarding the application of the personalized approach in certain patient groups, these are the reasons for the creation and refinement of one step melanoma surgery/OSMS [1-2,9-11]. Surgery following the path of common sense and medical thought. Similar thoughts regarding the one-stage surgical removal of melanomas are also shared by colleagues from the Spanish school of dermatological surgery [6].

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.

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