

Expert Calls for More Sentinel Node Biopsies

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PHOENIX, ARIZ. — Younger patients with even a thin melanoma may deserve a sentinel node biopsy because of a much higher likelihood of lymph node metastasis, regardless of any other histologic features, said Vernon K. Sondak, M.D., at the Second International Melanoma Research Congress.

Recent data suggest that a 35-year-old with a melanoma that is just 1 mm thick could have as high as a 20% chance of a positive node, said Dr. Sondak, a surgical oncologist at the H. Lee Moffitt Cancer Center and Research Institute, Tampa, Fla.

In a talk about sentinel node biopsy, Dr. Sondak defended the procedure as a useful clinical tool—despite disappointment that it does not make a bigger difference in survival—and said that its use probably needs to be expanded.

Currently, most major centers that treat melanoma use a cutoff of about 1-1.5 mm when deciding whether to have a patient

undergo sentinel node biopsy. Yet about three-fourths of melanomas diagnosed in this country are less than 1 mm in thickness and at the same time, the absolute number of deaths from thin melanomas is increasing progressively, and the procedure might be a way to make a difference, Dr. Sondak said.

But costs are an issue. It has been estimated that to perform a sentinel node biopsy on every case of melanoma would cost almost \$1 million for every patient with a positive node detected, he said.

Using Clark's level of invasion and/or the presence of ulceration as criteria to further winnow the pool of possible candidates for the procedure does not appear to work. Both ulceration and Clark's level predict outcome, but they do not predict positive nodes, Dr. Sondak said.

In previous investigations into predictive markers of risk, factors identified by some, but not all of the studies include younger age, a high mitotic rate, and the Breslow depth of invasion.

The first such study, from the John Wayne Cancer Institute in Santa Monica, Calif., reviewed 512 patients with melanomas less than 1.5 mm in thickness. The investigators reported that positive sentinel nodes were found in 7% of patients with a 1- to 1.5-mm melanoma, in 4% of patients with a 0.75- to 1-mm melanoma, and in 2% of patients with a melanoma thinner than 0.75 mm.

They also found that younger patients were more likely to have a positive node than were older patients.

Based on the results of that study, Dr. Sondak and his colleagues reviewed the records of 419 patients from a registry at

the University of Michigan. Their melanomas had a range of thicknesses, and there were similar percentages with positive nodes among the thin melanomas.

This study also found the same connection with age. The percentage of patients older than 60 years who had a positive sentinel node was 12%, and the percentage rose to 19% for those aged 35-60 years and to 26% for those younger than 35 years (Ann. Surg. Oncol. 2004;11:247-58).

The investigators also found that a high

mitotic rate—defined as at least 3 mitoses per square millimeter of the lesion—was associated with positive nodes, and was as predictive as the Breslow depth.

Another unpublished study appears to confirm the finding regarding mitotic rate. The study, reported by researchers at the University of Pennsylvania, specifically looked at patients with melanomas that were thin but had already entered a vertical growth phase. It included 167 consecutive patients who all had

melanomas of 1 mm or less in thickness.

In those patients, one or more positive nodes were found in 11% of the patients with a melanoma that had a high mitotic rate, but none was found in patients with a low mitotic rate, Dr. Sondak said. The study also found no cases of a positive node in patients older than 60 years.

Although the data about age and mitotic rate are preliminary, Dr. Sondak said he already uses the information in his discussions with patients. ■

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