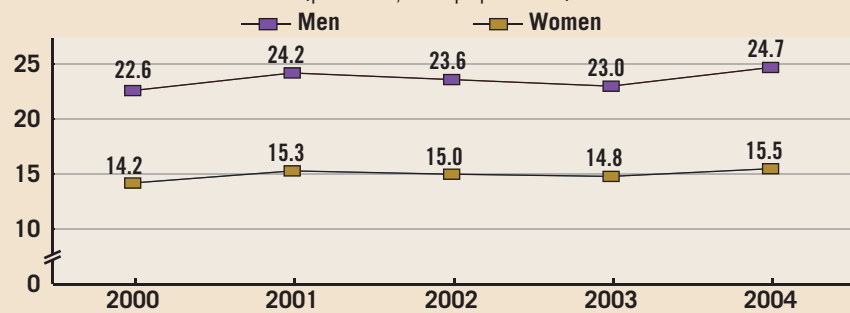


DATA WATCH

Incidence of Melanoma of the Skin

(per 100,000 population)



Source: Surveillance, Epidemiology, and End Results program

ELSEVIER GLOBAL MEDICAL NEWS

Wider Margins Needed for Melanoma In Situ Removal

BY JEFF EVANS
Senior Writer

NAPLES, FLA. — In situ melanomas that were incompletely and inadequately removed at the time of initial treatment recurred at the surgical margin with an invasive component nearly one-quarter of the time, according to a 25-year review of

surgery for such lesions presented at the annual meeting of the American College of Mohs Surgery.

The finding from the single-center study suggests that wider surgical margins are necessary to prevent recurrences, said Dr. James R. DeBloom II, who is in private practice in Greenville, S.C.

Of 202 marginally recurrent melanomas that Dr. DeBloom and his colleagues have seen since 1980, the lesions have appeared most commonly on the cheek (34%). Standard excision has been the most commonly failed initial treatment (48%).

A total of 84 these lesions were biopsy-proven melanoma in situ, and 19 of these (23%) revealed an invasive component at the time of the salvage surgery. Another 24 lesions were treated initially as biopsy-proven invasive melanoma. Of these, 15 (63%) recurred with a shallower Breslow depth or as melanoma in situ, 1 (4%) recurred at the exact same level of invasion, and 8 (33%) recurred at a greater Breslow depth than before.

The overall mean Breslow depth for these initially invasive melanomas increased from 1.53 mm to 2.8 mm at the time of recurrence, Dr. DeBloom reported.

These results show “that residual disease cannot only persist, but it can also invade and worsen the patient’s prognosis and should not be taken lightly,” he said.

Instead of using the confusing term locally recurrent melanoma, which has been given many different definitions, he and his colleagues prefer to use more specific terms—residual or marginally recurrent melanoma—to describe “a clinical reappearance of previously treated melanoma that is immediately adjacent to the scar of primary treatment,” he said.

Of all diagnosed melanomas, 17%-25% are on the head and neck. Melanomas on those locations have a marginal recurrence rate after excision of 9%-13%. “This tells us that our current treatment protocols for head and neck melanoma may be insufficient,” Dr. DeBloom said.

Marginal recurrences may develop because surgeons can “cheat on margins and make them small for cosmetic and functional reasons,” he said.

It also is hard to determine where the clinical margin is, especially on sun-damaged skin that may have many other pigmented lesions and a high frequency of amelanotic melanomas at the margin. Also, routine pathologic examination looks at less than 1% of the total margin, “so when we get a negative report we all feel good about that but it does not preclude a true positive margin,” Dr. DeBloom said.

He also said that the 1992 recommendation from the National Institutes of Health for 5-mm surgical margins is “not sufficient for melanoma in situ and [is] not evidence based.” That is why he and his associates recommend a wider margin of 1 cm for melanoma in situ on the head and neck. ■

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