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Letter to the Editor



Novel Surgical Approach in Cutaneous Melanoma Patients: "Daring Ideas Are Like Chessmen Moved Forward. They May Be Beaten, But they May Start a Winning Game!?"

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Abstract

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For the first time, but again, we propose the idea of a one-step melanoma surgery as a "golden, unified standard" that should be at least discussed and, possibly accepted shortly as the "gold standard" for the treatment of patients with skin melanomas. Critical points or comments have been made to the current melanoma's treatment approach, which has been "transcendently followed" for years and which, according to some colleagues, is not logically justified. This approach needs serious changes, the only goal of which is to achieve a better outlook for the patients.

Although the proposed by us approach is not even a possible option in the European and American recommendations for the treatment of melanoma, it finds widespread use (or acceptability) in clinical practice in the form of specific, individually informed consent. Guidelines are not mandatory, and standards are not always met. Whether "good medical practices" will prevail as a logic and stereotype of clinical behaviour, whether they will be finally recognised and whether they will find an extra international response is unclear at the moment. However, the fact that they are enforced with success, indirectly speaks that the "wave of change" is already rising and the hope is to "remove the debris" and illogically justified decisions often defined by the American dermatological school as "expert". The choice of right solutions lies in following the logic, as well as in its simplicity. Often these decisions are in front of our eyes, but we look at the distant horizons: "Do we want to be discoverers?" Without even trying to give a simple answer to the question: "Aren't the treasures very often in front of us?"

In our previous manuscripts, we have been able to categorically challenge or at least put under doubt the current approach of the surgical treatment of patients with melanoma [1]. We tried to make our colleagues, and the medical community looks critically at some or most of the recommendations (laid down in US and European standards) for a clinical approach in melanoma patients. At this point, the question remains whether these new (innovative) recommendations would find an international response and would lead to a complete or definitive change in "old or outdated" treatment of melanoma (as a whole) in various dermatological societies and organizations [2]. Nevertheless, it should be noted that single-step or single-stage melanoma surgery and our

methodologies are not just a myth, but a new innovative approach with some benefits for the patients [1, 2].

The disadvantages of the previous (or current guidelines for the treatment of melanoma in Europe and America) could be summarized in the following important points, discussed below. Namely, these points should be considered not only from a medical but also from a deep psychological point of view, to give a simple answer to the question: "Are the changes necessary?"

1) Adverse effects on the patients as a whole, because of the need of at least two surgical interventions. Last but not least, the role of

psychological stress that can be avoided. Stress is caused by situations we do not want to be confronted with. Hence the question: "Are these two surgical sessions needed in patients with definitely clinically and dermoscopically established" "skin and mucosal melanomas and where the tumour thickness is established preoperatively by ultrasonography?"

Confusion in patients is due to the onset of stress or discomfort from the repeated surgical intervention, as well as due to the risks it hides for the medical staff, regardless of the signed patient's informed consent.

We think that the second intervention is unneeded. This intervention subsequently turns out that is even not always possible. In fact, the cases when patients refuse re-excision and determination of a draining lymph node are quit frequently. Typically, regular ultrasound controls are usually employed for these patients' groups to eventually detecting of a pathological increase in lymph nodes. That is a kind of "bargaining" or compromise between the patient and the medical staff, which leads to an unusual form of consensus. But this consensus is, in fact, a kind of "time-bomb".

2.1) Unclear resection fields; 2.2) Frequent change in the lymph flow after the primary excision, and 2.3) Lack of communication and awareness among the medical colleagues and units.

These facts are mutually reinforcing in a diabolical circle, of which, of the present recommendations for the treatment of melanoma, there is no deviation. It could be defined as an infinitely closed spiral or a diabolical circle.

The lack of photo material in over 80% of the patients with primary excisions of melanomas is a real fact. The operational protocols do not always contain the exact reference to excision fields (national observations), which leads to difficulties for the colleagues, who meet the patient secondary (to define the fields of re-excisions, national level).

In cases of initially defined smaller fields of surgical security margins - the solution could be found. At the same time, however, it should be taken into account that the time intervals (re-excisions) that are set and recommended by the experts are not always respected. And when the surgical field is wider, the lymph flow is likely to be altered (we mean the primary excisions). This, in turn, makes the removal of the draining lymph node meaningless (in cases of the need of re-excision with the determination of a draining lymph node), due to already compromised lymph flow.

The loss of additional precious time is often due to (1) the poor knowledge of the colleague, performed the primary excision (ignorance of the exact field of surgical security margins at the initial

excision), and 2) the lack of collegiality and communication (sometimes) between colleagues themselves (not rarely). Also, it is desirable for the second operator to comment these facts (including errors) with the patient, and in approximately 50% of cases, the patients themselves become uncertain and refuse secondary intervention (national observations).

Additional time is lost due to seeking a third opinion and recommendations from other specialists (in case of patient's uncertainty for the statements of the first two, again national observations).

In cases where the primary surgical interventions are performed by plastic and maxillofacial surgeons, we often encounter the fact that the various performed flaps made by them, compromise the lymph flow. This is one of the main reasons for denying of the performance of sentinel lymph node biopsy and removal, within the second consultation of the patient with another specialist (national data and observations). The cause is the compromised lymph flow.

3) Frequent non-following of the recommended terms for re-excision with/or without sentinel lymph node, proposed by the guidelines. The reasons for this are given in section 2. Additional subjective factors depending on the patients themselves are often the reason why these deadlines and terms are not observed, "I'm going to the sea!", "I need a break!", "My phone is broken!", "My daughter will consult the documents with Israel, I will call you after that!", "I have a lot of work to do in the company!", "I did not realise that everything is so serious?", "Do you think there are such risks?", "I'm in love now!", "We'll wait till my son's prom; I can not think of such things now, you remove the mole, anyway?"

4.1) The creation of additional financial difficulties (for medical staff and patients), in the framework of the two hospitalisations. In a number of countries, after primary surgery and diagnosis of melanoma with a tumor thickness of over 1 mm, for example, on-surgical units (when patient presents for the secondary intervention), the specialists refuse to perform secondary excision and the draining lymph node without: 1) extra payment with subsequent refer to the primary unit, where the first intervention was performed (national experience). But the primary units are not always able to provide this manipulation, and the deadlines for who and where to perform this additional service are frequently expired (national experience).

Or 4.2) The oncology unit requires an official check of the histological slice, leading to conflicts between the three participants and delaying additional the performance of a secondary excision with the draining lymph node (national experience). At a later stage, it would be explained to the patient that this is already meaningless.

Namely, these key points are the base of the new approach in melanoma patients. The introduction of a mandatory high-frequency ultrasonography followed by a single surgical intervention would help the optimization of the clinical management of melanoma patients.

Considering that guidelines are recommended, but not mandatory for following, we would suggest that this approach should be considered as a "gold medical standard" which should be obligatory and unified for every country in the world. In summarised conclusion - decisions are in front of us! As long as we want to realize them and to take the right path! Let's try at least!

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