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Editorial

Innovations and Innovative Approaches or Pseudo-Innovations in the Context of General Globalization? It's Time to Wake Up!

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Abstract

Globalisation, scientific and technical progress are the basis of numerous innovative therapies for oncologic and non-oncologic diseases. It is another matter how much and by whom they are desired, and whether they have to be applied. When and how often? Innovative approaches should go towards simplification, universal distribution and application while at the same time analysis between the potential initial investment and the achieved final result should be made. An illustrative example for this is the targeted therapy for melanoma with its low baseline criteria or basic rules for its surgical treatment. Another example could be the confocal microscopy in the context of dysplastic nevus syndrome. Therapies for various autoimmune diseases should also be considered critically. In the current OAMJMS issue, as well as in some of our other ideas and statements reported also in OAMJMS, we are trying to answer at least to a part of these dilemmas, to provoke a critical point of view and to ask some simple questions: “Should any innovation be considered as a face value? Which is potentially beneficial for our patients? How could we regulate the processes to minimise the need for expensive medications for certain diseases? And, of course, we are also turning to our own mistakes by visualising the results of them!

The essential questions in the context of progress and evolution in medicine and evolution, in general, affect some common human wisdom that is often ignored. We desire to be always first, move forward, and meanwhile be rich, desirable, glorified and famous … these two mutually exclusive directions or states of mind, I do not know, ... maybe ... maybe they are the reason to repeat our mistakes and not to learn from history as a whole? Perhaps the conditions for achieving one or another of the goals above are mutually exclusive, which gives rise to our subsequent absurd and sometimes inconsistent with the common-sense decisions? We are not able to think humanely, universally, reasonably and/or wisely, and meanwhile not prejudicing the interests of the status quo or someone? And if you harm those – you will be imposed “an embargo” by all possible means. The least of all is the financial one. Even a public reprimand, and ... a universal denial is possible! And here we come to the choice ... making the right decisions: black or white? Our decisions are followed by absurd consequences, or the lack of explicitness or the presence of a half-way policy in our decisions is followed by absurdities. Grey colour is undesired; it is for the politicians. In general, positioning is important. It results in a failure or rise. But not in “flickering”.

Or maybe these statements or rhetorical questions are wrong? And we should be chameleons? And surely there are such? At least I do not know any chameleons in medicine. Do you? Absurdities are a common human impediment caused by mercenary motives, by difficult to achieve, mutually exclusive desires inconsistent with healthy logic, and why not partly due to pure egoism?

Take melanoma and the new 2017

classification, for example? Think about the lack of an adequate response to questions related to therapeutic recommendations in any individual melanoma patient? All the way, up to the lack of personalisation of medicine in the early stages of the disease. What is this, ... you will ask? We will discuss it a bit later! Or ignoring important articles from magazines with a high impact factor? With very high impact factor! And with the highest impact factor! Is this not a serious problem – medical, human, health-related, personal? Magazines looking for results from multicentre double-blind, and I would specify – sometimes "totally blind" studies, although based on originally mistaken baselines? And how could this be admitted? Self-criticism is inherent to highly intelligent individuals only, and these are not always represented in high-quality, high impact magazines. I would ask, are there any editors in those magazines who have not seen "living patients"? At the meetings of the magazine boards, they usually announce that they will release 2-3 articles, just like that? A pure desire! Because their fingers "itch" to do so! So, how shall we then solve the problems related to innovative therapeutic approaches and classifications? By turning for advice to whom? Why can an editor of such a magazine publish 160 articles, say in NEJM, or 500 articles in Lancet, and cannot give a good answer to the question, "Why are you rejecting my article"? Or the answer is, "... because we have some other good articles and there is no room for you, unfortunately, but ... try somewhere else!" Or try again later! In other words, the spots are reserved for others? Unfortunately, I did not know that bookings were to be made early!? And do we have to leave a deposit, hahaha? By bank transfer or endowment? Next time I will ask this question ... I will do, for sure! When should I post an article that is better than 1,000 other articles … which is the right moment and are there any vacant spots … or maybe articles are less frequently released in general? Another interesting question would be, "When will logic triumph over lobbyism and selfishness? Is Christmas time convenient for you?" And when will you consider not only studies sponsored by the pharmaceutical industry, but also the "cast-iron arguments" of sound logic? These sometimes weigh more than sponsorship and fake magnanimity!

Why are certain general human and medical or humanity issues being rudely ignored? Why are two surgical interventions necessary in certain patients, where just one is sufficient [1] [2]? Why the high-frequency ultrasound approach is not introduced as a diagnostic option at least in some melanoma patients [1][2][3]? Why don't we define the fields of surgical safety more clearly [1]? Is it necessary to treat melanomas of different tumour thickness equally and those of the same tumour thickness – differently? Who could ensure the freedom to choose a resection field, or in other words, its variability? All these questions have no definitive answer and are left without any possible discussion or optimisation, which is, in fact, a simple and not impossible approach. If we look a little deeper and a bit earlier into the "shared problems", perhaps we would also conclude that such "severe neoplasm" therapy is not so difficult? That the clarification of the "starting points" or the so-called "baseline criteria" ... might contribute to the lack of necessary progress about the millions of funds invested in a targeted therapy at a later stage? Funds that could be spent somewhere else? The more we ask these questions, the more we should think about whether these criteria are real, workable, applicable and enforceable? And who created them? Why do they remain unchanged for such a long time despite the misconceptions they contain? And above all, who has an interest in this? And for how long? Because, maybe ... "TIME IS MONEY", ... someone said! And someone else ... that "medicine is business"!

Recently, we had patients with melanoma of more than 16 and 8 mm who were successfully treated just surgically? Without any dissemination data. Until eight years ago, chemotherapy or polychemotherapy was the standard of care in these patient groups? And all of a sudden it was sunk to the bottom? Targeting, or OMICS appeared? What would we say now if someone suggested dacarbazine, for example, in metastatic melanoma? Or prophylactically maybe?

There is light in the tunnel, definitely, but the adaptation of tumour cell is amazing. Melanoma depends on multiple factors, and OMICS therapy (following a genetic typing test) is not available to all or at least to the majority of mortal individuals! Apparently, apart from "Europe at two speeds", there is also a "different speed" medicine!

And what shall we say about confocal microscopy? Patients with dysplastic nevi? And patients with identical clinical, dermatoscopic and histopathological signs of two or more lesions? Protect them from progression? And/or from excisions? It was found that borderline, dysplastic and/or normal melanocytic lesions in a patient (whether with dysplastic nevi syndrome or not) ... could show a different gene pool (based on OMICS analysis or another type of testing) and a different progression trend within an indefinite period, wasn't it? Well then? Who needed such innovation? I see that even the world's dermatoscopy guru-Prof. Giuseppe Argenziano has been a bit sceptical over the years about dermatoscopy and confocal microscopy ... but my observation is indirect, tacit (personal observations)? Or maybe his age has told its heavy word and suppressed his emotionality? And then, the next step is reconciliation? Who knows? Or is my interpretation wrong? Or, rather, his scepticism about explicit statements on final diagnosis results from his long experience and the lack of definitiveness or reduced degree of definitiveness (of methodologies) about the final diagnosis!? Then his response to the lectures would be, "Then cut it! That's simple!" And I agree with him, but I would like to add that here we

come to the following problem, “We have to know exactly when to cut it and how to cut it! And that’s not very simple. It’s complicated, very ... complicated.” It’s a bit easier through the dermatoscope and in front of the screen! Problems will start only afterwards. “What problems?”, You will ask.

Figure 1: Patient with advanced basal cell carcinoma of the forehead, treated inadequately or initially semi-invasive. Gradual progression of the disease and involvement of the eyelid. Started therapy with Vismodegib presents half-way success

And here, right here, during the categorisation of treatment groups of melanoma patients, while choosing an approach, we start “limping”, not “stumbling”, but literally “limping”, and limping seriously! What field should we use to make the “cut”? Simply put but well thought out! Shall we use a high-frequency ultrasound testing, try one-step melanoma surgery, explain this individual approach to the patient, determine his/her mental condition and possible reactions. Or should we proceed with excision and possible re-excision, i.e. follow the guidelines? Are the clinically determined limitations consistent with the histological ones? Why the guidelines recommend no re-excision if there is a discrepancy of shared limitations? Should I divert from the guidelines and ask for an individual consent from the patient? How shall I make sure that I am on the right track? Scars, lesion localisation, side effects, type of anaesthesia? Why no re-excisions are recommended at least in patients with nodular and superficial melanomas and established differences (different clinical and histological limitations following the resection) … by the international guidelines? Isn’t the histologically proven field of safety more important than the clinical one!? This has not been commented so far!???? We could define it as an individual approach and personalised therapy. Personalization that is 100 times more important than personalised, targeted therapy in advanced stage patients (Figs 1-4). As early personalisation may determine the risk of progression, and late one 1) is much more expensive, and 2) constitutes a constant daily struggle. Late personalisation results in progression (Figs. 1-4). It is like chasing the wind. Then, each patient should set their personalised therapy priorities. Or, if I may repeat myself, “We don’t have money, so we have to start to think!”

So, if Prof. Giuseppe Argenziano would excuse me for that statement, but I will explicitly state: 1) “The task of the dermatologic surgeon, the thinking dermatologic surgeon, the trying to think and thinking at least from time to time ... the dermatologic surgeon is much more responsible than the dermatologist's or confocalist’s task!”

It is one thing to watch the screen and say what should be done, and another … as they say … is simply, “Just do it!”

Figure 2: Patient with locoregional metastatic squamous cell carcinoma on the temple region. Massive locoregional metastatic process with facial paresis. Treated with cryotherapy with no histological verification of a tumour performed before it

Some time ago, as a child ... I enjoyed watching Kung Fu movies and was excited to the highest degree ... I often tried to imitate those characters, but in the course of time I found out it was not quite simple, as it required serious preparation (physical and mental). Moreover, despite the effort, implementation of practised movements is not always successful in practice. But: Just cut it ..., I still think it's a good expression! A pretty good expression. And I stopped watching movies! Or I do it less and less frequently!

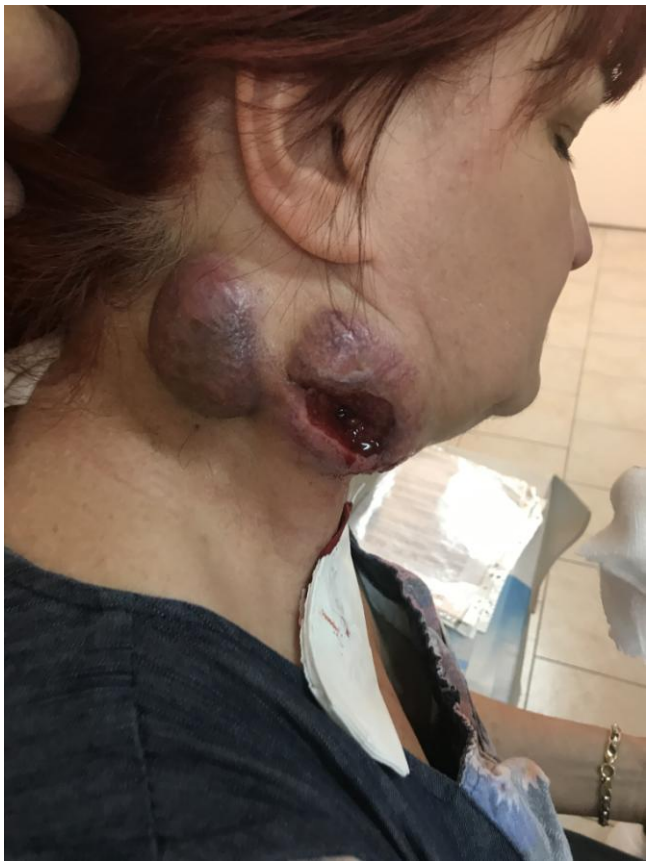

Figure 3: Patient with massively evolved local metastatic process within a histologically proven ameloblastic carcinoma. Surgical intervention is planned for removing the giant metastases, parotid gland and sublingual gland. Afterwards, postoperative radiotherapy will be conducted

Dear colleagues and friends from brotherly Macedonia, I hope that this new edition of the dermatological book within the high-quality OAMJMS of our highly valued and internationally recognized friend, scientist and colleague Prof. Mirko Spiroski, will give valuable highlights to all of us on how we should or should not proceed in certain situations! What are the new trends in vitiligo treatment, how to deal with rare clinical cases to achieving maximum safety of our patients? What should we expect from inadequate treatment of skin cancers and are our mistakes rectifiable? Is traditional medicine the most reliable one? Shall we observe the guidelines, and when this is not desired or at least "inhuman"? The thing is that before being therapists, we are still and ... I would say, though rarely ... or less and less frequently, also people! The problems we face as clinicians and dermatosurgeons surpass by several levels of complexity those of the initial conservative judgment and treatment recommendations in melanoma patients. More importantly, personalised medicine should be launched and is launched exactly at that stage and not at the terminal stage. Personalization should not be a mere equivalent of cash flows and targeted treatment, as well as of shamelessly expensive OMICS analyses?! Personalization is free of charge! Or at least should be! Personalization is our time, enthusiasm, satisfaction to win, our medical mind, medical thought, medical approach. Personalization is our human duty!

For estimation is determined by the radical nature of the approach and the clear rules – two things that are currently missing in the melanoma treatment, for example, worldwide. Now and until now. Let's hope this will change in the future, but the desire to change the status quo is one thing, and real actions – something else. Upgrading of a system that has been somewhat built as a "sand tower", is unthinkable for some... colleagues ... and lobbies in medicine – at least for now. Then, the forecast should also remain relatively the same. As well as our expectations. Plus, the applause at congresses and cocktails for how great we are!

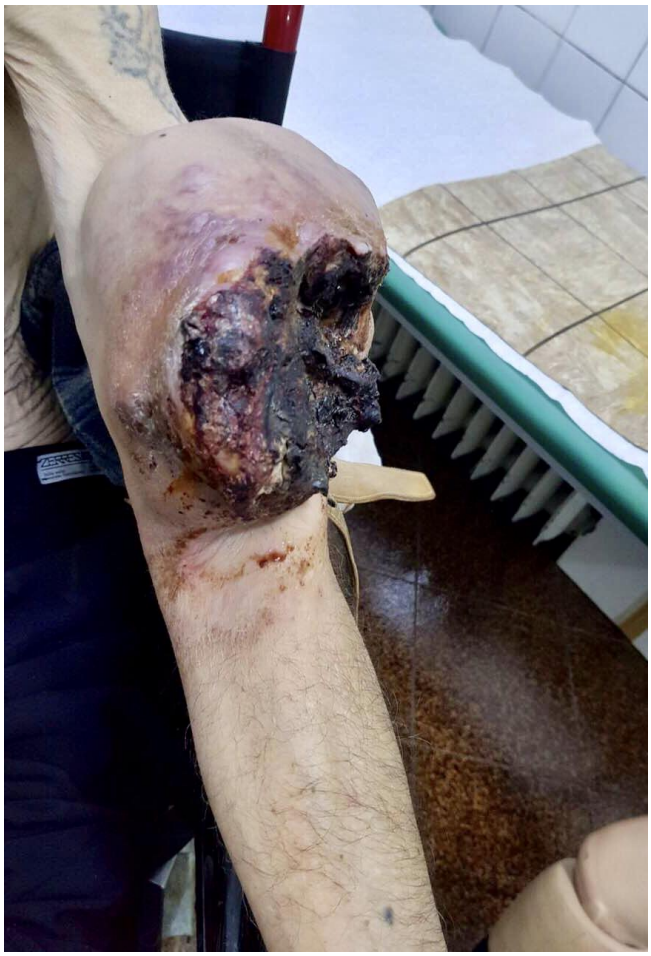

Figure 4: Giant tumour of the skin with bone tissue involvement in an elderly patient with poor social status. Subsequently, an amputation of the hand was performed

Of course, we should not be absolute pessimists. Criticism is necessary to realise at times or be aware of what we are forced to do or have done so far. And for what reasons. It is not easy to get to that point! Some people live all their lives without realising what they are doing and why they do it? Even to their last breath, it remains a dilemma for them. Was it right? I don't know?

I began realising what I was doing just after 17 years of work experience. More or less. And I am pleased to have a vision and a quest for something I want to change. The system put pressure on me; I followed the rules created by others until ... I had a little spare time to do some thinking. Even of my inadequate actions, which were not to be neglected after all? And I discovered my and our omissions ... as I had no choice, let alone a lobby! And money too! Then I could only be "logically aggressive". That was the only thing I was left! I had no choice!? The logically determined verbal aggression (as some say) based on "cast iron facts", expressed as tragic-comedy scenario (such as this editorial, for example) is maybe our only chance to impose innovative, different, unconventional opinion, to impose a change, generate positive energy to make our colleagues leave their comfort zone and bring one or another action or undertaking to a successful end. Because success is discomfort. And this is certain. Stick to early personalisation (Figs 1-4).

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