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Cutaneous Melanoma and Sentinel Lymph Node Biopsy

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To the Editors:

As authors of a similar article,[1] we read with great interest the report by Koskivuo et al.,[2] in the December issue of the Annals of Surgical Oncology. We enthusiastically support the basic rationale for this paper and the two researched patient groups, which have been correctly balanced for most of the important prognostic factors, such as Breslow thickness, ulceration status, and tumor site. However, some other methodological and other points may not have been entirely correctly addressed.

In the previous study from our center,[1] we compared two patient groups that consisted of node-positive patients. One group underwent wide local excision (WLE) and developed a regional lymph node metastasis for which we performed a therapeutic lymph node dissection (TLND). The other group had a positive sentinel node (SN) and underwent a completion lymph node dissection (CLND). Recently we have updated our follow-up information; the median follow-up time is now 5 8 months for the TLND group and 5 1 months for the SN + CLND group. When survival rates were calculated from the diagnosis date of the primary tumor, there seemed to be a trend towards a 14% survival benefit for the CLND group ($P = 0.065$). However, when patients with minimal SN tumor burden (according to the Rotterdam criteria < 0.1 mm in maximum diameter[3,4]) were excluded, because their prognosis is identical to SN-negative patients, this survival benefit disappeared ($P = 0.333$). Treatment (WLE followed by TLND versus SN followed by CLND) was not an independent prognostic factor for survival.[1]

The initial paper from our institute[1] was already scrutinized for its lack of follow-up balance between the two groups (the WLE-only group versus the SN-staged group), which is now 58 (+2) versus 51 (+14) months. The present study[2] has an even greater misbalance in follow-up: a median of 7 4 months for the WLE versus 16 for SN group. It stands to reason to expect that the SN group will develop more recurrences and deaths.

Even though the WLE group has a significantly longer follow-up, there seems to be a critical misbalance in *nodal* disease between the two groups. There were 72 *nodal* recurrences in the WLE group (11.7%) versus 50 positive SNs (16.4%). This is even without the *nodal* relapses ($n = 5$; 1.6%) in the SN group.[2] This suggests that not all positive sentinel nodes will develop into palpable nodal disease.

The authors state that improved regional disease control is an obvious therapeutic advantage of SN staging and immediate CLND. This statement can only be made in the context of a comparison of nodal recurrence rates after SN + CLND versus those after TLND. This comparison has not been made in the present study. Instead the authors compare the 1.6% nodal recurrences after SN + CLND with the 11.7% of patients that undergo a TLND after WLE only. This is obviously an incorrect comparison since the lymph node dissection in one group has already been performed and therefore this comparison does not make sense.

Another important observation in light of another recent publication from Sheri et al.[5] in the October edition of this same journal, but also in light of a

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study from our institute, is the rate and survival of patients in the Starz I tumor burden (<0.3 mm) category.[6] The rate of Starz I patients was 9/49 (18%), which is virtually identical to the results from our institute.[3], [4] More importantly was the observation of a 100% overall survival rate from this group, which is again a confirmation of the excellent survival of patients with minimal SN tumor burden from other series and recently from a multicenter experience presented at ECCO 14 in Barcelona in September 2007.[3]

Finally, we agree with the authors with regard to the fact that SN staging is necessary to provide the optimal treatment to melanoma patients. In the absence of effective chemo- or immunotherapy, such treatments need to be identified by the conduct of randomized controlled trials for which SN status is a crucial stratification. SN staging will have increasing competition however from ultrasound-guided fine-needle aspiration cytology (FNAC), which may be able to replace the current SN staging in most patients based on a trial in 400 patients as reported in the Presidential Session of the last ECCO meeting.[7]

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