

Surgical Management of Melanoma

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KEYWORDS

- Melanoma • Surgery • Sentinel node biopsy • Lymphadenectomy
- Metastasectomy

KEY POINTS

- Management of the primary melanoma: wide excision is well established for the management of primary melanoma of any stage and thickness, using guidelines based on numerous randomized clinical trials.
- Management of clinically negative regional nodes: sentinel node biopsy reliably identifies occult nodal metastases and provides important prognostic information that is unavailable through any other modality. Available data indicate that it should be routinely used in otherwise healthy patients with clinically node-negative melanomas greater than or equal to 0.76 mm in thickness.
- Management of node-positive melanoma: optimum strategies for managing node-positive melanoma are being developed, and should be individualized based on the tumor burden within the node. Although radical lymphadenectomy should be the mainstay of treatment of any patient with macroscopic nodal disease, some patients with small-volume microscopic disease in the sentinel node(s) do well without completion lymphadenectomy. The role of postlymphadenectomy radiation in patients with macroscopic nodal involvement, particularly when multiple nodes are involved and/or extranodal extension is present, remains controversial but randomized trial data provide strong evidence that radiation can decrease regional recurrence inside the treatment field.
- Management of oligometastatic melanoma: resection of limited stage IV melanoma is associated with long-term survival in a small but significant percentage of cases. As systemic therapy options improve, increasing use of preoperative therapy to improve resectability rates should be considered. Surgery also plays an important role in controlling individual lesions that have failed to respond to, or that have escaped from, treatment while other tumors in the same patient have responded or even disappeared.

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INTRODUCTION

The medical management of metastatic cutaneous melanoma has changed greatly over the past several years, spurred on by progress in the understanding of the molecular biology of melanoma and of the human antitumor immune response. These scientific advances led to the development of new drugs, which proved their value in large clinical trials. In comparison, little has changed in the surgical management of localized and metastatic melanoma in the past decade, but the fundamental principles on which that surgical management is based were also established in large clinical trials and have withstood the test of time. Even with the introduction of more effective drugs for the treatment of metastatic melanoma, surgery remains the mainstay of treatment of every patient in whom complete excision of all disease is feasible, even those with regionally advanced or oligometastatic disease. In view of the rapid advances of the past few years, treatment decisions regarding the surgical and medical management of melanoma should ideally be made by a multidisciplinary team of specialists working together. For optimum results, it behooves each member of that team to understand the fundamental principles and key supporting clinical data underlying the various available management options. This article summarizes the fundamental principles and key supporting clinical data underlying the modern surgical approach to treating cutaneous melanoma of all stages. Although many of the principles described also apply to treatment of melanoma arising on mucosal surfaces, a detailed discussion of the treatment of those forms of melanoma is beyond the scope of this article.

SURGICAL TREATMENT OF LOCALIZED DISEASE

Surgical Treatment of Primary Melanoma

Radical wide excision (often referred to as wide local excision, a term with no intrinsic meaning because there is no such thing as a nonlocal excision) is the standard-of-care treatment of all forms of localized, biopsy-proven primary cutaneous melanoma (stages 0–III), including cases in which there is clinical evidence of regional nodal metastasis. There are 2 fundamental aspects to the radical wide excision procedure: wide excision refers to the planned removal of a predefined and measured amount of normal-appearing skin beyond the visible edge of any residual pigmentation, lesional tissue, or biopsy scar. This wide excision contrasts with the narrow excision used to biopsy suspect pigmented skin lesions, wherein the lesion is removed with only a millimeter or two (nonmeasured) of adjacent normal skin to provide the pathologist with the opportunity to examine the entirety of the clinical lesion. Radical excision indicates that the removal of normal tissue extends down to the level of the underlying muscular fascia, in contrast with the more limited amount of subcutaneous tissue that is normally excised in treatment of a typical nonmelanoma skin cancer–like basal or squamous cell carcinoma. It has never been shown that removing the muscular fascia is necessary for the success of the procedure,^{1,2} and practice patterns differ in whether to always, never, or selectively remove the underlying fascia.³

The width of excision for an invasive primary melanoma is based on data derived from a series of randomized controlled trials,⁴ and the recommended width of excision increases for thick primary tumors within the limits of anatomic constraints.⁵ **Table 1** summarizes the recommendations for invasive cutaneous melanoma by thickness and tumor location used by most surgical oncologists, and in keeping with the current National Comprehensive Cancer Network guidelines. Although these guidelines are based on data from randomized trials, there are still unanswered

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