Head and Neck Melanoma

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KEYWORDS

• Head and neck melanoma (HNM) • Parotidectomy • Sentinel lymph node
• Treatment of primary lesion • Treatment of draining lymph node

KEY POINTS

- Wide local excision is the mainstay in the treatment of the primary lesion with consideration given to specific anatomic constraints in head and neck melanoma (HNM).
- Sentinel lymph node biopsy (SLNB) is considered in all lesions with ulceration, mitoses greater than or equal to 1/mm^2, stage1B or higher, and in all high-risk nonmetastatic melanoma.
- Lymphatic drainage patterns in the head and neck can be atypical and may involve the parotid gland.
- Higher rate of locoregional recurrence has been reported in SLN-negative patients in HNM compared with cutaneous melanoma elsewhere.
- Location of primary, SLNB status, node-positive disease, and the drainage pattern determines the extent of neck dissection and parotidectomy.
- Reconstructive strategy must be considered in multidisciplinary teams with reconstructive surgeons for large head and neck defects.

INTRODUCTION

Epidemiology

It is estimated that melanoma of the head and neck comprises 6% to 25% of all cutaneous melanomas.[1–3] Head and neck melanoma (HNM) is uncommon in patients under 30 years of age and is usually seen in adults older than 70 years.[4] Men are at higher risk of developing HNM than women,[5–7] and the incidence of melanoma of the face and neck is two times greater in men than in women, although the differences

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are smaller in younger age groups.[8] Sixty to 90% of HNMs occur on the face,[3,9] with the scalp, neck, and ears less commonly involved (Fig. 1).[10–14] The higher incidence of HNM in relation to total body surface area may be explained by the fact that the head and neck area is more affected by increased exposure to ultraviolet radiation and the higher density of melanocytes in the head and neck.[3,15]

Risk factors for HNM include the following:

- Continuous (occupational) sun exposure
- Higher levels of occupational sun exposure, whereas extremity melanoma was associated with a higher total sun exposure[16,17]
- Lighter skin[17,18]
- Increased number of sunburns
- Nevus count, although a positive association between nevus counts to HNM is weaker than that between nevus counts and trunk or extremity melanoma[17]

CLINICAL PRESENTATION

History

As with cutaneous melanoma at any site on the body, early detection and diagnosis of HNM are vital for effective and timely therapeutic intervention. Approximately half of the time, melanoma is self-discovered, with 26% discovered by medical providers and the rest by family members or others.[19] The most common presenting symptom is color change or growth of a preexisting lesion.[20] Other presenting symptoms include itching, bleeding, ulceration, and pain, or paresthesias that would be a manifestation of late symptoms, occurring in thick melanomas.[20] Patients should be asked about risk factors including sun exposure, history of sunburns, and especially family history, because up to 10% of melanoma cases report a first-degree or second-degree relative with melanoma.[21]

Physical Examination

A meticulous and complete skin examination along with examination of typical and atypical lymphatic drainage basins should be performed, noting the number, type, and characteristics of moles or nevi. The American Cancer Society recommended ABCDEs (asymmetry, border, color, diameter, evolving) provide a simple guideline

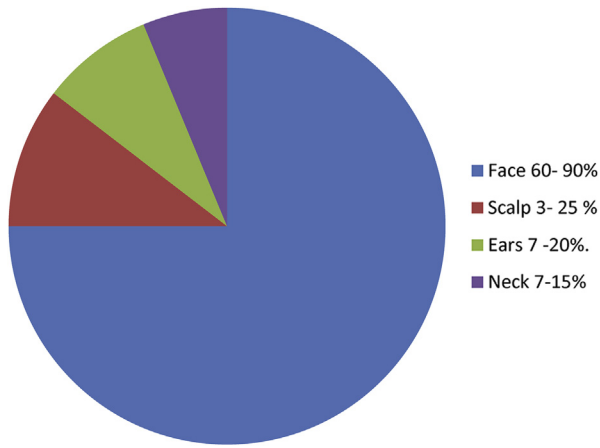

Fig. 1. Distribution of HNMs. (*Data from* Refs.[10–14])