Ann Surg Oncol (2017) 24:S660
https://doi.org/10.1245/s10434-017-6170-2

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

LETTER – MELANOMAS

Reply to comment on: Detailed Pathological Examination of Completion Node Dissection Specimens and Outcome in Melanoma Patients with Minimal (< 0.1 mm) Sentinel Lymph Node Metastases

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TO THE EDITORS:

We thank Madu and colleagues for their interest in our article on the incidence of non-sentinel lymph node involvement in melanoma patients with minimal tumor burden in sentinel nodes.[1] There are a number of issues raised in their letter that we consider deserve further comment. Madu et al.'s statement that benefit from completion node dissection is negligible because only 0.29% of the lymph nodes were tumor-positive is misleading because it does not touch the heart of the matter, which is that additional metastatic nodal disease was found in one of our twenty patients i.e. 5%! They quote a large study in which patients with a minimal sentinel node metastasis did not undergo a node dissection but were observed for 5 years.[2] In fact, the 5% of patients who developed nodal recurrence during follow up in that study concurs with our finding. So, there is agreement on the 5% risk of additional nodal involvement in melanoma patients with minimal tumor burden in their positive sentinel node.

The difference of opinion centers on how patients with minimal sentinel node tumor burden should be managed until further evidence becomes available from MSLT II. Madu's statement that ultrasound with fine needle aspiration cytology is a viable alternative to completion node dissection is not substantiated by sound scientific evidence. Although we agree that this approach deserves to be explored, the 95.3% false negative rate of ultrasound preceding sentinel node biopsy at Madu et al.'s institution does not bode well.[3] The survival benefit that the sentinel node procedure was shown to generate in node-positive patients occurred after completion node dissection. Hence, we maintain that the latter procedure currently remains the safest option for sentinel node positive melanoma patients.[4]

REFERENCES

1. Holtkamp LH, Wang S, Wilmott JS, Madore J, Vilain R, Thompson JF, et al. Detailed pathological examination of completion node dissection specimens and outcome in melanoma patients with minimal (< 0.1 mm) sentinel lymph node metastases. Ann Surg Oncol. 2015;22:2972–7.
2. Van Akkooi ACJ, Van der Ploeg IM, Voit CA, Hoekstra HJ, Schäfer-Hesterberg G, Nowecki ZI, et al. Long-term follow-up of patients with minimal sentinel node tumor burden (< 0.1 mm) according to Rotterdam criteria: A study of the EORTC Melanoma Group. J Clin Oncol. 2009;27(15s):abstr 9005.
3. Van Rijk MC, Teertstra HJ, Peterse JL, Nieweg OE, Valdés Olmos RA, Hoefnagel CA, et al. Ultrasonography and fine-needle aspiration cytology in the preoperative evaluation of melanoma patients eligible for sentinel node biopsy. Ann Surg Oncol. 2006;13:1511–6.
4. Morton DL, Thompson JF, Cochran AJ, Mozzillo N, Nieweg OE, Roses DF, et al. Final trial report of sentinel-node biopsy versus nodal observation in melanoma. N Engl J Med. 2014;370:599–609.

First Received: 17 October 2017;
Published Online: 27 October 2017

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