You Are Going to Cut How Much Skin? – Locoregional Surgical Treatment

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Presenter Disclosure

- **Faculty/Speaker: Justin Rivard**

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  - **Other:** None

Mitigating Potential Bias

- Not Applicable

Learning Objectives

- Describe how to take an appropriate biopsy
- List the extent of local surgery including margins for a wide local excision
- Discuss the indications for a sentinel lymph node biopsy
- Describe what to look for on the locoregional exam during follow up visits

Biopsy

- Principles of biopsy
  - Narrow excision
    - Partial incisional biopsy occasionally acceptable
      - Large, face, palm, sole, ear, subungle, digit
  - Full thickness
    - Avoid superficial shave biopsies
  - Be mindful of plane of excision to facilitate wider excision if melanoma confirmed
    - Longitudinal on extremities

Biopsy

- Detailed clinical information should be included on the pathology report
  - Anatomical location
  - Incisional vs. excisional
  - Size of the lesion

Margins

- Wide Local Excision
  - Width of excision depends on
    - Melanoma thickness
    - Surgical site

Tumour Thickness	Excision Margin
In situ	0.5cm
≤ 1mm	1cm
1-2mm	1-2cm
2-4mm	2cm
>4mm	? 2cm

  - Generally excise down to underlying fascia

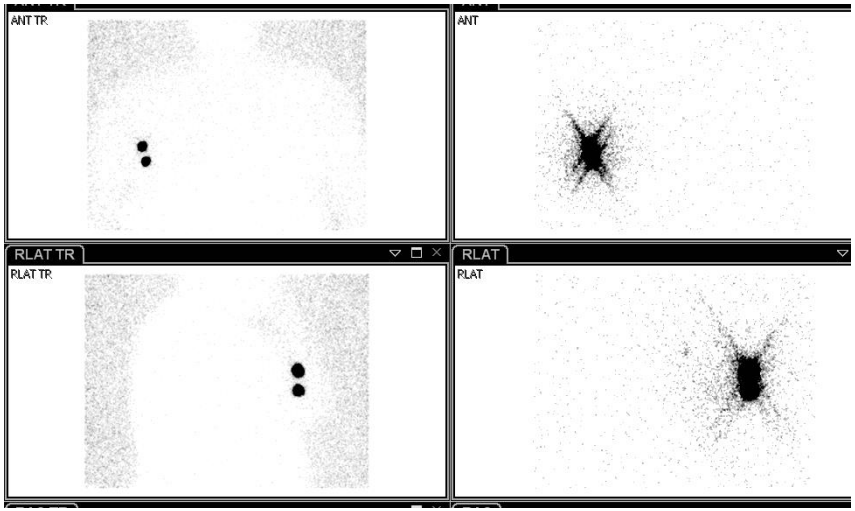
Margins

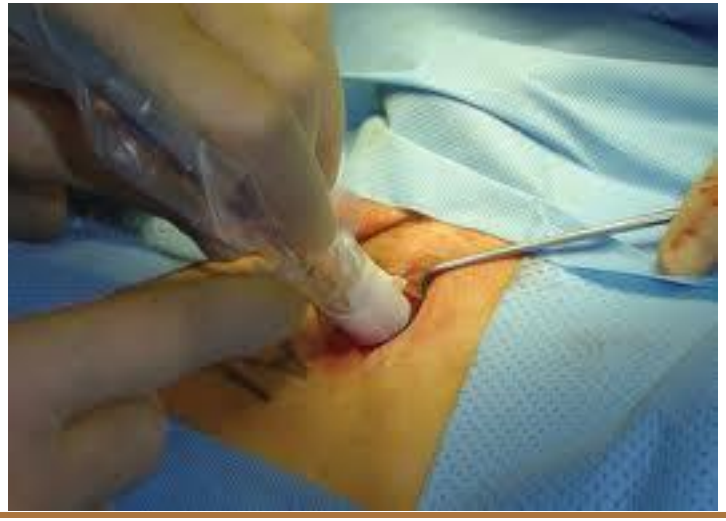
- SPECIAL SITES
- SPECIFIC COSMETIC & SURGICAL CONSIDERATIONS
  - FACE
  - EAR
  - FINGERS & TOES
  - SOLE OF THE FOOT

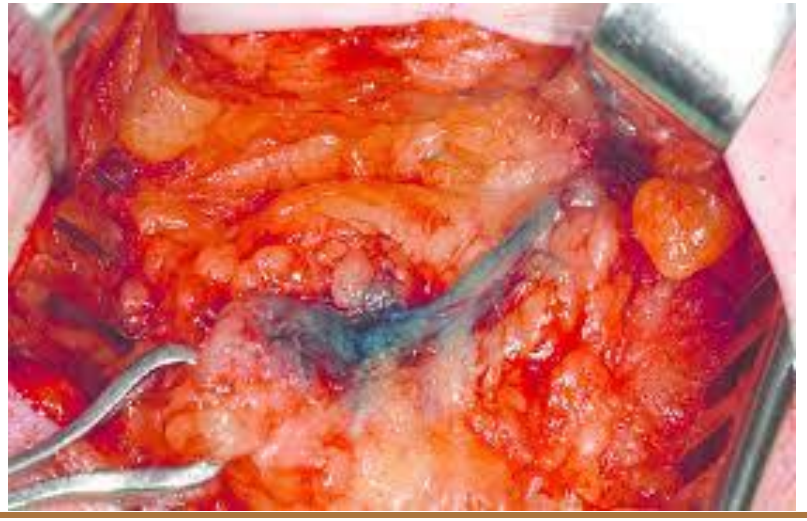
Sentinel Lymph Node Biopsy

- 1st LN in the draining basin that directly receives lymph from a solid tumour
  - Absence of metastatic disease in this LN should exclude cancer in the rest of the basin
  - Malignant cells become trapped in the subcapsular plexus of the LN
- Minimally invasive assessment of nodal status
  - Selection of patients for lymphadenectomy
  - Prevent morbidity of elective LN dissection
  - Improved sensitivity of histopathologic detection of LN mets

Sentinel Lymph Node Biopsy







Sentinel Lymph Node Biopsy

- Age and comorbidities play a factor
- T1b – T3
  - >0.8mm is T1b with AJCC 8th
- Select T4 (>4mm)

Sentinel Lymph Node Biopsy

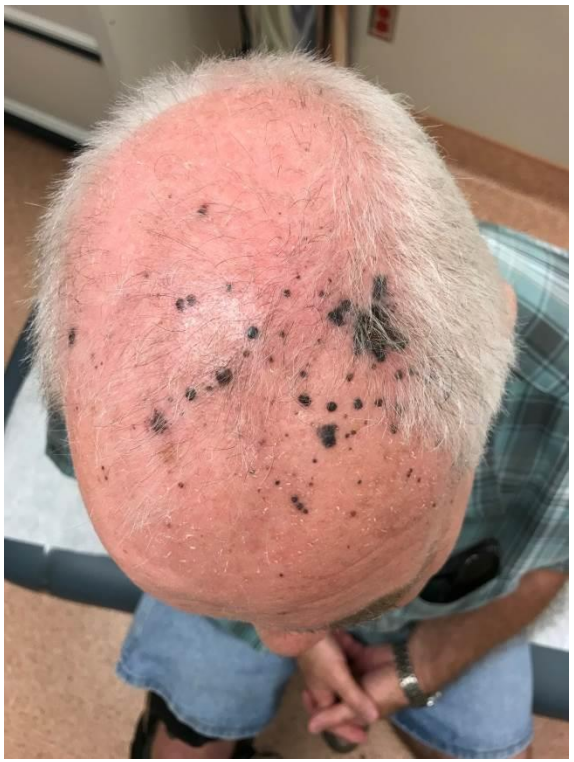
- Multicenter Selective Lymphadenectomy Trial (MSLT-I)
  - 20% better melanoma-specific survival in those managed with SLNB vs. observation
    - 62% vs. 42%
    - Not seen with thick melanoma

Sentinel Lymph Node Biopsy

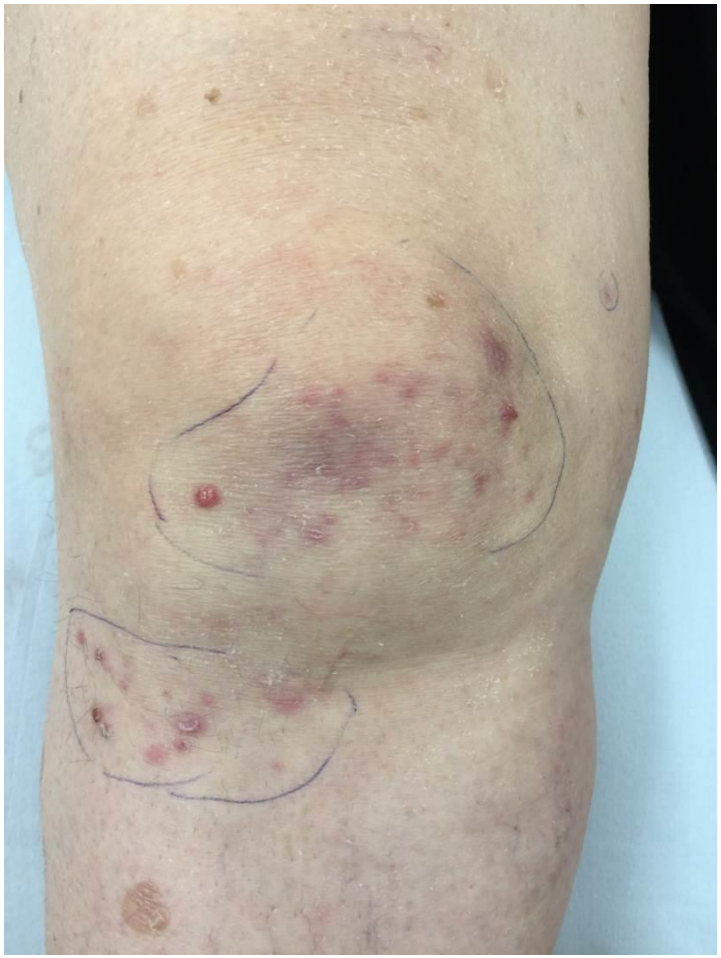
- Multicenter Selective Lymphadenectomy Trial (MSLT-II)
  - After +ve SLNB
    - CLND vs. observation (incl. US of nodal basin)
  - No difference in melanoma-specific survival
  - Improved DFS in CLND
    - 68% vs. 63%
  - Higher lymphedema in CLND
    - 24% vs. 6%

Follow up

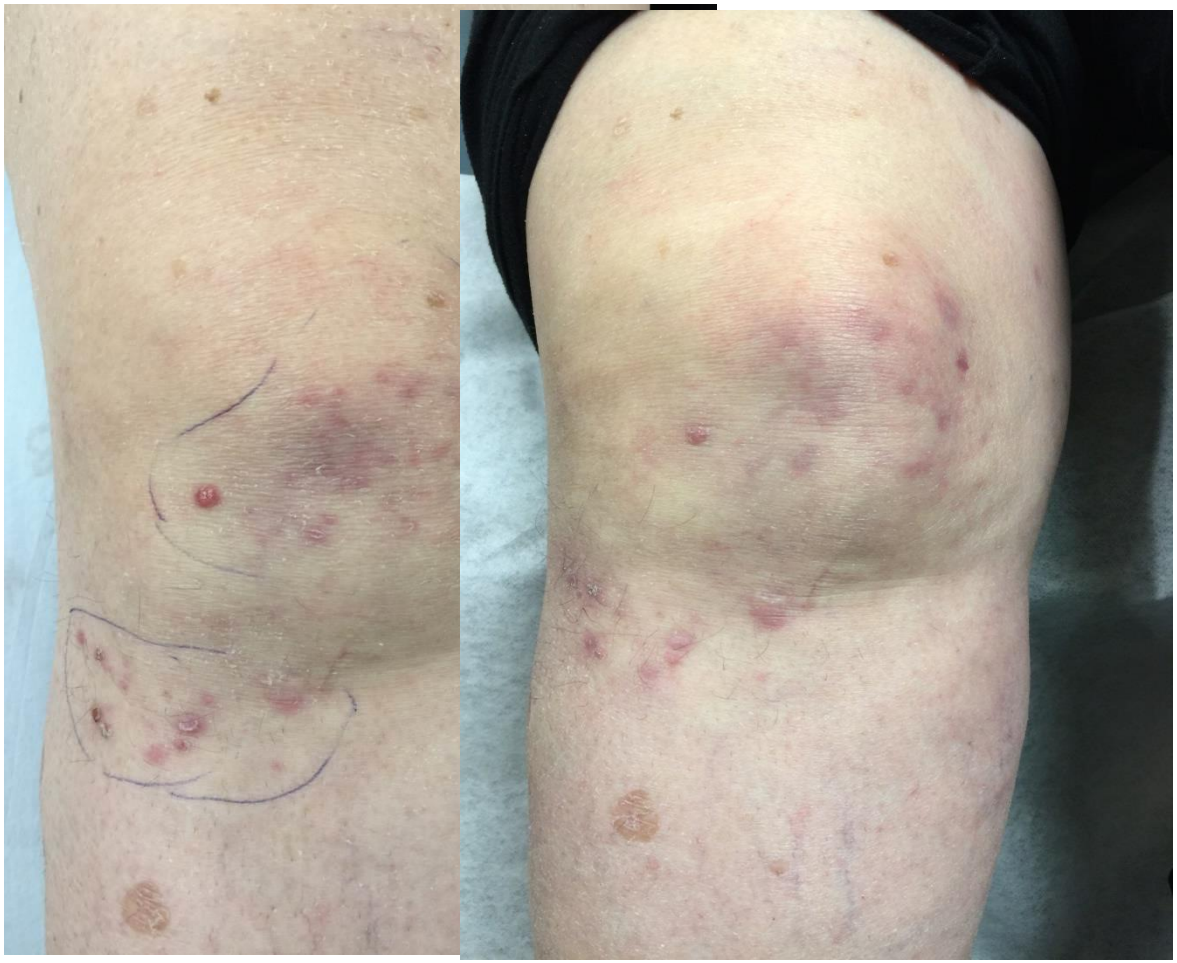
- Particular attention to the scar and surrounding area
  - New pigmentation
  - New nodules



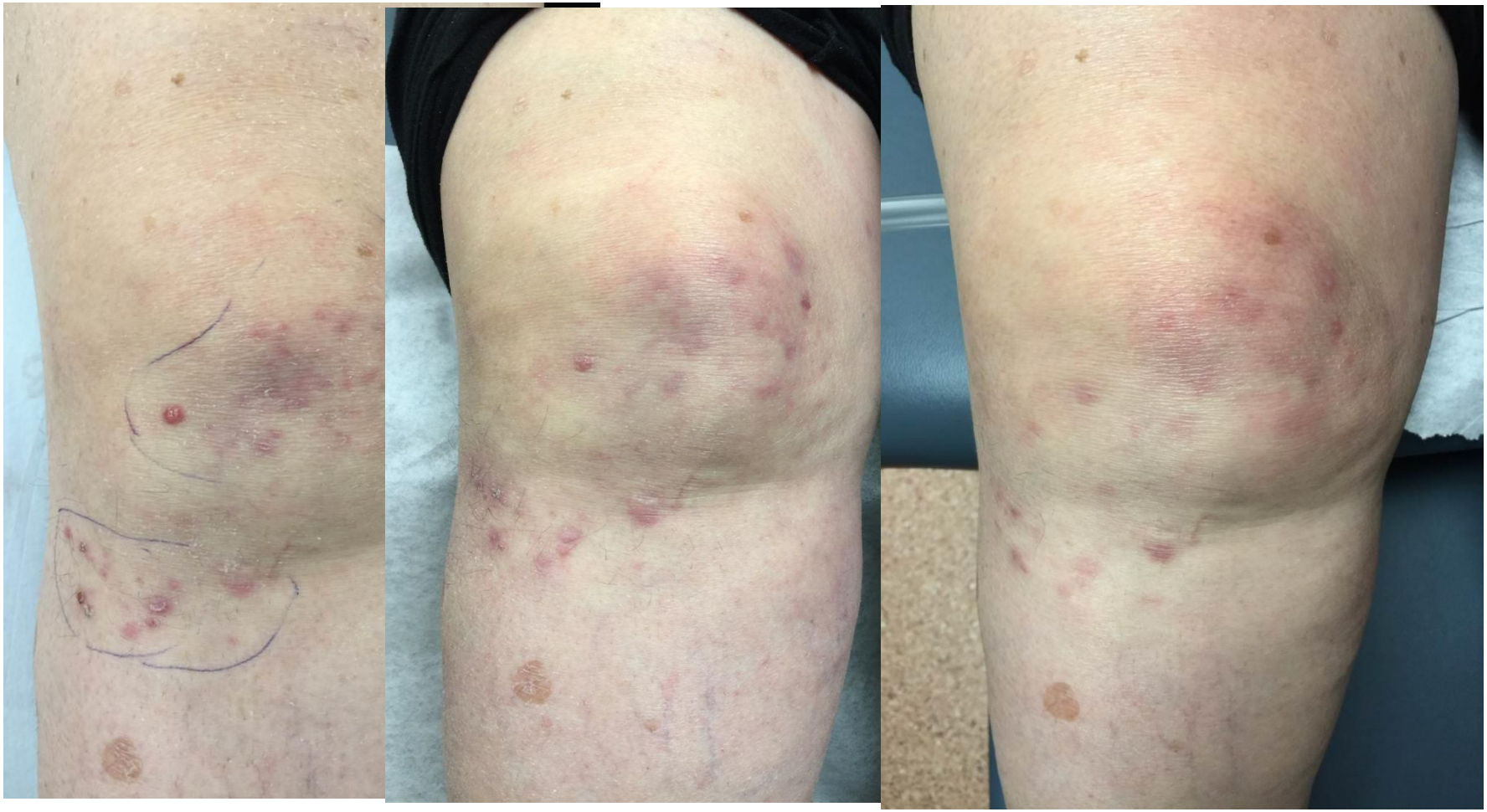
Follow up



Follow up



Follow up



Follow up

- Regional lymph node basin
  - And everything in between the primary and the lymph node basin
    - In transit metastasis can present as pigmented lesions or subcutaneous nodules

- General skin survey and lymph node exam

Take Home Messages

- Initial biopsy should be full thickness, narrow excision along the longitudinal access
- Margins of excision are based on the Breslow's depth of the primary melanoma
- SLNB is indicated for T1b and above
- Ongoing surveillance of scar and regional lymph node basin
  - Biopsy any suspicious lesion or LN