Clinical Stage I melanoma, who had an elective lymphadenectomy as opposed to similar patients without a dissection, represented only a modest difference in survival. It is our feeling that a 10 percent variation in survival in a large group of patients is an appreciable number. The number of patients who developed recurrent melanoma who were not subjected to a lymph node dissection (52 percent) was significantly higher than seen in patients having an elective lymph node dissection (19 percent). Perhaps the major reason for this wide difference is that 17 percent of patients who underwent elective lymph node dissection were found to harbor microscopic metastases within their regional lymph nodes. One can suspect that if 17 percent of patients having melanoma in clinically negative lymph nodes do not have a lymphadenectomy, there is a strong possibility that recurrent melanoma will eventually develop, since we have no proof at present that retaining lymph nodes containing tumor cells is beneficial to the patient.

No mention was made in our paper of lymphedema secondary to lymph node dissection since the paper was concerned with survival statistics and not with listing or discussing any complications associated with lymphadenectomy. Dr. Moore found it difficult to understand how elective lymph node dissection favorably affected the incidence of local recurrence unless, as he stated, "a superior local resection was associated with the procedure." Dr. Moore has probably answered his own question, since any surgeon who is about to undertake an extensive operation such as a lymph node dissection would probably be very aware of the importance of a simultaneously aggressive approach to the biopsy site of the primary melanoma.

The authors are fully aware of the drawbacks of any retrospective review of melanoma and believe it is unwise to promote vigorously or condemn strongly an elective lymph node dissection based solely on one's personal experience and previously taught concepts. Even though we feel that elective lymph node dissection is indicated in patients with Clinical Stage I melanoma, not until a well planned and well controlled prospective study is carried out can one be certain that the type of treatment one advocates is optimal.

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To the Editor:
I wish to make some comments and present the opposing point of view with reference to the article, "Malignant Melanoma: Current Concepts of Lymph Node Dissection," by Harry S. Goldsmith, M.D., et al., which appeared in the July/August 1972 issue of Cancer—A Journal for Clinicians, pages 216–220.

One of the purposes of the authors' studies which were reported in full in Cancer 26: 606–609, 1970, was "to evaluate whether the performance of routine lymph node dissection for melanoma is justified in the absence of palpable regional lymph nodes," and it appears that the authors have concluded that such elective lymph node dissections are justified.

1. Clinical Assessment of Nodes.

Much depends on the clinical assessment of the lymph nodes draining a primary malignant melanoma of the skin. If they are not palpable, they are assessed as clinically clear. If they are palpable, they may be regarded as clinically clear, clinically involved or suspicious.

It must be realized that many normal people have palpable nodes resulting
from minor skin injuries or infection. The fact that they are palpable does not necessarily mean that they are clinically involved and the use of these terms interchangeably, as in their paper, causes much confusion. If the regional nodes are soft, mobile and less than 1 cm. in diameter, they may be assessed as clinically clear, particularly if the contralateral nodes are similar.

Various authorities have cast doubt on the accuracy of clinical evaluation of lymph nodes. Knutson et al. have reviewed the literature and find clinical evaluation unreliable. In their series from the Ellis Fischel State Cancer Hospital in Missouri, they reported that 22 percent of patients whose regional nodes were thought to be clear proved after excision to have microscopic deposits of melanoma and 37.5 percent of patients whose regional nodes were thought to be clinically positive were proven after excision to be microscopically free of metastases.

This view conflicts completely with our experience in Queensland. We have found clinicians in Queensland to be remarkably accurate in evaluating lymph nodes. In the records of the Queensland Melanoma Project, there are 191 patients who underwent lymph node dissection when the nodes were assessed as clinically involved. In 180 (94 percent) the presence of metastases was confirmed by microscopic examination.

Three hundred elective dissections were done for patients with apparently normal lymph nodes and metastases found in 15 (5 percent), 10 in males (8.5 percent) and 5 in females (2.7 percent). Fifty-seven dissections were done for patients whose nodes were regarded as suspicious. Microscopic metastases were found in 13 (23 percent) with 6 in 32 males (19 percent) and 7 in 25 females (28 percent).

In our retrospective study we previously reported an accuracy of 90 percent in the evaluation of clinically involved nodes. These results suggest that accurate clinical assessment of nodes is possible, despite the contrary reports.

Lymph nodes clinically involved with melanoma have the following characteristics. They are always palpable and are usually greater than 1 cm. in diameter. It is noteworthy that they may vary in size from time to time and this may be due to hemorrhage and necrosis. Sometimes they develop with remarkable rapidity over a period of weeks and sometimes they come up almost overnight with much subcutaneous bruising. In these circumstances, they may be tender but they are usually not. In consistency they are firm and rubbery, rather than hard. Because of the limited reaction around melanotic deposits, they are usually relatively mobile and are rarely fixed to adjacent structures. While it is easy in most cases to decide which nodes are clinically clear and which are clinically involved, there will always be a group where the nodes are classed as suspicious.

2. Excision of Microscopic Metastases Preferable.

The authors refer to an overall better survival rate in Clinical Stage I patients who had a lymph node dissection (78 percent) compared with those who did not (68 percent). But they have failed to take other factors which have been shown to influence the prognosis into account. I refer particularly to the sex of the patient, the site and histogenetic type of tumour and the depth of invasion by the tumour cells. Nor have they stratified the two groups in such a way that those with nodes found to be histologically positive were compared with those who were followed and later developed a recurrence.Only by stratifying their groups in this way could their findings of improved survival be proved to be valid.

To sum up, it is our view that the regional lymph nodes draining a primary melanoma should be excised if they are clinically involved or suspected to be so.
But if they are apparently normal, observation is recommended in preference to elective dissection, except where a deeply invasive or nodular melanoma overlies, or is immediately adjacent to the regional nodes.

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To the Editor:

The authors read with interest the letter by Dr. Davis, Coordinator of the Queensland Melanoma Project. Dr. Davis felt that our paper failed to consider various factors which influence the prognosis of melanoma and also failed to separately evaluate patients with melanoma who eventually required a therapeutic lymphadenectomy as compared to patients who underwent an elective lymph node dissection. Our paper published in Ca—A Cancer Journal for Clinicians was an abstract and did not allow for in-depth evaluation of these questions. Their importance, however, is relevant and they have been studied and reported in previously published articles. 1,2

Dr. Davis does not feel that an elective lymph node dissection is justified in patients with clinically negative lymph nodes; based on his clinical material, we would agree completely. A recent paper from the Queensland Melanoma Project stated: "Patients in Queensland present for treatment of melanoma at an earlier stage than do those in other countries." 3 Treating patients with melanoma early in the natural history of this disease probably explains why only 5 percent of patients in Queensland had histologic evidence of melanoma in clinically negative lymph nodes. In the United States, however, the situation is completely different with approximately 20 percent to 50 percent of patients having histologic evidence of melanoma in clinically negative lymph nodes. 4,5 It is hard to imagine that this marked difference in the percentage of patients who have melanoma in clinically negative lymph nodes is due simply to a superior ability of Australian clinicians in physical diagnosis.

In the United States, justification of an elective lymphadenectomy is accepted by many surgeons because of the high incidence of melanoma in what are initially considered to be clinically negative lymph nodes. In Australia, it would be very difficult to justify the performance of an elective lymph node dissection, knowing that only 1 out of 20 patients with clinically negative lymph nodes would harbor melanoma within these nodes.

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