To the Editor:

The purpose of this letter is to express several reservations concerning 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 Ca—A Cancer Journal for Clinicians, pages 216–220. I realize the problems associated with synoptic articles but it is still important that such articles not mislead the reader.

First, there is no critical evidence that the treatment of melanoma has continued to improve. We all hope that our efforts are increasing in effectiveness, but it seems doubtful in this instance since we have not found techniques of controlling blood-borne metastases and the surgical procedures for removal of local and regional growths have not changed much over the last 35 years.

Second, it is stated that the over-all survival rate of those patients with clinical Stage I lesions who had regional node dissections was 10 percent greater than that of similar patients without dissection. This modest difference is at variance with a later figure indicating that recurrent melanoma was observed in 52 percent of the patients without dissection and in only 19 percent of those with lymph node dissection. One possible conclusion might be that most of the patients without dissection could be cured of their recurrences by subsequent surgical excision. Further, there is no mention of the complications of regional lymph node dissections such as incapacitating edema of the leg and the frequent (20 percent) and serious occurrence of "satellitosis" or diffuse recurrence of disease distal to the groin dissection.

The Table on page 219 is somewhat puzzling because it is difficult to understand how dissection favorably affected the incidence of local recurrence unless a superior local resection was associated with the procedure.

There well may be clinical justification of "prophylactic" groin dissections in patients with malignant melanoma, but it isn't evident from published reports. Finally, in my opinion, there is a significant difference in the effectiveness and complication-free application of regional node dissection of the neck, axilla and groin. Care should be used in generalizations about such disparate procedures.

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To the Editor:

In response to Dr. Moore's letter, it is unfortunate that he felt our paper on melanoma ambiguous in several instances, and the authors welcome the opportunity to clarify the questions he raises. Dr. Moore maintains that we have presented no critical evidence that the treatment of melanoma has continued to improve. Since the natural history of melanoma has remained constant and the treatment of this disease relatively static over the past several decades, we are in total agreement with Dr. Moore. What has changed, however, is patient awareness of the potential danger of a pigmented nevus which has led to an improvement in the results of treatment. In our paper we did not say that the treatment of melanoma continues to improve, but that "the survival statistics in melanoma continue to improve."

Dr. Moore felt that the 10 percent variation in survival of patients with
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 Ca—A Cancer 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