Letter in Reply

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Melanoma Management

Letter in reply: increase of sentinel lymph node melanoma staging in The Netherlands; still room and need for further improvement

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First draft submitted: 27 August 2020; Accepted for publication: 9 November 2020; Published online: 23 November 2020

Keywords: elderly • head and neck • melanoma • sentinel lymph node • socioeconomic status • staging

The proportion of sentinel lymph node biopsy (SLNB)-staged melanoma patients increased in The Netherlands, according to The Netherlands Cancer Registry, from 24% (2004) to 55% (2011) to 65% (2016) [1–3]. It is important to note that very large regional differences were observed in The Netherlands, 74% SLNBs in the northeast of The Netherlands compared with 56% in the rest of The Netherlands ($p < 0.01$). It is remarkable to see that in 2015 and 2016 no further increase was seen in SLNB staging in the northeast of The Netherlands, in contrast to the rest of The Netherlands [3].

The Imperial College Healthcare NHS Trust in London mentions interesting data in the letter to the editor [7]. It is encouraging to see that the percentage of SLNBs has increased from 46% (2016) to 88% (2018). The latter percentage is even better than the 74% in the Northeast of The Netherlands. It is important to mention that these percentage of SLNBs are not completely comparable, since the percentage of 74% in the Northeast of the Netherlands is based on 14 hospitals (at 17 locations) with SLNB percentages ranging per hospital from 47 to 97%.

Following our expectation, the application of the SLNB staging, according to the 8th edition American Joint Committee on Cancer guidelines, also in The Netherlands, will continue to increase now that more effective systemic treatment for stage 3 disease has become available. The main question is which SLNB positive patients (stage IIIA) might benefit from the adjuvant immunotherapy or targeted therapy.

Sentinel node tumor burden, according to the Rotterdam and/or Dewar criteria are important prognostic factors for survival and also predictive factor for additional positive (nonsentinel) lymph nodes [4]. Distinguishing metastatic melanoma from benign common nevi (CN) and melanophages can be a diagnostic challenge [5]. The 8th American Joint Committee on Cancer staging edition does not account for sentinel node (SN) tumor burden. On the contrary, the maximum diameter of the largest tumor lesion in the SN (1.0 vs >1.0 mm) is used for participation in adjuvant clinical trials. Stratifying by tumor ulceration and SN tumor burden resulted in four positive SN groups from which low-, intermediate- and high-risk prognostic classes could be derived and guided adjuvant therapy in clinical practice [6].

It should be taken in to account that there are still no data available to demonstrate that adjuvant systemic immunotherapy or targeted therapy in SLNB in intermediate- and high-risk SLNB positive patients with microscopic disease will contribute to a significantly improved and cost-effective disease-free and overall survival. For the time being, SLNB will only be able to contribute to optimal melanoma staging, in case of a positive SLNB, regional tumor control.

Financial & competing interests disclosure

The authors have no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties.

No writing assistance was utilized in the production of this manuscript.

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