Dear Colleague,

Melanoma is the topic of this Surgical Review. Most patients with Melanoma are referred after having had an excisional biopsy by their primary physician or dermatologist. Recently we have seen an increase in cases especially in young women related to Ultraviolet exposure either naturally from the sun or through the use of tanning facilities.

The most important piece of information from the biopsy is depth of invasion measured in millimeters or Clark's level which is a pathologic descriptive measure. I base my treatment on an excellent review published in the **New England Journal of Medicine 351; 10, September 2, 2004**.

Melanomas need to be surgically re excised. In the past larger margins were thought to be necessary, but smaller margins have now been shown to be equally effective. Most melanomas can be excised and closed primarily with local advancement flap, rarely is a skin graft needed. Melanoma in situ requires a 0.5cm margin, lesions less than 1mm in thickness require a 1 cm margin, lesions between 1 and 2 mm thickness require a 1 to 2 cm margin and lesions greater than 2mm thickness require a margin greater than 2 cm.

Melanoma was the first disease in which sentinel lymph node biopsy was utilized. This procedure involves the preoperative injection of a radioactive marker followed by lymphatic mapping. The surgeon then uses a gamma probe to identify the sentinel node which first concentrates the radioactive marker. In patients with melanomas less than 1mm in thickness sentinel node biopsy is usually not indicated. Sentinel node biopsy is indicated in those patients with melanomas with depth of invasion greater than 1mm or in those patients that exhibit a Clark's level 4 depth of invasion. Determination of the status of the sentinel lymph node provides the patient and physician with prognostic information. In those patients that lack evidence of distant metastatic disease a positive sentinel lymph node usually means that the patient would benefit from surgical removal of the involved lymph node group such as axillary or inguinal lymphadenectomy.

I make sure that all patients with melanoma no matter how superficial see an oncologist for consultation. The key to survival with melanoma is recognizing the disease while the depth of invasion

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is still superficial and will allow a surgical cure. Patients with deeper invasion likely will need the help of our oncologists.

I hope this has been informative. Please don't hesitate to call with any question involving surgical disease and treatment

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