BC Cancer Agency
CARE & RESEARCH
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BC Surgical Oncology Network

Newsletter

www.bccancer.bc.ca/son

Winter 2008

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In This Issue...

Profile of a Surgical Tumour Group: Skin

Dr. Chris Baliski, Surgical Oncologist, Kelowna and Chair of the Skin Surgical Tumour Group.

The Skin Surgical Tumour Group is one of 13 tumour site groups the Surgical Oncology Network established to focus on specific areas of cancer treatment. This is the third in a series profiling the initiatives and plans of these groups. The Colorectal and Endocrine Groups have been featured in previous issues.

The Skin Surgical Tumour Group is chaired by Dr. Chris Baliski, from Kelowna. Dr. Baliski is a surgical oncologist, who trained in Calgary, before moving to BC. He first worked at St. Paul's Hospital in Vancouver before settling in Kelowna. The group currently consists of six other surgeons, from across the province, who are interested in melanoma care.

Melanoma incidence is on the increase: over 3,000 new cases are diagnosed in Canada each year and over 500 in BC. One in seventy-five North Americans will develop melanoma. This makes melanoma the second fastest increasing type of cancer with a 2.0% annual increased incidence in males, and 1.1% in females (in Canada). The age-standardized incidence rate more than doubled between 1978 and 2007. Unfortunately, survival rates have not increased and death from melanoma now accounts for 1% of all cancer deaths. *(statistics obtained from Canadian Cancer Society, BC Cancer Agency and Alberta Society of Melanoma web sites.)*

We need more recognition that melanoma is a common problem. That awareness includes increased knowledge about the risk of sun exposure and how to identify unusual lesions in order to make an early diagnosis. But this needs to happen at the primary care level. Most surgical referrals with a diagnosis of melanoma come from general and family physicians or from dermatologists in larger centres.

> Over 3,000 new cases are diagnosed in Canada each year and over 500 in BC

As a surgeon seeing a new patient with melanoma, the goal is to make sure they get appropriate treatment. This means staging, excision of the tumour with an appropriately wide margin, consideration of sentinel lymph node biopsy, and referral to the BC Cancer Agency. Patients may then be considered for adjuvant therapy or enrolment in clinical trials. Surgical management may be complicated, as patients can be referred from the primary level to a wide range of surgical specialists, including dermatologic, plastic and general surgeons. This can make coordination of care challenging.

Con't on Pg. 3

Dr. Noelle Davis, Founding Network Chair and Provincial Program Leader Steps Down

Dr. Noelle Davis completed her second five-year term, as the Provincial Surgical Oncology Leader for the British Columbia Cancer Agency, at the end of December 2007. Dr. Davis has been instrumental in developing the new Breast Cancer Surgical Clinic at the Vancouver Cancer Centre, leading the overall Surgical Oncology Program and developing the Surgical Oncology Network province-wide. She has partnered with colleagues across the surgical community within the BC Cancer Agency and in the regional health authorities, to develop standards and guidelines for cancer surgery. She has also led and supported academic meetings and educational forums in the province and has had oversight of the quality evaluation of rectal cancer surgery in the province.

Dr. Davis has provided leadership in this crucial area of cancer care during the evolution from isolated areas of clinical surgical excellence in sub-specialized surgical oncology at the BC Cancer Agency to a more extensive and multifaceted level of surgical oncology services, academic research, musculoskeletal surgery, gynecological cancer surgeries in partnership with the well established Gynecological Oncology Program at the BC Cancer Agency, aspects of neurosurgery, thoracic surgery and head & neck surgery, to name several areas of development and teaching across the spectrum of general surgery.

Dr. Davis will continue on with her role as breast cancer surgeon at the British Columbia Cancer Agency Vancouver Centre and Vancouver General Hospital. She will remain a very active participant in the areas of general surgery and in the Surgical Oncology Program and will continue her involvement with the Surgical Oncology Network as Chair of the Clinical Practice Committee and member of the Council Executive.

Network News

Effective January 2008, Dr. Diane Miller, Chair of the BC Cancer Agency Gynecological Oncology Tumour Group, and a gynecology oncology surgeon, has been appointed Acting Chair of the Surgical Oncology Network and Acting Leader of the Provincial Surgical Oncology Program.

Dr. Miller's areas of special interest include all aspects of gynecological malignancy. She has been involved in clinical trials with carcinoma of the ovary as well as surgical and screening trials with cervical cancer.

The BC Cancer Agency is now in the process of recruiting a Provincial Leader for Oncology Surgery, in partnership with the University of British Columbia and Vancouver Costal Health Authority.

The following Council members completed their terms at the end of 2007:

- Dr. Peter Doris, Fraser Health Authority Representative on the Council Executive and the Chair of the Research and Outcomes Evaluation Committee.
- Dr. Ken Brown, Chair of the Pediatric Surgical Tumour Group.
- Dr. Richard Finley, Chair of the Esophageal/Lung Surgical Tumour Group.

Effective January 2008, the Network welcomes Dr. Carl Brown as the new Chair of the Research and Outcomes Evaluation Committee. Dr. Brown has been an active member of the Committee since joining last year, and brings his interest in outcomes reporting and a Master's degree in Clinical Epidemiology from the University of Toronto to this new role.

The Surgical Oncology Network would also like to welcome Dr. John Yee, Assistant Professor at UBC and Director of the Lung Transplant Program, as a designate of the UBC Department of Surgery to the Council Executive.

Upcoming Conferences

Canadian Association of General Surgeons Regional Meeting
in association with the 2008 International Outcomes Conference
February 14-16, 2008
Banff, AB, Rimrock Hotel
Website: www.eventplan.net/csa/index.html

Pacific Coast Surgical Society
February 15-18, 2008
San Diego, CA
Hotel Del Coronado
Website: pac-coast-surg.org

BC Surgical Society Annual Meeting
March 20-22, 2008
Delta Sun Peaks Resort, BC
Website: www.bcss.ca

Canadian Surgery Forum 2008
September 11 - September 14, 2008
Location: Halifax NS
Website: www.cags-accg.ca

Profile of a Surgical Tumour Group: Skin

Con't from Pg. 1

Facilitating this type of care is an area of interest for the Skin Surgical Tumour Group.

Unfortunately, there still may not be a lot to offer patients after surgery. In BC, Interferon is offered only to patients with clinically palpable lymph node involvement. At this time there are no major studies supporting its use in high risk melanoma (deep, node negative or microscopic node positive disease).

A study published last year in the New England Journal of Medicine *(NEJM 355:1307-1317, Sept 2006)* underlines the importance of a sentinel lymph node biopsy as an essential part of appropriate melanoma management. The procedure appeared to improve mortality and recurrence rates in a subset of patients (see review on page 8).

> Everybody with intermediate thickness melanoma should be considered for a sentinel lymph node biopsy

Dr. Baliski believes that this study was "one of the most important to come out in the last several years. Everybody with intermediate thickness melanoma should be considered for a sentinel lymph node biopsy, as this may increase their survival. I think offering this is the standard of care now."

In some areas of the province, sentinel lymph node biopsy is still not available. Smaller centres may lack a gamma probe or access to nuclear medicine facilities. However, most of the larger centres including Prince George, Nanaimo, Victoria, Vernon, Kelowna, and Kamloops and the majority of the Lower Mainland hospitals offer the procedure. Ideally this should be done before a wide excision, particularly if significant rotation flaps are used for closure. Unfortunately, patients can sometimes still fall through the cracks. If a patient misses getting the procedure at the time of the initial surgery, it is still possible to do it later under some circumstances. And there is some evidence that this will be worthwhile, even though the primary melanoma has already been removed.

Efforts are underway to increase the surgical voice on the BC Cancer Agency multidisciplinary Skin Tumour Group. There are still challenges to overcome in the BC Cancer Agency referral process. Currently, newly diagnosed patients with non-metastatic melanoma that are referred to the BC Cancer Agency by their primary care physician are seen by a dermatologic oncologist at the Melanoma Clinic. They are then referred for a surgical opinion if a wider excision or sentinel node biopsy, is needed. This can result in an unnecessary delay in access to surgical care. An increased presence of surgeons in the BC Cancer Agency Skin Tumour Group would facilitate the development of a triage process that would allow patients to be seen by a surgeon earlier.

While melanoma is the primary focus of the Skin Surgical Tumour Group, occasionally, there is a need for sentinel node biopsy for unusual skin tumours, like merkel cell carcinoma, or for lymph node dissections for metastatic squamous cell cancers. Other skin malignancies, like basal or squamous cell skin cancer, are usually well managed by plastic and dermatologic surgeons.

> Dr. Baliski's priority is to organize the collection of data on melanoma patients in BC

The Skin Surgical Tumour Group plans to meet soon and begin BC specific research on melanoma. Dr. Baliski's priority is to organize the collection of data on melanoma patients in BC. A starting point would be to review the data available through the BC Cancer Agency in order to evaluate what percentage of patients are getting sentinel lymph node biopsies and appropriate margins on their melanoma. Follow up data will ultimately provide quality assurance by reflecting the accuracy rates of the sentinel lymph node procedures. Data reviews such as these might also be able to identify other patterns. For instance, Dr. Baliski is seeing an increase in younger patients in his practice, but does not have the data to assess just how significant this is.

The Surgical Oncology Network has previously held an educational series on melanoma management and is working on arranging another in the future. The members of the Skin Surgical Tumour Group have recently revised and updated the surgical section on melanoma management in the BC Cancer Agency Clinical Management Guidelines to reflect the need for consideration of sentinel node biopsy and appropriate management of involved nodal basins, with complete radical node dissections. We would like to see increased participation by plastic and dermatologic surgeons in the Skin Surgical Tumour Group and anyone interested should contact Yasmin Miller, the manager of the Surgical Oncology Network or Dr. Baliski directly.

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Clinical Conundrums

Clinical Conundrums is a new section for the SON Newsletter where brief clinical scenarios that have been discussed informally are presented for the general readership.

Q: I have recently excised a small subcutaneous mass (1cm) from the abdominal wall of a young woman thinking it was either a deep sebaceous cyst or a stitch granuloma from a prior c-section (1 year prior). The path has just come back as an atypical granular cell tumor, margin positive, with a note about risk of local recurrence. Is this a patient that should be seen at the BCCA or should I just do a wider excision?

A: Granular cell tumours are rare tumours of nerve sheath origin that occur primarily in the upper aerodigestive tract, skin and subcutaneous tissues, though they can occur anywhere. These are generally benign, but can have atypical features that increase the risk for local recurrence, or even be frankly malignant. Whenever you are faced with unusual pathology, it is worth having it reviewed at the BCCA. There are requisitions available for this that you can submit directly to pathology. If the review confirms the diagnosis of 'atypical granular cell tumour' these can be managed with a wider excision (including the deep aspect). Follow-up should then consist of examining the patient every 6 months for local recurrence for a couple of years thereafter.

Canadian Partnership Against Cancer and Synoptic Reporting Tools

This article provides an overview of the Canadian Partnership Against Cancer and one of its priorities – the development of synoptic reporting tools. The BC Surgical Oncology Network is a partner in this national initiative.

The Canadian Partnership Against Cancer (CPAC) was established in November 2006 by the federal government with a commitment of $260 million over five years. Jeffrey Lozon, President and CEO of St. Michael's Hospital in Toronto, was appointed as Chair, and Dr. Simon Sutcliffe, President of the BC Cancer Agency, was named Vice Chair.

CPAC is responsible for implementing the Canadian Strategy for Cancer Control, whose objectives are to reduce the number of new cases of cancer among Canadians, enhance the quality of life of those living with cancer, and lessen the likelihood of Canadians dying from cancer. The work of the Partnership is organized around the priority areas of the Canadian Strategy for Cancer Control. There are nine Action Groups, each headed by a Chair and comprised of health practitioners, administrators, epidemiologists, analysts and cancer survivors.

One of the nine Action Groups is the Cancer Control Guidelines Action Group, which is Chaired by Dr. George Browman, Medical Oncologist with the BC Cancer Agency, Vancouver Island Centre, and Chair of the UBC BC Cancer Agency Research Ethics Board. The mandate of this Action Group is to establish the use of guidelines for cancer control through capacity-building, developing and disseminating tools for guideline development, and implementing guideline recommendations.

A key priority for the Guidelines Action Group is the development of synoptic reporting tools, to encourage the complete reporting of surgical and pathological data in patients with cancer. The use of uniform reporting templates can achieve this goal and facilitate the incorporation of evidence into everyday practice. While we have the ability to track incidence and death rates of specific cancers through provincial cancer registries, there is no comprehensive, standardized reporting system in place to collect pre-treatment cancer staging, key surgical data, pathology and other important outcomes in these patients.

Surgical procedures are an important component of the process of health care. Operative reports contain information critical for effective patient care, particularly in patients with cancer who may require adjuvant chemo- or radiotherapy. However, operative reports are notoriously inadequate in the documentation of surgical procedures. Traditional dictated operative reports are the official medical documentation of an operation but the content of these documents is not standardized or regulated. During residency training, surgeons receive little or no formal teaching in how to properly document an operative procedure.

A national workshop on Synoptic Reporting Tools, organized by CPAC, was held in Toronto on May 14, 2007. Seventy-five people from across Canada attended the workshop, representing pathology, cancer surgery, cancer program administration and informatics. There was enthusiastic support for the identification, implementation and evaluation of a national approach for synoptic reporting of cancer surgery and pathology. A recommendation came from the floor for the role of synoptic reporting, which stated: "Synoptic reporting of surgery and pathology should be the standard method of data capture to optimize cancer outcomes." This recommendation was subsequently voted upon and near-unanimous support was received, demonstrating

that the time is right to move forward on synoptic reporting to improve practice. Based on this response, the Cancer Control Guidelines Action Group agreed to establish a planning committee to help move forward on the recommendations from this workshop.

The Synoptic Reporting Tools Project Planning Committee was subsequently organized and a meeting was held September 8, 2007. The Committee established terms of reference for the projects, which included the following principles: they must be multidisciplinary, involve collaboration between at least two provinces, adhere to national standards, be important to patients, physicians and/or the health system, and operative reporting must be part of the tool. The Committee identified four tumour sites for the initial projects: breast, colorectal, head and neck, and ovarian cancers. Application guidelines were developed and circulated to Committee members, who were invited to submit proposals for review.

On October 3, 2007, the BC Surgical Oncology Network held a meeting to discuss synoptic and outcomes reporting and developing an application to the Cancer Control Guidelines Action Group. Participants included surgeons and health administrators in BC, and Dr. Walley Temple and Evangeline Tamano of Cancer Surgery Alberta.

In keeping with the terms of reference and application guidelines, the BC Surgical Oncology Network is partnering with other provinces on two proposals - one for colorectal cancer and the other on breast cancer. The proposals outline a pilot project to implement a web-based surgical medical record (WebSMR), now in use in Alberta, and integrate it with pathology and outcomes reporting in British Columbia, Alberta, Manitoba, Ontario and Nova Scotia for breast and colorectal cancers.

The project leads in BC are Dr. Carl Brown (St. Paul's Hospital) for colorectal cancer and Dr. Noelle Davis (BC Cancer Agency and Vancouver General Hospital) for breast cancer. In BC, the project will be piloted at three sites: St. Paul's Hospital, Vancouver General Hospital and the BC Cancer Agency, Vancouver Cancer Centre. The primary aim is to implement an integrated data collection and outcomes reporting system for colorectal and breast cancer. This project will enable the collection of surgical, clinical, pathology and outcomes data, and generate reports that demonstrate how surgical and clinical factors directly affect patient outcomes such as survival, quality of life and recurrence. The ultimate goal is to determine the processes, feasibility and utility of implementing this system on a wider scale.

The value of this initiative is the development of an effective data management and outcomes strategy. The measurement of outcomes for cancer care begins with the ability to record and report accurate treatment and staging data at the entry point of care. These data are often extracted retrospectively from hospital documents of variable validity. This pilot project aims to overcome these systemic deficiencies in cancer reporting. Moreover, the phased integration of colorectal and breast cancer guidelines with a robust data management vision would permit effective knowledge translation and provider-based change management by having real time feedback of outcomes to the surgeon in an accurate and meaningful manner.

The applications are now under review by the Cancer Control Guidelines Action Group. An update on the proposals will be provided in the next newsletter.

For more information on the Partnership and its Action Groups, please refer to the website at: www.partnershipagainstcancer.ca.

RECTAL CANCER UPDATE: THE LAST 5CM - DISTAL TME AND BEYOND

The 2008 Surgical Oncology Network Fall Update will be taking place on **October 25, 2008** and will focus on Rectal Cancer and "The Last 5 CM - Distal TME and Beyond"

Learning Objectives

- Review technical aspects of distal TME dissection – abdominoperineal, abdominosacral, transsphincteric.
- Review preoperative imaging techniques.
- Review indications for preoperative adjuvant radiation and chemotherapy.
- Discuss and plan best practice protocols for rectal cancer management.

Features:

- World expert speakers.
- Touch-pad learning – Each presenter will begin/ end with 3 multiple-choice questions that contain the main points for the presentation.
- Opportunity for lively discussion sessions.

An optional Live OR case on MIS Spincter-Preserving APR will be offered at an additional cost on Friday October 24.

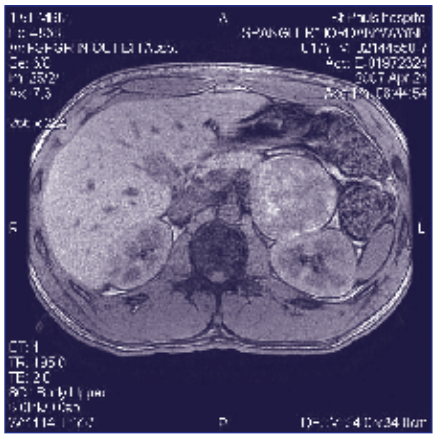
Registration brochures and information will be available soon. Please check: www.bccancer.bc.ca/HPI/SON for more information.

SON Fall Update - Endocrine Surgical Oncology

Reviewed by Dr. Rona Cheifetz

On October 27, 2007 the BC Surgical Oncology Network held its Annual Surgical Oncology Update at the Fairmont Waterfront Hotel. General and ENT Surgeons, endocrinologists, and surgical residents from around the province attended the fully accredited educational event.

Dr. Nadine Caron (General and Endocrine Surgeon) from Prince George chaired the morning sessions.

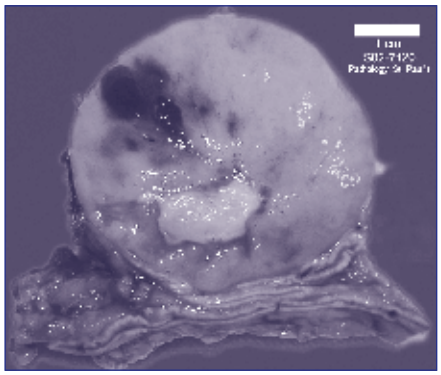


Adrenal Imaging on CT

Dr. Sam Bugis (Chair of the Endocrine Surgical Tumour Group) from St. Paul's Hospital presented an overview on the approach to the adrenal incidentaloma. In addition to providing a practical approach to the topic, including follow-up recommendations, Dr. Bugis pointed out two good review articles for those of us who want to read more:

1. Shen WT, Sturgeon C, Duh QY. From incidentaloma to adrenocortical carcinoma: the surgical management of adrenal tumors. J Surg Oncol. 2005 Mar 1;89(3):186-92. Review.

2. Young WF Jr. Management approaches to adrenal incidentalomas. A view from Rochester, Minnesota. Endocrinol Metab Clin North Am. 2000 Mar; 29(1):159-85, Review.



Adrenal Tumour

Dr. Chris Baliski (Surgical Oncology, Kelowna) was sponsored by the BC Surgical Society and took on the challenge of discussing pancreatic neuroendocrine tumours. This topic generated an interesting discussion around the pancreatic 'incidentaloma' and whether or not functional assessment should be undertaken for these lesions or whether they should be assumed to be carcinomas.

Dr. Barb Melosky (Medical Oncology, BC Cancer Agency) discussed the medical approach to neuroendocrine tumours and carcinoid. Currently, evaluation of these patients includes measurement of serum chromogranin A levels, 24 hour urine 5HIAA and both MIBG and Octreotide scanning. Complete surgical resection provides the best outcome but therapy with somatostatin analogs can help with symptom management and radionucleotide targeted treatment is available through the Cross Cancer Centre in Alberta for patients with unresectable disease.

After a coffee break, the late morning was focused on parathyroid disease. Dr. Sabrina Gill (Endocrinologist, St. Paul's Hospital) presented a very clear and practical approach to the work-up of hypercalcemia and reviewed the current guidelines for parathyroidectomy.

Dr. Rob Irvine (ENT, St. Paul's Hospital) discussed the role of new technology in the surgical approach to hyperparathyroidism. While surgical exploration remains the gold standard for localizing parathyroid adenomas, more patients are undergoing pre-operative imaging with sestamibi scans and ultrasound. While cure rates are not increased with this technology, it does impact operative planning and the need to explore both sides of the neck. This may impact postoperative complication rates. Dr. Irvine also discussed intra-operative PTH monitoring. This technology is not widely available in BC but is available in centres doing high volumes of parathyroid surgery.

Challenging the Experts

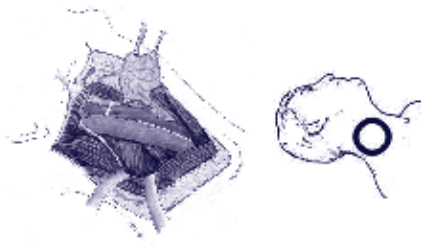
We ended the morning with an entertaining and instructive panel discussion on challenging cases in parathyroid disease. Dr. Caron presented the panel members with various scenarios incorporating vitamin deficiency, missing glands and a multitude of other conundrums.

After a delicious lunch, the entire afternoon was dedicated to the thyroid gland, with multiple sessions chaired by Dr. Bugis.

Dr. Orlo Clark, visiting speaker from San Fransisco

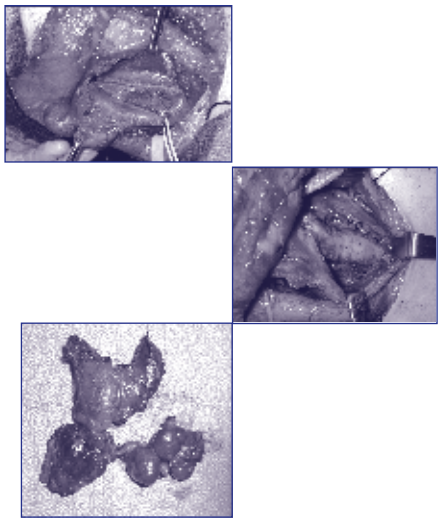
Dr. Orlo Clark, the international renowned Head of Endocrine Oncology in San Francisco, started the session with discussion of the indications for surgery for thyroid nodules. This is an area that continues to challenge those of us with an interest in the field and it was interesting to hear how an expert deals with these problems.

Dr. Tom Thomson (Pathology, BC Cancer Agency) explained the cytologic challenges faced in the definitive diagnosis of thyroid nodules. He made a concerted effort to help us understand what the pathologists are talking about in their paragraphs on follicular cells, colloid, hypercellularity, etc. Dr. Thomson also discussed technical aspects of fine needle aspirations that might increase the diagnostic yield of the procedure.



Operative Approach to Metastatic Thyroid Cancer

Dr. Rick Nason (Head and Neck Surgeon, Cancer Care Manitoba) was our Royal College sponsored speaker. Dr. Nason gave a fantastic presentation on the recommended extent of lymphadenectomy in thyroid cancer. His talk was accompanied by superb intra-operative pictures of neck dissections.



Thyroid Cancer: Intraoperative Images

Dr. Nason emphasized that there is no role for 'berry picking' procedures in the management of clinically evident lymphadenopathy (despite its ongoing inclusion in the BC MSP Fee Schedule).

Dr. John Hay (Radiation Oncology, BC Cancer Agency) discussed the role of radioactive iodine, external beam radiation, serum thyroglobulin monitoring and Thyrogen stimulation in the adjuvant therapy and follow-up of patients with well differentiated thyroid cancer. Fortunately, with the use of Thyrogen (recombinant TSH) patients no longer have to tolerate withdrawal of thyroxine and symptomatic hypothyroidism in order to have their follow-up iodine scans.

Dr. Sam Wiseman (Surgical Oncology, St. Paul's Hospital) opened our eyes to the future of pre-operative thyroid diagnosis with a look at the possibility of gene profiling as a means of identifying thyroid malignancy. Through his research, Dr. Wiseman has identified a number of genes that are expressed more commonly in thyroid cancers that may act as markers of malignancy that could be applied in the clinical setting.

Finally, after another caffeine infusion to help with the late afternoon hour, Dr. Bugis chaired an entertaining and informative panel discussion on thyroid surgery, picking the minds of our visiting professors and local experts. Many members of the audience took the opportunity to ask the panelists questions about their individual approaches to challenges in thyroid surgery.

Endocrinology and Art

We closed the day with a different slant. After a wine and cheese reception, Orlo Clark presented his current research on Endocrinology and Art. He and his wife have been traveling the world seeking examples of endocrine disease in works of art. The number of famous painting showing women with goiter was remarkable (including the painting over the table at the restaurant where the speakers had dinner that evening!).

It was a great day with lots of opportunity for questions and discussion amongst the participants and the speakers.

Copies of these presentations will be posted on the SON Website at http://www.bccancer.bc.ca/HPI/SON/default.htm where we archive all the SON educational events for those who unfortunately couldn't attend.

Resident Travel Award For BC Surgery Residents & Fellows

The BC Surgical Oncology Network Resident Travel Award is a competitive award intended to motivate physicians, early in their training, to pursue an interest in surgical oncology and to allow them to present research findings at conferences. There is no predetermined number of awards each year. The SON Council Executive will grant awards based on availability of funding. Approved applications may be funded in whole or in part up to a maximum of $1000. The total annual funding for all awards will not exceed $5000 annually. Deadlines are: **May 1** and **November 1** of each year.

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The BC Provincial Surgical Oncology Council exists to promote and advance quality cancer surgery throughout the province by establishing an effective Network of all surgical oncology care providers and implementing specific recommendations. The Network will enable quality surgical oncology services to be integrated with the formal cancer care system. Communications to enhance decisionmaking, evidence-based guidelines, a high quality continuing education program, and regionally based research and outcome analyses are the initial priorities.

Morton DL, et al. Sentinel-Node Biopsy or Nodal Observation in Melanoma. NEJM 2006; 355(13): 1307-1317

Reviewed by Dr. Chris Baliski

This study by Morton et al. is pivotal to the debate about the relevance of sentinel lymph node biopsy (SLNB), and the significance of removing clinically occult metastasis in regional lymph nodes in patients with melanoma. Over an 8-year period (1994 – 2002), patients with intermediate thickness melanomas (1.2 – 3.5 mm) were randomized in a 60:40 fashion to SLNB versus observation. The SLNB group underwent completion lymphadenectomy if the sentinel lymph node (SLN) was pathologically positive, while the observation group was followed closely and underwent a therapeutic lymphadenectomy if clinically obvious disease presented. A total of 1269 patients were enrolled in the study and eligible for analysis.

Patients randomized to SLNB had a higher overall 5-year survival (78.3% vs 73.1%), but there was no improvement in melanoma specific 5-year survival (87.1% vs 86.6%), which was the primary end point of the study.

The incidence of SLN micrometastasis was 16%, remarkably similar to the 15.6% nodal relapse in the group followed clinically. Among patients with pathologically involved lymph nodes (SLNB vs later clinical involvement), the group undergoing early intervention in the form of a SLNB had an improved outcome (72.3% vs 52.4% 5-year survival).

This study raises several relevant points. First, it suggests that micrometastatic disease does not remain dormant, and likely progresses to clinically obvious disease. Second, early intervention in those with clinically occult disease improves their survival. Third, removing lymph nodes in patients without disease does not impact survival. Although there was no overall improvement in disease specific survival at this interim analysis, there appears to be a definite therapeutic relevance to the use of SLNB in those with regional metastasis from melanoma. This study helps validate SLNB as the standard of care in the treatment of patients with intermediate thickness melanomas, and further supports the use of completion lymphadenectomy in those with pathologically involved sentinel nodes.

New Features for the SON Newsletter

Two new recurring sections have been added.

The first is ***Clincal Conundrums*** where brief clinical scenarios are presented and discussed.

The second section is on ***Articles of Interest*** which would include a review or synopsis of and/or reference to the article.

If you would like to submit question or if you have read an interesting article for which you would like to submit a review, please send it to:

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