Supplemento G Chir Vol. 30 - n. 5
Maggio 2009

Pelvic sentinel lymph node biopsy: is it worthwhile in melanoma patients?

J. SOTELDO[1], E.L. RATTO[1], S. GANDINI[2], G. TRIFIRÒ[3], G. MAZZAROL[4], G. TOSTI[1], M. RASTRELLI[1], F. VERRECCHIA[1], F. BALDINI[1], A. TESTORI[1]

[1] *Division of Melanoma and Sarcoma European, Institute of Oncology Milan (Italy)*
[2] *Division of Epidemiology and Biostatistics, European Institute of Oncology, Milan (Italy)*
[3] *Department of Nuclear Medicine, European Institute of Oncology, Milan (Italy)*
[4] *Division of Pathology and Laboratory Medicine, European Institute of Oncology, Milan (Italy)*

Background

Sentinel node biopsy (SNB) is the standard of care for staging of patients with clinical stage I and II cutaneous melanoma. No literature exists in performing SNB in patients with pelvic hot-spots at the dynamic lymphoscintigraphy in presence of concomitant inguinofemoral SNs. Nowadays, it is common practice to perform superficial inguinal SNB, followed by ilio-obturatory and inguinal dissection in case of sentinel node (SN) positivity. The aim of the current study is to investigate the role of the pelvic sentinel node in the natural history of melanoma.

Methods

Between 2000 and 2007, 104 clinical stage I/II melanoma patients with primary tumors of the lower limb and lower trunk presenting hot spots localized both in superficial (groin) and deep (iliac-obturator) areas during dynamic linfoscintigraphy, were retrospectively collected from the IEO melanoma database. Only the superficial SNs were excised. SN positive patients underwent ilioinguinal dissection. SN negative patients did not receive further surgical treatment. Follow-up was planned four-monthly with clinical controls and ultrasound (US) of the groin. An annual chest X ray and abdominal US were performed.

Results

The median follow up period was 49 months (Standard Deviation 22.4; range, 10-98 months). The median Breslow thickness was 1,8 mm (range 0,4-13 mm, SD 2.09). Thirty one primary melanomas (30%) showed histological ulceration. Of the 104 patients, 83 were SN negative (80%). All SN positive patients underwent ilio-obturatory and inguinal dissection. Two patients (2.4%; 95% CI: 1.5%-8.8%) with negative SNs had pelvic recurrence during follow up. Among patients treated with ilioinguinal dissection, 3 (14%; 95% CI: 4%-35%) were found to have positive pelvic lymph nodes. At 5 years, 79% of all patients were alive, 66% were alive and free of disease and no significant difference was found by SN status (Log-rank P-values: 0.31 and 0.15, for OS and DFS respectively): in particular 95% CI of 5-years DFS ranges from 57% to 82% for negative SNB and from 28% to 78% for positive SNB. 5-year OS in SN negative patients was 78% and in SN positive patients 79%.

Conclusions

A little worse progression of the disease, in term of pelvic recurrence and DFS, has been assessed in patient presenting pelvic hot-spots at lymphoscintigraphy, not treated with ilioinguinal dissection, respect the data present in literature. Skip metastases to deep sentinel nodes could explain the greater rate of pelvic recurrence and the worse DFS in SLN negative patients. The sample size of our study cannot bring to conclusive results; we recommend further studies to improve our knowledge in the role of pelvic sentinel node in the natural history of melanoma.

KEY WORDS: melanoma, pelvic sentinel lymph node.

Corrispondenza Autore:
Dott. Vito Leopoldo Troilo
Via Cappuccini, 71/d
70017, Putignano - Bari
E-mail: vtroilo@libero.it