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Immediate Lymph Node Dissection on Detection of Sentinel Lymph Node Involvement Does Not Increase Survival in Cutaneous Melanoma[☆]



FR-La linfadenectomía inmediata tras la afectación tumoral del ganglio centinela no aumenta la supervivencia en el melanoma cutáneo

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PALABRAS CLAVE

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Sentinel lymph node (SLN) involvement is one of the most important prognostic factors in melanoma. Even in patients with micrometastases, SLN involvement is associated with a poorer prognosis, similar to that of patients with clinically

detectable metastases.¹ Current international guidelines recommend that lymph node dissection be performed as soon as SLN involvement is demonstrated. However, lymph node dissection does carry the risk of morbidity, and there is no prospective evidence demonstrating the impact of this technique on disease prognosis.²

Faries et al.³ recently published the results of the Multicenter Selective Lymphadenectomy Trial II (MSLT-II), a prospective multicenter randomized clinical trial whose main objective was to evaluate the benefits of immediate lymph node dissection in patients with SLN involvement. Patients assigned to the dissection group underwent lymph node dissection (n=967), while patients assigned to the observation group underwent observation with frequent nodal ultrasonography (n=967). Patients in the observation group who developed clinically or sonographically detected nodal metastasis underwent immediate lymph node dissection. Nodal metastasis was determined by means of immunohistochemical tests or reverse-transcriptase-polymerase-chain-reaction (RT-PCR) assay. Patient randomization was stratified according to Breslow thickness, ulceration, and method of nodal metastasis detection (histologic versus RT-PCR assay). Patients underwent a clinical examination every 4 months for the first 2 years, every 6 months until the fifth year, and annually thereafter. The observation group underwent nodal sonographic assessment at each follow-up visit for the first 5 years. The median follow-up period was 43 months. Results after 3 years of follow-up: Intention-to-treat analysis and per-protocol analysis found no significant differences in the rate of melanoma-specific survival between the dissection

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group and the observation group (86% in both groups; $P = 0.42$ by the log-rank test; per-protocol analysis). Likewise, there were no significant differences between subgroups based on prognostic factors or in distant metastasis-free survival. However, the disease-free survival rate was higher in the dissection group than in the observation group (68% vs 63%; $P = 0.05$), as was the rate of disease control in locoregional lymph nodes (92% vs 77%; $P < 0.001$). The main adverse effect, lymphedema, was more frequent in the dissection group (24% vs 6.3%; $P < 0.001$). However, lymphedema was severe in just 3% of the patients who had this condition.

In summary, in the MLST-II study, early dissection allowed greater locoregional control of melanoma but had no impact on melanoma-specific survival and was associated with a higher rate of adverse effects. These results are consistent with those of retrospective studies⁴ and the DeCOG-SLT prospective clinical trial,⁵ which studied 483 patients using a methodology comparable to that of MLST-II. Finally, EORTC-1208 (MINITUB), a prospective study currently underway, is evaluating observation only as an alternative in patients with SLN involvement.⁴ The results are expected to be published in 2019 or 2020.

The MSLT-II results add to the existing body of evidence.^{4,5} In patients with SLN involvement, it appears logical to propose a more conservative management approach consisting of frequent clinical and sonographic monitoring with

immediate dissection in the event of clinical or sonographic detection of metastasis. This approach would achieve adequate disease control with fewer adverse events and probably at lower cost.

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