

Letters

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Comments on Management of Cutaneous Melanoma M0: State of the Art and Trends, Rossi et al., Eur J Cancer 1997, 33, 2302–2312

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WE READ with interest the paper recently published by Rossi and associates [1] in the *European Journal of Cancer* concerning the management of cutaneous melanoma. On margins of excision, the authors state "If melanoma *in situ* is completely excised (primary biopsy reveals a free margin greater than 2 mm), no local recurrence should occur, ...". On which literature data do they base this statement? We accept that a "millimetre question" may seem a slight question, but in our experience we have had some local recurrences [2]. Data from the literature recommend excision of melanoma *in situ* lesions with a 3–5 mm border of a clinically normal skin [2, 3]. Our present attitude is to consider adequate treatment an excision with 3 mm margins except for superficially extended lesions (larger than 2 cm), because large lesions may have an appreciable incidence of local recurrence. When possible, these lesions deserve a wider excision to produce the same surgical clearance as that obtained by a minimal excision of a smaller lesion.

1. Rossi CR, Foletto M, Vecchiato A, Alessio S, Menin N, Lise M. Management of cutaneous melanoma M0: state of the art and trends. *Eur J Cancer* 1997, 33(14), 2302–2312.
2. Bartoli C, Bono A, Clemente C, Del Prato I, Zurrada S, Cascinelli N. Clinical diagnosis and therapy of cutaneous melanoma *in situ*. *Cancer* 1996, 77, 888–892.
3. NIH Consensus Conference: Diagnosis and Treatment of Early Melanoma. *J Am Med Assoc* 1992, 268, 1314–1319.

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Response from C.R. Rossi

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IN THEIR letter concerning our review 'Management of cutaneous melanoma M0: State of the art and trends' [1], Bartoli and Bono state that 'data from literature recommend excision of melanoma *in situ* lesions with a 3–5 mm border of clinically normal skin' [2, 3]. We, however, stress that no definitive data have yet confirmed exactly how wide the optimal margin of excision should be for *in situ* cutaneous melanoma in order to prevent local recurrences.

There is general agreement that 5 mm might be a reasonable compromise, based on the observation that with this margin a cure can be achieved in the vast majority of cases, and that any local recurrence (even if the primary is infiltrating) does not seem to affect patient survival [4]. This was mentioned in our review.

Bartoli and Bono recommend a margin of 3 mm, except for superficially extended lesions (larger than 2 cm). We agree with this in principle, but our review is also in line with the concept expressed in the most recent booklet of the WHO Melanoma Programme: 'It is not necessary to re-excise these lesions (*in situ* melanoma) if the primary biopsy reveals a margin greater than 2 mm' [5].

1. Rossi CR, Foletto M, Vecchiato A, Alessio S, Menin N, Lise M. Management of cutaneous melanoma M0: state of the art and trends. *Eur J Cancer* 1997, 33, 2302–2312.
2. Bartoli C, Bono A, Clemente C, Del Prato I, Zurrada S, Cascinelli N. Clinical diagnosis and therapy of cutaneous melanoma *in situ*. *Cancer* 1996, 77, 888–892.
3. NIH Consensus Conference: Diagnosis and treatment of early melanoma. *JAMA* 1992, 268, 1314–1319.
4. Veronesi U, Cascinelli N. Narrow excision (1 cm margin): a safe procedure for thin cutaneous melanoma. *Arch Surg* 1991, 136, 438–441.
5. Mackie RM, Cascinelli N, Kirkwood JM, Ross MI, Santinami M, McCarthy WH. *Clinical Management of Melanoma*. W.H.O. Melanoma Programme Publications, No 4. Milan, 1996.