Melanoma Updates 2020

Current Status of Sentinel Lymph Node Mapping and Completion Lymphadenectomy

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Dr. Meredith McKean: Hi. So I'm Meredith McKean. I'm a clinical investigator in our melanoma and skin cancer research program here at Sarah Cannon based in Nashville. I'm also an investigator in our drug development unit. I'll be discussing a few topics today. Sentinel lymph nodes and completion lymphadenectomy in melanoma. So patients that have, it's very clear cut that patients that have a melanoma greater than one millimeter in depth should undergo a Sentinel lymph node biopsy. The utility of this been demonstrated in the MSLT trials. So, MSLT 1 demonstrated, the benefit of recognizing, whether or not melanoma had traveled to a Sentinel lymph node. And now a number of our adjutant therapies are based on whether or not melanoma has spread to lymph node. In general, the data that we have is that any patient with a melanoma depth greater than one millimeter should undergo a Sentinel lymph node biopsy. Melanomas that are less than one millimeter in depth, then I would say a melanoma between 0.8 millimeters to one millimeter in depth. Those lesions should be discussed with a surgeon.

There can be additional risk factors that are taken into consideration based on patient's age, whether there are other high-risk features, including ulceration high mitotic index, lymphovascular invasion, that might increase that risk of that melanoma having to travel to a Sentinel lymph node. A Sentinel lymph node, if it is positive, then that means that patient has at least stage three melanoma. And at that point, if it's greater than one millimeter and present in the lymph node that can indicate receiving an adjuvant therapy, meaning a medication in the setting where there's no known disease, what your goal in giving a medication is trying to decrease the risk of that melanoma coming back. So if a Sentinel node is indicated for a melanoma that's greater than one millimeter in depth, unless you have additional risk factors and up until the point that so based on the depth, but then if a patient already has clinically noted lesions.

So if a patient can feel a lymph node in that area, or if a patient's having symptoms and have been done, and there is confirmed disease elsewhere, a Sentinel lymph node biopsy would not be indicated in that situation, in a biopsy of that lesion concerning for metastatic disease would be indicated instead. So in summary then, so a patient that has greater than one millimeter melanoma in depth, those patients should undergo a Sentinel node unless there's any known disease elsewhere. In general, staging scans are not done before a Sentinel lymph node biopsy is performed unless the patient's having symptoms. And that's based on guidelines. It's only if a patient has symptoms, that's already prompted imaging. As far as undergoing a completion, lymph node dissection, the guidelines and recommendations for this has changed.

So that MSLT 2 study looked at patients that had a positive lymph node but no clinically noted lymph nodes. Those patients under either underwent observation with an ultrasound or they underwent surgery and they re removed all the lymph nodes in that lymph node basin. And what MSLT showed us is that for patients that had a positive Sentinel node that underwent a completion lymphadenectomy, so removing all the ones notes in that area, those patients did have a slightly lower risk of a local recurrence. So in that location, but had no difference on the patient's overall survival, which is really our, you know, the most important thing that we're doing, all these different treatments to try to maximize, is trying to help patients live longer. And so because of that study that came out a couple of years ago, now, patients that have a positive Sentinel node without any other lymph node involvement, no symptoms, those patients just undergo surveillance or just monitoring with imaging.

And maybe offered agiment therapy based on a discussion with their physician. Those patients would not undergo an upfront surgery. Now, if patients develop recurrent disease in those lymph nodes, then that's a different situation and surgical resection could be considered. Also patients that have lymph nodes that they can feel at time of diagnosis, or if a patient a consideration is that a patient that has several lymph nodes that show up on scans, and with conversation, they've decided that they wanted to start with a surgery before treatment. Those are different situations that you may consider doing surgery upfront, but in general, for a standard patient that has primary melanoma, a positive Sentinel node, we no longer recommend removing all those lymph nodes because it does not improve overall survival.