



Surgical Associates of Palm Beach County is the oldest and largest Multi-Specialty Surgical group practice in South Palm Beach County

INTRODUCTION

Surgical Associates of Palm Beach County (SAPBC) is a Multi-Specialty Surgical group practice with over 200 years of combined surgical experience. SAPBC has a reputation for leadership and innovation in the surgical community, and has built a reputation for excellence in surgical care over the past four decades.

Our mission is to provide the highest quality, state of the art, and personalized care possible for our patients. We take pride in our individual specialties and work hard to maintain our expertise. Our surgeons are proficient in the latest minimally invasive surgical techniques, including Laparoscopy, solid organs, Thoracoscopy and Endovascular surgery.

SAPBC is capable of providing skilled care for most General Surgical, Colon and Rectal, Vascular, Thoracic, Breast and Surgical Oncologic conditions. The combined training, experience and technical skill of our surgeons has made our practice a true Center of Excellence. However, if any of us believes a patient would be better served with treatment elsewhere, we will gladly and honestly make that referral and help get a timely appointment.

Because of all the recent advances occurring in Medicine, especially within the field of Surgery, we feel that it is important for our referring physicians to have an understanding of the latest treatment modalities available to their patients and what we as a group have to offer.

With the above in mind, SAPBC will be sending you bimonthly newsletters informing you of the latest treatment modalities available to your patients for various surgical conditions. Our goal is to keep you informed so that you can make the most intelligent recommendation to your patients, and most of all, feel comfortable referring them to our group.

We appreciate the trust you have given us to care for your patient's surgical problems and will endeavor to provide them with the highest quality surgical care. When your patients need surgery, you need to know that they are getting experienced, fully capable care performed to the highest standards.

As always, thank you for your continued support.

For more information please visit our website



www.sapbc.net



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Malignant Melanoma.

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Malignant melanoma is one of the most common cancers and one of the most serious skin cancer affecting humans. It is estimated that 53,600 patients are diagnosed with melanoma every year in the United States. It arises from the malignant transformation of the melanocytes in the skin, and favors lymphatic spread. The most common site for this tumor is the skin (cutaneous melanoma), but other organs can be affected as well, like meninges, eyes, digestive tract and lymph nodes. The incidence increases with age but it can affect patients at any age. It is associated with exposure to UV rays in the sunlight, and affects fair skin people more commonly, especially in sun exposed areas (trunk, extremities, face and head). Dark skin people develop melanoma in the nails, palms or soles. Metastatic melanoma spreads via lymphatic to liver, lung, brain, intestines and other organs.

The risk factors to develop melanoma according to researchers are: dysplastic nevi, more than 50 ordinary moles, fair skin, personal history of melanoma or other skin cancers, family

history of melanoma, immunosuppression, severe blistering sunburn, UV

Risk Factor	Examples
Skin type	Fair skin Freckles Blonde or red hair Blue eyes
Environmental exposure	Excessive exposure to sunlight or tanning booths Tendency to burn, not tan History of severe sunburns
Preexisting skin lesions	Atypical moles (dysplastic nevi) Many benign moles
History	Personal history of melanoma Personal history of other skin cancers Family history of melanoma Immunosuppression

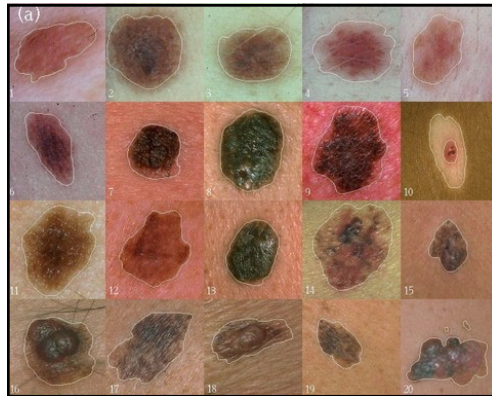
Source References 8,9

radiation exposure. The first sign of melanoma is a change in the size, shape, color, or feel of an existing mole. Most melanomas have a black or blue-black area. Melanoma also may appear as a new mole. It may be black, abnormal, or "ugly looking." Usually, the "ABCD" rule applies: asymmetry, borders (irregular), color (uneven), diameter (>5mm). Some melanoma may present with only one or two of these characteristics.

Melanomas in an early stage may be found when an existing mole changes slightly, for example, when a new black area forms. Newly formed fine scales and itching in a mole also are common symptoms of early melanoma. In more advanced melanoma, the texture of the mole may change. For example, it may become hard or lumpy. Melanomas may feel different from regular

moles. More advanced tumors may itch, ooze, or bleed. But melanomas usually do not cause pain. A skin examination is often part of a routine checkup by a health care provider. People also can check their own skin for new growths or other changes. Melanoma can be cured if it is diagnosed and treated when the tumor is thin and has not deeply invaded the skin. However, if a melanoma is not removed at its early stages, cancer cells may grow downward from the skin surface and invade healthy tissue. When a melanoma becomes thick and deep, the disease often spreads to other parts of the body and is difficult to control. Diagnosis is made by a biopsy of a suspicious lesion. This can be done with a incisional or excisional biopsy depending of the size of the lesion. Lesions suspicious for melanoma should never be shaven or cauterized. The biopsies are most often performed at the doctor's office (Dermatologist or Surgical Oncologist) under local anesthesia. A experienced dermatopathologist should examine the samples and report several characteristics including: thickness (Breslow and Clark's levels), status of the margins, mitosis, vertical growth phase, histological subtype, lymphovascular invasion, tumor infiltrating lymphocytes, neurotropism, ulceration and regression.





After the diagnosis is confirmed, the main therapy in melanoma is the complete excision with adequate margins from 1-2cm margins depending on the depth of the primary lesion. Lesions with a Breslow level less than 1mm should be treated with 1cm margin around the lesion, for lesions with depth >1mm a margin of 2 cm is indicated. The use of sentinel lymph node biopsy, a minimally invasive technique to identify patients with positive nodes requiring nodal basin lymphadenectomy, was introduced by Morton et al.. Having positive sentinel nodes upstage the patients and carries worse prognosis. Positive sentinel nodes also indicates the need for completion lymphadenectomy of the affected nodal basin for staging and control of local relapse. The survival is not affected by completion lymphadenectomy and new studies are comparing observation vs completion lymphadenectomy for sentinel positive patients.

Sentinel nodes are indicated in lesions > 1mm deep or > Clarks Level II—III or melanomas with high risk features.

Imaging studies for better staging like CTscan, MRI and PETscans are indicated for patients with melanomas deeper than 1mm or with positive lymph nodes, and helps to identify metastatic disease and additional affect lymph node basins. Additional therapy with High dose interferon is indicated for advanced staged melanomas (>1mm deep, Clark's level IV or V with

adverse features) and those with nodal involvement. Other therapies are indicated for diffuse disease.

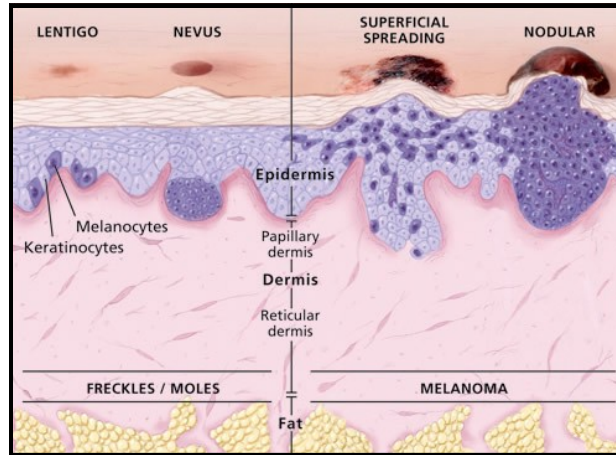
In-transit metastasis are those subcutaneous deposits following the lymphatic distribution, are treated with primary resection if they are few and resectable with clear margins. Other alternatives include hyperthermic limb perfusion or infusional therapy in those patients with unresectable in-transit metastasis.

Radiation therapy is indicated for those nodal basins with risk of recurrence including patients with multiple positive nodes or extranodal extension.

The survival rate is based on stage. Survival of >90% is seen in patients with tumors <1mm thick and negative nodes and it is 50-90% in patients with melanoma >1mm thick. 20-70% 5 year survival is observed in patients with positive nodes depending on the number of involved nodes. Patients with metastatic melanoma is usually less than 10%.

The NCCN panel recommends a close follow up in patients with melanoma based on stage. Usually melanoma in situ or <1mm thick are usually cured with surgery and requires detailed skin examinations every 3 to 12 months for 5 years. Patients with melanomas >1mm thick need detailed skin examination every 3 to 6 months for 2 years and every 3 to 12 months for 3 years and yearly thereafter. They should also get chest xray, LDH and hematocrit level every 6 to 12 months. CT scan and PET scan are indicated if any abnormality is identified during the surveillance to rule out recurrent or metastatic disease. Any suspicious metastasis to lymph nodes or other sites should be confirmed with FNA biopsy. As Surgical Oncologist, we offer the adequate surgical treatment for malignant melanoma in all stages. This includes wide local excision with immediate reconstruction, sentinel node biopsy, completion lymphadenectomy of the affected nodal basin, limb infusion and continuous surveillance after completion of the treatment.





Normal Mole	Abnormal Mole	Sign	Characteristic
		Asymmetry	when half of the mole does not match the other half
		Border	when the border (edges) of the mole are ragged or irregular
		Color	when the color of the mole varies throughout
		Diameter	if the mole's diameter is larger than a pencil's eraser

Photographs Used By Permission: National Cancer Institute



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Dr. Molina is Board Certified in Surgery by the American Board of Surgery. He is a Fellow of the Society of Surgical Oncology. He specializes in Hepatobilliary surgery, with interests in Esophageal Disorders, Hiatal Hernias, Breast Cancer, Pancreatic Cancer, Liver neoplasm, Laparoscopic Surgery of the GI tract, Melonoma, and Endoscopic Ultrasound.

