

Letter to the Editor

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In reply to “To count or not to count – that is the question”

Dear Editor,

I would like to comment on the editorial by Almut Böer-Auer entitled, “To count or not to count – that is the question!” [1] and the subsequent survey about the mitotic index (MI) as a result of the seventh edition of the melanoma staging and classification of the AJCC, published by Balch et al [2]. The staging and classification of melanoma by the so-called experts changes every two to four years and not precisely due to consistent and useful scientific progress in the diagnosis, etiopathogenic or therapeutic issues, but according to the objectives and interests preset by these same “experts.”

During my 30 years of clinical diagnosis, and especially since the year 2000, at which time I started reading and diagnosing the biopsies of each and every case at my hospital in which melanoma is suspected, the MI has had no importance for me at the moment of making a therapeutic decision, even though the dermatopathologists on my team have reported the MI as “low, medium or high.” I would never dream of phoning a pathologist to be informed of the MI in any case of melanoma. The MI given by the dermatopathologist in his report is irrelevant to me. On the other hand, if the melanoma has hemolymphatic invasion or neurotrophic differentiation,

I would be more worried. Only a few histopathological features – whether it is in situ or not, if there is vascular embolus or neural compromise, its thickness with all its flaws – and almost nothing else will make me change my course of action after confirming a diagnosis.

In my point of view, the importance given to the MI has only one and shameful purpose: to have more SLNBs (sentinel lymph node biopsy) made and therefore earn more money. The SLNB as it has been proven (MSLT-1) – and as foretold by Ackerman – is a procedure which does not offer any benefit to the patient with melanoma, no matter what its thickness is [3-7].

As it has frequently been written in this journal, I have been able to follow numerous cases of thin melanomas which have had dreadful endings in a short time and many other cases where melanomas were thick, ulcerated and with a lot of mitosis that after years remain alive. The consensus guidelines of staging and treatment for melanoma have reached the point that only papers and lectures which are in favor of SLNB are accepted and those that are against this procedure are censored [8]. Most of these “experts” are surgeons or oncologists who practice SLNB as a routine even in melanomas which are less than 1 mm thick or thicker than 4 mm. As I see it, the dermatologists that face this neoplasia day after day are scarce.

There is no doubt that the dermatologist is the best physician to address melanoma and, coupled with the dermatopathologist, is the one who will be responsible for the final diagnosis and treatment. Due to the narrow surgical margin with which we operate on the melanomas in our Department of Dermatology, we rarely refer any cases to a surgeon. We operate on them ourselves, and in our experience, we have had no cases of recurrence/persistence. Lymph node surgery is only carried out if some node is palpable at the moment of the diagnosis or in the follow-up. SLNB is not done in our department. We do inform the patient of the risk/benefit aspects of the procedure, and if the patient decides to have it performed, we refer him/her to another center.

It would be interesting to conduct another survey in the last issue of *Dermatopathology: Practical & Conceptual* in which well-known clinical dermatologists could be asked what importance he/she gives to the MI reports from the pathologist and if in a melanoma of 1 mm or less thick finding mitotic features would induce him/her to have a SLNB performed by a surgeon. It is my belief that such a survey would give us an idea of the number of dermatologists who think for themselves and those who just do what everybody does.

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