Melanoma: Head and Neck Regional Disease

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Disclosures

• None
Objectives

• Review surgical treatment and indications for adjuvant treatment of head and neck melanoma

• Review the role of Sentinel Lymph Node Biopsy and Neck Dissection in the management of head and neck melanoma
Melanoma Prevalence

- Head and neck melanoma accounts for 30% of all cases, due to sun exposure and melanocyte density.
Treatment of the Primary Lesion

- Wide Local Excision with appropriate margins (NCCN guidelines)
  - in situ = 5mm
  - 0-1mm = 1cm
  - 1-2mm = 1-2cm
  - >2mm = 2cm

- Acceptable to modify margins for anatomical considerations

- Intra-op frozen sections not reliable
Risk of Occult Regional Disease

- Tumor thickness: 0.76 - 1.5mm, 5% risk
- Tumor thickness: 1.50 – 4.0mm, 20% risk
- Tumor thickness: >4.0mm, 35% risk
- Overall 15-20% of clinically Stage I and Stage II lesions have occult Stage III disease
Sentinel Node Biopsy

- Introduced by Morton, et al, 1992
- Replaced elective neck dissection
Sentinel Node Biopsy

- Indicated for >0.75mm thickness, unknown thickness or ulcerated lesions of any thickness
- Allows detection of occult regional mets
- Promotes accurate staging and decision making for adjuvant therapies
Sentinel Node Biopsy

• Pre-op injection of radioactive sulphur colloid by nuclear medicine with subsequent SPECT scanning (usually 24 hrs in advance to reduce background during surgery)

• Injection of lymphazurin blue at time of surgery

• Location of injection is key!
Sentinel Node Biopsy

- False negative rate up to 10%
- Limit false negatives: remove all suspicious nodes, blue nodes and those with >10% of ex-vivo radioactive count of the most radioactive sentinel node
- Be prepared for parotidectomy (facial nerve monitoring)
Indications for Neck Dissection

• Clinically N+ disease
  • needs imaging (PET) first
• Positive sentinel lymph node - Recent data changing paradigm
• No role for elective node dissection (N0 or SLNB negative)
Neck Dissection

• Include involved lymph nodes and nodes at greatest risk according to drainage patterns, possibly including parotid

• For microscopic disease: functional neck dissection preserving SCM, CN VII & XI, and IJ

• For macroscopic disease: sacrifice of non-lymphatic structures should be based on clinical invasion
Radiation Therapy

- Melanoma historically deemed “radio-resistant”
- Historically used as primary treatment for unresectable disease or those medically unfit for surgery
- Adjuvant treatment for adverse features of primary tumor, regional disease and mets
Radiation Therapy for Primary Site

- Desmoplastic
- Positive Margin
- Locally Recurrent
- >4mm + ulceration
- >4mm + satellitosis
Radiation Therapy Cervical Nodes

- ECE
- Parotid
- 2 or more nodes or node > 3cm
- Locally Recurrent LN
- SLN+, no CLND
Systemic Therapy

- Interferon
- Immunotherapy
  - Ipilimumab (anti-CTLA 4)
  - Anti PD-1/PD-L1
Summary

• Surgery is still the primary and sometimes only necessary treatment for most melanomas

• For head and neck melanoma, Head and Neck Surgical Oncology consultation is advised