Five-millimeter lateral margins are appropriate in the treatment of melanoma in situ

To the Editor: We read with great interest the original papers by Kunishige et al published in 2019 and in 2015.[1,2] We found striking the high number of lesions that, according to their results, require at least margins >6 mm in the treatment of melanoma in situ (MIS) with Mohs micrographic surgery, with up to 18% of operations potentially leaving melanoma nests behind. Moreover, for nonlentigo maligna (non-LM) MIS, the standard treatment in daily practice in many centers, including ours, demonstrates to us that 5-mm margins are indeed adequate.

We proceeded to review the follow-up of MIS patients treated in our center with a 5-mm surgical margin in the period from January 7, 2006, to June 30, 2014, which therefore had a minimum follow-up of 5 years. Patients were monitored by in-office examination by a dermatologist. The variables we recorded were location, age, sex, lateral and deep margins, and adverse outcomes (recurrence and presence of a second tumor). We excluded patients with nail unit location, LM subtypes, or familial melanoma syndromes, and those patients with recurrence or a second melanoma. These last patients were excluded to eliminate the possibility that a new metastasis or any kind of melanoma cell growth could be potentially attributable to the previous tumor. Results are summarized in Table I. None of the patients showed recurrence or a second melanoma during a mean follow-up of 6.3 years.

Table I. Results summary

378 total melanomas
60 patients with melanoma in situ treated with a 5-mm lateral margin and deep to subcutaneous fat
Mean age: 61 years (range 28-91 years)
Location:
Upper extremities (33%)
Lower extremities (33%)
Back (20%)
Head and neck (4%)
Anterior trunk (2)
Mean follow-up: 6.3 years (minimum, 50 months; maximum, 124 months; median, 71 months)
No recurrence and no second melanomas

In the Kunishige et al[1] study reviewing 34 years, during the 1990-2003 period, HMB-45 was used as the immunostain, which they considered as unreliable in their report. Were most of the cases with wider margins from that period? Also regarding location, the study analyzed head and neck vs trunk and extremities, including acral and genital areas in the last group. How many of their cases requiring margins larger than 5 mm were located at these special anatomic sites? Although the study is important and has great impact, we think that these factors could partially explain such a surprising high number of cases requiring margins larger than 5 mm.

We agree that melanoma margins can be unpredictable, particularly in a background of chronically sun-damaged skin on the head and neck or acral locations, as demonstrated by Shin et al.[3] The National Comprehensive Cancer Network and the American Academy of Dermatology guidelines for melanoma management recognize the variability and complexity of MIS, and therefore, margin recommendations range from 5 to 10 mm, specifying that >5 mm may be required for LM subtype.[4] However, in addition to our comment, this article has even prompted national societies such as the German Society of Dermatosurgery to publish the recommendation of either maintaining the 5-mm margin or performing a complete margin analysis.[5]

The limitations of this brief report are that it is a retrospective study of clinical records and the sample size is small.

In conclusion, our experience is that 5-mm margins are appropriate for MIS on the trunk and extremities, excluding acral and genital locations. Until new evidence is available, only additional factors could justify a different margin as the initial approach.

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