# Progress toward diminishing the murkiness of Merkel cell carcinoma management

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***Key word:*** Merkel cell carcinoma.

Is there a more difficult task in dermatology than treating patients with Merkel cell carcinoma (MCC), an aggressive neuroendocrine tumor with a propensity for metastasis and a mortality rate exceeding that of melanoma? The diagnosis is usually unsuspected, with the lesion often considered to be a cyst or basal cell carcinoma; informing patients about their potentially fatal malignancy is a daunting endeavor.

In this issue of the *Journal of the American Academy of Dermatology*, there are 7 articles addressing MCC.

Tam et al[1] investigated whether women and men have disparate outcomes in MCC by studying the National Cancer Database and Surveillance, Epidemiology, and End Results Program database; women had a statistically significant survival advantage in both databases. The reason for this discrepancy is speculative but may be due to differing immunologic responses. Advances in digital imaging and microarrays may help predict prognosis. Moran et al[2] showed that MCC tumor cells with larger nuclear area and nuclear circularity were more likely positive for Merkel cell polyomavirus, correlating with improved overall survival.

In staging MCC, sentinel lymph node biopsy is considered crucial; however, optimal use of imaging is less clear. Maloney et al[3] studied a cohort of 331 patients with metastatic MCC. Those with a head/neck primary site had a higher proportion of liver metastasis, and those with a trunk primary site had a higher proportion of bone metastasis. Nguyen et al[4] evaluated 3670 patients in the National Cancer Database, concluding that an increased number of metastatic lymph nodes was associated with decreased survival ($P < .001$).

*Abbreviation used:*

MCC: Merkel cell carcinoma

Current MCC guidelines do not recommend baseline imaging for most patients. Singh et al[5] assessed 492 patients with clinically uninvolved regional nodes, finding that 13.2% were upstaged by imaging (8.9% in regional nodes and 4.3% in distant sites). Among 92 patients with clinically involved regional nodes, 10.8% were upstaged to distant metastatic disease. Large (>4 cm) and small (<1 cm) primary tumors were both frequently upstaged (29.4% and 7.8%, respectively). The researchers suggest that "baseline imaging is also indicated for clinically node-negative patients because upstaging is frequent and markedly alters management and prognosis."

National Comprehensive Cancer Network guidelines recommend wide excision with 1- to 2-cm margins for MCC treatment. Wilkerson et al[6] performed Mohs micrographic surgery (MMS) or wide local excision with marginal assessment (frozen sections) on 22 patients with MCC. Thirteen (59.1%) patients had a positive initial margin (first stage), with all patients having negative margins upon excision of a subsequent stage. Given the importance of negative margins, the investigators suggest that a method of complete margin assessment be used.

Tarabadkar et al[7] analyzed 188 patients with MCC presenting without clinical nodal involvement.

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Adjuvant radiation-treated patients tended to have higher-risk tumors (larger diameter, positive microscopic margins, immunosuppression), yet had fewer local recurrences than patients treated with surgery only (1% vs.15%; $P = .001$). The researchers concluded that for patients with MCC treated with adjuvant radiation, local control was superb, even with significant risk factors and narrow surgical margins—they propose an algorithm for MCC management.

As the incidence of MCC continues to increase worldwide, be cognizant of forthcoming diagnostic and therapeutic advances to tame this oncologic beast.

**Conflicts of interest**

None disclosed.

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