LETTERS TO THE EDITOR

IS PROPHYLACTIC POPLITEAL NODE DISSECTION NECESSARY IN MALIGNANT MELANOMA OF THE FOOT?

Sir,

One major controversy in the treatment of malignant melanoma of the foot relates to the prophylactic groin dissection. However, literature has been relatively silent concerning prophylactic popliteal node dissection with or without groin dissection.

A case of melanoma of the right foot with popliteal node metastases five years after the removal of the primary lesion on the sole of the foot is hereby reported.

J.H.M.Q. is a 45-year-old male Saudi who presented on 20th February, 1990 with a one-year history of a painless ulcer on the lateral aspect of the sole of the right foot. On February 25, 1990 the ulcer and a palpable inguinal lymph node were biopsied. The ulcer confirmed malignant melanoma extending to the papillary and reticular dermis. The inguinal lymph node was positive for metastases.

Eight days after the biopsy, i.e. 4th March , 1990, the patient had a wide excision of the ulcer and a block dissection of the right groin. The melanoma was classified as Clark's level IV. Immediate post-operative course was uneventful and he was being followed-up in the outpatient clinic.

Patient was re-admitted again on 12th November, 1994 because of pain and swelling in the right popliteal fossa. Examination revealed a nodule at the edge of the skin-graft of the previous excision, a swelling just above the right lateral malleolus, a swelling in the right popliteal fossa and another one in the right iliac fossa. However, it was the popliteal swelling that was giving the patient a lot of discomfort.

On 24th November, 1994 the right popliteal swelling was explored and the mass which was posteriorly located to, and stretching the popliteal artery, popliteal vein and the posterior tibial nerve, was removed intact. The nodule just above the lateral malleolus was also removed. Both turned out to be malignant melanoma secondaries.

Even though this has become a widespread disease, the rationale for the popliteal fossa dissection was pain caused by the metastases impinging on the popliteal structures.

According to the International Union Against Cancer (UICC) classification, it has been shown that in solitary cutaneous malignant melanoma, patients in group pT4a, pNO (primary tumour thickness of more than 4mm or invasion of subcutis and absence of regional lymph node metastasis in elective lymph node specimen) have a 5-year survival rate of 72.8%(1) and patients with regional lymph node metastases have an average 5-year survival rate of 39% depending on the number of involved lymph nodes, and not the size of metastases(1).

A multicentre study from nine different medical centres suggests that elective lymph node dissection for the treatment of the non-metastasised malignant melanoma shows improvement of five-year survival rate of about 20% in males in certain circumstances(2). It has also been shown that histologically, Clark's classification for malignant melanoma is a better predictor of survival than Breslow's classification(3)

In this case presented, it is conceivable that as long as metastases are present in the popliteal fossa, block dissection of the groin alone may not necessarily arrest the spread of the tumour cephalad. Therefore there may be justification for also performing a popliteal fossa dissection if inguinal node dissection is to be performed in cases of malignant melanoma of the lower extremeties particularly in the lateral lesions of the sole.

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