

Actual Perspectives in Surgical Management of Metastatic Melanoma

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Melanoma can metastasize everywhere (Figures 1 and 2).

The reported 5-year survival for patients with metastatic melanoma is dramatically poor [1].

Advanced melanoma continues to be a challenging disease to treat.

In the past, no systemic therapies have consistently impacted the overall survival of this kind of patients, and surgery has been considered the best therapy in patients with solitary metastases, especially confined to the subcutaneous tissues, non-regional lymph nodes or lung, when carefully selection of patients indicated a favorable biology of the disease.

Actually the emergence of innovative diagnostic and therapeutic developments gives the chance to surgical oncologists to combine surgery with novel immunotherapies and molecularly targeted therapies, to improve survival in patients with metastatic melanoma, above all to resurvey surgical intervention in all stage IV melanoma patients who are candidate for these new treatments [2,3].

Additionally electrochemotherapy, a non-thermal tumor ablation modality, whereby the application of electric currents on cancer tissue renders the cell membrane permeable to non-or low permeant antineoplastic drugs, thus potentiating their cytotoxic effect directly inside the cellular DNA, also represents a precious option for obtaining

rapid tumor control in patients with symptomatic superficial skin and subcutaneous metastases [4].

Surgery remains the method of choice for melanoma metastases, if complete removal is practicable. No data exist on adjuvant therapy following successful resection in stage IV disease. Inclusion into a clinical trial should be considered and close clinical and radiological follow-up is suggested.

Every patient with metastatic melanoma requires an interdisciplinary evaluation on an indication for surgical therapy, if technically possible.

References

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Figure 1: Melanoma metastatic to eyelid.

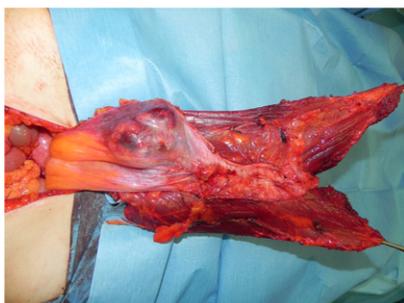


Figure 2: Visceral metastases by melanoma.

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