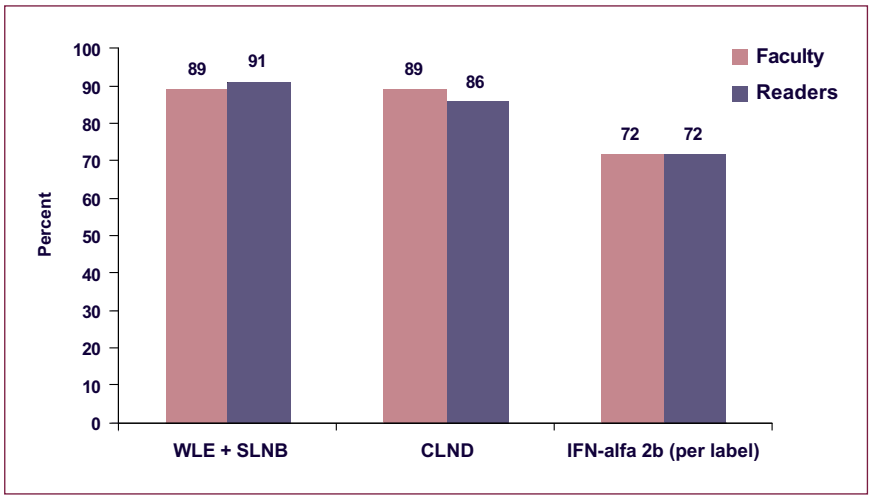
Feedback on Case 1: 2.0 mm Melanoma

Check here each month for the polling results from our previous cases. We will report on the answers given by you, our readers, to the pre test and post test questions, so that you see how your management style compares to the styles of your peers and our faculty.

Case 1 (January issue) concerned a 45-year-old man with a 2.0 mm thick, Clark level, nonulcerated melanoma on the arm. At the time of this writing, the management approach of the participants matched that of the faculty in most instances.

See the graphic for a comparison of the pre-test questions. Most faculty and readers would elect for a wide local excision (WLE) and sentinel lymph node biopsy (SLNB) rather than a simple local excision or WLE without SLNB. Also, if the SLNB was positive, most faculty and readers would opt for a CLND. If the remaining nodes were negative, the majority would recommend 1 year of IFN alfa-2b per label, although a notable percentage (18% of faculty and 15% readers) would consider enrollment in the ECOG 1697 clinical trial (IFN alfa-2b vs. 1 month observation). Fewer (8% of faculty and 4% of readers) would recommend a melanoma vaccine.



Strategy: 2.0 mm, Clark Level IV melanoma.

Since so many of the readers were in accord with the faculty, it was not surprising that only a small percentage (15%) would change their management strategy based on reading the newsletter. After reading the article, 100% of readers would have performed a SLNB (up from 91%), while the percentage who would recommend IFN-alfa 2b per protocol after CLND were similar pre and post poll (72% vs. 74%).

These results are consistent with an aggressive approach to high-risk melanoma that includes SLNB, CLND, and adjuvant therapy for micrometastatic nodal disease among the faculty and the readers.