



## Diagnosis of Primary Cutaneous Melanoma: Make More Good than Harm

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### Editorial

Melanoma, the pigmented malignant tumor of the skin, although its treatment has shown tremendous improvement in the recent decades, still is a life-threatening disease, a serious burden on the society, not to mention the suffering for the patient and relatives. Melanoma is a neoplastic disorder produced by malignant transformation of the normal melanocytes, cells responsible for the production of the pigment melanin, at the dermal-epidermal junction of the skin. Melanoma is getting more and more common due to thinning of the depletion of ozone layer in Earth's atmosphere, changing of sunbathing habits and the spread of the use of the solarium.

Exposure to UV radiation is the most important modifiable risk factor for melanoma [1]. UV-B radiation, the so called "sunburn spectrum", is the most damaging and has been a major concern. People who work indoors, and who enjoy the sunbathing intermittently and intensively during holiday seasons, or recreational activities are prone to melanoma.

Early detection is possible by self-examination, education of the public on sun protection, and by opportunistic screening, i.e the examination of entire body surface with a special instrument, dermatoscope. Organised population screening is not feasible due to insufficient evidences of effectiveness.

### Prevention

Family physicians have the opportunity to diagnose the pigmented lesion early enough for a timely biopsy; however, to perform by themselves an excisional biopsy of skin lesions suspicious for melanoma is not advisable [2]. The patients suspicious for melanoma need to be referred to dermatologist who is specialist in diagnostics (including performing biopsy) and treatment of melanoma. For an accurate diagnosis and for optimal stages, biopsy of a suspicious lesion is necessary. However, doing biopsy deserves special caution and skill. The correct way to perform such a biopsy is to make a full-thickness excision of the entire lesion with a 1 mm to 2 mm margin of normal skin. The depth of excision should include the full thickness of dermis, and should extend into the subcutaneous tissue; this allows the assessment of the architecture of lesion, permits an accurate measure of thickness which is critical for prognosis and influences the surgical treatment recommendations.

The best predictor of metastatic risk is the depth of invasion of primary melanoma measured with an ocular micrometer, defined Breslow [3] and Clark [4] and, important in staging and prognostic stratification, an important histopathology feature closely associated with the risk of melanoma and death from melanoma. The current melanoma staging system of American Joint Committee on Cancer (AJCC) identifies tumor in TNM-stages [5].

Sentinel lymph node biopsy technique was introduced in the early 1990s as a less invasive procedure than complete lymph node dissection to allow histopathological evaluation of the sentinel lymph node, which is the first node along the lymphatic pathway from a primary tumour [6]. The biological hypothesis that the pathological status of the sentinel lymph node reflects the entire pathological situation of all the other nodes of the region was confirmed by clinical experience, consequently, if the sentinel lymph node is pathologically negative, all the other nodes of the same area are cancer-free [7].

The author would like to conclude warning: melanoma is the most aggressive malignancy which deserves particular attention. After "a suspect lesion" is detected, the diagnostic procedure is better to leave to a dermatologist who is especially knowledgeable and skilful to manage it. The inadequate excision can make more harm than good.

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