

New aspects of surgery for cutaneous malignancies

Summary of the Ph.D. Thesis

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List of full papers related to the subject of the dissertation

- I. **Kocsis A**, Karsko L, Kurgyis Z, Besenyi Z, Pavics L, Dosa-Racz E, Kis E, Baltas E, Ocsai H, Varga E, Bende B, Varga A, Mohos G, Korom I, Varga J, Kemeny L, Nemeth IB, Olah J: Is it Necessary to Perform Sentinel Lymph Node Biopsy in Thin Melanoma? A Retrospective Single Center Analysis. Pathology and Oncology Research 2020; 26 (3): 1861-1868. doi: 10.1007/s12253-019-00769-z.

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- II. Mohos G, **Kocsis Á***, Erős G, Korponyai C, Varga Á, Bende B, Varga J: Reconstruction of alar-perialar defects with a combined subcutaneous and cutaneous pedicled rotation-advancement nasolabial flap. Journal of Investigative Surgery 2020; 33(7):666-672. doi: 10.1080/08941939.2018.1538397 Mohos G and Kocsis Á contributed equally to the work

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- III. **Kocsis Á***, Mezőlaki N*, Porkoláb D, Mohos G, Kis E, Varga J, Baltás E, Ócsai H, Korom I, Varga E, Németh IB, Kemény L, Oláh J: Órszemnyirokcsomó áttét kimutatása vastag melanomában esélyt ad ígéretes adjuváns kezelésre Orvosi Hetilap 2020 (accepted for publication)

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List of other full papers

- I. Varga J, Mohos G, Varga Á, Erős G, Bende B, Németh IB, **Kocsis Á**: A possible technique for the complex reconstruction of exposed breast implant: applicability and microcirculation of the capsule flap. Journal of Investigative Surgery 2019; 32(6):530-535. doi:10.1080/08941939.2018.1442532

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- II. Varga J, Pintér S, Mohos G, Kis E, **Kocsis Á**, Nagy K, Kemény L: Kutyaharapás után kialakult felső ajak hiány rekonstrukciója Kazanjian lebennyel. *Bőrgyógyászati és Venerológiai Szemle* 2009; 85(2):83-85.
- III. Vas K, Gaál M, Varga E, Kovács R, Bende B, **Kocsis A**, Kemény L: Effects of the combined PDL/Nd:YAG laser on surgical scars: vascularity and collagen changes evaluated by in vivo confocal microscopy. *Biomed Research International* 2014; 2014:204532. doi: 10.1155/2014/204532. Epub 2014 Sep 9.
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- IV. Varga J, Bende B, Altmayer A, Gaál M, Kis E, **Kocsis Á**, Mohos G, Varga Á, Vas K, Veréb Z, Kemény L: Új terápiás lehetőségek a plasztikai sebészet és a dermatológia határterületén. *Bőrgyógyászati és Venerológiai Szemle* 2019; 95(2):69–73. DOI 10.7188/bvsz.2019.95.2.7

1. INTRODUCTION

1.1. Epidemiology of skin malignancies

Non-melanoma skin cancer (NMSC) and malignant melanoma (MM) are the most common form of cancer in the Caucasian population. Although malignant melanoma is not as frequent as the non-melanoma skin cancer, but accounting for 90% of the deaths associated with skin malignancies and therefore is the most lethal form of skin cancer.

The NMSC refers to all skin cancers that do not arise from melanocytes. Squamous cell carcinomas and basal cell carcinomas (BCCs) account for 99% of cases. The incidence of basal cell carcinomas is 3 to 5 times that of squamous cell carcinomas.

These tumours derive from epidermal cells, usually on sun-exposed areas, according to a recent study, the most common site of BCCs is the head and neck region (80%). The BCCs usually grow slowly, while SCCs may develop more rapidly. However, both types of tumours may cause significant local destruction, asymmetry or disfigurement. There are various treatment modalities available depending on size, location, clinical and histological features, age, and comorbidities. Nevertheless, surgical excision with a proper surgical margin is still the gold standard treatment. Complete removal of the tumor is essential to local tumour control and results in healing in the vast majority of patients. According to a recent study, the nasal region (31,82%) was the most common site of BCC, followed by the periorbital (13,64%) and cervical (12,5%) units. In this study, half (50%) of the nasal BCCs affected the alar region.

1.2. Surgical treatment of skin malignancies

Over the past few decades, similar to breast cancer patients, the mechanical approach has been replaced by a biological approach in the surgical treatment of melanoma.

The 1st version of the American Joint Committee on Cancer (AJCC) Tumor Node and Metastases (TNM) Melanoma Staging system provided a different approach to surgical treatment instead of the prophylactic radical selective regional block dissection. Based on the Multicenter Sentinel Lymphadenectomy Trial (MSLT) – 1 sentinel lymph node biopsy was found biologically relevant in intermediate thickness melanoma, and the sentinel lymph node positivity was found to be the single most important factor in overall survival. The latest and most important advancement in the therapy in the 2010s was the FDA approval of checkpoint inhibitor immunotherapy and a few years later, the targeted therapy in metastatic melanoma. In the adjuvant setting, for patients with high risk resected melanoma immun checkpoint

therapy such as PD-inhibitor is the preferred drug of choice. After multimetastatic (>3 positive lymph nodes) block dissection or resected lymph node metastasis with capsular involvement, additional irradiation also should be considered.

The indication of SLNB has changed several times over the decades because its beneficial effect on overall survival has been mostly demonstrated in intermediate-risk primary melanoma (with an absolute tumor thickness of 1–4 mm).

On the other hand, a debate has been going on in the literature about the need of sentinel lymph node biopsy in case of thin (<1mm) and thick (>4mm) melanomas. However, most authors agree that SLNB may be recommended in these cases after a thorough discussion with the patient of the potential benefits and risk of harms associated with the procedure.

The predictive role of sentinel lymph node positivity in thin melanoma has been investigated and reported by several authors. There is a consensus in the literature that the metastatic involvement of regional lymph nodes is still one of the most important prognostic factors of thick and thin cutaneous melanomas as well. However, the criteria and the indications of thin melanomas for SLNB are inconsistent and the results both contradictory and incoherent.

According to AJCC 7th recommendation (2009), SLNB should be considered in the case of melanomas ≤ 1 mm in thickness, with ulceration or with even a single mitotic figure. The local guidelines for thin melanomas were modified at our department in early 2011 and the AJCC 7th adopted, as SLNB was offered not only if ulceration was present but if mitotic rate $\geq 1/\text{mm}^2$ of the tumour area. According to the new AJCC 8th guidelines, which was published in 2017, the tumour thickness measurements should be recorded to the nearest 0.1 mm, not 0.01 mm. The definitions of T1a and T1b tumours were revised (T1a <0.8 mm without ulceration, T1b 0.8-1.0 mm with or without ulceration or <0.8 mm with ulceration), and the dermal mitoses are not considered for pT1b, however, mitotic activity should be noted as an independent prognostic factor. There have been other key changes in the N and M classification as well.

More recently, it has even been questioned whether the extension of radical node dissection is necessary in cases with histologically positive sentinel lymph nodes. Nowadays, more and more high-level evidence supports the fact that complete radical node dissection, which is associated with increased morbidity, improves neither the overall survival nor the progression-free survival of patients with melanoma. Instead of the radical surgical treatment of lymph nodes, systemic therapies are becoming more relevant.

The indication for the modern adjuvant therapy of melanoma cannot be established without the histological assessment of sentinel lymph node biopsy; thus, this staging method is more and more recommended in the guidelines. Nowadays, stage III melanoma (i.e., melanoma with metastatic involvement of the regional lymph nodes) is the prerequisite for both targeted and immuno-oncological adjuvant therapies.

The aim of surgical treatment in the case of NMSCs is the complete resection of the tumour with preserving the function and achieving the best possible cosmetic result. In the case of low-risk tumours the recommended safety margin for BCCs and SCCs is 4 and 6 mm, respectively. In case of high-risk NMSCs Mohs-surgery or excision with wider surgical margin is recommended. However, this margin is not generally specified, mostly individual and depending the exact subtype of the tumour.

In our practice, in case of tumours when primary closure of the defect is not possible slow Mohs-surgery or multistage technique is performed.

The defect of the removed tumor in this procedure is closed only after tumor-free margins are proved, with delayed coverage. This technique provides reliable surgical care in a tissue-friendly manner, with acceptable speed and outstanding cost-effectiveness.

According to the epidemiological data the tumours in the alar region of the nose are relatively common and should be considered high risk according to the 2018 NCCN Guidelines, therefore wider surgical resection margin or Mohs (or slow Mohs) – surgery is recommended. After the removal of the tumour in the alar region, the remaining defect usually involves multiple cosmetic units, destroying the supra-alar, alar-facial groove, and the melolabial fold. Traditionally, the defined C-shaped perialar area includes the superior labial tissue, melolabial fold, medial cheek, and nasal tissue superior to the nasal alar crease. If the defect is localized to a single esthetic unit and side-to-side closure is not possible, owing to the size, V-Y advancement island pedicle flap is the most frequently chosen technique. It is an important principle that if the defect affects more than 50% of an esthetic subunit, the whole subunit is advised to be reconstructed with the excision of the remaining subunit. Maintenance of the natural curvatures and facial symmetry without impaired airflow is an important factor when performing flap closure in the alar region. Defects localized to the nasal ala and C-shaped region usually require multiple combined flaps and further additional procedures.

1.3.Aims

1. We aimed to investigate the predictive value of mitotic rate and to analyse further clinicopathologic predictors of positive SLNB by examining the common feature of these metastasizing cases in order to prevent the majority of the T1b melanoma patients from undergoing SLNB. Cases were also reassessed according to the AJCC8th guideline and additional statistical analyses were performed to re-evaluate the prognostic value of the well-known histological parameters considering AJCC8th.
2. The surgical approach of the centers designated for the treatment of melanoma is not completely uniform. There are centers where sentinel lymph node biopsy has been largely omitted in the treatment of melanomas thicker than 4 mm. Since the risk for distant metastasis development is high in this patient group, the early administration of systemic therapy is essential. Currently available clinical data suggest that the detection of clinically occult metastases is the only option to indicate targeted and immuno-oncological adjuvant therapies; thus, the failure to perform sentinel lymph node biopsy significantly should reduce patient survival. Given the Hungarian situation, the question arises of how many patients with thick melanoma at high metastatic risk might be unable to take advantage of novel adjuvant therapies because sentinel lymph node biopsy has not been performed. At our the Department, we have consistently performed sentinel lymph node biopsy in patients with melanoma thicker than 4 mm; therefore, we decided to evaluate the proportion of sentinel lymph node positivity in this high-risk patient group.
3. Since the BCCs are frequent in the alar and perialar region, our aim was to introduce a variation of cutaneous-subcutaneous pedicled rotation-advancement flap for the reconstruction of the thin alar and adjacent deep perialar defects in a single step procedure with an appropriate cosmetic result.

2. PATIENTS AND METHODS

2.1.Melanoma

2.1.1. Patients with thin melanoma

A retrospective review was conducted involving patients treated at our department with thin melanomas (<1mm) between January 2011 and December 2014. During these four years, 625 primary melanomas were diagnosed at our department. Four hundred and three pT1 melanoma patients entered our study; among these cases, 152 patients suffered from pT1b

ulcerated or mitotic rate $\geq 1/\text{mm}^2$ melanomas according to the AJCC7th staging system. SLNB was offered to most eligible patients with pT1b melanomas as part of their surgical management in the absence of clinically evident nodal disease, or known distant metastases. SLNB was not advised if any sign of dissemination was detected in the case of high biological age, severe comorbidities or pregnancy. Some patients had declined surgery. Seventy-eight cases of SLNB were included in the study based on the criteria which are listed below.

2.1.2. Patients with thick melanoma

In our retrospective study, the medical records of newly diagnosed melanoma patients with tumor thickness over 4 mm were reviewed at the Department of Dermatology and Allergology, University of Szeged over a 5-year period (from 2007 to 2011). The parameters evaluated included prognostic factors, such as gender, age, Breslow's thickness, localization, and histological assessment of the sentinel lymph node.

2.2. Patients with alar-perialar defects

Ten patients were included in this study, mean age was 77. Skin defect was localized to the alar region, the alar-facial groove, the upper lip and the cranial part of the nasolabial fold after the tumor was removed. The extent of the defects following tumor excision ranged from 1.8cmx1.8cm to 2.6x2.9cm. Histological examination revealed basal cell carcinoma with tumor-free margins in all cases. Reconstruction was only performed once final histological result was obtained. This took 2–3 days, during which period a temporary coverage was used. The mean follow-up was 7.5months (ranges from 5 to 15months).

2.2.1. Surgical Procedure

The flap was designed by marking the nasolabial fold and a curved line from the distal-lateral part of the defect according to the relaxed skin tension lines. These lines matched in a distal point, marking the size and shape of the flap. Incision was performed on the lateral line, followed by subcutaneous tissue dissection and mobilization of the lateral wound edge, if necessary. The cutaneous branches from the medial part and the subcutaneous perforator branches from the inferior part of the flap were hereby preserved. The flap was pulled to the cranial point of the defect. If necessary, a cut back was performed distally in the nasolabial fold so that the flap could be easily placed into the defect. Following temporary fixation of the proximal part a marking was performed on the flap according to the alar-facial groove. The flap was thinned proximally from this marking. This part was used to cover the alar fragment of the defect. The prospective fold can be fixed to its base in the alar-facial groove with one or

two 5/0 absorbable sutures if the flap is elevated. Wound closure was performed with 5/0 absorbable and 5/0 permanent sutures. Drainage or compression was not necessary. An examination was performed 10 days after the surgery, stitches were removed this time. The second examination was in the 3rd postoperative week. Following this, the patients were examined in each 3 months. During the postoperative period, different complications were monitored and evaluated as described below. If it was necessary, antibiotic therapy was launched which involved daily 1.000 mg cefuroxime (2x500 mg) administered orally.

2.2.2. Result evaluation methods

Laser Doppler Flowmetry

Laser Doppler flowmetry was chosen for the determination of the microcirculation since it is an accepted and reliable method for this aim. Perfusion of the flaps was monitored by means of the PeriFlux System 5000 (Perimed, Jarfalla, Sweden), as described in a previous study.

Evaluation of Complications

The following signs and aspects were monitored: edema, erythema, hematoma, trap-door deformity and need for resuturing/reoperation.

Patient Satisfaction

Each patient was asked to complete a patient satisfaction questionnaire in the 6th postoperative month.

3. RESULTS

3.1. The role of sentinel lymph node biopsy in thin melanoma

In addition of local wide excision SLNB was also performed in 78 cases. The majority of patients were sentinel node-negative (n=69); in nine cases (11.5%) metastasis was detected in the regional lymph nodes. Complete lymph node dissection (CLND) was performed in 7/9 positive SLN cases. Additional metastatic LNs were found in two cases.

Site of the primary tumour and SLN

Among patients who underwent SLNB, the most frequent location of the primary tumours was the dorsal region of the trunk (27/78 overall, 14/34 in men and 13/44 in women); however, a high proportion of the tumours were located on the lower limbs in the women

(16/44). In our series, the SLN positivity was independent of the location of the primary tumour (Fisher's exact test $p=0.9312$).

As regards the location of the sentinel nodes, 46 patients had axillary SLNB, in seven cases from both sides. Six of these 46 patients had metastatic lymph nodes. Three patients had sentinel nodes from both the axillary and inguinal regions; one of these patients had a positive sentinel node. In 22 cases, the nodes were removed from the inguinum (1 positive) and in the case of two patients from the popliteal region as well (1 positive). Four patients had sentinel nodes in the neck, and one patient had a sentinel node at an atypical site (over the scapula).

Age and gender

The overall male/female ratio was 1:1. Of the patients who underwent SLNB, 43.5% were male, and the median age was 48.5 years (range 20–77 yrs). The onset of melanoma diagnosis did not differ significantly in the node-negative (48.8 yrs) and node-positive (46.3 yrs) groups. However, the mean age with pT1b/nodal involvement was 58.2 and 31.5 years among men and women, respectively. Moreover, in the younger age group (<35 yrs) the SLN positivity rate was 22.2%, which is higher than the average in all cases.

Multivariate logistic regression modelling demonstrates the association between SLN positivity and age, gender, Breslow, Clark level, and regression. The presence of regression in the primary tumour increases the probability of sentinel positivity by 5.796-fold. There was a significant correlation noted between histological regression and sentinel lymph node positivity, however, no significant relation between the other characteristics examined (age, gender, Breslow, Clark level, mitosis index; Nagelkerke R square=0.7). After reassessing the pT stage according to the AJCC8th guideline, 37 patients were reclassified from pT1b into pT1a category. By repeating the statistical analyses there was no significant association between reclassified stage and SLN positivity indicating that regression may have independent prognostic value on the lymphatic spread of melanoma.

3.2. The role of sentinel lymph node biopsy in thick melanoma

Between January 1, 2007 and December 31, 2011, we diagnosed 1133 patients at our Department with melanoma; out of these patients, 116 had a thick (Breslow's depth >4 mm) primary tumor (10%). We performed sentinel lymph node biopsy in 78 cases. In 19 cases, the presence of palpable metastatic lymph node had already made the assessment of the sentinel lymph node unnecessary. In addition, in 7 patients, the advanced age/presence of comorbidities disallowed us from performing the intervention. In 2 cases, there was a

technical failure, and one patient refused to undergo the intervention. The mean age of the patients with thick melanoma was 60.97 years (n=107) at the time of the diagnosis, whereas it was slightly lower (57.89 years) in cases that were subjected to sentinel lymph node biopsy (n=78). This finding is consistent with the fact that we did not perform the intervention in 7 cases with a higher age (>80 years). We detected no significant difference concerning the age of histologically positive (57.64 years) and negative (58.769 years) patients. The localization of sentinel lymph nodes showed the following distribution (n=88): 51 (57.9%) in the armpit, 24 (27.2%) in the inguinal region, and 6 (6.8%) in the neck. Atypical sentinel lymph nodes were detected in the popliteal region in 4 cases, and in-transit nodes on the back of 3 patients. Of the 78 sentinel lymph node biopsies, 28 (36%) had no histologically detectable melanoma metastasis, whereas 50 (64%) had histologically detectable lymph node metastases. These patients gave almost two thirds of the cases, and that is a remarkably high rate, and these patients could be classified into stage IIIC, according to the latest (8th) edition of AJCC TNM. The mean Breslow's depth was 6.79 mm in high-risk melanoma patients (n=107), 6.40 mm in patients undergoing sentinel lymph node biopsy, 6.25 mm in patients with positive SLNB, and 6.67 mm in patients with negative sentinel lymph node biopsy.

3.3. Successful alar-perialar reconstruction and good aesthetic results with our method

We performed a combined cutaneous and subcutaneous pedicled rotation-advancement skin flap, contrary to the widely applied subcutaneous island pedicle flap. With this method, there is no (or short) incision in the nasolabial fold. This preserves the vascular supply better and provides more preferable cosmetic results with fewer scars.

As concerns perfusion of the flaps, laser Doppler flowmetry has revealed a significant decrease in the blood flow after preparation of the flap as compared to the baseline. However, microcirculation has shown a considerable improvement during the 1st postoperative day. Day 1 perfusion values did not differ significantly from baseline. Sufficient blood flow was observed in the later period, as well. Week 3 values did not display significant difference as compared to the baseline.

Mild edema was noticeable in three cases during the 2nd-8th postoperative weeks that was resolved with scar treatment and massage of the flap. In two cases, mild erythema was observed which ceased after the antibiotic therapy. Mild trap-door deformity was found in one case. Hematoma was not observed and none of the patients required reoperation/resuturing.

The 6-month postoperative cosmetic result was outstanding. There were no further complications or need for additional correction. The majority of the patients reported only mild or moderate postoperative pain. They were also satisfied with the esthetic and the functional results of the intervention.

4. DISCUSSION

4.1. Sentinel lymph node biopsy and prognostic factors in thin melanoma

SLNB has become standard procedure for the staging of the regional nodal basin in patients diagnosed with thin melanoma and remains one of the most important predictive factors of the outcome for these patients. Several authors have attempted to identify predictive risk factors for nodal metastases in thin melanomas, including Breslow thickness, ulceration, regression, Clark level, age, and tumour-infiltrating lymphocytes to prevent overtreatment of these patients. However, no widely accepted consensus exists as to which patients are at risk for nodal metastases.

Age and Gender

Younger patient age is associated with a higher nodal metastasis rate among melanoma patients in general; however, the available studies in thin melanoma are inconsistent on this factor, and there is no widely accepted specific age cut-off value under which SLNB should be performed. In our study, we did not apply a particular cut-off age for SLNB (range 20–77 years). We placed emphasis on the characteristics of the tumour rather than on comorbidities or biological age. However, our study did not identify any significant difference with regard to age among the SLN-positive and -negative groups. On the other hand, a marked difference was observed between male and female patients with metastatic SLNs. The mean age of SLN-positive men was 58.2 years versus 31.5 years among women. This might be the result of the small sample size of patients involved, and further investigation may be required.

Breslow thickness

The thickness of melanoma is generally considered the most useful prognostic factor in patients with thin melanoma. In a study of 121 thin melanoma cases, Hinz et al. found that all SLN-positive patients belonged to the subgroup of tumour thickness range 0.9–0.99 mm. Han et al. reported that a Breslow thickness of ≥ 0.76 mm is associated with a 4.9–12.8% rate of SLN metastases. However, according to these studies, only 0–2.3% of melanomas < 0.76 mm is associated with nodal disease. Our results are similar for thin melanomas < 1 mm (11.5 %)

but we have found a relatively high positive sentinel rate (8%) for primary melanomas <0.8 mm. While Murali et al. reported that patients with thin melanomas of <0.50 mm have negative SLN stage, Bagaria et al. reported that melanomas of <0.50 mm are identified as a factor of worse prognosis in term of SLN metastases. In our series, 1/9 cases of primary melanoma <0.50mm had nodal metastasis. Interestingly, we found no significant difference in sentinel nodal metastases between the <0.76 mm and the 0.76–1.00 mm groups.

Ulceration

According to the latest two AJCC Melanoma Staging and Classification schemes, thin melanomas continue to be classified as T1b by the presence of ulceration. Several studies have reported that ulceration is a rare event (1–15%) in thin melanomas. In our series, only 12 melanomas were ulcerated among the 152 pT1b tumours (7.9%). In the group of patients that underwent SLNB, 8/78 primary tumours (10%) showed ulceration. In their study of 147 thin melanoma patients, Yonick et al. found that ulceration (and Breslow thickness) was an independent predictor of nodal disease. However, most studies have not shown ulceration as a significant predictor. Kesmodel et al. reported that 181 thin melanoma patients with positive SLNs showed no signs of ulceration in the primary tumour. Our results are consistent with these findings. None of the primary thin melanomas showing ulceration had nodal metastasis.

Mitotic rate

Mitotic rate (MR) is defined as the maximum number of dermal mitoses per mm². According to the staging system for melanomas in the AJCC^{7th} edition, even a single mitosis can be categorized as T1b in the case of a small dermal tumour area, and, therefore, SLB should be considered. However, with only one mitotic figure being the cut-off point, this method may be unreliable even with an additional immunohistochemistry. Several authors have reported that primary melanoma mitoses predict SLN status. Furthermore, Sondak et al. have found young patients (<35 years) that showed an MR correlation with a positive SLN. Interestingly, this was not the case with Breslow thickness. Other studies showed no such association, even revealing that up to one-third of SLN-positive thin melanomas have zero mitosis. In our study, there was no observable significance in mitotic rate between the node-positive and -negative group (Student t-test; $t=-0.688$; $df=76$; $p=0.494$).

Regression

The clinical significance of clinical and histological regression in melanoma is still debated, with numerous studies reporting a higher rate of metastasis in thin, regressed melanomas. In

our previous study, we also found that tumour regression predicts a higher risk of sentinel node involvement in melanomas <2.0mm in a series of 134 melanoma patients. Other authors showed no association with recurrence or survival. This contradiction could be explained in part with the lack of a uniform definition for regression. Without these uniform criteria, the reproducibility of the results may be difficult. At our department, we used the criteria suggested by the Pathological Group of the WHO Melanoma Programme for the definition of regression. This includes the presence of a zone of tumour-free epidermis and dermis in which there is fibrosis, often along with inflammation and dilated vessels, flanked on one or both sides by a tumour. These criteria for regression are also involved in the study by Botella-Estrada et al. regarding (i) decrease or absence of melanoma cells in the dermal component of the tumour, presence of (ii) fibrosis, (iii) inflammatory infiltrate, (iv) melanophages, (v) neovascularization, (vi) epidermal flattening and (vii) keratinocytic/melanocytic damage. Features (i–v) together are considered obligatory elements for the diagnosis of regression. The extension of regression was horizontally evaluated and divided into focal or main categories; the cut-off point was a percentage of 75% in the horizontal extension of primary melanoma.

In our recent study using univariate and multivariate logistic regression analysis, regression turned out to be the only significant independent predictor of SLN metastases (OR=5.123). These results confirm our previous findings that patients with Breslow <2.0mm but regressing melanomas have a four-time higher relative risk of developing nodal metastases than patients with non-regressing melanomas. This may verify our previous hypothesis that histological regression can result in a decreased Breslow thickness measurement and thus in some cases an erroneously more favourable prognostic estimate. In contrast, the overvaluation of early regression signs may also result in false regression data for statistical analyses.

4.2. Benefits of sentinel lymph node biopsy in thick melanoma

Over the five-year study period, 1133 melanoma patients were diagnosed and treated at the Department of Dermatology and Allergology, University of Szeged, Hungary. According to the Hungarian Cancer Registry, it is one-tenth of the 9862 melanoma patients diagnosed during the same time period in Hungary. Based on the data of melanoma patients treated at our department, there are up to hundred of advanced melanoma patients with absolute tumor thickness over 4 mm every year who may need to be treated with adjuvant therapy or are expected to respond more effectively at conducting adjuvant therapy with innovative agents.

Since the turn of the millennium, with the advancement in molecular sciences, it has become known that alterations in the RAF-MEK-ERK signaling pathway play a major role in the

development of this type of tumor. In patients with metastatic melanoma with V600 mutation of the BRAF gene, BRAF-MEK inhibitors are the current standard of care. For BRAF wild-type metastatic tumours, immunotherapy is the first-line treatment, with PD-inhibitors being the preferred drug of choice. As a result of these treatments, the survival rate of melanoma patients has improved remarkably, and nowadays, every third patient treated with metastatic melanoma is still alive after five years, which is a significant improvement compared to the previous, very modest average survival of a few months.

In the phase III CheckMate238 trial, efficacy and safety of nivolumab was compared to ipilimumab as an adjuvant therapy in stage IIIB, IIIC, and IV melanoma. In stage IIIB and IIIC melanoma patients, the 12-month relapse-free survival was 72.3% in the nivolumab group and 61.6% in the ipilimumab group. In stage IV melanoma, this rate was 63.0% and 57.5% in nivolumab and ipilimumab, respectively.

COMBI-AD was the first prospective phase III placebo-controlled trial which demonstrated that BRAF-MEK inhibitor combined treatment as a 12-month adjuvant therapy significantly improves relapse-free survival after complete resection in stage III melanoma with V600 mutation. This study results showed that the estimated 3-year relapse-free survival in the dabrafenib–trametinib combination group was significantly higher compared to the placebo arm, 58% and 39% ($p < 0.001$), respectively. In 2018, Eggermont et al. published the results of the phase III, randomized, double-blind, placebo-controlled EORTC 1325 trial (Keynote 054), in which 200 mg of pembrolizumab administered every three weeks was evaluated in the treatment of resected stage III melanoma with high risk of recurrence.

In the clinical study above, patients were classified for TNM based on AJCC 7th edition. Accordingly, 1019 patients with histological stage IIIA, IIIB, or IIIC who underwent R0 resection and complete regional lymph node dissection following sentinel lymph node positivity were randomly assigned in 1:1 ratio to one of the study arms. Only patients with stage III melanoma were enrolled whose metastases had a maximum diameter larger than 1 mm. Patients received pembrolizumab or placebo 18 times in total in approximately 1 year or until recurrence or the development of unacceptable side effects. After a median follow-up of 15 months, pembrolizumab was found to be associated with a significantly higher recurrence-free survival (RFS) compared to placebo. The 1-year RFS with pembrolizumab was 75.4% [95% confidence interval {CI}, 71.3–78.9], while it was 61.0% in the placebo group ([95% CI, 56.5–65.1]). The hazard ratio (HR) of recurrence and / or death was found to be 0.57 (98.4% CI, 0.43–0.74; $p < 0.001$).

In the subgroup analysis of 853 patients with PD-L1-positive tumors, the 1-year RFS was slightly higher (77.1% [95% CI, 72.7–80.9]) than in the whole pembrolizumab arm. The beneficial effects of pembrolizumab on progression-free survival were observed in both the BRAF wild-type group and the BRAF mutant group. Serious adverse events (grade 3–5) were reported in 14.7% of the patients treated with pembrolizumab compared to 3.4% of the patients treated with placebo.

In our study, the mean age of patients with thick melanoma was around 60 years. It means that the number of productive work years lost in this patient group is expected to be high, which implies that the importance of effective adjuvant treatments is significant, not only for the individual but also economically to the society. One-tenth of our patients with melanoma had a tumor thickness over 4 mm, with an average of 6.79 mm. In a recent publication, Argentinean authors have evaluated their biopsy results of sentinel lymph nodes in patients with thick melanoma. In their study, 6.7% of the patients with melanoma had a thick tumor, which is lower than the 10% of the patients with melanoma treated in our department.

The proportion of thick tumors in our region remains high. Since the clinical signs of melanoma are recognizable by macroscopic examination, the wide dissemination of the information to the lay public about the suspicion of skin cancers will continue to be essential.

In our study, we found a very high proportion of positive sentinel lymph nodes, in almost two-thirds (64%) of the patients, which ranges on a wide scale from 22% to 64% based on various literature data. Nonetheless, numerous studies confirm the role of SLNB in the treatment of thick melanomas, which have a significant role in the disease-specific survival, length of relapse-free period, and overall survival. In thick melanoma, the main argument for not performing sentinel lymph node biopsy is that in these tumors, in particular, the hematogenous spread of the disease is a determinant of the disease course, and according to these researchers, performing SLNB has no effect on the recurrence or mortality.

4.3.Reconstruction of alar-perialar defects and application of our novel method

The combined reconstruction of alar and perialar regions is difficult. The alar region has a rigid structure and low mobility, while the perialar soft tissues are different. Preserving the natural alar contours and concavities of the alar crease also keeping the respiratory function and symmetry with the contralateral side is important. Direct closure is only preferable in case of small defects, because it can easily cause alar rim distortion. Skin grafts may result in depressed scars and impaired nasal valve patency when used to repair deeper alar defects.

Almost all local and regional flaps have significant drawbacks. The single staged nasolabial transposition flap results in a deformed alar groove thus producing an obvious asymmetry with the contralateral side. The conventional subcutaneous pedicled island flaps may also lead to distortion and more frequently pin-cushioning or trapdoor effect due to the all-round incision of the flap. The combination of these procedures or multiple correctional surgeries can also be laborious and costly. Our aim was to find a one-step intervention which fulfills all the above mentioned requirements with the least complications. The blood supply of our flap is dual. It can be considered as the combination of the unipedicle melolabial advancement flap and the melolabial island advancement flap described by Baker. Contrary to the above mentioned ones, our flap receives blood supply from two different directions. On the one part, cutaneous vessels enter the flap from the area of the nasolabial fold (because the flap is not incised medially). Furthermore, the flap is not undermined (except the cranial part) therefore it has subcutaneous perforators, as well. For the better mobilization, cutback can be performed hereby making a hatchet flap, however it is not necessary in most cases. This technique allows the reconstruction of alar and perialar defects localized to more esthetic subunits. As concerns preparation of the flap, two different movements shall be performed. The flap is first moved to the inferior part of alar rim like an advancement flap. This is the pivot point around which the cranially thinned flap is rotated into the remaining part of the defect. Regarding the results of the follow-up, there were no partial or complete flap losses. This may originate in the above mentioned advantageous blood supply which involves both cutaneous branches and subcutaneous perforators. Although surgical intervention itself may lead to a decrease in capillary flow during the early postoperative period, this parameter shows regeneration then. Neither hematoma, nor recurrence of the tumor was observable. Although in two cases sign of infection was detected, this may originate in the age and the comorbidities of the patients. Symmetry with the opposite side remained intact with no significant distortion or disfiguring of facial folds or creases. Large defects may be accompanied with the risk of temporary or permanent distortion of upper lip and melolabial fold. The biggest defect in our study was 2.6x2.9cm which has not led to such problem. However, each case shall be judged individually, and our elderly patients possess a skin laxity which may facilitate the procedure. However, a slight edema of the flap was seen in some cases but this resolved with scar treatment and massage of the flap by the end of the 8th postoperative week. Mild trap-door deformity was found in one case and there was no need for a second operation in any of the cases. Furthermore, the patients were satisfied with the results of the intervention.

5. CONCLUSIONS

1. **Mitotic rate alone is not a sufficiently powerful predictor of SLN status in thin melanomas.**
2. **Regression might be an additional adverse feature** that aids in identifying those T1 patients most likely to be SLN-positive, therefore sentinel lymph node biopsy might be considered in the case of patients with widely regressive thin (<0.8 mm) melanomas.
3. **The proportion of both thick melanoma and sentinel lymph node positivity is high in our region.** We estimate that **sentinel lymph node biopsy**, which helps to **determine the exact pathological stage, may be essential for optimal treatment in up to a hundred patients a year nationwide.** All these data further support the concept that surgical treatment of melanoma should be performed only in the centers where personal and technical requirements for performing sentinel lymph node biopsy can be met.
4. Reconstruction after NMSC in the alar-perilar region is a frequent task in the facial oncoplastic surgery. **Our flap design in this region provides the benefits of the combined vascular supply of subcutaneous and cutaneous pedicled flaps without the disadvantages of all-round incisions, causing trapdoor deformities.** It is suitable for the reconstruction of both deeper perialar and thinner alar defects with the appropriate cosmetic result.

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