

LETTER TO THE EDITOR

Merkel Cell Carcinoma: Our Therapeutic Algorithm

Treatment of Merkel Cell Carcinoma

TO THE EDITORS:

Merkel cell carcinoma (MCC) is a growing health problem and the second most common cause of nonmelanoma skin cancer death; nevertheless, its optimal treatment is uncertain.¹⁻⁴ Recently, studying its propensity to recur locally and regionally, Warner et al. assessed the roles of sentinel node (SN) biopsy and radiotherapy. They performed a retrospective analysis of 17 patients for a median follow-up 16 months. Of 11 patients, 3 had a positive SN biopsy and, despite adjuvant radiotherapy, 2 developed regional lymph node recurrence (RLN). Of eight patients who had a negative SN biopsy, five also had RLN recurrences. There were nine patients who received adjuvant radiotherapy (RT) to the primary site, with no in-field recurrences, and eight who received RT to their RLN field, with only two developing regional nodal recurrences—both were SN biopsy positive. They concluded that SN status may not be an accurate predictor of locoregional recurrence, and that radiotherapy, both locally and to regional nodes, provides effective infield disease control.¹

We would like to report our clinical experience on the SN biopsy and RT for the treatment of MCC. We utilize a simpler therapeutic algorithm, which we perform routinely for patients with MCC. Our method considers that the poor prognosis of MCC seems to be related to its high and speed tendency to locoregional metastasize,²⁻⁴ therefore, our algorithm is based on a wide local excision, SN biopsy, lymphadenectomy, and postoperative adjuvant RT. For this article, we reviewed our management of 11 patients with MCC: 6 men and 5 women, median age 73 years, evaluated during the five last years (Table 1). These 11 patients were evaluated for the type of surgical treatment and clinical outcomes. Diagnosed lesions were localized: three on upper extremity (right deltoid, right forearm, right thumb), four on head (cheek, left frontotemporal, scalp, eyebrow), and four on lower extremity (left and right leg, left inguinal, left foot). Diagnosis was performed by biopsy for the histological and immunohistochemical

examinations. As first step after MCC diagnosis, an excision of 3-cm wide cancer-free margins was performed around the primary lesion, combined with SN dissection. Seven patients had full-thickness and three had partial-thickness skin grafts as a reconstructive procedure. One patient underwent left thumb amputation and locoregional flaps as a reconstructive procedure. As further steps, lymphadenectomy and RT to the primary site were performed on the SN-positive patients. Then, short-term and long-term follow-up were planned.

Six of the 11 patients were positive for SN metastasis; they underwent radical lymphadenectomy (positive from 11 to 16 metastasis lymph nodes) and RT.

On the other hand, 5 patients of the 11 were negative SN metastasis. Of these, one showed a local recurrence at the 16-month follow-up. This patient underwent wide excision, lymphadenectomy, and RT.

Therefore, after MCC diagnosis, our algorithm includes three steps: (1) wide local excision (3-cm free margin) and SN biopsy; (2) lymphadenectomy; (3) RT to the primary site.

At follow-up (range 22–72 months), nine patients were disease-free (81%). Of the six patients who were treated with lymphadenectomy and RT, four resulted tumor-free (67%) and two died of distant metastases (33%) (Table 1).

According to the literature,⁴⁻⁶ our experience suggests the SN dissection is a valid helpful tool to diagnose early lymphatic spread and a reliable staging index of tumor. We think that positive sentinel node looks like a poor prognosis, and for this reason it should be considered index of staging in MCC. As for skin melanoma, the identification of metastasis lymph node with following lymphadenectomy can reduce MCC spreading risk and patient's death. Besides, it can avoid an extremely aggressive surgery, which has a high morbidity rate in the elderly.

We would like to add that an algorithm, including local excision with 3-cm free margin, SN, lymphadenectomy, and RT, could represent a good practice, which is fundamental for both prognosis and therapy of MCC.

Moreover, our revision suggests the following: a wide neoplasm excision (3-cm disease-free margin), overall, decreased local recurrence. Radical lymphadenectomy, associated to adjuvant RT, seems to sterilize locoregional relapses.

We believe that all patients with MCC should be treated by wide local excision plus SN dissection, and patients with positive nodes should be treated with lymphadenectomy and RT.