

## 9-mm Surgical margin required for both LM and MIS as diagnosed in real-world community practice



*To the Editor:* It is true that many pathologists do not use the diagnostic term lentigo maligna (LM) but instead lump all subtypes together as melanoma in situ (MIS). This highlights the very crux of the problem. Because of this convention, surgical margin guidelines cannot be based on subtype. Fortunately, our research showed there is no significant difference in subclinical extension between the 2 entities as used in real-world community practice.<sup>1</sup>

Many of our 2335 lesions were >1 cm in diameter. This size is typical of noninvasive melanoma (NIM) at time of diagnosis. A study of 340 consecutive primary NIMs from 11 different practices reported 77% were >1 cm in diameter.<sup>2</sup> Nehal's<sup>3</sup> own study of LM reported the average lesion size was 11.3 mm. Regardless, when our analysis was restricted to lesions <1 cm in diameter, 1-cm margins were still needed.

The evidence for 5-mm margins is indeed empirical. Despite this common gut feeling, evidence from Nehal's studies confirm that wider margins are necessary.<sup>3</sup> In her study of LM, the average excision margin was 8 mm. Only 92.4% of lesions cleared with a 9-mm margin.<sup>3</sup> In her recent publication, MIS required an *average* surgical margin of  $6.5 \pm 2.4$  mm.<sup>4</sup> These studies add to the preponderance of evidence supporting the use of 1-cm margins for LM and MIS, and occasionally wider margins on the head and neck.<sup>1</sup>

We agree that one size does not fit all when dealing with NIM. Special consideration must be given to those that have wide subclinical extension or invasive components, but how does one predict that? The rule of 10s states specialty site melanomas

are 10 times more likely to have positive margins or upstaging.<sup>5</sup> In search of characteristics that could predict the safe use of 5- or 6-mm margins, we analyzed the smallest trunk and extremity lesions (Table 1). In this location, lesions <0.9 cm in diameter approached 95% clearance with 6-mm margins, but the clearance rate dropped once the diameter was  $\geq 1$  cm. More pertinent to the objective of our study, clearance rates for LM subtype matched those of MIS.

It should not be missed that the vast majority of NIM on all locations can be cleared with 5- or 6-mm margins (79% on the head and neck and 84% on the trunk and extremities).<sup>1</sup> Until better prognostic tools are available, Mohs technique or staged excision enable the clinician to attempt narrower margins.

We thank Dr Nehal for her commentary.<sup>6</sup> Her work corroborates our findings that 5 mm is not always adequate for MIS. Our study shows subtype is not a good way to determine which MIS can be safely removed with narrower margins. Location and lesion size may be better predictors of subclinical extension.

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Funding sources: None.

Conflicts of interest: None disclosed.

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**Table 1.** Clearance rates for small noninvasive melanomas on the trunk and extremities

Diameter size and subtype	n	Surgical margin size, %			
		6 mm	9 mm	12 mm	15 mm
<0.8 cm					
LM	18	94.4	100.0	100.0	100.0
MIS	61	91.8	96.7	98.4	100.0
LM and MIS	79	92.4	97.5	98.7	100.0
<0.9 cm					
LM	37	94.6	100.0	100.0	100.0
MIS	103	94.2	98.1	99.0	100.0
LM and MIS	140	94.3	98.6	99.3	100.0
<1.0 cm					
LM	49	87.8	98.0	98.0	100.0
MIS	136	91.2	98.5	99.3	100.0
LM and MIS	185	90.3	98.4	98.9	100.0

LM, Lentigo maligna; MIS, melanoma in situ.

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<https://doi.org/10.1016/j.jaad.2019.06.034>