Additional audience questions and answers to SNB Webinar

1. Does SLNB helps with improving the treatment and improve survival? Yes. It stages patients accurately and allows tailoring of follow up to risk. Most patients are negative, so they get reassurance. It selects patients with positive nodes before they present with bulky lymph node disease (overall 16% of intermediate thickness and 40% of thick melanoma patients) and if they do present later with palpable nodes they require a regional lymph node dissection. Most patients with a positive SNB avoid a regional lymph node dissection. SNB positive patients are eligible for adjuvant Nivolumab on the BMS access program and when the PBS approves adjuvant therapy it is likely to be based on accurate staging and proven positive lymph nodes by SNB. Adjuvant therapy improves survival by about 50%.
2. What percentage of SLNB patients would undergo local anaesthesia instead of general? I do LA + sedation in the operating theatre in about half my patients over 75 and anyone else who isn't suitable for a GA or it is simple to do depending on the site and depth of the sentinel nodes.
3. What research is currently being done to try and make SNB redundant? Laboratory research is looking at better molecular genetic markers of prognosis. Accurate prognostic staging is important to get the balance between risk of disease and morbidity of treatment when having a balanced discussion about the pros / cons of adjuvant systemic therapy. We are quite a way off having biomarkers related to the primary tumour that allow selection of patients for systemic adjuvant therapy and also predict that the adjuvant therapy will eradicate any microscopic lymph node disease that will otherwise present later on and require a regional lymph node dissection.
4. Do all melanoma centres in Australia advise all Pts with Stage 1B or greater that if they decline SLNBx then that will deny them access to future adjuvant trials? No, we do not. We offer any patient eligible for a clinical trial that opportunity. If the clinical trial protocol requires that the patient needs to have SNB status to be eligible then they make the choice as to whether to have the SNB and whether they want to exclude themselves. Their choice doesn't change our relationship with the patient who we will continue to do the best treatment for within the limits of their preferences and what is available.
5. Why can't GPs order yearly PET SCANS Ask MSAC.
6. Correct me if I am mistaken but wasn't the PFS only 12-15% in the immune checkpoint group compared to the control group in the trial of

adjuvant treatment in sentinel lymph node positive patients? The hazard ratio in Eggermont et *al*. Pembro vs Placebo was 0.57 and was consistent across macroscopic and microscopic nodal disease patients. The absolute benefit will be less and will depend on the survival of the patient with the degree of nodal involvement and their primary tumour features. If their overall risk of death is 30% then your figures are about right for absolute risk reduction.

7. What cases is any would you still advocate for CLND after +ve SLNB, if any? Nearly all, unless they don't want to do "active surveillance". Head and neck cases we are a little bit more anxious about, particularly in the parotid gland around the facial nerve but still offer both options with a preference for not doing the dissection.
8. How much does the scar of WLE interfere with the drainage of lymphatics? Someone declines SNB at time of WLE, but then want one some months later? Depending on where the primary site is on the body and the intrinsic variability of the lymphatic draining in that area then it may be reasonable but I would explain that the false negative rate would be higher. After a complex flap it would be much less likely to be reliable. If the chance of the SN being positive is small then I would be less likely to do it after previous WLE.
9. With the 1st case study where the lady had a truncal melanoma with drainage to bilat axilla, intermuscular triangle and retroperitoneum: Is there a role to perform the sentinel node biopsy on everything other then the retroperitoneum for higher risk disease? Yes but the chance of having a positive SN in her was only 4% according to the MSKCC nomogram. Thus (all else being equal with lymphatic flow dynamics) then each site had a 1% chance of being positive. I decided, with her, that this was not enough to warrant the general anaesthetic and multiple incisions.
10. This is not related to the subject but has anyone examined the theory that incision or shave biopsy can trigger metastasis? Not that I'm aware. The reason I'm asking this is that the great majority of metastatic melanomas are the ones who have had local excision. How often you see a metastatic melanoma with unknown primary? 10 –15% of stage 3 patients.
11. After SLNB shows positive (N1a occult) - do you PET as the next imaging? Yes, I discuss it with the patient and also MRI brain. It is unlikely to be positive but gives a baseline for future comparison and finds occult distracting lesions like cysts on liver or scars in the lungs etc. What do you do if iliac node then has "low avidity" - ? repeat PET or try to biopsy that node? If it didn't map on lymphoscintigraphy to the pelvis at the time of the SNB and it is non-specific avidity and nothing

abnormal about the appearance of the node then it is most likely reactive to the recent procedure and therefore I'd most likely repeat in 4-6 months. Pelvic nodes can be hard to biopsy if bowel is in the way or they are behind iliac vessels etc.

12. How does one know or check if ones local cancer surgeon would be an appropriate person to perform SLNB on my melanoma patients , vs regional centre of excellence (600 kms away)? Ask them how many they have done and what training they have had. Ask how are they going to do lymphatic mapping.
13. If you have a positive SNB how do you determine if other lymph nodes are involved without biopsying other nodes? Wait and see but monitor closely with active surveillance.
14. On neo-adjuvant setting, if no evidence of disease after neo-adjuvant therapy, does the patient need surgery or just surveillance. We don't know yet. There is a clinical trial about to start (PRADO) testing that hypothesis. Patients with resistant disease will have full surgery still but those with pathological complete response or near pCR will be randomised to excision of the index node and observation vs completion dissection.
15. I am AP working in Japan where acral lentiginous melanoma is common compared to other types. Is this SLNB approach applied to acral lentiginous melanoma, Yes. No reason not to. They have the same risk of lymph node metastases.
16. I have referred all patients with melanomas thicker than 1mm to my regional centre in a capital city. None have had a SNB. Thoughts Ring up the surgeon / surgeons involved and say that you believe your patients deserve to have internationally accepted standard of care that leads to treatments that improve their survival chances. It isn't acceptable for patients not to be offered SNB. Offer the patients to be sent the nearest city where it is done.
17. Does the quality/type of the original biopsy (primary) impact on ability to have a SLNB? No. A flap closure or wide excision may impact on lymphatic drainage. An excision biopsy, punch or shave won't. You may under-stage the primary with partial biopsy though.
18. Is there any body region where SLNB cannot be performed? Not on the external body. Even accessible mucosal sites, eyelids and conjunctiva can be mapped. These require an experienced nuclear medicine team.