hepatic vein thrombosis that was either primary in nature or developed secondary to vena caval obstruction. Neither balloon angioplasty nor laser obliteration is likely to be safe or effective for such patients, who account for the majority of Budd-Chiari cases seen in this country. There may be, however, a role for invasive radiologic procedures in the postoperative management of these patients. In our experience both anastomotic and non-anastomotic venous stenoses have been managed successfully with a combination of percutaneous transluminal angioplasty and/or percutaneous transvenous stent placement.

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August 9, 1990

Dear Editor:

It seems to me that Drs. Crowley and Seigler, the authors of "Late Recurrence of Malignant Melanoma" (August 1990), missed an excellent opportunity to make a contribution to the debate concerning the current concept of local excision of thin melanomas of that amount of tissue that can be closed primarily is sufficient in a 10-year follow-up study. They indicated in their article, as I read it, that tumors less than 1 mm in depth represented approximately 25% of their cases (this was illustrated in Table 2.) In Table 4 they indicated that local skin recurrence occurred in approximately 34% of their cases.

The additional factor that would have been helpful would be a correlation of those thin melanoma excisions with the local skin recurrences (if any) to determine if there was any relationship between the extent of the surgical excision and the recurrence of the tumors.

GEORGE F. BALE, M.D.
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October 14, 1990

Dear Editor:

Dr. Seigler and I thank Dr. Bale for his letter regarding our article "Late Recurrence of Malignant Melanoma."

Approximately 25% of patients with complete histologic records had melanomas measuring less than 1 mm. These thin melanomas included 6 patients with extremity primaries, 10 patients with trunk primaries, and 5 patients with head/neck primary lesions. Interestingly only three of these patients experienced local recurrence. Most of these patients (11 of 21) had recurrence in the regional nodes and a large percentage (7 of 21) at distant sites, including lung, bone, and gastointestinal tract. The small number of patients (three) with thin melanomas who experienced local recurrence make analysis of the influence of margins of excision extremely difficult.

As indicated in Table 4, there were 17 patients with cutaneous melanomas who had local recurrence. These included 7 patients with extremity primaries, 7 patients trunk primaries, and 3 with head/neck primary lesions. These 17 local relapses occurred in the total population of 155 patients with cutaneous melanomas, for a total of 11% (rather than 34%). The Breslow thickness in this group of patients ranged from 0.45 mm to 3.35 mm. Again, only three of these patients had melanomas measuring less than 1 mm.

The issue of recurrent disease and survival in patients with thin melanomas (less than 0.76 mm) was evaluated for a group of 681 patients seen at the Duke University Melanoma Clinic. I would refer Dr. Bale to this paper by Slingluff et al. in a previous issue of the *Annals of Surgery* (1988; 208:150–161). In this analysis two clinical risk factors (axial primary site and male sex) and two histologic risk factors (Clark's level IV and severe histologic regression) were associated with an increased incidence of recurrence. Local skin recurrence was seen in 5% of patients and margins of excision were evaluated for this group of patients. Of those patients who experienced local recurrence, patients with margins of excision less than 1 cm had recurrence no sooner than those with wider margins, suggesting that narrow margins of excision (less than 1 cm) did not play a role in the risk of subsequent recurrence.

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March 9, 1990

Dear Editor:

We read with interest the article entitled "Is Preoperative Angiography Useful in Patients with Periampullary Tumors?" by Dooley and associates (Ann Surg 1990; 211:649–655).

The authors evaluated the role of preoperative visceral angiography as a staging test adjunctive to computed tomography scan in patients with periampullary tumors. Thirteen of twenty-eight patients with positive angiographic evidence of vascular involvement were not explored and 6 of the remaining 15 who were explored had successful resection of the tumor. This false-positive rate of angiography (6 of 28) is quite high and disconcerting. The conclusion that all 17 patients with vascular occlusion as shown on angiography were unresectable is erroneous because only four of these were confirmed to be unresectable on exploration. But even if one believes that all of the 11 patients with total vascular occlusion were unresectable, the advantage of identifying this group of patients in 11 of 90 patients (12%) is offset by unwanted laparotomy in 14 of 90 patients (15%) in the angiogram-normal but unresectable group.

The data regarding peritoneal and liver spread is not available in 11 of 13 patients who were not explored (two had liver secondaries). Fifteen of the remaining seventy-nine patients had evidence of liver and peritoneal spread, which would have been amenable to detection by laparoscopy, a safe, cost-effective and accurate method.[1]

The question mark posed at the end of the title is very valid, and it should have been followed by an emphatic 'No.'

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