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At least one centimetre for each millimetre

The width of the excision margin for cutaneous melanoma remains a matter for debate. Since the pioneer description by Handley of the findings at necropsy in a patient with malignant melanoma with extensive spread of the tumour along the fascial planes around the primary lesion,[1 2] wide three dimensional surgery has been the vogue.[3 4] Nevertheless, Breslow and Macht challenged the view that a 5 cm margin of healthy tissue should be removed with all melanomas, finding that patients with superficial melanomas had an excellent survival irrespective of the size of the resection margin.[5] Since then many workers have agreed that the loss of a large area of skin is unnecessary for tumours of limited thickness.[6-9]

Should, then, we excise all melanomas with a narrow margin? Ackerman and Scheiner have emphasised that it is sufficient to extirpate the primary lesion and little more than that; if histological assessment confirms that the resection margins are free of tumour then no further local surgery is warranted.[10] Thus, they contend, surgery for cutaneous melanoma should be no different from that for other primary tumours in the skin. Nevertheless, their reasoning warrants further scrutiny. The biological behaviour of melanoma is distinctive in its tendency to form satellite and in transit metastases in the skin around the primary lesion or in the region between the primary lesion and the lymph nodes. Such metastases usually surface near the primary melanoma and subsequently spread over the entire regional area. Wide local excision aims at the eradication not only of the primary tumour but also of any occult satellite lesion in its immediate vicinity.

The importance of satellites in the management of melanoma should not be underestimated. Although clinically apparent in a minority of cases, satellite lesions are common microscopically and their prevalence is related to the thickness of the tumour.[11] Day *et al* found no microscopic satellites at all in lesions of under 1 mm thick, but these were present in almost two thirds of lesions over 4 mm thick.[11] Similarly, Elder *et al* found that satellites and local recurrences occurred only in melanomas over 2 mm thick.[12] It seems reasonable, therefore, to tailor the extent of local surgery to the thickness of the tumour.

Yet the published studies have failed to show that wide excision improves patient survival.[5 8 9 12] The two largest published series show a striking increase in the frequency of "local" failure with narrower margins.[8 9] In the World Health Organisation study the rate of local recurrence was about three times higher in patients whose tumours had been excised with narrow tissue margins than in those subjected to wide excisions, irrespective of the thickness of the tumour.[8 13] Similarly, in the Munich series the local recurrence rate was 10% for cases with margins of 3 cm or less and 3% for those with margins of more than 3 cm.[9] In both studies the differences were statistically significant. Generally local recurrence presages a dismal outcome, a fact which has been appreciated since the days of McNeer,[14] yet in these series patients' ultimate survival was not substantially affected by the width of the excision margin. This paradox may be due to the heterogeneity of the various subsets, to the use of single factor statistical analyses instead of proportional hazards regression models, or to the follow up periods having been too short.

If we can prevent local recurrence by wide excision we should consider the procedure in each case, but especially for thick lesions. Many dermatologists and surgeons who have grown up in the era of safe margins of excision will hesitate to practise the new vogue of minimal procedures.[10] The removal of an extra margin of ostensibly normal skin appears justified in high risk cases to remove any tumour satellite that may be present. Day *et al* recommend a 1·5 cm margin for low risk melanomas and a 3 cm margin for the high risk ones, dictated by the thickness and location of the primary tumour.[15] These authors suggest that, because of their poor prognosis, BANS lesions (upper *b*ack, posterior upper *a*rm, posterior *n*eck, posterior *s*calp)[16] should be excised with a 3 cm margin when they are of an intermediate thickness; for non-BANS melanomas of intermediate thickness an excision of 1·5 cm of clinically normal skin is adequate. Nevertheless, the BANS concept has recently been challenged.[17]

Whether localisation as such is a criterion for the width of the excision margin still needs further study. Until we have more data we should not rely on minimal resection margins. Only in very thin melanomas ($\leq$1 mm) should the margin be 1 cm; in the intermediate thickness range (1-2 mm) a margin of 2-3 cm may be necessary; and for thick lesions (>2 mm) a 3-5 cm border should be excised so long as this does not include important structures. The clinician has the far from easy task of navigating between Scylla and Charybdis: on the one hand, increasing tumour thickness necessitates wider surgical excision; on the other, cosmetic and functional considerations may demand that this margin is smaller.

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Do minor affective disorders need medication?

Minor affective disorders usually present with symptoms of anxiety or depressed mood. Difficult life events are often important in causing these,[1 2] and improvement tends to occur within six to 12 months.[3 4] These disorders may not be associated with a severe disturbance of behaviour or a disruption of normal life, but they do cause considerable distress and are particularly frequent among patients who consult general practitioners.[5]

Over the past 20 years psychotropic drugs, especially minor tranquillisers, non-barbiturate sedatives, and antidepressants, have become increasingly popular in the treatment of patients with minor affective disorders. Nevertheless, both the value and the dangers of this form of treatment are still uncertain. Though they appear to be safer than alcohol or self prescribed medication,[6] their long term use may be associated with serious disadvantages and may not even be effective.[7] Indeed, some studies have suggested that in patients with moderate or low levels of anxiety psychotropic drugs are no better than placebo.[8] The potential hazards of psychotropic drugs include a proneness to road traffic accidents,[9] excessive dependence with adverse reactions on withdrawal,[10] deliberate self poisoning,[11] aggressive outbursts,[12] and interaction with alcohol.[13] In addition, the cost to the National Health Service is immense,[14] for these are probably the most frequently prescribed drugs in general practice.[15]

So which patients really benefit from psychotropic drugs, and what will happen if these drugs are not prescribed? New evidence is provided by Catalan *et al*, who examined the effects of withholding anxiolytic drugs from patients who would normally have been given them by their general practitioners.[16] Patients who had not consulted their general practitioner for a psychiatric disorder during the preceding three months and who had not received psychotropic drugs during this time were allocated randomly to treatment either with anxiolytic drugs or by brief counselling. The latter included explanation of symptoms, exploration of underlying problems and ways of dealing with them, as well as reasons for not prescribing. The two groups were compared for psychiatric state, social adjustment, and satisfaction with treatment as well as the use of prescribed and non-prescribed medication during the seven months of the study. The result was striking: the two groups of patients made similar and parallel improvement in all measures of outcome. Neither group increased its consumption of alcohol, tobacco, or non-prescribed drugs, and the group not treated with drugs did not appear to make greater demands on the general practitioners' time. About a third of the patients remained unimproved, the more severely disturbed patients tending to do less well.

Thus simple counselling may be as effective as treatment with psychotropic drugs in the management of minor affective disorders, and it is not appreciably more time consuming. The principles of counselling may be used to good effect by all doctors: we need to listen, perhaps advise about symptoms, and recognise that these may be a reaction to upsetting events rather than indices of endogenous disease. Perhaps the most essential ingredient of this approach is to realise how effective it may be. Nevertheless, it is unrealistic to assume that such insight will in itself be sufficient to change established clinical practice—which derives as much from patient expectation as overestimation of the efficacy of psychotropic drugs—and alternative strategies must be adopted.

Easy access to psychiatric advice, particularly in the health centre, and provision of treatment programmes for withdrawal of psychotropic drugs in patients who are unable to discontinue them without specialist help are within the remit of the psychiatric service. Gradual withdrawal of drugs under the supervision of general practitioners and with the back up of patient self help groups may reduce the amounts of drugs taken.[17] Psychiatrists might show a lead by using psychotropic drugs less often and by discouraging their use when advising others. Drug advertising might become less preoccupied with the wisdom of persuading doctors to adopt the newest preparation, and instead emphasise the need for caution before prescribing psychotropics. Guidance is also required on when and how to finish a course of treatment, even if symptoms have not resolved completely, to avoid a drift into ineffective chronic prescription of psychotropic drugs. Above all, however, we must realise that the greatest need of patients with minor affective disorders is to talk, however briefly, about themselves and the difficulties that they face. To be able to listen to them is one of the most important skills which a doctor should possess, and one which may also be shared with other professionals. More active intervention may amount to meddlesome and at times harmful interference.

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