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Dear Editor:

Shumate et al. reported the experience of the University of Alabama with recurrent melanoma.[1] The following important information was missing from their analysis: 1) the type of local recurrence and 2) the volume of recurrent disease. After radical surgery, locoregional recurrence has long been considered a grave prognostic sign. Tumors cells may return from a distant metastasis to the surgical site or in-transits may form as systemic defenses collapse. After limited surgery, locoregional recurrence is far less ominous. Residual tumor cells multiply and form a tumor mass, but their spread may be prevented by host defenses. I have suggested that this be termed local persistence.[2] In this study,[1] the primary lesions were treated with wide or very wide excision, and local recurrence was likely an ominous event. However, regional nodal disease was a form of local persistence and far less ominous. Patients suffered the staging risk of stage III disease, but promptly treated nodal disease may not have been an added survival threat. The authors should have distinguished between these types of recurrence and reported survival after each.

In addition, the authors should have reported the volume of the recurrent disease, especially in the regional lymph nodes. On several occasions, I have suggested that this is an important prognostic variable for melanoma and other solid tumors.[3–5] Its prognostic value occasionally is of greater importance than the volume of the primary lesion. In the discussion, Townsend asked whether there was any other way one could try to discern why those patients who had thicker lesion did not fare any particularly worse. I have suggested that the level of the primary lesions loses its prognostic significance if the volume of nodal disease exceeds the volume of the primary, or the recurrence itself is a sign of systemic disease.[6] Surgeons rarely have measured the volume of recurrent cancer because the event itself was so ominous that measurements were not helpful. In this era of limited surgery, it is important to determine the volume of recurrent disease. This often is difficult, especially in retrospective studies. Nevertheless, surgeons must try to find effective ways to obtain this information.

I repeatedly have suggested that after limited surgery, local persistence does not become an additional survival threat unless it exceeds the volume of the primary lesion. This appears to be true for most, if not all, solid tumors.[7] This important observation has not been refuted, but it remains virtually ignored. I also have suggested a biological explanation for the often innocent behavior of locally persistent disease.[8] This hypothesis, too, has not been refuted and remains virtually ignored.

I have been discussing these important aspects of surgical oncology for more than 15 years. In 1989, I made some of these points regarding breast cancer to Urist and Maddox.[9] Since 1989, I also have submitted to this journal eight manuscripts that elaborated on the ideas that have been briefly summarized in this letter. These manuscripts were all rejected for publication. (Fortunately, many of my suggestions have been published in nine letters-to-the-editor of *Annals*.) Like engineering, surgical oncology will only become a science when adequate measurements are taken and competing ideas are debated openly. Surgical oncology remains in the grip of a paradigm shift. Free and uncensored debate of these issues may not occur as long as those who historically have advocated radical surgical remain in power. They control the means of communication and expect their subordinates to support their cherished and outmoded beliefs.

References

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Dear Editor:

The term local recurrence refers to the anatomic site of tumor reappearance. It does not define whether the recurrence is due to persistent disease from the primary excision or a systemic metastasis. We defined local recurrence anatomically as one that occurs "within 5 cm of the original excision site."