

the sentinel node or at the time of SNB have melanoma cells distal to the sentinel node and still in transit. Thus, although a negative SNB is an encouraging prognostic feature, patients will still need to be counselled that they may have a recurrence of their melanoma. In keeping with results from other groups, our data do not suggest that patients who have had SNB have a higher than expected incidence of in-transit recurrence.⁴

Conclusions

Although knowledge of sentinel node status is an additional significant prognostic indicator, this knowledge does not change routine management of patients, as no widely accepted effective adjuvant treatment is available to SNB positive patients after node dissection. The recently reported results of EORTC 19852 adjuvant interferon therapy for stage 2b and 3 melanoma showed no overall survival benefit,⁵ and the early report of the benefit of interferon in the US study ECOG 1684 was not confirmed by the same group in ECOG 1690.^{6,7}

Until the full results of MSLT1 are published, sentinel node biopsy should not be a routine procedure for melanoma patients but should be used as a staging procedure in centres entering patients into adjuvant trials for patients with stage 3 melanoma. Knowledge of sentinel node status is necessary to stratify melanoma patients being entered into these trials and should be part of the protocol.

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What is already known on this topic

Before 1990, common practice in Europe was to widely excise the primary melanoma and then observe the patient, delaying lymph node surgery until nodes were palpable

North American practice was to offer elective node dissection of the appropriate draining nodal basin to most patients with primary melanomas thicker than 1 mm

Many European centres are introducing sentinel node biopsy as a routine procedure despite the lack of evidence that this and completion lymphadenectomy extend overall survival

What this study adds

This prospective observational study shows that sentinel node status is a significant prognostic factor and is independent of both tumour thickness and ulceration

Until data from randomised trials are available, sentinel node biopsy status should be considered in patients entering adjuvant trials but should not become a routine standard of care

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Immediate, underlying, and macro-underlying causes

When filling in death certificates, doctors list both the immediate cause of death and the underlying cause, be that a disease which initiated the train of morbidity leading to death or the circumstances surrounding the accident which produced a fatal injury. Identifying underlying causes in this way provides information of great importance to public health by highlighting the main sources of avoidable mortality in a population.

I wonder, however, whether doctors have yet realised the full scope of the death certificate as a tool for compiling information to be used in guiding policy makers to the best way of promoting public health and wellbeing. For example, when recording the underlying cause of a heart attack in a manual labourer in his 50s, how about digging a little deeper than coronary artery disease to note the socioeconomic disadvantages that constrained this person's ability to quit smoking and take more exercise compared with people of higher socioeconomic status? Or, when recording

the death of a teenager who crashed her car while over the legal alcohol limit, why not note the concerted efforts by the alcohol industry in the past decade to increase sales by marketing drinks aimed at young women?

Of course, doctors are unlikely to be called on to make sociopolitical and economic judgments of this kind any time in the near future, and probably rightly so. As a thought exercise, however, I find the idea of introducing a "macro-underlying" section to the death certificate rather compelling. After all, what better way could there be for stimulating government action on issues of social justice than a sudden, sharp epidemic of deaths due to social inequality?

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