

examined factors (primary tumor thickness according to Breslow, presence of ulcerations, lymphocytic infiltration) and the onset of metastases in the sentinel lymph node was determined.

Results

The primary malignant melanoma lesion was on the upper extremity in 6 patients (20%), it was on the trunk in 3 patients (10%) and on the lower extremity in 21 patients (70%).

The examination of the localization of the tumor lesion related to the type of the malignant melanoma showed that all of the patients with melanoma on the upper extremity (6 patients) and on the trunk (3 patients), had a nodular type of malignant melanoma. The lesions on the lower extremity were of nodular type in 16 patients, acral type in 3 patients, amelanotic type in one patient and a lesion with superficial spreading in one patient. Therefore, 24% of all nodular malignant melanoma were found on the upper extremity, 12% on the trunk and 64% on the lower extremity. All (100%) of the acral and amelanotic tumor lesions, and lesions with superficial spreading were located on the lower extremity (Table 1).

The results of this study showed that there was a statistically significant correlation of the vertical thickness of the tumor according to Breslow and the

presence of the lymphocytic infiltration with the sentinel node positivity for metastasis. Higher value of Breslow indicates higher possibility for metastasis in the sentinel nodes. A more intense tumor lymphocytic infiltration is related to the lower possibility for metastasis in the sentinel nodes (Table 2).

The correlation between the ulceration of the melanoma lesion and the positivity for metastasis of the sentinel node was statistically insignificant.

Discussion

Primary skin melanoma can be classified according to the TNM classification of American Joint Committee on Cancer (AJCC). This classification defines the tumor, lymph nodes and metastasis (15).

The main factors that influence on T stage are the thickness of the tumor tissue measured in mm according to Breslow and the ulceration of the tumor. The stage of the lymph nodes (N) is determined by the spreading of the melanoma cells in the regional lymph nodes. The identification of the first drainage lymph node (sentinel node) is performed using radioactive colloid. The status of the sentinel node, confirmed by biopsy, is the most significant independent clinical pathologic factor which determinates the survival of the patients with primary malignant melanoma (16, 17, 18, 19, 20, 21).

Table 1. Distribution of the tumor lesions according to the type of the malignant melanoma and its localization

Localization	Type of malignant melanoma				Total
	nodular	acral	amelanotic	supp.spread	
Upper extremity	6 (24.0%)	0 (.0%)	0 (.0%)	0 (.0%)	6 (20.0%)
Trunk	3 (12%)	0 (.0%)	0 (.0%)	0 (.0%)	3 (10.0%)
Lower extremity	16 (64.0%)	3 (100.0%)	1 (100.0%)	1 (100.0%)	21 (70.0%)
Total	25 (100.0%)	3 (100.0%)	1 (100.0%)	1 (100.0%)	30 (100.0%)

Table 2. Correlation between the presence of ulceration, tumor thickness according to Breslow and lymphocytic infiltration and the onset of metastasis in sentinel lymph node.

		Sentinel lymph node		Total	
		negative	positive		
Ulceration	negative	9 (30.0%)	5 (16.7%)	14 (46.7%)	p=.293
	positive	9 (30.0%)	7 (23.3%)	16 (53.3%)	
Total		18 (60.0%)	12 (40.0%)	30 (100.0%)	
Breslow	1-2mm	9 (30.0%)	1 (3.3%)	10 (33.3%)	p<.001
	2-4 mm	9 (30.0%)	4 (13.3%)	13 (43.4%)	
	> 4 mm	0 (.0%)	7 (23.3%)	7 (23.3%)	
Total		18 (60.0%)	12 (40.0%)	30 (100.0%)	
TIL	TIL +	12 (40.0%)	1 (3.3%)	13 (43.3%)	p<.001
	TIL +-	6 (20.0%)	5 (16.7%)	11 (36.7%)	
	TIL -	0 (.0%)	6 (20.0%)	6 (20.0%)	
Total		18 (60.0%)	12 (40.0%)	30 (100.0%)	

*TIL + severe lymphocytic infiltration
 TIL +- milde lymphocytic infiltration
 TIL - no lymphocytic infiltration