

ASO Author Reflections: Resection Margins in Merkel Cell Carcinoma: Is a 1 cm Margin Wide Enough?

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PAST

Merkel cell carcinoma (MCC) is a rare cutaneous malignancy with no clinical trials addressing margins of resection for primary lesions (unlike melanoma). Margins from 1 to 2 cm are widely used, largely by analogy to melanoma. We have learned from numerous randomized trials of excision width in patients with primary melanoma that wider margins are not always better and can be associated with graft or flap reconstruction and wound healing issues. Moreover, MCC is generally far more radiosensitive than melanoma, which may impact the need for wide margin resections.^{1,2}

PRESENT

We studied 240 MCC patients who had narrow (1 cm) or wider excision margins (broken into 1–1.9 cm and ≥ 2 cm margin groups). After median follow-up of nearly 2 years, we found that local recurrence rates were the same regardless of margins taken; overall and disease-specific survival were also not perceptibly affected by margin width. What we did see is that those patients with wider margins had significantly more grafts and flaps used to close their defects.³

An important point to note is that adjuvant radiation to the primary site was used frequently in all three resections groups: in 53% (1 cm), 72% (1–1.9 cm), and 76% (≥ 2 cm). Despite somewhat more adjuvant radiation being used in the groups with wider margins, we did not see a difference in local recurrence rates. No clinicopathologic factors were found to correlate with local recurrence or survival.

FUTURE

Merkel cell carcinoma primary tumor excision guidelines have never been rigorously studied. Rationales for narrow versus wide margins are not based on robust high-level clinical evidence. This paper can be used as a framework for formulating treatment guidelines and recommendations. Formally establishing optimum excision margins for MCC patients would require a multicenter randomized trial where local recurrence-free survival and disease-specific survival could be assessed by prospectively assigning patients to either a 1 cm or 2 cm margin of excision, with formal criteria for equitable use of primary-site postoperative adjuvant radiation across both arms.

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