Malignant melanomas are among the deadliest and fastest-growing malignant tumors. Although several decades ago they were considered rare, their frequency has increased dramatically in recent years. They cause 65% of skin cancer deaths. 70–90% affect the face—most frequently—the cheeks, 7% - the neck, 7% - the auricle, 3% - the hairy part of the head. 1.7–3% of all melanomas affect the mucosa [1, 2]. Overall 5-year survival rate is 17%; 10-year - 5% [3].

Melanoma usually appears as a new or evolving nevus. The American Cancer Society ABCDE-guidelines of early melanoma warning signs [4] are as follows:

- Asymmetry
- Border irregularity
- Color variation
- Diameter: usually > 6 mm, monitor for growth!
- Evolving: (particularly in amelanotic forms).

The so called “warning sign” of melanoma is a pigmented or clinically amelanotic lesion that simply looks different from the rest and may lack the classic ABCDE criteria (e.g., nodular, amelanotic, or desmoplastic melanomas) [5].

The appearance and growth of melanoma differ depending on the morphologic type (table 1).

<table>
<thead>
<tr>
<th>Subtype</th>
<th>Guidelines for treatment</th>
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<tbody>
<tr>
<td>Superficial</td>
<td>Excision of the primary lesion should be with 1cm free margin.</td>
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<tr>
<td>Nodular</td>
<td>Excision of the primary lesion should be with 1cm free margin.</td>
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<tr>
<td>Lentigo maligna</td>
<td>Excision of the primary lesion should be with 1cm free margin.</td>
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<tr>
<td>Desmoplastic</td>
<td>Excision of the primary lesion should be with 1cm free margin.</td>
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<tr>
<td>Vulgaris</td>
<td>Excision of the primary lesion should be with 1cm free margin.</td>
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The gold standard for melanoma diagnosis is histopathologic examination of clinically suggestive skin or mucosal lesions. An excisional biopsy (or deep saucization technique) with narrow margins is preferred when possible. In the case of lentigo maligna, a broad, paper-thin shave biopsy or multiple smaller biopsies are preferred. The biopsy report should include the following:

- Tumor thickness (Breslow depth);
- Presence of ulceration;
- Anatomic level of invasion (Clark level), no invasion deeper than subcutaneous fat is necessary as per 2010 AJCC staging
- Presence of mitoses, noted as 0 or 1 or more per millimeter squared;
- Presence of regression (associated with lower rates of sentinel node positivity and improved disease-free survival) [8];
- Lymphovascular invasion
- Host response tumor-infiltrating lymphocytes.

Surgery is the best treatment option. It is accepted that excision of the primary lesion should be as wide as possible (1cm for melanomas with depth of less than 2mm and 2cm – with depth over 2mm). According to Krown and Chapman [11] the free margins for deeper lesions are not well studied. In HNS adequate margins may not be possible or advisable due to cosmetic or functional causes Lenz [12].

Radiotherapy is controversial, but recently imaged data that adjuvant radiation may be beneficial in some patients with aggressive disease [13]. There are reports that definitive radiotherapy is also possible, but so far the results are not compared to surgery [14].

According to some studies selective neck dissection may be used for total tumor removal (e.g., clinically negative neck, nonfixed disease, and small nodes) [15]. Radical neck dissections are not recommended. Due to the high risk of occult metastases, in cases with porarid involvement parotidectomy with neck dissection is viable [16]. In primary tumors in parietal, frontal, temporal region, cheek and ear [17] recommends superficial parotidectomy. There is no reliable data that therapeutic neck dissection improves survival [18]. The incidence of local recurrence in neck dissection is higher than that after axillary or inguinal dissections [19]. “Wait and watch approach” is recommended in clinically negative neck.

Sentinel node biopsy is limited due to numerous reasons: complicated drainage with a lot of potential SLN; technical difficulties and close location make detection and isolation difficult; 25–30% of SLN are in the parotid gland; there is need of pathologists and nuclear medicine specialists [17]. But SLN can be localized successfully in over 90% of cases by combined use of staining and lymphoscintigraphy [20].

No survival benefit has been found after adjuvant chemotherapy, nonspecific immunotherapy, radiotherapy and vitamin therapy [21]. Adjuvant interferon (IFN) alpha-2b, is the only therapy approved by FDA in cases of high risk melanoma (stage IIIB, IIC, and III). Various experimental melanoma vaccines and monoclonal antibodies also show promise in the adjuvant setting [22].

We’d like to report 2 of our malignant melanoma cases. A 38 years old man with melanoma of the right retromandibular region, excised twice at another clinic with ultrasonographic and CT evidence of a formation with diameter of 15mm under the operative scar and many neck lymph nodes with diameter up to 15mm. Intact parotid gland, lungs and mediastinum. By layered dissection was excised a lymph node located retromandibularly in front of the SCM muscle and was sent for fresh frozen section with result metastasis from malignant melanoma. A left sided modified neck lymph dissection type 3 was done, including the lymph nodes and soft tissues from level 1, together with the submandibular gland and levels 2-5. The accessory nerve was identified and preserved. The parotidectomy was reached and a node, located under the parotid tail was removed. In 2 of the nodes from level 2 were found metastases, one of which infiltrating the capsule and the surrounding fatty tissue. There were no postoperative complications and the patient was directed to a specialized oncologic committee for further chemotherapy.

The second case was of a 71 years old male, who for many years had a brown nevus with diameter of about 2cm on the posterior surface of his left ear. About 5 months ago the nevus started to grow and “raised over the skin”. At the time of examination on the posterior surface of the left auricle there was an exophytic, easy bleeding formation with granulated surface and diameter about 3cm, with maximal thickness 2.5cm (fig.1). The anterior auricular surface was intact. There was no palpable evidence for cartilage involvement. In the retroauricular area at the level of the lobules was palpated a nonadherent, solid lymph node with diameter about 1cm. A horizontal skin incision was performed and the nevus was excised. The auricular cartilage appeared intact and decision for preservation of the ear was taken (fig.2).

The cuts were extended in the occipital area and a skin flap was formed, in order to cover the posterior auricular surface. An explorative neck dissection was performed with negative histological result. At the last control examination no evidence for residual tumor or metastases was found.

Conclusions:

- MM is often a deadly disease.
- The best treatment option is surgery.
- Its extent is defined by the stage and location of the tumor.
- More advanced stages are with poor prognosis, but immuno-medications, based on specific receptor antibodies seem to be promising.
- The good collaboration with specialists in dermatology, image diagnostics, pathology and nuclear medicine is important for the early recognition and adequate melanoma staging – main prerequisites for successful treatment.