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Dear Editors,

With great interest but also some amazement we have read the article by Garbe et al. [1] that in its title promises an interpretation of the current AJCC classification of melanoma, but particularly in the section on work-up and evaluation of the sentinel lymph nodes (SLN) goes far beyond this [2]. In order to give the recommendations a hint of guideline characteristics, agreement among the 16 authors is given in percentages. Can this be equated with an expert consensus? An expert on a given medical issue in our opinion is someone who is involved with the area in question on a daily basis and has published on the subject. For SLN diagnostics there are colleagues in the German-speaking nations who better fit this definition than the authors. The editorial by E.-B. Bröcker, which is well worth reading, rightly raises very critical questions [3]. Expressed bluntly, even a 100-percent vote cannot claim legitimacy in view of the heterogeneity of the scientific and clinical focuses of the group of authors, especially since proponents with great expertise in histopathological diagnostics of SLN with other views apparently have been excluded from the discussion and voting.

The following statements must be made in this matter:

1) International consensus recommendations for the evaluation of SLN in melanoma patients were already published in 2000 [4] and 2009 [5], of which only the latter is quoted in the paper by Garbe et al. These actually do leave different options open, but nonetheless define minimum standards which every case should meet. Histopathological examination of only one half of a SLN is explicitly discouraged, particularly as we are not aware of published studies on the equivalence of this method. Garbe et al. fail to provide a reference to support what we perceive as a daring assertion. On the contrary, we suspect that the comparatively low histological positivity rate of melanoma-related SLNs in Tübingen [6] may be explained by such methodology. A national recommendation deviating from the international guidelines is not only superfluous here, but even counterproductive.
2) None of the micromorphometric classifications proposed for SLN involvement has been generally accepted. Even the Rotterdam classification [7] is not an element of the current AJCC staging system, although A. M. Eggermont, one of its main proponents, is at the same time coauthor of the decisive publication [2]. In contrast, the S-classification [8] proved superior to the Rotterdam classification in two independent comparative studies from Amsterdam [9] and Hannover [10] with respect to prognostic value for overall survival. The weak points of the Rotterdam classification were discussed by its initiators themselves recently in the Journal of Clinical Oncology [11]. The attempted improvement by combination with the Dewar classification certainly limits everyday practicability and especially the reproducibility of this new construct. We recommend reading the discussions of this paper [12, 13].

We ourselves currently measure both the tumor penetration depth as well as the maximum diameter of the largest metastasis in SLN involvement. With only slightly more effort this allows for not only comparative studies on the predictive value of the individual parameters, but also the option of a well-reproducible combination classification with potentially even greater prognostic value. Perhaps this synthesis will be included in the next revision of the AJCC classification.

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