The sentinel node with a minimal metastasis in particular is subject to considerable discussion. This concerns patients with a single metastasis in the subcapsular area, with a Starz level I or II, or a minimum size of less than 0.1 mm. The currently available evidence seems to endorse a wait and see approach, but the duration of follow up in the various studies is too short for a definitive stance.
Does the prospect of a perhaps somewhat improved chance of survival after a node dissection outweigh the known substantial risk of unnecessary morbidity? Most melanomologists would currently proceed with a node dissection. Another option is to carry out a selective node dissection. SPECT/CT enables the accurate localization of sentinel nodes but also of second-tier nodes. A pilot study with a median follow-up of five years suggests that it is safe to limit the node dissection in the groin to the level of the second-tier nodes if these are not affected.
In conclusion, the surgeon has to tread carefully between chance of survival and risk of morbidity from node dissection until there is unequivocal evidence for the practical implication (or lack thereof) of an involved sentinel node.

47 INVITED

For Patients With Distant Metastases − Surgery is First Choice of Treatment

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The American Joint Committee on Cancer staging criteria defines sub stages of stage IV Melanoma based on the site of metastases: M1a-soft tissue or nodal recurrence, M1b -Lung and M1c-Other.
Complete Surgical Resection can result in favorable overall survival for M1a and M1b sub stages: Median survival rates of 15−50 months (mts) and 5-year survival (5 y Surv) rate of 14−61% in patients with M1a, and a median survival rate of 18−28 mts and 5 y Surv of 14−50% for M1b patients. Results for M1c patients are less favorable except for single small bowel metastasis.
Cytoreductive Surgery, a novel approach to multiple site metastatic melanoma, is enabled today due to reduced morbidity and mortality from complex surgical procedures and improved staging with CT, MRI and PET scans allowing better distinction between single vs. multiple metastases.
Canvaxin™ is an experimental specific active immunotherapy composed of three human replication-incompetent melanoma tumour cell lines, developed at the John Wayne Cancer Institute (JWCI). Studying adjuvant specific active immunotherapy for cytoreductive surgery in the minimal residual disease setting has been scientifically appealing.
Morton et al, JWCI, conducted a retrospective matched pair analysis of stage IV melanoma patients who had undergone surgical resection, comparing 107 patients with stage IV melanoma who received Canvaxin™ in phase II clinical trials to 107 who did not receive it. Results indicated that those patients who received Canvaxin™ experienced an approximate doubling in median overall survival when compared to those who did not: 38 vs. 19 mts ($p = 0.0009$) and a 5 y Surv rate of 39% vs. 20%.
A Double-Blind Phase 3 Trial (MMAIT IV) of BCG and Canvaxin™ vs BCG and Placebo as Post-Surgical Adjuvant in Metastatic Melanoma showed a 5 year disease free survival rate of 27.4% for Canvaxin™ and 20.9% for Placebo ($p = 0.418$). Median survival for the Canvaxin™ arm was 31. 5 mts and for placebo was 38.7 mts, with a 5 y Surv of 39.6% and 44.9% for Canvaxin™ and Placebo respectively ($p = 0.245$).
Conclusions: Observed survival in the Canvaxin arm of MMAIT IV is similar or slightly better than JWCI phase II, but the BCG and Placebo arm survival was higher than expected, highlighting the major role of surgery. This high survival rate may be attributed to the effectiveness of cytoreductive surgery or BCG immunotherapy. A newly designed trial of surgery vs. surgery and BCG vs. non-surgical treatment has been recently initiated.

48 INVITED

A Critical View − Selection is the Standard

Abstract not received

Special Session (Sat, 24 Sep, 14:15−15:15)
Adolescent and Young Adult Cancer Patients: Are We Meeting Their Needs?

49 INVITED

Why are Adolescents Diagnosed Later With Cancer?

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The difficulties in ensuring prompt diagnosis, referral and treatment of cancer in young people are thought to be a contributing factor for poorer outcomes. Published studies hypothesise reasons for patient delay, suggesting that in the absence of physician and parental awareness, that includes frequent observation, diagnosis relies on self-reporting, that may be unreliable. What is absent from this body of evidence is the voice of the young person that might illuminate determinants for late diagnosis that relate more to behaviour and experiences of accessing health care.
An interpretive qualitative research study was undertaken to understand how young people 16−24 years experience the diagnostic phase. Twenty-four young people between two to four months from diagnosis, with a solid tumour, were recruited from four cancer centres in England. Narrative interviews were undertaken as well as analysis of medical notes. Data were analysed to examine how accounts were constructed and connected to broader contextual issues concerning cancer and this age group, diagnostic timelines and entry into specialist care.
Shared themes shaped a group narrative and an emerging conceptual framework. This included the individual's perception of, and meaning given to symptoms; the impact of others in determining the identification of a threat within symptoms; the negotiation of generalist health care and then entry into specialist care. A narrative of delay was evident in some stories. This paper will briefly present what is currently known about delay in this age group before focussing on young peoples' accounts, which has contributed to the evidence on delay.

50 INVITED

Life Four to Six Years Beyond Diagnosis

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Findings regarding effects on social life after treatment for childhood cancer are scarce. Moreover, they are not consistent. Our research group has followed a national cohort of school children diagnosed with cancer with focus on social life. Results from a follow-up conducted four to six years after diagnosis ($n = 63$, age 12−22) will be presented. The aim of the study was to investigate how survivors of childhood cancer experience school and relationships to peers four to six years after being diagnosed for cancer. A further aim was to compare self-reported quality of life between survivors and peers. The young persons were interviewed over the telephone regarding how they perceive their lives. In addition they answered questions measuring quality of life. A matched control group was drawn from the general Swedish population ($n = 234$, age 11−23).
The semi-structured interviews were analyzed using qualitative content analysis. The preliminary results show physical and mental impairments affecting life, e.g. participation in activities, change in relationships to others and influences on personal identity and attitude towards life. Overall, the survivors appear to get along well in life.
Quality of life was measured with the KIDSCREEN-27 including five dimensions: Physical Well-being, Psychological Well-being, Autonomy & Parent Relations, Social Support & Peers and School Environment. Preliminary results show only one significant difference between the survivors and the control group, regarding the dimension Autonomy & Parent Relations. In this dimension, the survivors showed a higher mean ($p < 0.05$), indicating better quality of life. One explanation for this could be experiences related to having had cancer such as a closer contact to parent(s) during treatment periods. A tentative explanation for why the remaining dimensions did not differ between the groups could be that possible negative effects due to cancer treatment are revealed later than four to six years after diagnosis or that the cancer experience did not affect the quality of life to a large extent.