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CORRESPONDENCE

Correspondents are asked to be brief

Treatment of Malignant Melanoma

SIR,—Your leading article (10 February, p. 306) presenting some aspects of contemporary thought on melanoma is, I believe, inadequate in certain respects.

It is misleading to state that cutaneous melanoma is unpredictable in its behaviour, the implication being that other malignant tumours are predictable in their behaviour or that it belongs to a group of tumours about which information is so scarce as to be inadequate for prognostic purposes. Neither is true. For example, there is a well-established relationship between prognosis and a large number of clinicopathological relationships—sex of the subject, anatomical location of the tumour, its size and histogenetic type, depth of invasion, clinical involvement of regional nodes, and radiosensitivity, to name the obvious ones.[1 2] As in the case of the lymphomas there is an abundance of information of prognostic importance.

Again it is not "agreed that in the management of melanoma incisional biopsy must be avoided." On the contrary, I would suggest that it is a mandatory procedure to obtain a diagnosis on a large ulcerated cutaneous lesion of doubtful histogenesis before any treatment is given. Furthermore, informed opinion is that there are no known harmful effects from biopsy carried out on the unulcerated lesion.[3] Where radiotherapy may claim to be the treatment of choice—that is, for the melanotic freckle and its conjunctival homologue—confirmatory biopsy should be an invariable preliminary. The final sentence "External radiotherapy produces a poor response in most cases"—is misleading in its simplicity, which again has about it the suggestion that melanoma is one disease only, and an unpredictable one at that.

Finally, there is the statement that "the primary tumour must be excised with a very wide margin of skin at the earliest possible time and the defect covered with a skin graft." How wide? I have noticed that surgeons, the most frequent writers on the therapeutics of melanoma, either provide no guidance on dimensions, tailor it according to the anatomical site involved and the likely cosmetic problems presented, or resort to recommending one of the series of prime numbers 1, 2, 3, 5, 7, 11 cm as a suitable margin of clearance around the tumour, regardless of its size. So far as I am aware the choice of such numbers enjoys no pathological basis, nor sanction, but is an attempt to circumvent the subsequent appearance of satellite nodules. Since no method of surgical treatment guarantees freedom from this complication the recommended area of excision would still appear to be a debatable point, possibly to be determined by appropriate surgical research.—I am, etc.,

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1 Maillard, G. F., *Annales de Dermatologie et de Syphiligraphie*, 1971. **98**, 5.
2 Clark, W. H., Jr., from, L., Bernardino, E., and Mihm, M., *Cancer Research*, 1969, **29**, 705.
3 Epstein, E., Bragg, K., and Linden, G., *Journal of the American Medical Association*, 1969, **208**, 1369.

Central-core Disease and Malignant Hyperpyrexia

SIR,—The report by Dr. M. A. Denborough and others (3 February, p. 272) of core-like areas in type 1 fibres in malignant hyperpyrexia myopathy is interesting, but they are not justified in referring to this myopathy as central-core disease as if it were a specific entity. Focal areas of absence of mitochondria in histochemically stained sections have already been reported by us in malignant hyperpyrexia myopathy,[1 2] but we have preferred to use the term "moth-eaten fibres" to avoid any suggestion that the finding is specific. Our illustrations of the mitochondria-deficient areas, identical with those of Dr. Denborough and his colleagues, have been shown at international meetings and are shortly to be published.[3] They are less numerous in our cases, possibly owing to a difference in the muscles examined.

Those with more than average experience of muscle biopsy realize that focal areas of mitochondrial absence, whether accompanied by preservation of myofibrils in electron micrographs (core-like fibres) or their disarray (target or targetoid fibres) are relatively common in neuromuscular disease in isolated fibres. To refer to all those with the former characteristics as central-core disease would clearly be ridiculous. Central-core disease is poorly defined, but the term should be reserved for cases which at least resemble the original descriptions.[4] We believe that the patient described by Dr. Denborough and his colleagues suffered from malignant hyperpyrexia myopathy, and