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Editorial

Is recurrent vaginal melanoma a lethal disease?

Melanoma is a highly aggressive and invasive disease, and occurs most commonly among the White populations. Since this disease is rare among the Asian populations, it is not so familiar to most physicians in Asian countries. In the 2011 issue of the JCMA, Lin and colleagues reported a case of melanoma[1] that is worthy of our attention. The reasons are shown below. First, this Taiwanese woman was diagnosed as having primary melanoma of the vagina.[1]

Second, although this woman initially underwent very aggressive and extensive treatment, including radical vulvectomy and total vaginectomy, and reconstruction with a rotation flap, followed by immediate immunotherapy, the patient had a relatively short disease-free interval (7 months). Then, the nightmares began with recurrence again and again in both local and distant areas.[1] This is consistent with the recent report from Frumovitz et al, which showed that malignant vaginal melanoma, even when localized at presentation, has a very poor prognosis.[2] Using the "never give up" strategy, aggressive and active multi-modality combination therapies were given to this patient again and again, and she remained alive for more than 30 months.

Of most importance, this patient underwent repeated complete resections of the tumors in the local area, suggesting that the repeat surgery should be considered as an adjuvant therapy for local recurrent tumor. In fact, a recent report also favored the role of surgery in the management of malignant vaginal melanoma, because the patients who underwent surgery were found to survive significantly longer than those who did not ($p = 0.01$).[2]

Furthermore, this case of Dr. Lin[1] in this issue raises a question about the possibility or necessity of long-term treatment for cancer patients if the cancer is theoretically never cured. To respond to this question, the concept of metronomic therapy should be introduced. Metronomic chemotherapy is the process of administration of cytotoxic drugs on a more continuous basis—with a much shorter break period or none at all, and with generally low doses of various cytotoxic drugs or combinations with other newer—targeted therapies, for example, antiangiogenic agents.[3] However, the candidate medications that have been used recently and frequently for metronomic therapy are not so patient-friendly. Many of them should be given by parenterally, not orally. For example, a Phase 2 pilot trial of combined intravenous metronomic paclitaxel and oral celecoxib showed an impressive result for patients with metastatic melanoma,[4] but surely no one would like to be treated with a continuous intravenous infusion of paclitaxel 10 mg/m^2 for 96 hours weekly.

Cancer treatment is still a big challenge. Although "cure" is a goal, "stability" might be an alternative if cure is impossible. As a doctor, the concept of "a more friendly treatment, a more acceptable outcome" should always be reminded.

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