

Melanoma of the lower extremity: A demographic review in the new millennium

Carl H. Manstein, Omar E. Beidas and Mark E. Manstein
Holy Redeemer Medical Center, USA

Melanoma accounts for 4% of all skin malignancies and 75% of all skin cancer deaths. Currently the 8th most common malignancy in the United States, the incidence of melanoma has rapidly increased. Treatment of melanoma on the lower extremity includes wide local excision and possible use of sentinel node biopsy evaluation. The aim of this article is to describe the new AJCC's new staging system for skin melanoma and present demographic, prognostic, and treatment data. A 10-year retrospective review was conducted based on charts from a single surgeon practicing in a private plastic surgery office in a middle class suburb of a large city. Charts were parsed for age at diagnosis, gender, location, Breslow depth, Clark's level, and the presence of ulceration, regression, and nodularity. We present a series of 35 patients and their interesting demographic data. The lower leg was the most common site of involvement, and more than half of all lesions had a Breslow depth less than 0.5 mm. One patient died of her disease in her 90s and another refused treatment. Melanoma of the lower extremity has had an evolution in both the diagnosis and treatment of this disease.

Biography

Carl H. Manstein received his MD from Temple University in 1976 and his MBA from LaSalle University in 1998. He is the former President of the Robert H. IVY Society of Plastic Surgeons.

Omar E. Beidas completed his MD from Temple University in Philadelphia, PA. He is currently a first-year plastic surgery resident at the University of Oklahoma with an expected graduation date of June, 2017.

Mark E. Manstein graduated with his MD in 1978 from Medical College of Pennsylvania. He is currently Chief of Plastic Surgery at Holy Redeemer Medical Center in Meadowbrook, PA.

omar-beidas@ouhsc.edu

An alternative to vaccination

Malyshkin A P
Orenburg State Medical Academy, Russia

The traditional classification of infectious microorganisms into normal, pathogenic, and opportunistic disregards that normal microorganisms may cause diseases, or pathogenic ones coexist with healthy carriers. In effect, all microorganisms in a host are opportunistic. There is no essential difference between "normal" and "pathogenic" microfloras: both are infectious and both may either cause diseases or persist in healthy carriers. Moreover, normal microflora is more infectious—it infects all individuals of the host species. This is an endless epidemic, unrivalled by any cholera and plague epidemics as regards the number of victims.

According to the active susceptibility concept,¹ normal microflora is absolutely infectious because the host needs it as a symbiont, the microorganism's infectiousness being the host's active property: we infect ourselves with what we need. Since "normal" and "pathogenic" microfloras are essentially similar in all other respects, it is conceivable that the susceptibility to "pathogenic" infectious microflora is also active. Passive susceptibility, with the host being merely an accidental nutrient medium for pathogens, exists, too (e.g., susceptibility to tetanus and botulism), but these pathogens are not contagious.

Note that the host is actively susceptible because it needs some products of the microorganisms' genes rather than the microorganism per se. This indicates an approach to alternative prevention of infectious diseases²: ones the host body is provided with the required products of microbial genes in another way, there will be no need to activate the susceptibility mechanism, and the host will become naturally insusceptible to the given agent.

malishkin_54@mail.ru