Melanocytic tumors: pitfalls and how to deal with them?

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Case 1: a pitfall without very important consequence!

woman, 39 years old, scapular pigmented lesion, 7mm (diameter).
to summarize…

- 39-yr old woman
- atypical intraepidermal melanocytic proliferation

Questions:

- Is this lesion atypical enough to propose a diagnosis of in situ Superficial Spreading (SSM) Melanoma?

- What are the consequences of such a diagnosis?
How to analyze an atypical intraepidermal melanocytic proliferation?

• First step: analyze clinical context
  – age? (< or > 40yrs old?)
  – is the lesion clinically atypical?
  – does the patient present a dysplastic nevus syndrome?
How to analyze an atypical intraepidermal melanocytic proliferation?

Second step: histologically is there any reason to explain intraepidermal atypia?

- Signs of traumatism or irritation?

- Signs of previous treatment (biopsy, cryotherapy, laser...)?

Tronnier experiment:
- Half nevus traumatized by scotch tape
- Half nevus got sunburnt (UV=2DEM)
After 1 week histological aspect of in situ SSM which regressed after 3 weeks
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- Second step (twice): histologically is there any reason to explain intraepidermal atypia?

Melanocytic stimulation by sun?
due to pregnancy?
due to recent melanoma?
How to analyze an atypical intraepidermal melanocytic proliferation??

- Third step: could this lesion be a specific well-known, benign entity?
  - Reed nevus
  - Spitz intraepidermal nevus

Be sure of spitzoid cytology for a patient older than 40 yrs!!
Step 4: Weigh up the pros and cons for malignancy

• Malignant?
  - age 39 yrs old
  - no irritation or traumatism
  - no previous melanoma
  - polymorphous architecture with
    - intraepidermal ascent of cells
  - +/- moderate atypical melanocytes
  - lymphocytic dermal inflammation

• Benign?
How to conclude this diagnosis?

• In this case: either
  – in situ SSM
  – or very atypical intra-epidermal melanocytic proliferation
  – or in Britain: MIN (melanocytic intraepidermal neoplasm)

• Whatever your conclusion it is essential to be certain that the surgical excision is complete with narrow margins (5mm)

• Because in this case the patient is cured

• In case of doubtful intra-epidermal lesion (younger patient, moderate atypia)
  – Prefer descriptive diagnosis
  – But if you are worried be sure that the excision is complete with 5 mm margins
  – So be very precise with your clinician
Case 1:
atypical intra-epidermal melanocytic lesion
a minor pitfall!

because the consequences for patient are not very important if the lesion is completely removed!