Management of patients with melanocytic and non-melanocytic neoplasms

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Characteristic Dermoscopic Pattern of Recurrent Nevi and Recurrent Melanomas

Recurrent Melanoma

1. Circles (face especially)
2. Eccentric hyperpigmentation at the periphery
3. Chaotic growth pattern
4. Noncontiguous growth pattern
5. Pigmentation beyond the scar’s edge
Characteristic Dermoscopic Pattern of Recurrent Nevi and Recurrent Melanomas

### Recurrent Nevi
1. 30 yo (younger pts)
2. Pigment confined to scar
3. Torso
4. Time to recurrence 8 months
5. Growth pattern – centrifugal
6. Contiguous pigment

### Recurrent Melanoma
1. 63 yo
2. Pigment traverses the scar’s edge
3. H&N
4. Time to recurrence 25 months
5. Growth pattern – chaotic
6. Non-contiguous pigment

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Key RCM features for LPLK

- Typical honeycomb pattern of the spinous layer
- Elongated cords and / or bulbous projections at the dermal epidermal junction
- Numerous plump-bright cells and / or bright stellate spots in the superficial dermis
- Absence of:
  - Bright nucleated / dendritic cells in a pagetoid pattern in the epidermis
  - Atypical / broadened honeycomb pattern
  - Tumor islands in the dermis

Reflectance Confocal Microscopy Criteria of Lichen Planus-like Keratosis

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Results - RCM features of LPLK

- Typical honeycomb pattern
- Elongated cords and bulbous projections
- Plump-bright cells and small bright cells in the superficial dermis
- Thickened fibers of collagen

Out of the 28 lesions, 12 lesions (42.8%) displayed all 4 RCM criteria and 14 lesions (50%) showed three criteria. Only 2 cases (7.1%) showed less than 3 RCM criteria for LPLK.

Treatment of facial melanoma on sun-damaged skin

1. Surgical excision
2. Staged excision
3. Mohs micrographic surgery
4. Nonsurgical interventions
   A. Imiquimod
   B. Radiation therapy
Surgical excision

Surgical excision is the mainstay of treatment.

But........

There is a problem!

It has been recognized that wide local excision with 0.5–1 cm margins is occasionally insufficient for facial melanomas on sun damaged skin, as opposed to other types of melanoma *in situ*.

Treatment of facial melanoma on sun-damaged skin

1. Surgical excision
2. Staged excision
3. Mohs micrographic surgery
4. Nonsurgical interventions
   A. Imiquimod
   B. Radiation therapy
Staged excision with rush permanent sections (a.k.a. “slow Mohs”) is thought to be the optimal treatment for LM/LMM, with recurrence of 0–5% at 23–57 months.

The most common surgery is geometric excision although there are several variations of this surgical method, including square, perimeter, contoured, and spaghetti.

Of the 161 lesions with a negative pigment network 35.6% proved to be melanomas 17.4% - Clark/dysplastic nevi with high-grade cytological atypia 3.8% - Spitz nevi

All melanomas with NPN showed at least one additional melanoma-specific dermoscopic features

Finally, a third of melanomas showing NPN arise in association with a nevus, a higher frequency than that reported in the literature for the association between melanomas with nevi.

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Poster presented at the American Dermoscopy Meeting Mt. Ranier 2017
A possible diagnostic tool might be gene profiling with tape stripping.

LINC00518
Long Intergenic Non-Coding RNA 518

PRAME
Preferentially Expressed Antigen in Melanoma

1 Collect Sample and Mail
2 qPCR Analysis (CLIA Lab)

Sens: 91% Spec: 69%

Clinical, dermoscopic and reflectance confocal microscopy characterization of facial basal cell carcinomas presenting as small white macules papules on sun-damaged skin

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Forty-five lesions were included:

Study population had fair skin and extensive sun-damage in all the cases. Lesions were inconspicuous and only 13.3% were noted by the patients themselves. The lesion mean size was 3.7 mm.

Visualized with dermoscopy, 55.6% (n=25) were white and 42.2% had pink (n=19) and 2.2% (n=1) had blue hues.

Histopathologic examination, 71.1% (n=32) showed a nodular and superficial BCC subtype, 13.3% (n=6) were infiltrative, and 4.4% (n=2) were morpheaform.

28.9% of the lesions under dermoscopic examination lacked the classic dermoscopic criteria that would lead to the diagnosis of BCC.

BCC-specific structures were found in all but one cases using RCM.