

NEWSLETTER

www.dermoscopy-ids.org

Notes by the Editor

In this 2nd issue of the IDS Newsletter we will focus on dermoscopy of amelanotic melanoma. This group of melanomas still represents a challenge for every clinician given the broad spectrum of possible differential diagnoses.

In this context we like to make you aware of the recent publication by Dr. Scott W. Menzies, who conducted a study via the IDS investigating the value of dermoscopy in the diagnosis of amelanotic and hypomelanotic melanomas (ref. Arch Dermatol 2008; 144:1120-7).

Please note that the IDS Newsletter aims to provide space for all IDS members to send their own cases or to express their opinion about the IDS and dermoscopy in general.

Finally, we are excited to announce the 2nd World Congress of the IDS to be held in Barcelona, Spain, on November 12-14, 2009.

Have a look at the final program: <http://www.congress2009.dermoscopy-ids.org/>

We look forward seeing you in Barcelona!

*-Iris Zalaudek-
Editor-in-chief*

SAFE THE DATE!!!

The text "2nd congress of the international dermoscopy society" is written in a mix of blue and black fonts. The "2nd" is large and blue, "congress" is in a cursive blue font, and "of the international dermoscopy society" is in a bold black font. In the background, there is a large, multi-colored cake with a white frosting swirl on top. A circular inset shows a close-up of the cake's surface, which has a pattern of small, colorful dots, resembling a dermoscopy image.

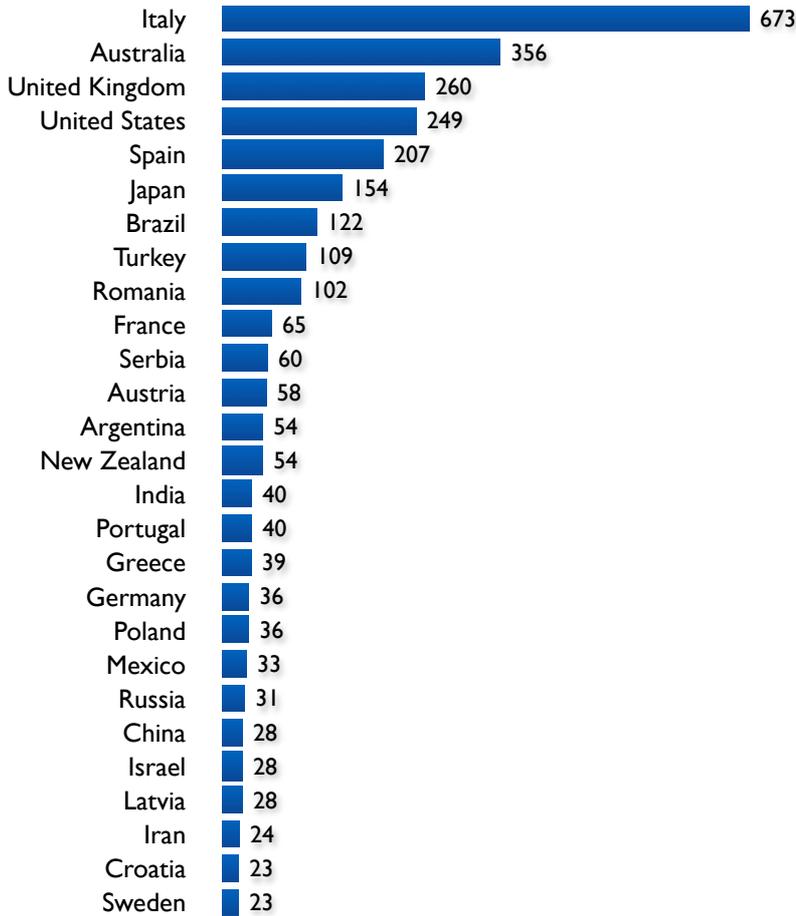
2nd congress
of the international
dermoscopy
society

12-14 november 2009
barcelona, spain
hotel fira palace

Some statistics around the IDS and dermoscopy of non-pigmented skin tumors

IDS MEMBERS: February 2009

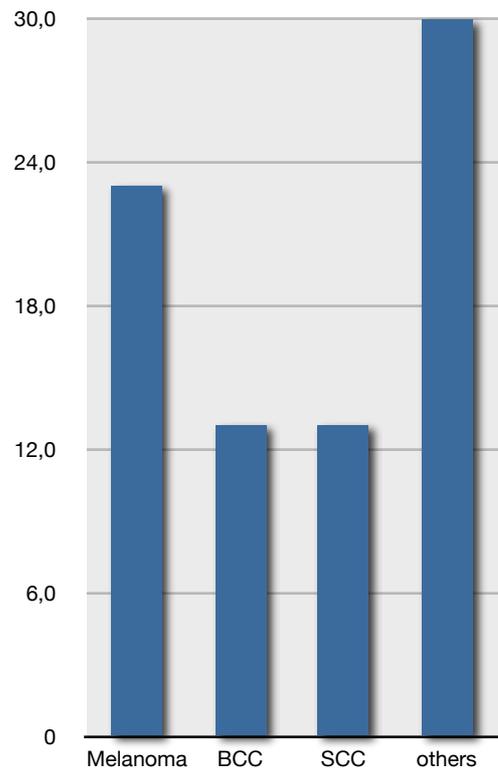
Our membership is worldwide. Currently 3350 members from 114 different countries are represented. 27 countries are represented by more than



NUMBER OF PUBLICATIONS in PubMed dealing with dermoscopy of non-pigmented skin tumors:

Total: 79 publications

Search words: dermoscopy AND vascular AND vessels AND non-pigmented AND amelanotic AND featureless AND melanoma
Abbreviations: Basal cell carcinoma (BCC); Squamous cell carcinoma (SCC),



Meetings

7th October 2009: Sub-Specialty Meeting - EADV Congress in Berlin: Dermoscopy update (preliminary program)

- 09:30 -09:40: Elvira Moscarella/Giuseppe Argenziano (Italy): Benign:melanoma ratio in the dermoscopy era: a worldwide survey
- 09:40-09:50: Harald Kittler (Austria): A new algorithm for the diagnosis of unpigmented lesions dedicated on vessels
- 09:50-10:00: Rainer Hofmann-Wellenhof (Austria): My best rules not to miss melanoma

- 10:00-10:10: Susana Puig (Spain): Dermoscopy of familar melanoma
- 10:10-10:20: Stefnaia Seidenari (Italy): Small melanoma versus small nevus: do we see the difference?
- 10:20-10:30: Wilhelm Stolz (Germany): Stem cell theory and dermoscopy
- 10:30-10:40: Lidia Rudnicka (Poland): Trichoscopy update
- 10:40-10:50: Iris Zalaudek (Austria): How many patients should we scree to find one more melanoma?
- 11:00-11:30: Discussion

The Case of the Quarter

Discussion Forum of the IDS

Are you interested in publishing one of your cases in the IDS Newsletter? Do you wish to comment on some topics recently published in the field of dermoscopy? The section of the Case of the Quarter is dedicated to special cases provided by members of the IDS. If you are interested in publishing your case, please contact the Editor-in-chief (iris.zalaudek@gmail.com).

August 2009

*By François Breuillard
Discussion Forum of the IDS*



Age: 67 years

Sex: female

Location: lower leg, right.

History: present for one year. Non-pigmented slightly squamous. Irregular and glomerular vessels-like appearance. Will be removed soon.

Question: Bowen? Nodular melanoma?

Answers:

Muir James (6/9/2009 2:42:50 PM):

On the clinical I'd be going for irritated seb k, i also thought about clear cell acanthoma and eccrine poroma. Amelanotics can fool you. I'd probably have shaved this off.

Alhazaa Mahlab (6/9/2009 4:50:26 PM):

The BV looks polymorphous including hairpins & linear irregular with one or two pearls in strings in the centre, & keratotic, little tricky multiple DDX is there, better right shave biopsy.

Zalaudek Iris (6/9/2009 9:52:25 PM):

I agree with Jim ... amel mm can fool us all. The point that the lesion is nodular and still shows coiled vessels makes me however thinking more about SK or Bowen, since nodular amel MM of such size (to my limited experience) tends to reveal less vessels, which are more elongated. But I would not put a penny on that observation :-((

Callan Michael (6/9/2009 11:51:36 PM):

I'll go for Seb k, but easy to shave if any concerns.

Landi Christian (6/10/2009 10:05:59 AM):

I would say eccrine poroma (d.d. SK and SCC), I think it's too thick to think about Bowen.

I agree it needs to be excised (or shaved) because it's nodular, ulcerated and "strange".

Fox Gary (6/19/2009 3:46:02 AM):

Since nobody's mentioned DF, I'll add that as an outside possibility. Just had one that I didn't do a dermoscopic photo on L/E that had nicely coiled vessels and I thought was a chip shot for Bowens. Histo: superficial BCC. Legs don't play fair.

Histopathologic diagnosis: nodular melanoma Breslow depth 3.6mm

Comment by Iris Zalaudek:

Amelanotic nodular melanoma is a great masquerader both clinically and dermoscopically.

For its clinical diagnosis not the ABCD but the EFG criteria should be applied (E=Elevation, F=Firm on palpation; G=growth over 1 month).

Dermoscopically various types of vessels including linear-irregular, hairpin or as in this case glomerular vessels may be the only clue for the diagnosis.

As a rule, any rapid growing amelanotic nodule showing atypical vessels should be always excised to rule out amelanotic melanoma

Selected Abstracts

DERMOSCOPIIC EVALUATION OF AMELANOTIC AND HYPO- MELANOTIC MELANOMA

Authors: Menzies SW et al.

Summary: This study sought to identify predictive dermoscopic features of amelanotic and hypomelanotic melanoma. Glass-plate dermoscopy devices were used to image 105 melanomas (median Breslow thickness, 0.76 mm), 170 benign melanocytic lesions, and 222 nonmelanocytic lesions lacking significant pigment (amelanotic, partially pigmented, and light colored). All were scored for 99 dermoscopic features. The most significant negative predictors of melanoma were the presence of >3 milia-like cysts (OR, 0.09), regularly distributed comma vessels (OR, 0.10), comma vessels as the predominant vessel type (OR, 0.16), symmetrical pigmentation (OR, 0.18), irregular blue-gray globules (OR, 0.20), and multiple blue-gray globules (OR, 0.28). The most significant positive predictors were the presence of a blue-white veil (OR, 1.3); scar-like depigmentation (OR, 4.4), multiple blue-gray dots (OR, 3.5), irregularly shaped depigmentation (OR, 3.3), irregular brown dots or globules (OR, 3.2), the presence of 5 to 6 colours (OR, 3.2), and central vessels as the predominant vessel type (OR, 3.1). In the test set, a simple model differentiating melanomas from all nonmelanomas was 70% sensitive and 56% specific, and a model differentiating all malignant lesions from benign lesions was 96% sensitive and 37% specific.

Comment: Amelanotic and hypomelanotic melanomas are amongst the most difficult lesions to diagnose clinically and contribute quite significantly to the estimated number of undiagnosed or delayed diagnosed melanomas. This article underscores nicely the value of dermoscopy for this specific group of melanomas lacking significant pigment.
Reference: Arch Dermatol. 2008;144(9):1120-7 <http://archderm.ama-assn.org/cgi/content/abstract/144/9/1120>

DERMOSCOPIIC FEATURES OF MELANOMAS ASSOCIATED WITH MC1R VARIANTS IN SPANISH CDKN2A MUTATION CARRIERS

Authors: Cuéllar F et al

Summary: This study involved nine CDKN2A gene mutation-positive Spanish individuals in whom a melanoma was diagnosed during specific follow-up (patients had familial or personal history of previous melanoma). The researchers aimed to describe dermoscopic features of early melanoma in these patients and to evaluate the possibility of a correlation between particular dermatoscopic pattern and melanocortin 1 receptor (MC1R) gene variants. Three of the patients were noncarriers of the red hair MC1R polymorphism, three had one red hair MC1R polymorphism and three had two red hair MC1R polymorphisms. Dermoscopic analysis of suspect melanocytic lesions revealed a significantly higher mean ABCD total dermoscopy score in noncarriers of red hair MC1R polymorphisms than in carriers of two MC1R gene red hair variants (6.8 vs 4.4; p=0.014).

Comment: Persons with two MC1R red hair variants are dermoscopically difficult to diagnose, as their melanomas are more commonly "featureless". We are very excited by these findings and inspired by them. We are in the process of initiating a research project correlating MC1R allele frequencies with dermoscopic naevus types and melanoma types.
Reference: Br J Dermatol. 2008 Sep 15. [Epub ahead of print] <http://tinyurl.com/5zzafp>

Independent commentary by Dr H. Peter Soyer, Professor of Dermatology at the University of Queensland, President of the International Dermoscopy Society and President of the International Society of Teledermatology.
Conflict of interest declaration: Dr H. Peter Soyer is co-founder of e-derm-consult GmbH, a spin-off company of the Medical University of Graz, providing holistic solutions for teledermatology. He also provides telederm consultation for MoleMap Australia Pty.

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