



International Dermoscopy Society

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Interested in submitting a quiz case for the IDS Newsletter ?

Just send an email to:
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Dear readers,
2012 was a year full of events for the dermoscopy community. The IDS congress in Brisbane last May was an outstanding scientific event and a big occasion for sharing knowledge and discuss projects. Two official meetings took place during the AAD congress in San Diego and the EADV congress in Prague last months, with a great participation of physicians interested in dermoscopy.

In the meanwhile IDS is growing year by year. The IDS members are now more than 6600. And the website of the society is the main source of information and the main way of communication and active participation among members.

In this light, I'd like to invite you to visit the website, where you will find information about the upcoming events and a valuable source of education, including podcasts and tutorials. Moreover, don't forget to read about ongoing studies, where all the IDS members are invited to actively participate.

In this edition of the newsletter we will continue with

our educational purposes and we will focus on dermoscopy of melanocytic lesions with features of regression. You will find a brief review of the current literature and the case of the newsletter focusing on this topic.

I'd like also to highlight new articles from the official journal of the society, *Dermatology Practicle and Conceptual*.

Finally,

I'd like to remind you the next Joint meeting of the International Dermoscopy Society, the International Society for Digital Imaging of the Skin, and the International Confocal Working Group during the upcoming AAD congress in Miami: March 1, 2013 - Time: 5:30 - 9:30 PM

Looking forward to seeing you soon in Miami

With all my best regards
Elvira Moscarella



DERMOSCOPY OF MELANOCYTIC LESIONS WITH REGRESSION

Regression is a well known histopathologic phenomenon that can involve both benign and malignant melanocytic skin lesions, but also non melanocytic tumors.

The dermoscopic hallmark of regression is the presence of blue-white structures (BWS).

BWS correspond to the presence of fibrosis (white areas) and /or large amounts of melanin pigment (blue areas), either within melanophages or pigmented melanocytes in the dermis.

Within blue-white structures we distinguish between 2 main categories: blue-white veil and blue-white areas.

Blue-white veil

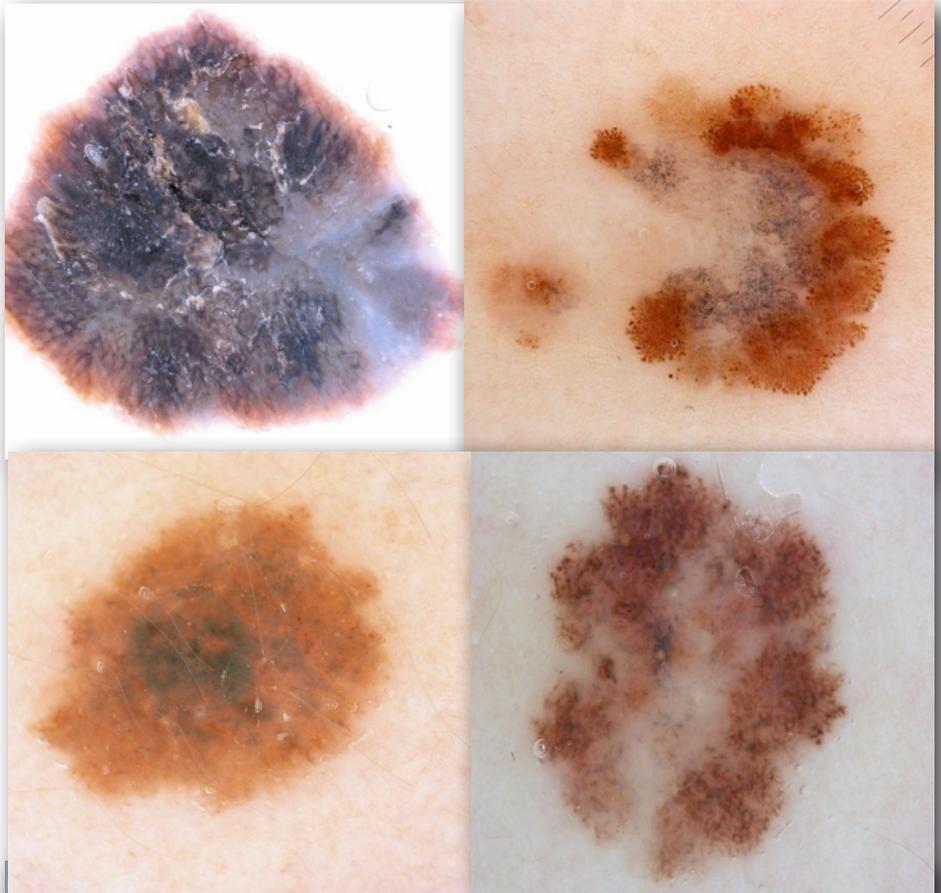
On histology, it corresponds to acanthotic epidermis with compact orthokeratosis and focal hypergranulosis above sheets of heavily pigmented melanocytes and / or melanophages in the dermis. This means that a blue-white veil usually corresponds to a clinically palpable area of the lesion. (fig left up)

Blue-white areas

In contrast to blue white veil, blue-white areas are seen in clinically flat lesions. They can be present together within a lesion, or we can have only white areas (white scar like areas corresponding to fibrosis) or blue areas (blue-grey areas and peppering)

Blue-white veil is usually suggestive of melanoma, but can be seen also in Spitz/Reed nevi.

Blue-white areas can be present in melanoma, but we can also find benign nevi showing areas of regression. However, it has to be underlined that the presence of



Blue-white structures

*Left up: Superficial spreading melanoma, Breslow 0.9 mm, showing a blue-white veil.
Right up: Superficial spreading melanoma in situ melanoma showing blue-white areas (white scarlike areas and peppering)*

*Left down: Compound nevus with central blue-grey areas of regression.
Right down: Atypical nevus with diffuse grey-blue areas of regression.*

regression can be a confounding feature also in histopathology. The amount of regression (>50% in suspicious lesions, < 50% in benign nevi), and the presence of additional dermoscopic features of melanoma can be helpful information guiding the management decision.

(see Massi D et al. 2001

Zalaudek I et al. 2004)

Reticular grey-blue areas

Recently, reticular grey-blue areas of regression have been described as an indicator of in situ melanomas with regression. Bassoli et al. found

the majority of in situ melanomas with regression in their study showed grey-blue areas with a reticular pattern, mainly distributed at the center of the lesions.

(Bassoli S et al. 2011)

Dermoscopy of fully regressive melanomas

Complete regression of melanoma can occur, eventually with metastatic spread of the disease by an unknown primary. Thomas et al. recently described the dermoscopic clues that can lead to the detection of the probable regressed lesion.

CASE OF THE NEWSLETTER

request #1566 by Muir James

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title of request Another!

age 72 years

sex: m

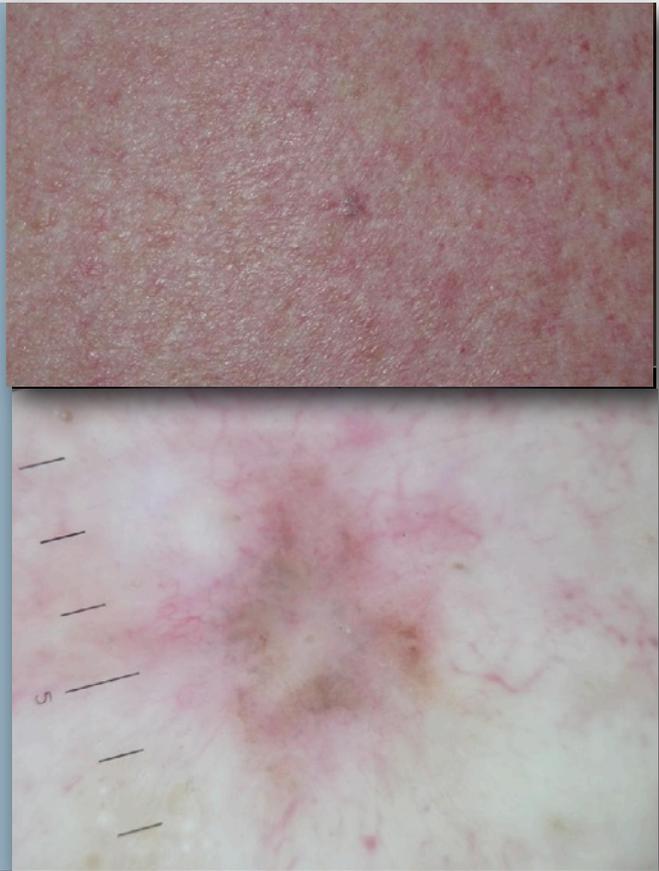
location lateral trunk, left

clinical history Sun damaged Australian bloke. Have removed 5 dysplastic naevi from him in last many months (all of which I thought were suspicious but none malignant).

diagnosis TBA

question

I had to remove this one. What is the diagnosis?



Bru Francisco:

There are many gray dots. I don't think the vessels are very valuable as the whole region seems to have many telangiectases. I think it can be keratosis lichenoides although one can not rule out BCC or even a melanocytic lesion. I think the removal is a good idea.
Greetings

Fox Gary:

Regression. Swimmoma.

Pyne John:

May well be LPLK.
Sharks swimming in the differential.
Jim's rule applies = excise.

Muir James:

Histology showed "Sections show level 2 superficial spreading malignant melanoma. It is non-ulcerated and has a Breslow thickness of 0.31mm. Dermal mitoses are inconspicuous and there is focal evidence of regression. The viable melanocytic proliferation appears completely excised with a minimum clearance of approximately 2.5mm. Changes of regression however extend to the edge."

I wasn't sure what this was (which is a good indication for histology). Regression as usual makes life hard.

Such a lesion explains why we see metastatic MM with no primary.

Giuseppe Argenziano:

so scary!!!

Muir James:

Agreed although we still went the knife which I guess is the main thing with these 'can'tgiveitanameomas'.

Lichenoid keratosis like melanomas

The term lichenoid keratosis refers to a solar lentigo or seborrheic keratosis undergoing regression. In early stages of regression, remnants of the preexisting benign lesion are visible clinically and dermoscopically together with a pepper like grey/blue pigmentation. Pathologists include lichen planus like keratosis (LPLK) in the differential diagnosis of melanoma. A solitary lesion, showing a lichenoid pattern of regression and no additional features suggestive of a keratinocytic lesion undergoing regression, must be carefully evaluated. The best clinico-pathologic correlation is required to carefully interpret the lesion.

Under dermoscopy, melanomas at late stage of regression may show a diffuse grey-blue pepper like pattern as the only dermoscopic feature.

Thus, the clinical and dermoscopic diagnosis of benign lichen planus like keratosis should be supported by the unequivocal recognition of features of the benign lesion undergoing regression.



Dermatology practical and Conceptual is the new official journal of the IDS. Following you find abstracts from the last issues of the journal.

The centennial of Bowen's disease-a critical review on the occasion of the 100th anniversary of its original description

Wolfgang Weyers, M.D.

A review by Weyers explores the history of Bowen's disease, first described in 1912.

Squamous cell carcinoma: variation in dermatoscopic vascular features between well and non-well differentiated tumours

John Pyne, MBBS, Devendra Sapkota, M.D., Jian Cheng Wong, Mstat

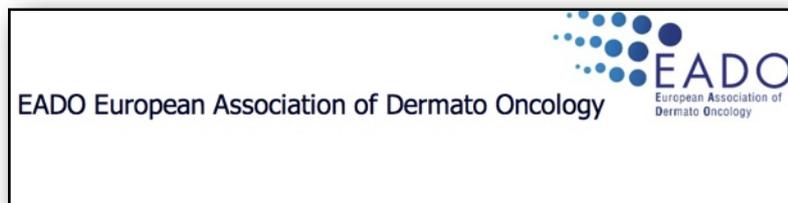
A research article by John Pyne in this issue of Dermatology Practical & Conceptual explores the differences between well and non-well differentiated squamous cell carcinomas with regard to their dermatoscopic vascular features.

Strategies for early recognition of cutaneous melanoma; present and future

Franziska Brehmer, M.D., Martina Ulrich, M.D., Holger A. Haenssle, M.D.

Cutaneous melanoma is a highly aggressive malignant tumor of skin melanocytes with an increasing incidence in most countries of the world, especially in the fair-skinned populations. Despite all preventive and therapeutic efforts, malignant melanoma is still the most lethal skin cancer. A delayed diagnosis results in an advanced stage and worsened prognosis. Once distant metastases are present, the five-year survival rate is less than 10 percent. At the same time, patients may be cured by an early diagnosis of cutaneous melanoma followed by a wide excision. Therefore, the early detection of melanoma at curable stages is crucial for the patients' survival. Besides the investigation of pigmented lesions with the unaided eye, a wide range of examination techniques for improved diagnostic accuracy have been developed and validated in

clinical trials. However, none of these techniques are able to provide a definite and final diagnosis or to replace an excisional biopsy of suspicious lesions followed by histological analysis. This review provides a concise overview of general principles as well as current and future strategies for an improved early diagnosis of cutaneous melanoma



European School of Dermato-Oncology: Fundamentals of Cutaneous Oncology.

Berlin, Germany, January 17-19, 2013

[Preliminary Program is now available.](#)

Target audience

This 2,5-day educational course targets doctors who are actively involved in the treatment of skin cancer. Dermatologists or other specialists who have completed specialist training, or residents in the final year of their training program, are likely to gain the most from this course. The maximum number of delegates is 100. In order to make the course available throughout Europe, places will be made available on a first come first served basis to all applicants.

Educational objectives

The principal aim of the course is to provide a comprehensive and detailed understanding of the decision-making process for the management of all types and stages of skin cancer. This will include diagnosis and primary treatment, management of loco-regional disease and distant metastatic disease, and adjuvant treatment. This is particularly relevant given the rapid progress in our understanding of melanoma and non-melanoma skin cancer, and the development of new treatments.