Types of melanoma?

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See related article on page 1013

There is, perhaps, no other class of neoplasm in the discipline of cutaneous medicine that evokes fear in patients as deeply as does melanoma. This sarcoma, seemingly unpredictable as it is in its clinical presentation and its histologic mimicry of melanocytic nevi and other lineages of neoplasms, is indeed worthy of our respect—but not our fear. Fear is overcome by knowledge, and methods of diagnosis and management are its consequence.

The last 60 years has been a period of focused research by dermatologists and dermatopathologists toward the desideratum of understanding *which* criteria, either alone or in combination, aid in establishing the diagnosis of melanoma. There has been a small, but intellectually potent, group of thinkers and writers who, during this period, have attempted to discover the criteria that dermatologists and dermatopathologists use to diagnose and report melanomas daily throughout the world. The most notable among these are Spitz, Allen, Helwig, Reed, Clark, Mihm, Ackerman, Elder, Breslow, Barnhill, and LeBoit.

Yet, these same authors, the developers of the language of melanoma, disagree often with each other about the meanings of the words applied to stand for different patterns of those dreaded neoplasms. One person's "superficial spreading melanoma" is another person's "lentiginous melanoma." "Nodular melanomas" for some are simply "nodules *of* melanoma" for others. One person's "vertical growth phase" is another person's refusal to accept such language on the grounds that no one knows what "vertical growth phase" really means, and that it is impossible to apply that phrase consistently. Some advocate different "types" of melanoma; others argue that the "types" are arbitrary and, therefore, meaningless. In recent years, the last 30 or so, there has been an entire "class" of melanocytic "dysplasias" or "atypical" melanocytic proliferations that some have regarded as "official" diagnoses of the putative "borderline" category. Others (including me) eschew this language, arguing that there is nothing borderline in nature, and that "borderline" is epistemological, not metaphysical—that "borderline" refers to one's uncertainty, not to the lesion in reality.

What is one to believe? To what authority does one appeal to resolve such questions?

The essence of the answer is 3-fold. First, one must observe the facts of nature: the lesions in their clinicopathological context. Second, one must develop objective language that applies to findings similar in sections of tissue available for microscopic analysis to formulate a valid diagnosis. Third, one must follow patients over the long term to discover the relationship of diagnosis to outcome.

In this issue of the *Journal*, Forman et al[1] studied a large group of patients with melanoma to compare their observations with studies from the literature. In their cohort of 771 patients, they found that lentiginous melanomas in the setting of severe solar elastosis were, by far, the most common presentation of melanoma (56%). Melanomas with a pagetoid pattern of melanocytes were a distant second (29%), and all other patterns comprised the remaining 15%. Their discussion was a lengthy recapitulation of previous studies that cited the so-called "superficial spreading type" of melanoma as more common than the "lentigo maligna type." Outcomes were not stated.

I am not surprised by these findings, nor do I believe that there is significance in them other than the fact that "lentiginous" melanomas and "superficial spreading" melanomas are forms *both* of "superficial spreading" melanoma clinically, if there is any real meaning in that phrase. Both grow radially at the dermoepidermal junction or

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intraepidermally (or both). Truth be told, there is significant overlap in pattern between these two different "types" when one studies many cases histopathologically, as Ackerman[2] stated in 1980.

Thus, the problem *with* the diagnosis of melanoma is the diagnosis of melanoma. Melanomas have different patterns, often in the same lesion; the diagnosis and margin definition often are difficult to establish regardless of pattern in a given tumor; and the prognosis for a given patient is not understood simply by applying a "type" with a Breslow measurement, a Clark level, and commenting on the presence of ulceration—and it never will. Why is this? It is because each melanoma plays out in its own way if given enough time, given any particular patient's immune status and context clinicopathologically.

Inferentially, Forman et al[1] have proved a point that needs to be stated repeatedly and often. References to these different "types" of melanoma are arbitrary, therefore unnecessary. The diagnosis of melanoma in situ or primary melanoma in the dermis with *any* pattern is sufficient for what must be done next: complete excision.

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