

Amelanotic melanoma mimicking cutaneous epitheliomas

Monica Napolitano, MD,^a Biagio Didona, MD,^b Francesca Passarelli, MD,^c
Giorgio Annessi, MD,^c and Riccardo Bono, MD^a
Rome, Italy

CLINICAL PRESENTATION

A 57-year-old man presented to our department with a slow-growing erythematous scaly plaque (3- × 1.5-cm) on the left scapula (Fig 1) that had appeared 3 years earlier. The lesion was asymmetrical and had a purple center and irregular, sharp, and slightly elevated margins.



Fig 1. Clinical image.

DERMOSCOPIC APPEARANCE

The dermoscopic analysis (Fig 2) revealed peripheral dotted vessels, linear irregular vessels, milky red areas, and white streaks, suggestive of melanoma. However, there were no structures or vascular patterns found in cutaneous epitheliomas, such as leaf-like areas, blue-gray ovoid nests, or arborizing or glomerular vessels. It is noteworthy that no brown, black, gray, or blue structures that would be suggestive of a melanocytic origin were found.

From the Epiluminescence Microscopy,^a I Dermatologic,^b and Histopathology^c Units, Istituto Dermatologico dell'Immacolata-IRCCS, Rome.

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Correspondence to: Riccardo Bono, MD, Head, Epiluminescence Microscopy Unit, Istituto Dermatologico dell'Immacolata-IRCCS, Via Monti di Creta 104, 00167 Rome, Italy. E-mail: r.bono@idi.it.

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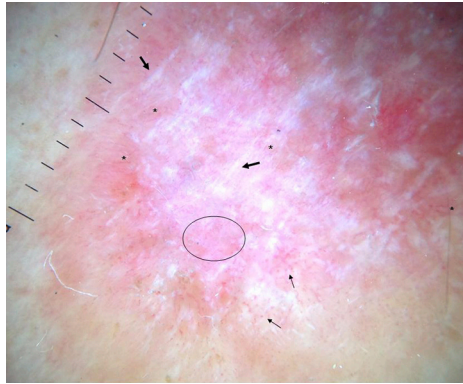


Fig 2. Dermoscopic image. Note the peripheral dotted vessels (*thin arrows*), linear irregular vessels (*asterisks*), milky red areas (*circle*), and white streaks (*thick arrows*).

HISTOLOGIC DIAGNOSIS

The histologic examination (**Fig 3**) revealed an asymmetrical proliferation of atypical melanocytes, arranged as single units and in nests, within all epidermal layers and in the papillary dermis, consistent with the diagnosis of superficial spreading melanoma, Clark level III, with a Breslow thickness of 0.9 mm.

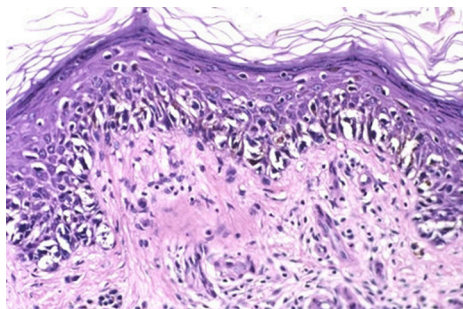


Fig 3. Histologic image.

KEY MESSAGE

The clinical presentation of the lesion was highly suggestive of superficial basal cell carcinoma or Bowen disease. Cutaneous epitheliomas may be surgically excised or, in discrete cases, treated with a topical, physical, or photodynamic therapy. By contrast, the peculiar vascular pattern seen during the dermoscopic evaluation^{1,2} pointed to amelanotic melanoma and led us to perform a prompt excision that histologically confirmed melanoma. This case underlines the importance of dermoscopy in the diagnosis of nonpigmented cutaneous lesions for a correct therapeutic approach.

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