

Acral Lentiginous Malignant Melanoma Mimicking Orf

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Özet

Altmışüç yaşında bayan hasta sağ el ikinci parmağında 6 aydır geçmeyen siyah kabarıklık şikayeti ile polikliniğimize başvurdu. Dermatolojik muayenesinde sağ el ikinci parmak dorsumunda periferinde pigmentasyon olan 1,5x1,5 cm boyutlarında siyah renkli nodül mevcuttu. Hasta, hayvanlarla temas tanımlamaktaydı ancak alıtta yatan bir nevus öyküsü bulunmamaktaydı. Öykü ve lezyonun klinik görünümüyle öncelikle orf düşünüldü, ancak dermoskopik inceleme sonucunda melanom şüphesi ile deri biyopsisi alındı. Histopatolojik inceleme sonucu malign melanom ile uyumluydu. Hasta Plastik ve Rekonstrüktif Cerrahi bölümüne konsülte edildi ve hastanın sağ el ikinci parmağı ampüte edildi. Aksiller lenf nodu örnekleme sonucu non-spesifik reaktif lenfoid hiperplazi ile uyumlu geldi. Ayrıntılı sistemi araştırmalar sonucunda metastaz saptanmadı. Malign melanom klinik olarak orfla karışabileceğinden acral lentiginöz melanom ayırıcı tanısında orf da akla gelmeli ve mutlaka dermoskopik inceleme yapılmalıdır.

Anahtar Kelimeler: Melanom, acral, ayırıcı tanı, orf

Abstract

A 63 year-old female patient with the complaint of a black blistered lesion on the second finger of the right hand for six months is presented. Dermatological examination revealed hyperpigmented nodule 1.5x1.5 in size with peripheral pigmentation localized on the dorsal aspect of the second finger of the right hand. She had contacts with animals, suggesting orf and gave no history of an underlying nevus that may be associated with melanoma. With the history and clinical appearance of the lesion, the first impression was orf but melanoma was suspected with dermoscopic examination. Punch biopsy was performed and the histopathological diagnosis was malignant melanoma. The patient was consulted with the Plastic and Reconstructive Surgery Department and the second finger of the right hand of the patient was amputated. Axillary sentinel lymph node sampling was associated with non-specific reactive lymphoid hyperplasia. Visceral metastasis was not detected according to the detailed systemic investigations. In conclusion, we suggest that malignant melanoma may mimic orf clinically and dermoscopy is a useful tool in differential diagnosis.

Keywords: Melanoma, acral, differential diagnosis, orf

Introduction

Acral lentiginous melanoma (ALM) is the fourth clinicopathologic variant of malignant melanoma recognized and introduced by Reed in 1975. It occurs commonly over the volar surface of hands and feet, subungual areas, fingers and toes. ALM probably represents the commonest expression of melanoma in blacks and constitutes only 10% of all melanomas on white skin. It is characterized by a lentiginous (radial) growth phase that evolves over months to years to a dermal (vertical) invasive stage (1). Differential diagnoses of ALM include seborrheic keratosis, actinickeratosis, basal cell carcinomas on acral areas, tinea nigra, acral junctional nevus, intracorneal haemorrhage, lichen planus pigmentosus, cutaneous involvement in multiple myeloma, subungual haemorrhage, pyogenic granuloma and acral melanocytic hyperplasia (2-6). In the literature search, we could not find orf in the differential diagnosis of ALM.

Case Report

A 63 year-old female patient with the complaint of a black blistered lesion on the second finger of the right hand for six months admitted to our outpatient clinic. Dermatological examination revealed hyperpigmented nodule 1.5x1.5 in size with peripherally pigmentation localized on the dorsal aspect of the second finger of the right hand (Figure 1). She had contacts with animals suggesting orf and gave no history of an underlying nevus that may be associated with melanoma. With the history and clinical appearance of the lesion, the first impression was orf but melanoma was suspected with dermoscopic examination (Figure 2). Dermoscopic examination revealed central ulceration, grey-white veil, black blotch, irregular globules and dots. There were also atypical pigment network and pseudopods.

Punch biopsy was performed from the lesion. On histopathological examination, diffuse melanocytic tumor was observed in dermis and tumor cells had positive staining with HMB-45 (Figure 3). So, histopathological diagnosis was malignant melanoma. The patient was consulted with the Plastic and Reconstructive Surgery Department and the second finger of the right hand of the patient was amputated. Axillary sentinel lymph node sampling was associated with non-specific reactive lymphoid hyperplasia. Visceral metastasis was not detected according to the detailed systemic investigations.



Figure 1. hyperpigmented nodule 1.5x1.5 in size with peripherally pigmentation localized on the dorsal aspect of the second finger of the right hand

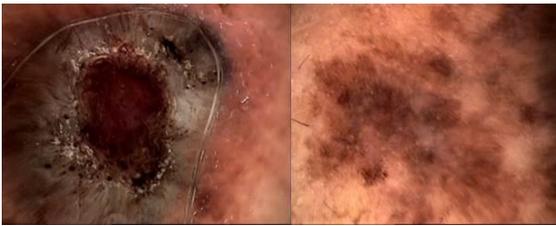


Figure 2. central ulceration, grey-white veil, black blotch, irregular globules and dots. There were also atypical pigment network and pseudopods

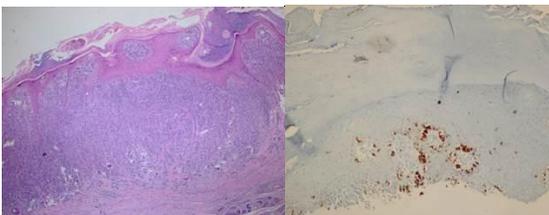


Figure 3. diffuse melanocytic tumor was observed in dermis (HEx40 and tumor cells had positive staining with HMB-45 (x40)

Discussion

ALM is the most common type of melanoma in dark skinned and Asian populations. This variant has been presented by lesions characterized by lentiginous macules occurring on the palms, soles and subungual areas. Traditionally, the three variants of cutaneous melanoma are categorized as lentigomaligna melanoma (LMM), superficial spreading melanoma (ssM) and nodular melanoma (NM). ALM represents a fourth group and is reported to constitute 7-9 % of all melanomas. Clinically, ALM resembles LMM in that the lesions are frequently macular, may be irregular in shape and may show variation in pigmentation. In contrast to LMM, these lesions usually do not occur in sun-exposed

areas of the skin and are distributed in regions that are free of hair. Both sexes are at equal risk for the development of ALM. The age at onset is usually in the third through sixth decades, which is similar to the onset of ssM and NM. Although relatively uncommon in whites, ALM may account for up to 50 % of melanomas occurring in blacks (7). Differential diagnosis of ALM is important. Acral lentiginous melanoma (ALM) of the sole sometimes has a hyperkeratotic appearance and mimics a pigmented wart (8), or a secondary traumatic hematoma in a pre-existing palmoplantar wart of the sole presents a diagnostic dilemma where it simulates an acral lentiginous melanoma (9). On the other hand acral pigmented Spitz nevus can be thought in the differential diagnosis of acral lentiginous malignant melanoma (10). In the literature search, orf has not reported in the differential diagnosis of ALM.

Dermoscopic examination is very important in the diagnosis of early malignant melanotic lesions on acral skin (11). Dermoscopic features of acral lentiginous melanoma are diffuse pigmentation, the parallel-ridge pattern, irregular lines with variegations in colours, spacing, width and disruption of parallelism. The presence of a parallel-ridge pattern and/or irregular diffuse pigmentation within the lesion is highly indicative of melanoma on volar skin. An irregular lines pattern is the most prominent dermoscopic feature of pigmented ALM of the nail apparatus. A distinctive dermoscopic feature of acral lentiginous melanoma in situ is diffuse and irregular pigmentation over the entire surface of the lesion. This feature is helpful for differentiating acral lentiginous melanoma in situ from acquired plantar melanocytic nevi (12,13).

In respect of our case, we suggest that or also should be remembered in the differential diagnosis of ALM and dermoscopy can help us for certain diagnosis.

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