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LETTERS TO THE EDITOR

Stage IIIC Solitary Dermal Melanoma☆

Melanoma dérmico solitario y estadio IIIC

To the Editor:

I read with interest the excellent article about primary dermal melanoma that was recently published in your journal.[1] While the authors did not specify the stage of the melanoma case they reported, they seemed to imply that it was stage IV.

The pathogenesis of tumors such as the one described, however, is not clear. There are several mutually nonexclusive hypotheses that can explain the presence of a single melanoma nodule in the dermis. Because not all the hypotheses involve a primary dermal origin, a more correct term for such a nodule would be *solitary dermal melanoma* (SDM).

SDM could originate from a primary tumor with a completely regressed junctional component, an intradermal melanocytic nevus,[2,3] or a dermal melanocytosis.[4] It might also be derived from a melanocytic cell that was trapped in the dermis during embryogenesis, or from melanocytes associated with appendageal structures.[5] In all these cases, the tumor would be considered localized melanoma (T1-4). The nodule, however, could also be a metastasis, in which case it would be classified as M1a if it were a distant metastasis or as N2c if it were an in-transit metastasis.

The above reflections simply mean that different stages will be assigned depending on how the tumor is considered (presuming that staging studies have not detected disease at other sites). In the cases of localized melanoma described above (T1-4a, as SDM will never be ulcerated), the tumor could be assigned a stage as high as IIB if it exceeds a depth of 4 mm, while it would be categorized as stage IV or stage IIIB if it were considered a distant or in-transit metastasis, respectively. Clearly, as shown by the literature, the assignment of one stage or another has a very important bearing on treatment, which can range from excision of the melanoma[1] to chemotherapy.[6,7]

Nevertheless, the above reflections are not what prompted me to write this letter, but rather the fact that the Final Version of the 2009 American Joint Committee on Cancer Melanoma Staging and Classification[8] specifies that single dermal nodules should be considered regional. In other words, they should be classified as N2c (stage IIIB). According to this classification, a stage III melanoma with T1-4 N2c M0 would have a 5-year survival rate of 69%, which is similar to the rate of 66% reported by Lee et al.[9] in the largest series of SDM published to date.

Although what I propose is probably not the best solution, until we have a better understanding of the pathogenesis of SDM or are able to identify the origin of each tumor, I think that single melanoma nodules in the dermis should be considered regional, classified as N2c, and called SDM.

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☆ Please cite this article as: Piqué-Duran E. Melanoma dérmico solitario y estadio IIIC. Actas Dermosifiliogr. 2014;105:433–434.

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Response to ''Stage IIIC Solitary Dermal Melanoma''☆

Réplica a «Melanoma dérmico solitario y estadio IIIC»

To the Editor:

We thank the author for his interest in our article and find his observations very interesting and enlightening. However, we believe it necessary to make some clarifications.

Even before the publication of the 2009 American Joint Committee on Cancer (AJCC) Staging and Classification, various authors had studied melanoma metastasis from an unknown primary site and concluded that survival in such cases was higher than in known primary cutaneous melanomas and metastases with a similar clinical presentation.

This improved survival has been reported for metastases in the skin and subcutaneous tissue and for local lymph node disease with an unknown primary site. The survival rates are similar to those expected for regional disease (stage III) and nonmetastatic disease.[1–3]

In the latest AJCC classification, single skin or subcutaneous metastases are considered to be satellite or in-transit metastases, while metastases in the lymph nodes are considered to be regional. In both cases they are categorized as stage III and are therefore associated with higher survival rates.[4]

This classification, however, is based only on the observation of better survival in such cases and no consideration is given to the origin of these cutaneous or subcutaneous lesions classified as satellite or in-transit (and therefore metastatic) lesions.

We are interested in the fact that these lesions might also have a primary origin, as this would have new implications for the management of patients beyond a mere classification determining survival and prognosis. As reported by Lee et al.,[5] 23% of patients with solitary dermal melanoma (SDM) may have nodal disease at the time of diagnosis or later and would therefore benefit from sentinel node biopsy and, if indicated, lymphadenectomy. It is noteworthy that sentinel node biopsy would not be indicated if the disease was already considered to be metastatic, although lymphadenectomy might be an option if there is nodal involvement following on from an in-transit metastasis.

Given the different potential origins of a single focus of melanoma in the dermis or subcutaneous tissue, we agree that a diagnosis of primary dermal melanoma is just one option when faced with SDM.

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☆ Please cite this article as: González de Arriba M. Réplica a «Melanoma dérmico solitario y estadio IIIC». Actas Dermosifiliogr. 2014;105:434.