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Melanoma With Meyerson's Phenomenon: Clinical and Dermoscopic Features☆

Melanoma con fenómeno de Meyerson: características clínicas y dermatoscópicas

To the Editor:

We present a 75 year-old woman with a history of venous insufficiency of the lower extremities. She consulted for a lesion that had arisen on her left ankle a year earlier and that had become erythematous and pruritic during the week prior to consultation. Physical examination revealed a slightly elevated, dark blue and brown lesion that was asymmetric and had poorly defined borders. It measured 1 cm in diameter. The lesion was surrounded by a halo of eczema and desquamation, and the region was edematous and presented varicose blood vessel dilatations (Fig. 1). The provisional diagnoses included an ecchymotic lesion associated with dermatitis secondary to venous stasis or a melanocytic lesion with halo eczema (Meyerson phenomenon).

A blue-whitish veil was observed on dermoscopy and there were irregularly distributed, structureless brown and black areas (Fig. 2A). Patches of glomerular vessels and dotted vessels and fine whitish desquamation were observed in the area of the halo (Fig. 2B).

The dermoscopic findings elevated our suspicion of a melanocytic lesion, specifically malignant melanoma with halo eczema, and excision biopsy was therefore performed. Histology of the lesion revealed a proliferation of atypical melanocytes with a radial and vertical growth phases, intraepidermal melanocyte migration, and nests and irregular plaques that infiltrated the papillary dermis (Fig. 3A). These atypical cells had large and irregular nuclei, with prominent nucleoli and occasional intranuclear vacuoles (Fig. 3B). The adjacent epidermis presented acanthosis with moderate spongiosis, lymphocyte exocytosis, and hyperkeratosis, associated with a perivascular mononuclear inflammatory infiltrate in the dermis (Fig. 3C). This confirmed the diagnosis of superficial spreading melanoma with Meyerson phenomenon and a Breslow depth of 1.12 mm. No ulceration, regression, blood or lymph vessel invasion, or neurotropism were observed, and the mitotic index was low.

Halo eczema or Meyerson phenomenon is a symmetric area of erythema and desquamation that surrounds a central lesion; it can be pruritic or asymptomatic. A number of hypotheses have been proposed regarding the etiology and pathogenesis of this phenomenon, the main one of which suggests an immune response with a predominance of $CD4^+$ lymphocytes over $CD8^+$ lymphocytes.[1] The phenomenon was first described in acquired melanocytic nevi, but there have since been reports in all types of melanocytic nevi (congenital, dysplastic) and even in nonmelanocytic lesions such as basal cell carcinoma, squamous cell carcinoma, and seborrheic keratosis.[1,2] Rodins et al.[1] were the first to report a Meyerson phenomenon in an in situ melanoma, and later Ferneiny et al.[3] described the finding in a superficial spreading melanoma with a Breslow depth of 0.75 mm.

The few studies that have been performed on the dermoscopy of melanocytic lesions with halo eczema suggest that the inflammatory phenomenon does not affect or mask visualization of dermoscopic structures and criteria, and thus does not interfere with correct identification of these signs.[2,4] In our case, the presence of a blue-whitish veil and of structureless areas suggested the diagnosis of melanoma.

Dotted vessels, distributed in patches, and yellowish scale crusts, similar to the findings of halo eczema in our case, are observed on dermoscopy in all types of dermatitis.[5] Ecchymoses present a homogeneous pattern of structureless purpuric areas on dermoscopy,[6] allowing us to exclude this diagnosis in our patient.

After reviewing the literature, we believe this is the first case in which the dermoscopic features of an invasive melanoma with Meyerson phenomenon are described. We agree with the authors cited above[1,3] that this phenomenon

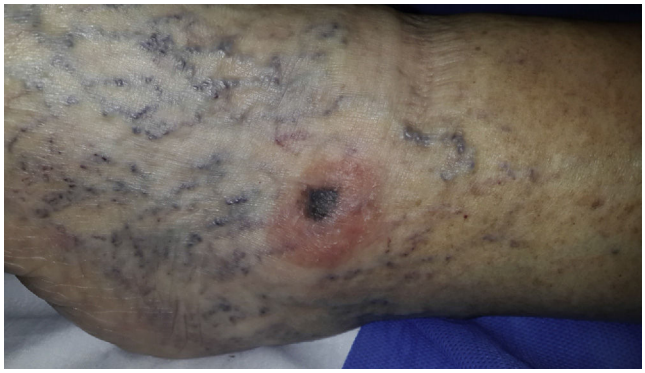

Figure 1 Clinical presentation. Elevated, asymmetric, dark blue and brown lesion with poorly defined borders and a diameter of 1 cm; the lesion is surrounded by halo eczema with desquamation. Background of edema and varicose blood vessel dilatation.

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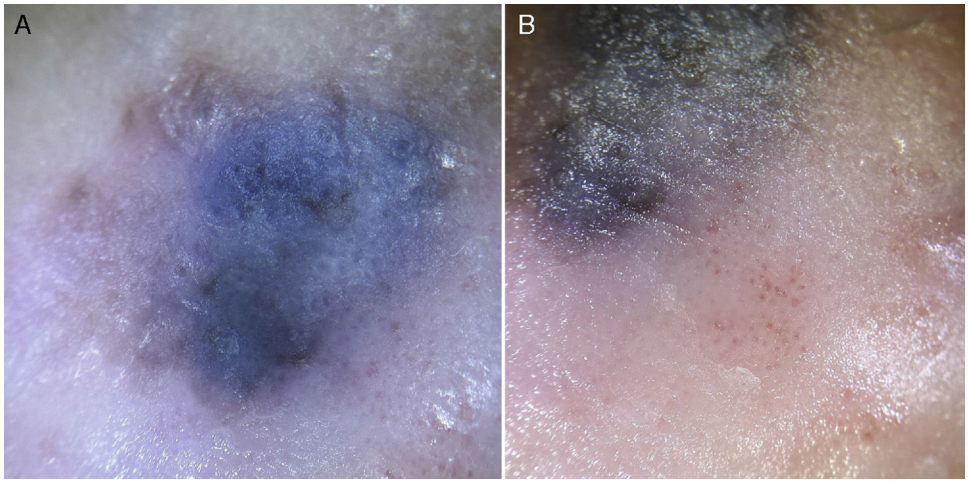

Figure 2 Dermoscopy. A, Blue-whitish veil and structureless brown and black areas in an irregular distribution. B, Glomerular and dotted vessels and fine whitish desquamation in the area of halo eczema.

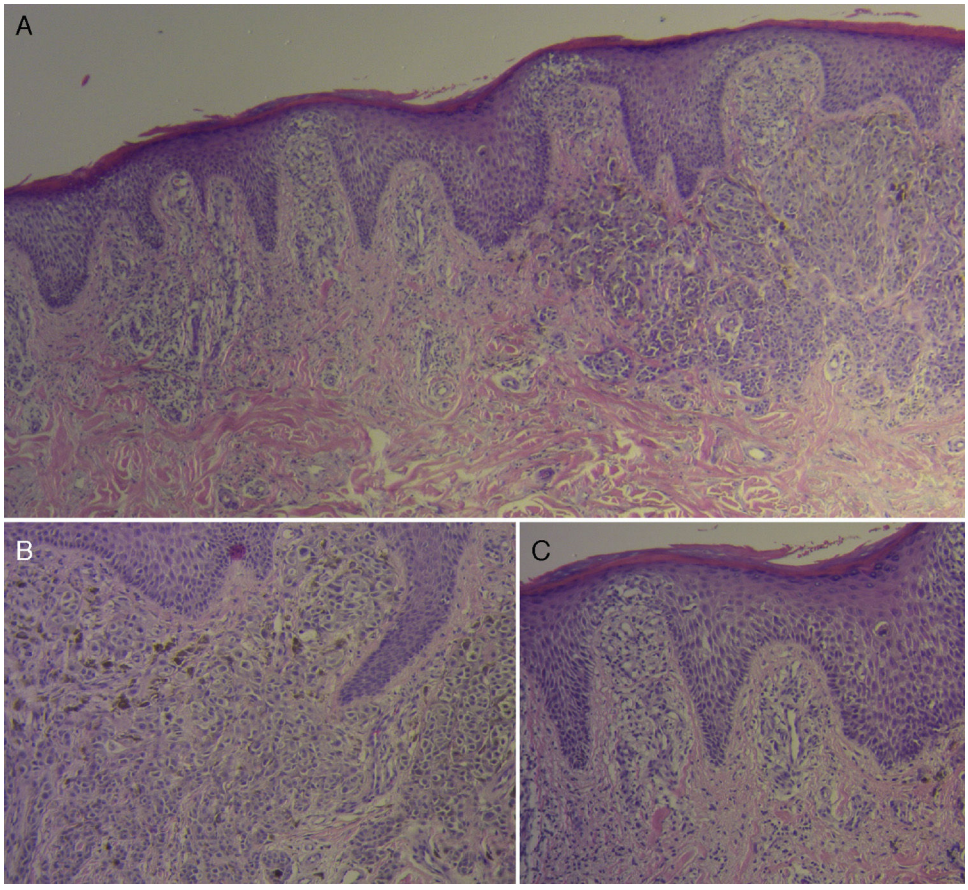

Figure 3 Histopathology: A, Proliferation of atypical melanocytes with radial and vertical growth phases, intraepidermal migration of melanocytes, and nests and irregular plaques that infiltrate the papillary dermis. Hematoxylin and eosin (H&E), original magnification ×4. B, Atypical cells with large and irregular nuclei, prominent nucleoli, and occasional intranuclear vacuoles. H&E, original magnification ×10. C, Adjacent epidermis with acanthosis, moderate spongiosis, and lymphocyte exocytosis, associated with a mononuclear inflammatory infiltrate in a perivascular distribution in the dermis. H&E, original magnification ×10.

is a sign that must not be undervalued, as it is not exclusive to nevi; the dermoscopic features of the pigmented lesion must be evaluated to determine whether it is benign or malignant, and the appropriate action taken.

Conflicts of Interest

The authors declare that they have no conflicts of interest and that they have not received funding for this study.

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Distal Digital Keratoacanthoma in Patients With Incontinentia Pigmenti☆

Queratoacantoma digital distal en paciente con incontinencia *pigmenti*

Dear Editor:

Distal digital keratoacanthoma (DKA) or subungual keratoacanthoma is a rare and aggressive variant of keratoacanthoma (KA) that typically arises in the distal subungual tissue or affects the proximal nail fold, giving rise to paronychia. It presents as a painful, expanding subungual tumor that frequently recurs.[1,2] We present a patient with incontinentia pigmenti who developed DKA.

A 59-year-old woman with a past history of incontinentia pigmenti consulted for the appearance 2 months earlier of a very tender lesion under the nail of her left great toe. There was no history of trauma. Physical examination revealed a hyperkeratotic tumor that was destroying the distal lateral border of the nail of the left great toe, with mild inflammation (Fig. 1). Plain x-ray of the foot showed no bone involvement. Histopathology of the lesion after surgical excision showed a hyperplastic epithelium surrounding central cystic areas; there were dyskeratotic keratinocytes with very little atypia. Staining for oncoprotein p53 was negative; staining for Ki-67 revealed occasional cells in division above the basal layer of the epidermis. These findings were compatible with subungual DKA. One-and-a-half months later, the patient returned due to the appearance of a lesion with similar characteristics in the area of the previous surgery, suggestive of tumor recurrence. Nail ultrasound showed thickening of the nail plate, under which was an isoechogenic, oval lesion measuring 0.71 cm in its longest axis (Fig. 2), with no increase in central vascularization on Doppler study. Based on these findings, a second surgical excision was performed, with the same diagnosis.

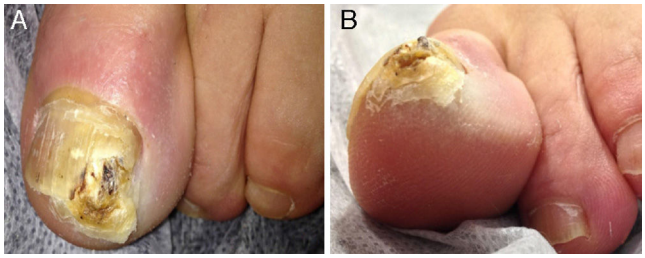

Figure 1 Hyperkeratotic tumor that has destroyed the distal lateral border of the nail of the left great toe: A, Superior view. B, Inferior-lateral view.

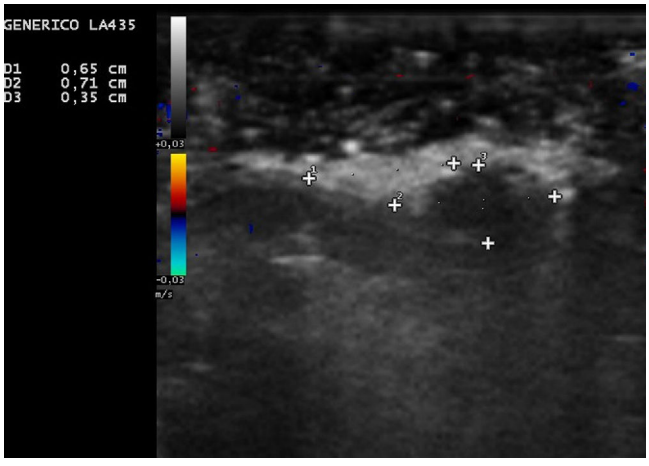

Figure 2 Isoechogenic oval lesion beneath the nail plate. There is no central vascularization.

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