Aspetti clinici particolari del melanoma

Ketty Peris
Management del melanoma dell’orecchio

Spessore di Breslow: 0.3 mm

Spessore di Breslow: 4.5 mm

margini di escissione chirurgica? SNB?
### Table: Surgical Margins Based on Tumor Thickness

<table>
<thead>
<tr>
<th>Stage</th>
<th>Tumor thickness (Breslow)</th>
<th>Surgical margins</th>
</tr>
</thead>
<tbody>
<tr>
<td>pT1, pT2</td>
<td>≤ 1–2 mm</td>
<td>1 cm</td>
</tr>
<tr>
<td>pT3, pT4</td>
<td>2.01–&gt; 4.0 mm</td>
<td>2 cm</td>
</tr>
</tbody>
</table>

Strength of consensus: 100%

### 3.2.3.3 Consensus-based recommendation

**GCP**

In melanomas (e.g. lentigo maligna melanoma, acral melanomas) in special anatomic locations, such as border sites in the face, on ears, fingers and toes, reduced safety margins may be used. Retrospective studies have demonstrated that with use of 3D-histology (micrographically controlled surgery) there is no increase in local recurrences or decreased overall survival. As data are limited for this situation, the surgeon should make the decision together with the informed patient.

Strength of consensus: 92 %
<table>
<thead>
<tr>
<th></th>
<th>External ear (n=45)</th>
<th>Vs other head and neck sites (n= 365)</th>
<th>P value</th>
<th>Vs all other sites (n= 2196)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age</td>
<td>63 y</td>
<td>68 y</td>
<td>0.6</td>
<td>58 y</td>
<td>0.01</td>
</tr>
<tr>
<td>Male patients</td>
<td>80%</td>
<td>54%</td>
<td>&lt;0-001</td>
<td>45%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SSM</td>
<td>49%</td>
<td>33%</td>
<td>0.34</td>
<td>72%</td>
<td>0.002</td>
</tr>
<tr>
<td>NM</td>
<td>36%</td>
<td>22%</td>
<td>0.06</td>
<td>18%</td>
<td>0.008</td>
</tr>
<tr>
<td>Median BT (mm)</td>
<td>1.8</td>
<td>1.6</td>
<td>0.72</td>
<td>1.2</td>
<td>0.46</td>
</tr>
<tr>
<td>Ulceration</td>
<td>19%</td>
<td>21%</td>
<td>0.81</td>
<td>26%</td>
<td>0.77</td>
</tr>
<tr>
<td>Mitotic rate ≥1/mm2</td>
<td>89%</td>
<td>62%</td>
<td>0.001</td>
<td>75%</td>
<td>0.08</td>
</tr>
<tr>
<td>Lymphovascular invasion</td>
<td>3%</td>
<td>5%</td>
<td>0.4</td>
<td>3%</td>
<td>0.35</td>
</tr>
<tr>
<td>VGP</td>
<td>89%</td>
<td>83%</td>
<td>0.37</td>
<td>82%</td>
<td>0.35</td>
</tr>
<tr>
<td>Regression present</td>
<td>8%</td>
<td>9%</td>
<td>0.93</td>
<td>19%</td>
<td>0.08</td>
</tr>
<tr>
<td>SLNB performed</td>
<td>67%</td>
<td>36%</td>
<td>&lt;0.001</td>
<td>50%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Positive rate of SLNB</td>
<td>7%</td>
<td>15%</td>
<td>0.22</td>
<td>19%</td>
<td>0.08</td>
</tr>
<tr>
<td>Overall survival rate</td>
<td>80%</td>
<td>82%</td>
<td>0.79</td>
<td>84%</td>
<td>0.41</td>
</tr>
</tbody>
</table>

45/2241 casi di melanoma; 2%

Melanoma dell’orecchio

- 1% di tutti i melanomi
- Revisione sistematica di 30 studi (858pz)
- Predominanza nel sesso maschile (78%); età media: 59.4 anni
- Sedi: elice (57%), lobo (17%)
- Istotipo: SSM (41%), NM (22%), LMM (21%)
- Spessore medio di Breslow: 2.01 mm; ulcerazione nel 20% dei pz.
- Mancanza di accordo sulla procedura chirurgica

ToiaF et al 2015
Melanoma dell’orecchio

• Rispettando la profondità dell’escissione, l’approccio più comune è quello di preservare il pericondrio e la cartilagine se non sono invase dal tumore

• Indicazioni per il SNB seguono quelle relative alle altri sedi corporee

• Sopravvivenza: 100% in stage 0, 71% e 53% in stage I e II, 0% in stage III.
Melanoma della lingua

Linfoadenomegalia bilaterale
Approccio terapeutico

- Asportazione palliativa della parte nodulare
- Glossectomia parziale o totale e linfoadenectomia
- Terapia medica (target o immunoterapia)
Melanoma del cavo orale

• Rappresenta circa 1.7 % di tutti i melanomi e il 6.3% dei melanomi testa/collo. Le localizzazioni al cavo orale sono più frequenti a livello della gengiva, mucosa del palato e labbro
• La melanosi mucosa può essere associata al melanoma del cavo orale (66%), pre-esistere nel 36% e simultaneo nel 30%
• Il melanoma localizzato specificamente alla lingua è raro (<50 casi)
• M=F; più frequente nei Giapponesi che nei Caucasic i
• Età > 40 anni
• Chewing gum; fumo

granular cell odontogenic tumor, mediate patient follow-up is absolutely necessary.

nomas have a poorer prognosis than skin melanomas, icyst, and odontogenic keratocyst.

of odontogenic cysts including radicular cyst, dentigerous lichen planus,

graph showing that approximately 15% of spindle-shaped melanoma cells are positive for S-100 protein (original magnification, that almost all melanoma cells are positive for HMB-45 (original magnification, 20

propria. Only some of the spindle-shaped melanoma cells and melanophages contain aggregates of melanin pigments in the case demonstrating a sheet of spindle-shaped melanoma cells with invasion from the basal layer of the epithelium into the lamina

showing a slightly elevated black tumor with smooth surface at the left lateral border of the tongue. (B) Microphotograph of our case of oral tongue melanoma. (A) Clinical photograph

J Formos Med Assoc

1,2


1). These lesions were asymptomatic. There weren´t

3 cm in size was found on the base of the tongue (Fig.

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316

http://dx.doi.org/10.1016/j.jfma.2013.07.013

Chang Gung Med J Vol. 25 No. 11

A 51-year-old man with a clinical history of esopha

bacterial positive for E. coli and Salmonella.

m2, s.c., three times a week for 48 weeks). Immuno

for four weeks;; maintenance: interferon-α2b: 10 million/

in childhood and appendectomy was referred to our de

mar 316

swallowing or phonation (Fig. 2).

Lee	

2013

um, suggesting that the tumor was a primary rather

nuclear antibody levels by levamisole treatment in patients

ACD, 5 days a week

A debridement and closure of the donor site. The recipient vessels were the

perforator of the descending branch of the lateral cir

anterolateral thigh flap nourished by a septocutaneous

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Melanoma della lingua - Diagnosi differenziali

- Tatuaggi
- Macule melanotiche
- Malattia di Laugier
- Nevo melanocitico
- Farmaci (e.g. antimalarici, antivirali, fenotiazine)
- Lesioni vascolari
- Pigmentazioni associate a malattie endocrine o sindromi
Melanoma della lingua - TERAPIA

- Chirurgica (glossectomia con flap dal m. retto addominale, pettorale, trapezio) che cerchi di assicurare la mobilità della lingua e mantenere la deglutizione, fonazione e la protezione delle vie aeree
- Radioterapia (palliativa)
- Adiuvante (IFN)
- Terapia medica (target o immunoterapia)
Melanoma della lingua - PROGNOSI

- Sopravvivenza a 5 anni: 6.6% - 20%
- Diversi fattori possono contribuire alla prognosi sfavorevole tra cui:
  - la mancanza di sintomi nelle fasi precoci della malattia
  - la difficoltà di ottenere un’ampia e radicale escissione
  - la ricca vascolarizzazione della lingua che facilita la disseminazione ematogeno
MELANOMA IPO/AMELANOTICO
Melanoma amelanotico

- Raro, 2–8% di tutti i melanomi
- Clinicamente è caratterizzato da una modesta presenza o assenza di pigmento
- Placca o nodulo rosa-rosso che può simulare il granuloma piogenico o emangioma. Può manifestarsi anche come una placca eritemato-squamosa, o un’ulcera che non guarisce, o una verruca ipertrofica
- Dermoscopia: pattern vascolare atipico
- Stadiazione, prognosi e terapia sono correlati allo stadio di malattia
lines seen with both polarizing and non-polarizing dermatoscopes are a clue to malignancy, they also occur in lichen planus as Wickham’s striae. Polarizing-specific white lines are a published clue to the benign conditions of scar tissue, Spitz nevus, dermatofibroma (DF), lichen planus like keratosis (LPLK) [22] and pyogenic granuloma (termed “white rail lines” in the reference cited) [23], as well as the malignancies melanoma and BCC [22]. With respect to melanomas, they were more prominent in invasive (41%) than in-situ (17%) melanomas [22].

Keratin clues
If a non-pigmented lesion is not ulcerated and there are no white lines as a clue to malignancy, then there is one step to assess prior to the need to perform vessel pattern analysis. If the lesion is raised, then the three keratin clues of clinical or dermatoscopic surface keratin, dermatoscopic white structureless areas or dermatoscopic white circles are valuable clues to malignancy, specifically SCC and KA. White circles have the highest specificity (87%) for SCC/KA with a sensitivity of 44% for this diagnosis [20]. Surface keratin is best appreciated clinically, as one of the purposes of dermatoscopy (including reticular white lines originally called negative, white or inverse network or reticular depigmentation) and then there are polarizing-specific white lines (also known as chrysalis and as shiny or bright white lines [21]), which are only seen with polarizing dermatoscopes (see Figure 4).

Both types of white lines are clues to malignancy [17], but they may also be seen in benign lesions, so the clinical context needs to be considered. For example, while white

Figure 3. Flowchart for the Prediction without Pigment algorithm. End-points colored red are highly suspicious for malignancy, while those colored green should be benign. All other endpoints should be assessed by weighing all clues, both clinical and dermatoscopic, as there are malignant options in the differential diagnosis. The diagnoses listed are not exhaustive but are selected to guide the decision process. It may be useful to have this flowchart open when looking at the lesions depicted in Figures 4-10. [Copyright: ©2014 Rosendahl et al.]

Abbreviations used: BCC—basal cell carcinoma; SCC—squamous cell carcinoma; KA—keratoacanthoma; DF—dermatofibroma; LPLK—lichen-planus-like-keratosis (benign lichenoid keratosis); PG—pyogenic granuloma; IEC—intraepidermal carcinoma (Bowen’s disease or SCC in-situ); SK—seborrheic keratosis; CCA—clear cell acanthoma

Figure 4. Polarized (A) and non-polarized (B) dermatoscopic image of a non-pigmented lesion reveals the dermatoscopic clue of polarizing-specific white lines. Note the perpendicular orientation of these lines. This is a fibroepithelioma of Pinkus—a variant of BCC. [Copyright: ©2014 Rosendahl et al.]

*White Clues
White lines, or in the case of a raised lesion: white circles, white structureless areas or surface keratin.