Two Challenging Acral Lesions

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7/25/2019, 9 AM - 12 PM
Mercury Ballroom
11:05-11:25 PM
DISCLOSURE OF RELEVANT RELATIONSHIPS WITH INDUSTRY

NYU receives compensation from MoleSafe for my telemedicine dermoscopic diagnoses. I will discuss off-label use of imiquimod.
Patient Sent From Podiatrist

Patient: Can This Just Be Blood?
*** POLL Patient says present for 10 years
What’s your next step?

- A) Take photo and tell the patient to come back in 3 months
- B) Clip the nail to see if it is blood or melanin
- C) Partial punch biopsy
- D) Take off the nail and excise the pigmented area
You may need more than one biopsy

- Initial biopsy → atypical melanocytic lesion, insufficient to call melanoma
- Surgery – removed the nail, excision
- Still atypical melanocytic, suggestive of melanoma in situ
- Surgical oncology – excision with 5 mm margin
- Melanoma in situ
Acral Biopsy Issues

• Ideally biopsy the entire lesion
• Not always practical for large acral lesions
• May have to pick representative area
• Use dermoscopy
• Punch biopsy of a portion of a large lesion
• Go deep or go home!
• Don’t give up if the initial biopsy says “Atypical intraepidermal melanocytic proliferation”
Acral AIMP more likely to be MM

- Zhang et al Derm Surgery 2016
- Diagnostic Change From Atypical Intraepidermal Melanocytic Proliferation to Melanoma After Conventional Excision
- Acral location was an important risk factor for upgrade to MM from AIMP (OR 9.24; \( p = .001 \))
- Don’t give up if you’re suspicious and haven’t sampled the whole lesion
Recurrent Acral Melanoma

- 47 y F with 2.25 mm acral melanoma with adnexal involvement
- Excised three times, SLNB neg
- Persistent / recurrent MMIS
- Surgeon sent for consideration of imiquimod
***POLL What would you now?

• A) Keep excising until you get a clear margin
• B) Radiation
• C) Imiquimod
• D) Systemic therapy
• E) Tell me more about using imiquimod for acral melanoma before I decide…
What we did

• A) Keep excising until you get a clear margin
• B) Radiation
• C) Imiquimod
• D) Systemic therapy

OFF-LABEL

There are several cases describing its use:

• Ocampo-Garza et al JDD 2017; Savarese et al Clin Exp Dermatol 2015; Sue et al BMJ Case Rep 2014
Imiquimod for large acral melanoma

- 85 yo F with a large ALM *in situ* (biopsy proven)
- Topical 5% imiquimod BID for 20 months
- At 20-month follow-up, no metastases to the lymph nodes or viscera were found clinically or on imaging studies

Imiquimod for subungual melanoma

• 82 yo M with subungual melanoma, excised with clear margins
• 2 years later, new adjacent clinical pigmentation appeared, biopsy showed recurrent MMIS
• Topical imiquimod 5% 5x weekly for 5 months → decrease in pigmentation
• Seven months later, hyperpigmented macule in the same site was observed, biopsy showed MMIS
• Another cycle of imiquimod 5% 5x weekly for 5 months was initiated – regression of the lesion and remained in clinical remission for 4 years

Ocampo-Garza et al JDD 2016
Our patient after six months of imiquimod 5% + tretinoin 0.1% cream
The pigment is gone, but is the melanoma really gone?
Biopsy showed residual MMIS
Imiquimod can clear pigment even with residual melanoma. Need to re-biopsy after treatment.
Acral MMIS are higher risk for subclinical spread

Shin et al JAAD 2017
More complications with acral melanomas

- Gumaste et al JNCCN 2014 – acral melanomas recur more often
- Rzepecki et al JAAD 2018

- The “Rule of 10s” versus the “Rule of 2s”: High complication rates after conventional excision with postoperative margin assessment of specialty site versus trunk and proximal extremity melanomas
  - ~10% risk of upstaging
  - ~10% risk of positive excision margins
  - ~10% risk of local recurrence
  - ~10-fold increased likelihood of reconstruction with a flap or graft
Are margin guidelines for thinner acral tumors sufficient?

- Thinner tumors are excised with narrower margins
- Margin guidelines are not site-specific
- Are insufficient margins the source of higher recurrence rates?

<table>
<thead>
<tr>
<th>Depth</th>
<th>Margin</th>
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<tbody>
<tr>
<td>In situ</td>
<td>0.5 – 1.0 cm</td>
</tr>
<tr>
<td>≤1.0 mm</td>
<td>1.0 cm</td>
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<tr>
<td>&gt;1.0 – 2 mm</td>
<td>1 – 2 cm</td>
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<tr>
<td>&gt;2.0 – 4 mm</td>
<td>2.0 cm</td>
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<tr>
<td>&gt;4 mm</td>
<td>2.0 cm</td>
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Field Cells May Be Source of Recurrent Acral Melanoma

- **Field Cells =** cells surrounding the tumor that look histologically normal but contain genomic amplifications

- Don’t skimp on margins
- Monitor patients for recurrence

Do we Need Wider Surgical Margins for Acral MM?

• Lee et al J. Surg Oncology 2016
• Retrospective cohort study of patients with acral MM
• 2 cm margin - reduced rate of local recurrence (HR, 0.120; \( P = 0.023 \)) and local and in-transit recurrence (HR, 0.187; \( P = 0.013 \)) compared with a <2 cm margin
• Only saw difference in melanoma > 1 mm, not thinner
• Disease-free survival and melanoma-specific survival did not differ between the two groups
BACK TO OUR PATIENT, 6 MONTHS LATER...
Repigmentation at biopsy edge
***POLL What would you do now?

- A) Re-excise the whole margin
- B) Take a 5 mm – 1 cm margin around the re-pigmented area
- C) Go back to imiquimod
- D) Radiation
- E) Systemic therapy
Summary

• If clinical suspicion says melanoma, don’t give up after one biopsy
• May need more than one biopsy to diagnose
• Acral melanoma commonly has subclinical extension, don’t skimp on margins
• Imiquimod (off label) can clear pigment, but need to re-biopsy
• Monitor acral melanoma closely for recurrence
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http://www.med.nyu.edu/dermatology/education/events-conferences/advances-dermatology
Thank you!

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