Dear Editor:

Acral lentiginous melanoma (ALM) is the most common type of cutaneous melanoma in Asians. Traditionally, ALM is believed to have a poor prognosis because of its aggressive behavior and a short radial growth phase, compared with that of lentigo maligna melanoma. We describe a case of recurrent ALM in situ around the primary site during 8 years.

A 56-year-old female patient presented with a black macule having an irregular border and color variegation on the left heel, which started 8 years ago (Fig. 1A). Dermoscopic examination showed a parallel ridge pattern and irregular pigmentation. She had undergone excisional biopsy (3-mm margin), which revealed only a few scattered atypical melanocytes along the basal layer. She had returned after 2 years (Fig. 1B) and then after 4 years (Fig. 1C) because of newly appearing brown patches around the first location. Serial punch biopsies revealed mild melanocytic hyperplasia without marked cytologic atypia again. The results made a pathologist hesitant to diagnose ALM in situ instead of “atypical melanocytic proliferation.” At that time, the patient didn’t want additional surgery; we recommended regular follow-up considering the possibility of atypical melanocytic proliferation. Most recently, she presented with further enlarged, multiple pigmented patches (Fig. 1D). She was treated with wide excision (1-cm margin) and split-thickness skin graft under the consideration of malignant melanoma. Bland lentiginous proliferation of atypical melanocytes confined to the epidermis prompted the final diagnosis of ALM in situ (Fig. 1E). Immunohistochemically, atypical melanocytes were stained positively for Melan-A, HMB-45, and anti-S-100 (Fig. 1F).

ALM was believed to have an aggressive biological behavior. However, in Asians, the specific population was reported inconsistent with the classical concept. After Nogita et al. described atypical melanosis of the foot, acral melanocytic lesions have been described with histopathologically subtle melanocytic proliferation, despite clinically malignant melanoma. These lesions did not show invasive behavior over a decade; though some of them reappeared around the primary site even after the surgical excision. There has been debate about the nature of these lesions; however, they are now considered as the precursor of ALM that fulfills both the clinical and dermoscopic criteria.

The most notable feature of our case was the recurrent melanocytic lesions appearing around the primary site in the absence of invasion during 8 years. Takata et al. suggested that acral and mucosal melanomas could originate from field melanocytes detected in normal-looking skin extending over the obvious lesion. These field cells harbor mutations of the KIT gene and amplifications of cyclin D1 or cyclin-dependent kinase 4 gene. Although our case initially showed only bland melanocytic proliferation without marked atypia or invasion, local melanoma could reappear from the residual field cells. Therefore, we recommend that the clinician should consider these lesions as ALM in situ and
treat with early complete excision. Also, it is better to perform an excisional biopsy for a review of the entire lesion in the suspicious acral melanocytic lesions. Finally, regular follow-up for several years is important for the detection of reappearing melanoma around the primary site, even after the surgical excision.

REFERENCES