
Age, gender, and topography influence the clinical and dermoscopic appearance of lentigo maligna

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Background: Little is known about the frequency of clinical and dermoscopic patterns of lentigo maligna (LM) in relation to specific anatomic subsites and patients characteristics.

Objective: We sought to assess the frequency of clinical and dermoscopic features of LM and to correlate them to specific anatomic subsites, and patients' age and gender.

Methods: This was a retrospective analysis of clinical and dermoscopic images of a series of consecutive, histopathologically diagnosed, facial and extrafacial LM.

Results: A total of 201 cases from 200 patients (mean age 69.51 ± 12.26 years) including 120 women were collected. Most cases were located on the face ($n = 192, 95.5\%$). In 102 cases, LM presented as clinically solitary facial macule (s/LM), whereas it was associated with multiple surrounding freckles in the remaining cases. s/LM were significantly smaller (<10 vs >10 mm; $P = .020$) and associated with younger age compared with LM associated with multiple surrounding freckles (mean age 67.73 ± 12.68 years vs 71.34 ± 11.59 years, respectively; $P = .036$). Dermoscopically, gray color irrespective of a specific pattern was the most prevalent finding seen in 178 (88.6%) cases.

Limitations: This was a retrospective study.

Conclusions: The knowledge about patient age, patient gender, and site-related clinical features of LM associated with gray color upon dermoscopy may enhance the clinical recognition of LM. (J Am Acad Dermatol 2015;72:801-8.)

Key words: dermoscopy; lentigo maligna.

The term “lentigo maligna” (LM) refers to melanoma in situ arising on chronically sun-damaged skin. The clinical diagnosis of early LM, even if coupled with dermoscopy, remains a challenge given its overlapping morphology with other pigmented macules that also commonly occur on sun-damaged skin. These include solar lentigo, flat seborrheic keratosis, freckles, lichen planus–like keratosis, and pigmented actinic keratosis.¹⁻⁸

Up to date, little is known about the influence of age, gender, and topography on the clinical and dermoscopic variability of LM.⁹

In this study, we analyzed the morphological patterns including a recently introduced simple dermoscopic clue called “gray color”¹⁰ in a series of consecutive, histopathologically proven facial and extrafacial LM and correlate these findings to patient demographics and lesion topography.

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METHODS

We retrospectively collected consecutive cases of histopathologically proven facial and extrafacial LM diagnosed between January 2012 and January 2013 at 4 academic skin cancer clinics in France, Italy, Serbia, and the United States.

Requirements for study inclusion were the availability of high-resolution distant clinical overview photographs of the affected area, a clinical close-up photograph of the LM, and high-resolution digital dermoscopic images showing at least two thirds of the lesion surface. There were no limitations regarding the technical equipment used to take the clinical and dermoscopic images.

For each case, patients' demographics (ie, age, gender), specific anatomic location, and histopathological diagnosis were recorded. The face was subdivided into 4 main topographical areas, which were further subdivided into detailed anatomic subsites: (i) the upper aspect of the face subdivided into the front, temple, periocular region, and scalp; (ii) the nose subdivided into the cartilaginous and bone portion; (iii) the ears subclassified into the cartilaginous area, the periauricular region, and the earlobe; and (iv) the lower aspect of the face subdivided into the cheeks, perioral region, and chin. The local ethics committee at each center approved the study.

All clinical overview, close-up, and dermoscopic images were evaluated in consensus by 2 clinicians with more than 5 years of experience in skin cancer diagnosis and dermoscopy (D. T-Z. and A. L.) for predefined clinical and dermoscopic parameters. Both evaluators were aware of the study aim.

Analysis based on the clinical overview and close-up images included: (i) assessment of the clinical size (ie, <10 mm or >10 mm regarding the largest axis of the lesion) using a ruler as a reference measurement tool; (ii) assessment of whether LM presented as a solitary lesion (s/LM) on otherwise normal-appearing skin (ie, no additional pigmented macules are seen in the surrounding skin) or LM was associated with multiple surrounding pigmented freckles in the affected area; and (iii) laterality (ie, assessment whether the lesions were located on the

left or right side of the face). Lesions located on the midline of the face or scalp and torso were not assigned to any of the sites.

All dermoscopic images were evaluated for the presence of predefined dermoscopic criteria, which are summarized in Table I and demonstrated in Fig 1.¹⁰⁻¹² If no consensus could be reached, the criterion was scored as absent.

CAPSULE SUMMARY

- The clinical diagnosis of lentigo maligna is a challenge.
- The clinical and dermoscopic features of lentigo maligna are influenced by patient age and gender, and the lesion's specific anatomic subsite.
- Irrespective of specific dermoscopic patterns, gray color appears the single most important criterion in the diagnosis of lentigo maligna.

Statistical analysis

Clinical and dermoscopic features were described with mean and SD or with frequency, as appropriate. Categorical variables were analyzed by χ^2 or Fisher exact tests and continuous data by the Student *t* test. Fisher exact test was used in cases where the expected values were less than 5 in the contingency table 2×2.

Statistical analysis of data was performed using R 2.15.3 software (R Foundation for Statistical Computing, Vienna, Austria).¹³

RESULTS

Clinical findings

A total of 201 LM cases, seen in 200 patients (mean age 69.51 ± 12.26 years, range 28-99 years) were collected. There was a significant female predominance ($n = 120$; 60.0%; $P = .008$) among all patients. Table II shows the patients' demographics and clinical characteristics of LM.

Location on the cheek was significantly associated with female gender ($P < .001$), whereas a significant male predominance was found for location on the scalp ($P = .025$) and cartilaginous area on the ear ($P = .025$). No significant difference was seen between both genders regarding age, size, and laterality.

Of the 201 cases, 102 (50.7%) LM presented as a solitary lesion on normal-appearing skin (s/LM), whereas the remaining 99 (49.3%) cases were associated with surrounding freckles in the affected area (Fig 2). Patients with s/LM were significantly younger compared with LM associated with multiple surrounding freckles (mean age 67.73 ± 12.68 years, range 28-95 years, vs 71.34 ± 11.59 years, range 45-99 years, respectively; $P = .036$). s/LM cases were significantly smaller (ie, <10 mm) compared with LM cases associated with multiple surrounding freckles ($P = .020$); in detail, whereas 59.8% ($n = 61$) of s/LM

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