

ORIGINAL ARTICLE

Dysplastic nevi with severe atypia: Long-term outcomes in patients with and without re-excision

Kathleen Engeln, MD,^a Kaitlin Peters, MD,^c Jonhan Ho, MD, MS,^d Jaroslaw Jedrych, MD,^d
Daniel Winger, MS,^b Laura Korb Ferris, MD, PhD,^c and Timothy Patton, DO^c
San Diego, California and Pittsburgh, Pennsylvania

Background: Dysplastic nevi with severe atypia (severely dysplastic nevi [SDN]) are frequently re-excised because of the concern that these lesions may in fact represent early melanoma. Data on long-term follow-up of these patients are limited.

Objective: We sought to determine the rate of subsequent melanoma development in patients with SDN who underwent re-excision versus those who did not and to determine factors associated with decision to re-excise.

Methods: A retrospective single institutional study was conducted with 451 adult patients (mean age 41.3 years) with SDN biopsied between November 1994 and November 2004, with clinical follow-up of at least 5 years.

Results: In 451 patients with SDN, re-excision was performed on 36.6%. Two melanomas were diagnosed in the re-excision specimens. Subsequent metastatic melanoma developed in 7 patients, all of whom had a history of melanoma. Margin comments influenced decision to re-excise.

Limitations: This was a retrospective study at a single institution.

Conclusion: Re-excision of all SDN may not be necessary. (J Am Acad Dermatol <http://dx.doi.org/10.1016/j.jaad.2016.08.054>.)

Key words: dysplastic; melanoma; nevus; pigmented lesion; re-excision; severe atypia.

“Dysplastic nevus” is a histopathologic term used to describe nevi with cytologic atypia and architectural disorder. Despite prior attempts to establish guidelines for histopathologic criteria,¹⁻³ studies show low reproducibility in grading dysplastic nevi even among experienced dermatopathologists, particularly in differentiating dysplastic nevi with severe atypia from radial growth-phase melanoma.⁴⁻⁸ Because of this confusion, some have proposed that the term “dysplastic nevus” be completely abandoned.^{9,10}

Recommendations for the management of dysplastic nevi were published previously. A 1992 National Institutes of Health (NIH) Consensus Conference statement on the diagnosis and treatment of early melanoma also mentioned dysplastic nevi.⁹ Although this consensus mentioned that margins of 0.2 to 0.5 cm be used when re-excision was indicated, it did not clearly define indications for re-excision. A more recent consensus statement by the Pigmented Lesion Subcommittee of the Melanoma Prevention Working Group addressed

From the Scripps Mercy Hospital^a and Clinical and Translational Science Institute^b; and the Departments of Dermatology^c and Dermatopathology,^d University of Pittsburgh Medical Center.

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Reprint requests: Timothy Patton, DO, Department of Dermatology, University of Pittsburgh Medical Center, Falk Medical Center, 3601 Fifth Ave, Fifth Floor, Pittsburgh, PA 15213. E-mail: tpattd@upmc.edu.

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the management of dysplastic nevi more precisely, advocating clinical observation for lesions with mild atypia, but recommending removal of dysplastic nevi with severe atypia when margins are involved after biopsy.¹¹ Despite the lack of a recommendation for dysplastic nevi with severe atypia when margins were uninvolved, a majority of dermatologists will perform re-excision when the pathology report mentions severe atypia, even when margins are clear, and this trend seems to be increasing with time.¹²⁻¹⁴

Few data exist on the natural history and risk of subsequent melanoma in patients with dysplastic nevi with severe atypia (hereafter referred to as “severely dysplastic nevus” [SDN]), particularly in patients whose lesions are not re-excised. We performed a retrospective analysis of patients with biopsy-proven SDN with at least 5 years of clinical follow-up to determine rates of developing subsequent melanoma at the site of the SDN, a second primary melanoma, and metastatic melanoma. We also investigated the association of factors including specialty of the physician who performed the biopsy, board certification of the pathologist, and margin status with the decision to perform a re-excision of the lesion.

METHODS

Regulatory oversight

This study was deemed to be exempt from full review by the University of Pittsburgh Institutional Review Board (under 45 Code of Federal Regulations 46.110).

Case selection

A retrospective chart review was conducted using the electronic health records on all patients with a diagnosis of SDN (including those with moderate-severe and focally severe atypia) who were biopsied between November 1994 and November 2004 with clinical follow-up of at least 5 years as determined by most recent office visit in our health system. The search terms used to identify cases from pathology reports were “severe,” “atypia,” and “nevus.” The diagnosis of SDN was at the discretion of the pathologist. Patients who were younger than 18 years at the time of biopsy or had fewer than 5 years of follow-up after diagnosis of the

SDN were excluded. The following data points were recorded: patient demographics, lesion location, method and date of biopsy, specialist performing the biopsy, if the pathologist who read the biopsy specimen was board-certified in dermatopathology, date of re-excision, margin involvement, additional pathology comments, presence and location of any subsequent melanomas, presence of any melanomas diagnosed concurrently with the SDN, history and Breslow thickness of any melanoma, and most recent follow-up date through May 2015. If patients had more than 1 SDN that met criteria for our study, only the first case was included in analysis.

Histologic review

In all, 100 cases were selected from the database for histologic confirmation of the diagnosis of SDN (both cases in which melanoma was found upon subsequent re-excision and an additional 98 randomly selected cases). Of the 100 cases, 98 were available for review and were independently evaluated by 2 board-certified dermatopathologists for the presence of severe atypia using criteria outlined previously.¹⁵

Outcome measures

The primary outcome of interest was the incidence of subsequent melanoma, both metastatic and recurrent, at the site of biopsy of the SDN. Other outcomes of interest were factors associated with performance of a re-excision of the SDN.

Statistical analysis

Analysis was performed on the first recorded SDN with at least 5 years of follow-up for each patient. Frequencies and percentages were reported for the categorical variables of interest. Continuous variables were reported with means and SD, or medians and interquartile ranges, as appropriate. Associations between categorical variables were compared via the χ^2 test. A *P* value of less than .05 was considered significant. All analyses were conducted in software (SPSS v.22, IBM Corp, Armonk, NY).

RESULTS

In all, 499 cases of SDN were identified using the search criteria and 451 distinct patients were

CAPSULE SUMMARY

- Dysplastic nevi with severe atypia (severely dysplastic nevi) are frequently re-excised because of the concern that these lesions may represent early melanoma.
- In our series, patients with severely dysplastic nevi did not develop subsequent melanoma at the same site during long-term follow-up when re-excision was not performed.
- Routine re-excision of all severely dysplastic nevi may not be necessary.

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