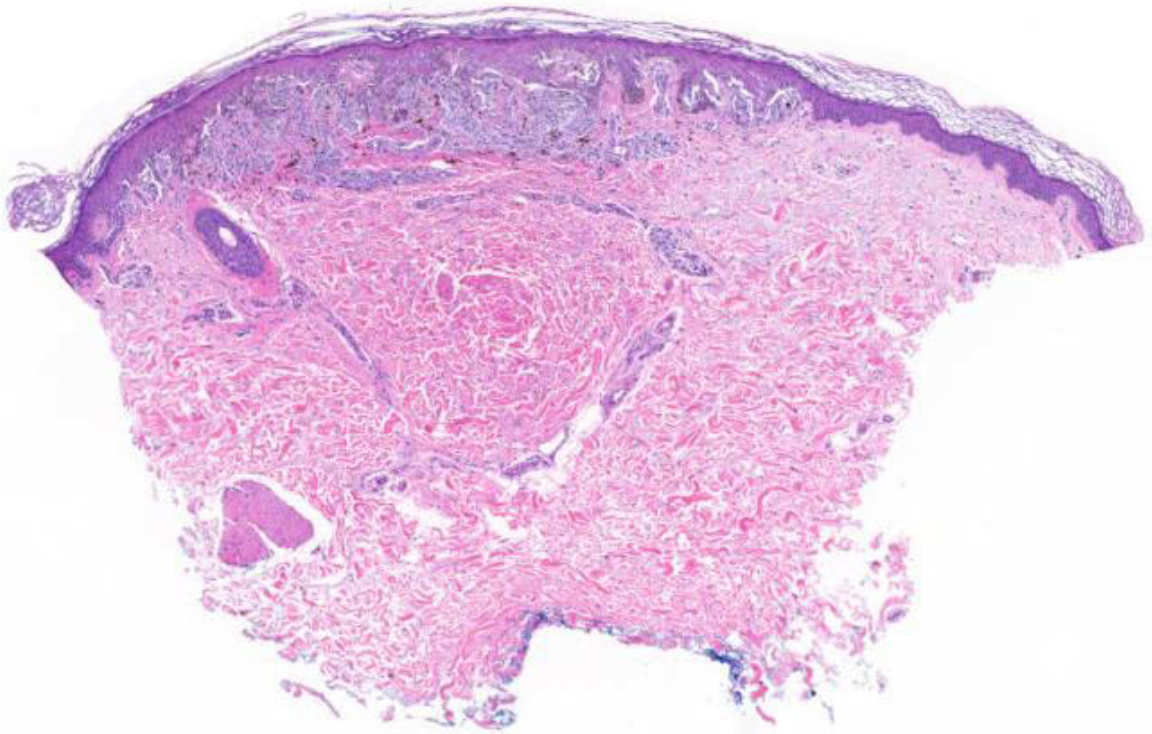
Case 16
39 year-old female with lesion of left anterior thigh

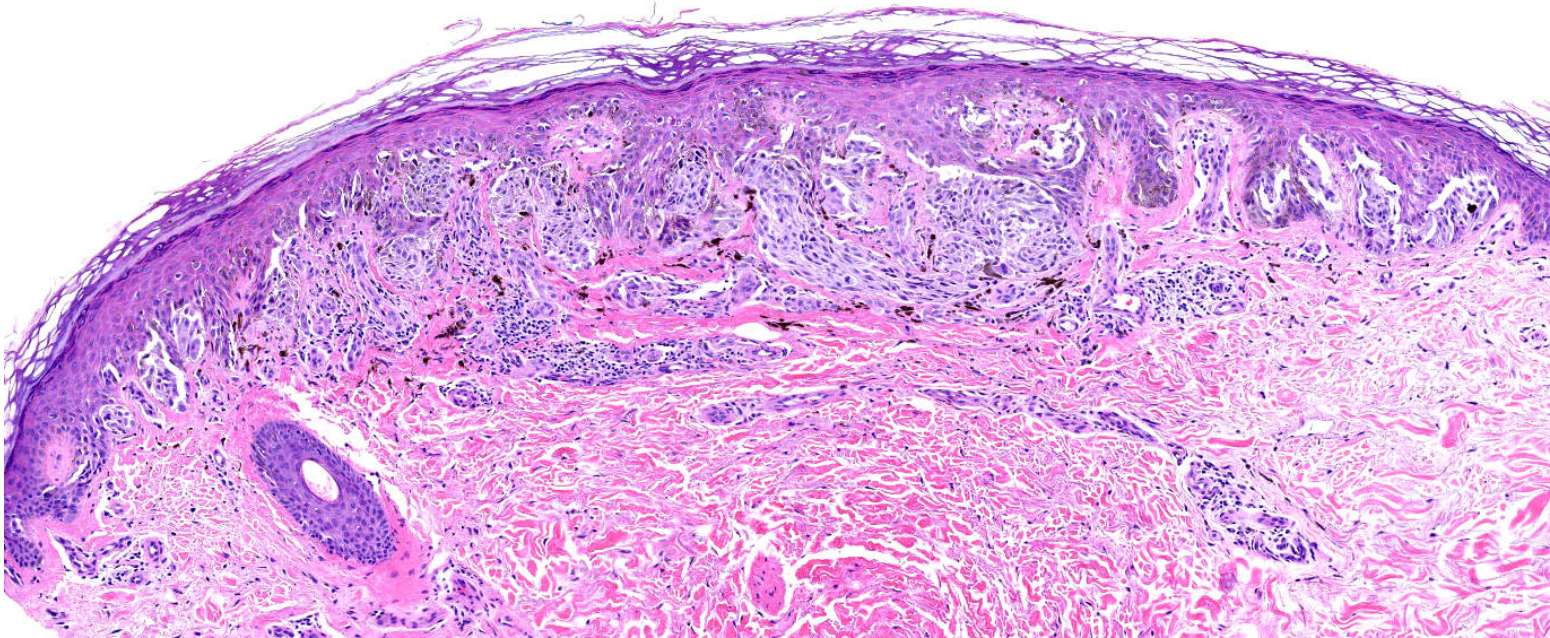
Histopathological Features

- Diameter: 2.1 mm
- Slight asymmetry
- Well-circumscribed
- No ulceration
- No effacemen



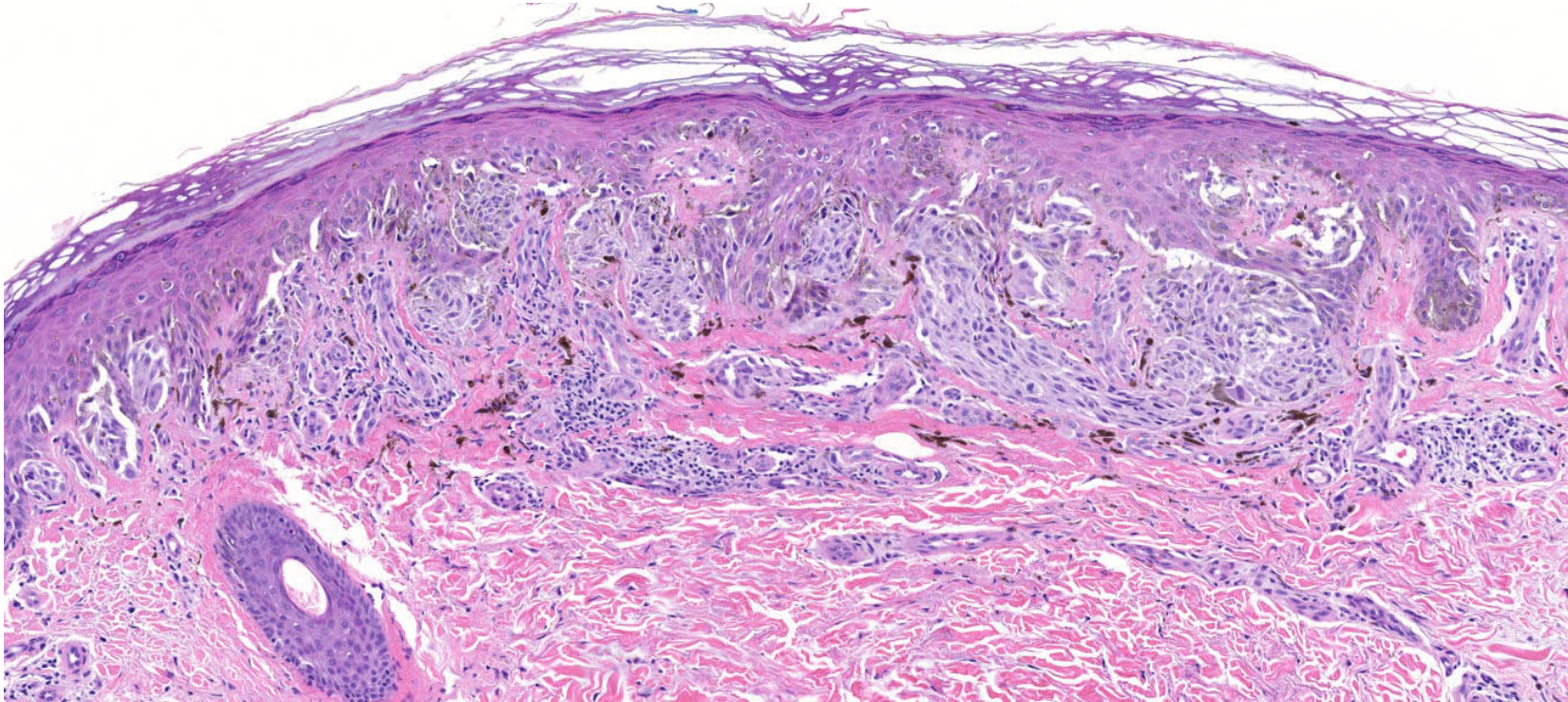
Histopathological Features

- Thickness: 0.32 mm
- Cell type: spindle, epithelioid
- Mitotic rate: 0 per per mm^2
- Solar elastosis



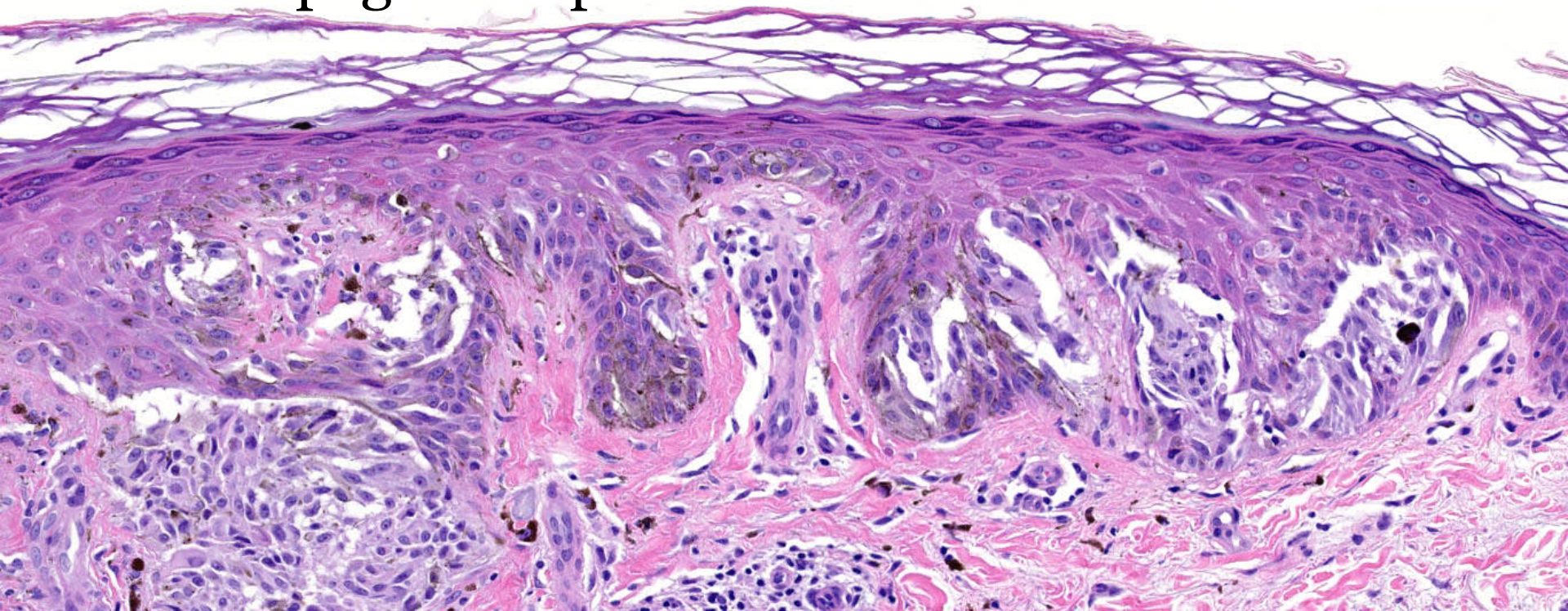
Histopathological Features

- Scant pagetoid spread
- Epidermal hyperplasia
- No Kamino bodies



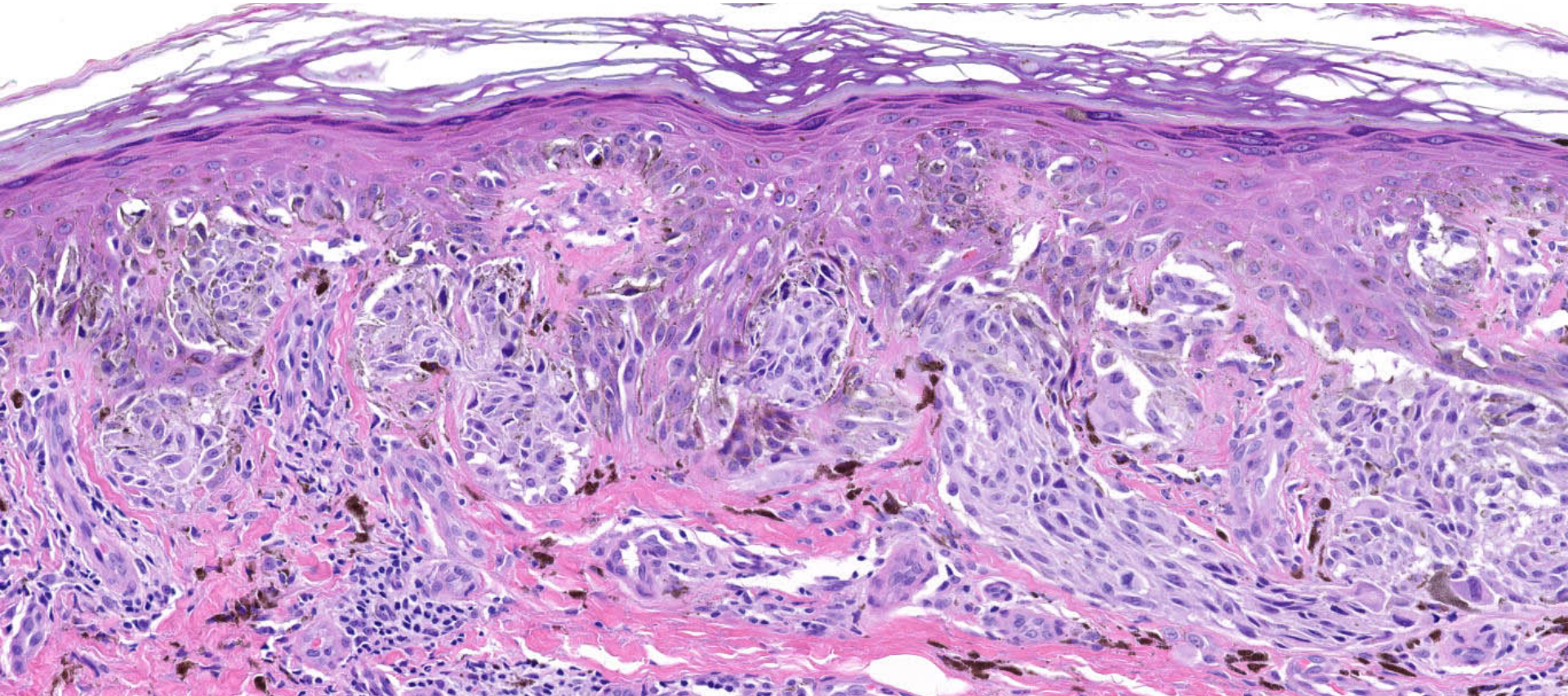
Histopathological Features

- Maintenance of retiform epidermal hyperplasia
- No conspicuous proliferation of melanocytes between rete
- Rare pagetoid spread



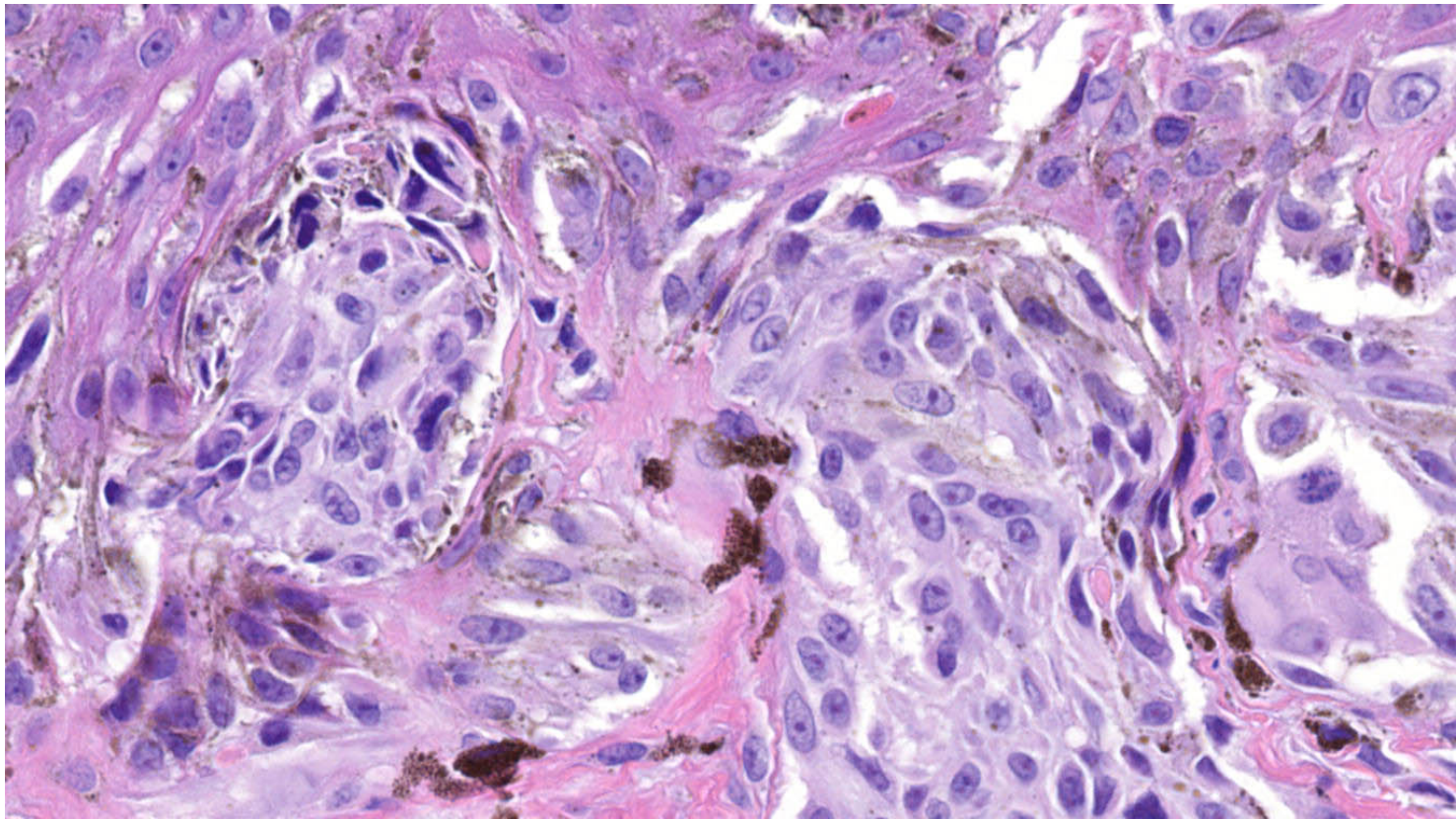
Histopathological Features

- Confluent cellular nesting
- Cytological atypia
- Loss of pigment synthesis with depth



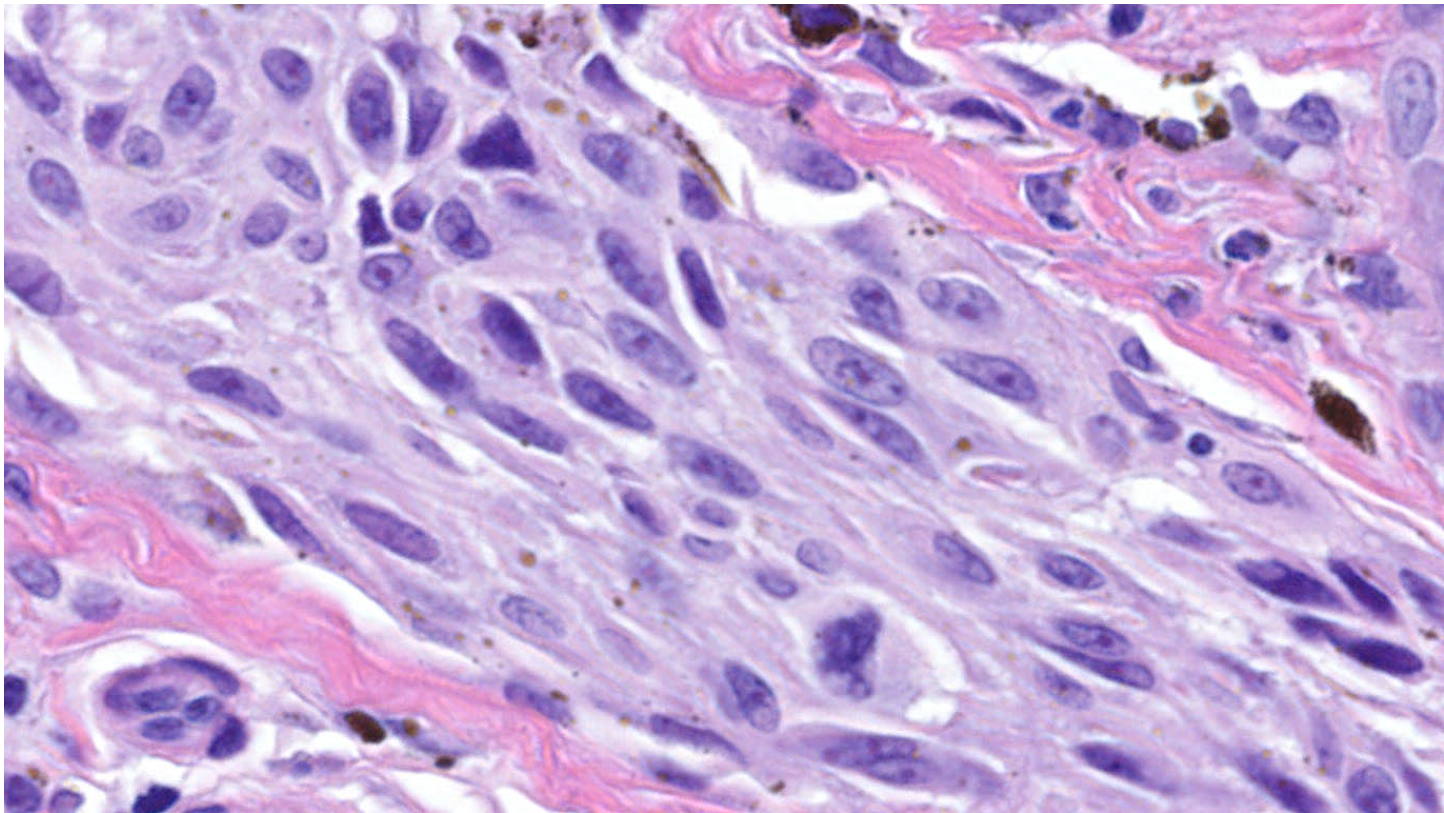
Histopathological Features

- Large nests and fascicles of melanocytes
- Large epithelioid and spindle cells
- Many nuclei with dispersed chromatin patterns



Histopathological Features

- Ground-glass cytoplasm
- Granular not “dusty” melanin
- Nuclear pleomorphism, hyperchromatism



1. What is the most likely diagnosis?

a. Compound dysplastic nevus
b. Spitzoid melanoma
c. Atypical Spitz tumor
d. Spitz nevus

Expert Panel Consensus

- Mpath Class III: Atypical Spitz tumor

MPATH-Dx* Class	Perceived Risk for Progression	Suggested treatment consideration	Examples
0	Incomplete study due to sampling or technical limitations	Repeat biopsy or short-term follow up	N/A
I	Very low risk	No further treatment	-Common melanocy nevus -Blue nevus -Mildly dysplastic nevus
II	Low risk	Narrow but complete excision (< 5 mm)	-Moderately dysplastic nevus -Spitz nevus
III	Slightly higher risk, greater need for intervention.	Complete excision with at least 5 mm but <1 cm margins	-Severely dysplastic nevus -Melanoma in situ -Atypical Spitz tum
IV	Substantial risk for local or regional progression	Wide local excision with ≥ 1 cm margins	Thin, invasive melanoma (e.g., T1a)
V	Greatest risk for regional and/or distant metastases	Wide local excision with ≥ 1 cm margins. Consideration of staging sentinel lymph node biopsy, adjuvant therapy	Thicker invasive melanomas (e.g., T1b, T2 or greater)

All Participant Interpretations for Case 16

		N	%
Class III	**Class Subtotal**	**19**	**50 %**
	Spitzoid: **Atypical Spitz** **	**9**	**23,7 %**
	Spitzoid: Atypical Spindle	5	13,2
	Atypia: Dysplastic Nevus: Severe	3	7,9
	Atypia: Lentiginous Melanocytic: Severe	1	2,6
	MLUMP: SAMPUS	1	2,6
Class II	**Class Subtotal**	**16**	**42,1 %**
	Nevus: Spitz Nevus	9	23,7
	Nevus: Pigmented Nevus	3	7,9
	Atypia: Dysplastic Nevus: Moderate	1	2,6
	Atypia: Atypical Nevus NOS: Moderate	1	2,6
	MLUMP: Atypical Melanocytic Junctional	1	2,6
	MLUMP: Atypical Melanocytic Compound	1	2,6
Class IV	**Class Subtotal**	**3**	**7,9 %**
	Invasive Melanoma: Superficial Spreading	2	5,3
	MLUMP: MELTUMP	1	2,6
	Total	**38**	**100 %**

2. What statements are most likely true about this lesion?

a. The lesion is low risk
b. The lesion is high risk
c. Wide excision with at least 1 cm margins is standard therapy.
d. A kinase fusion might be associated with this tumor.

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3. Are any ancillary studies needed?

a. Yes

b. No

4. What ancillary studies would you order?

5. Would you re-excise the lesion?