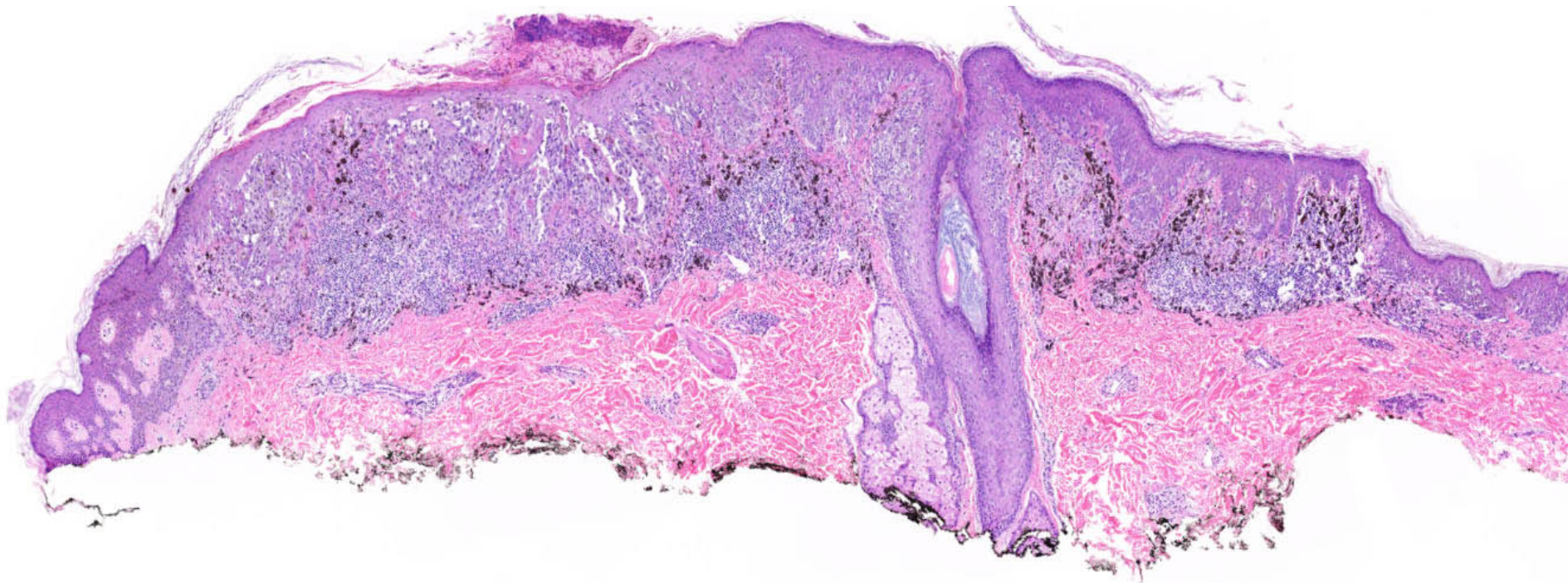


Case 17
23 year-old male with
lesion on right chest

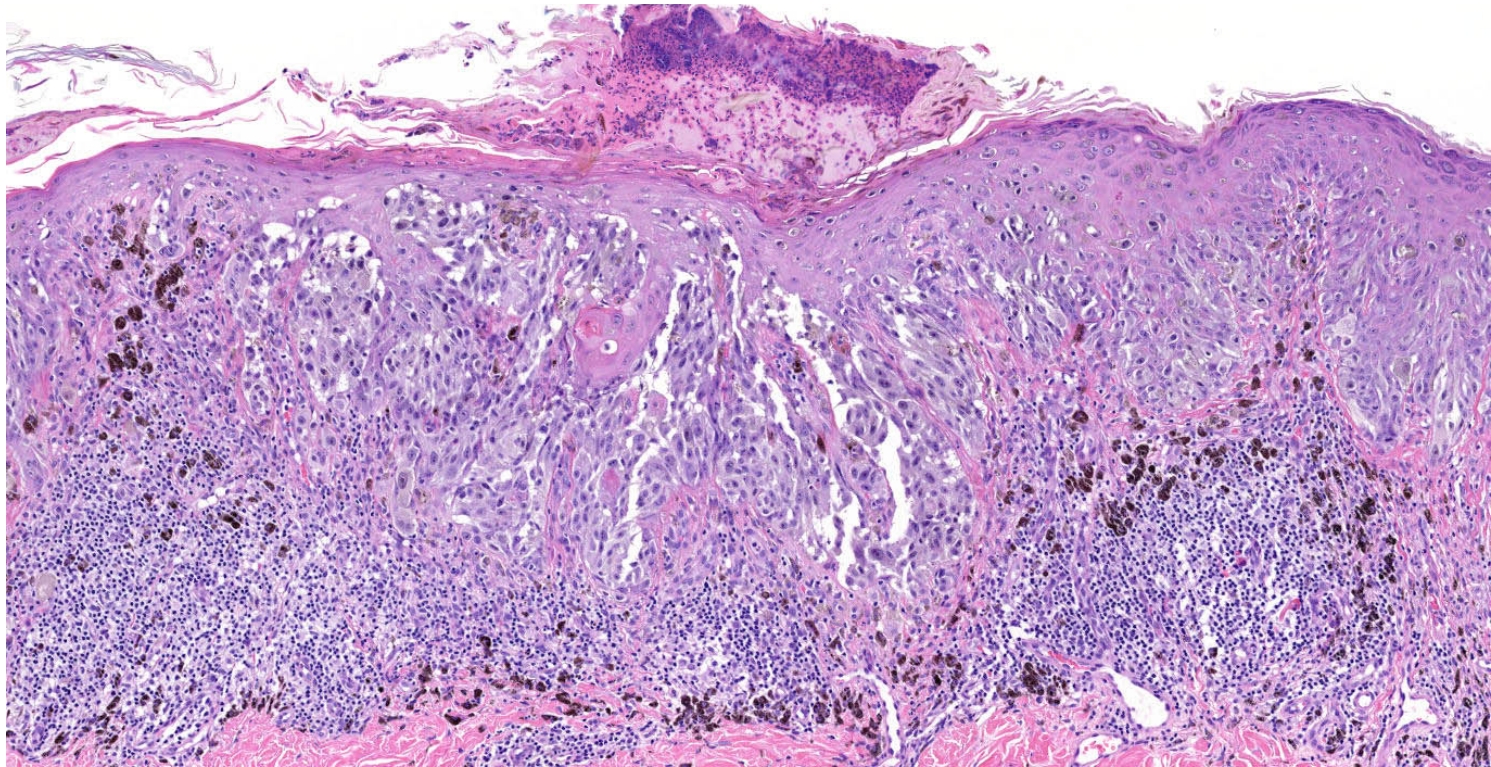
Histopathological Features

- Diameter: 5.8 mm
- Asymmetrical
- Poorly circumscribed
- Solar elastosis



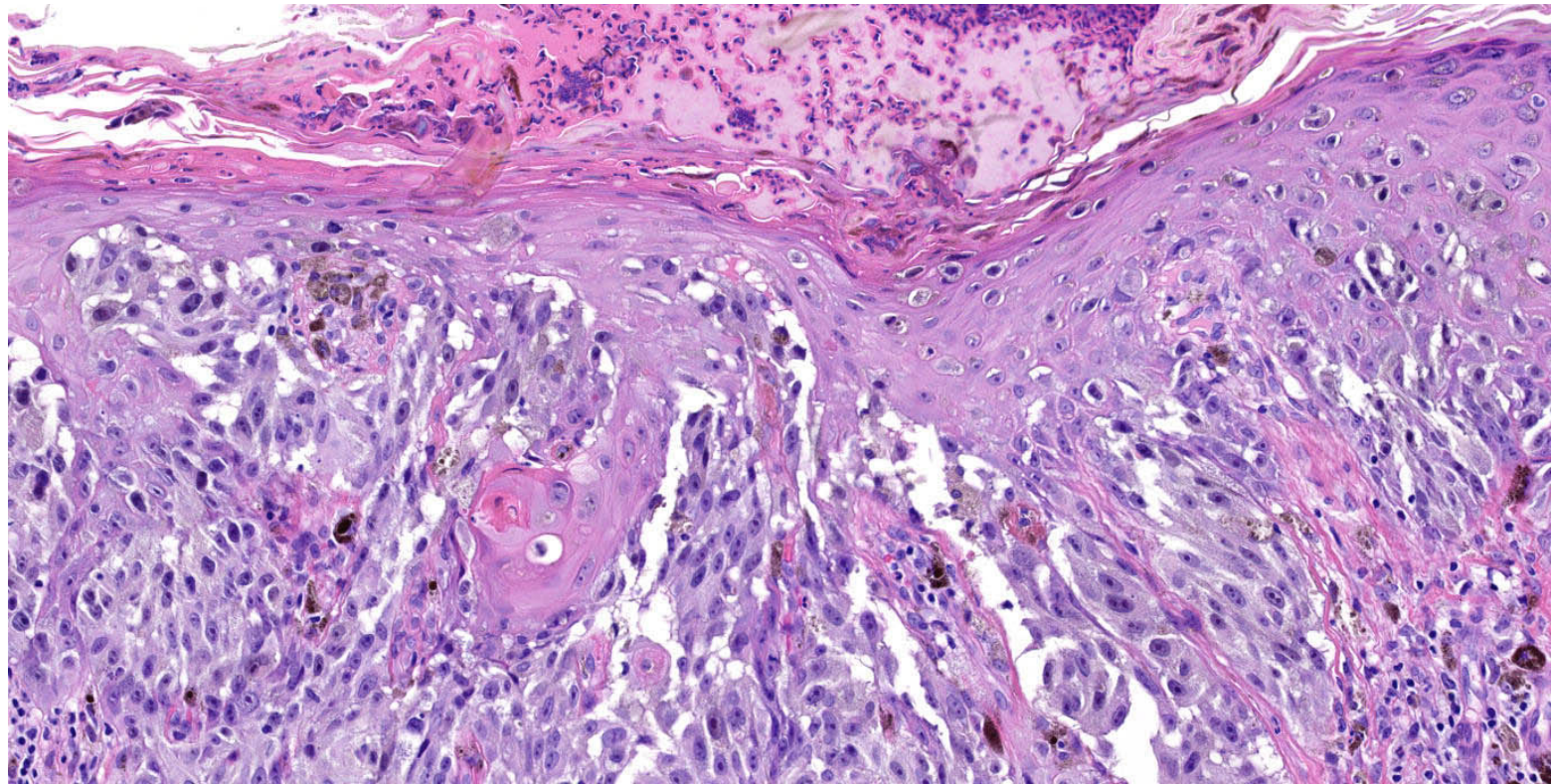
Histopathological Features

- Irregular epidermal hyperplasia
- Confluent irregular junctional hypercellular nesting of melanocytes
- Dense lymphocytic infiltrate



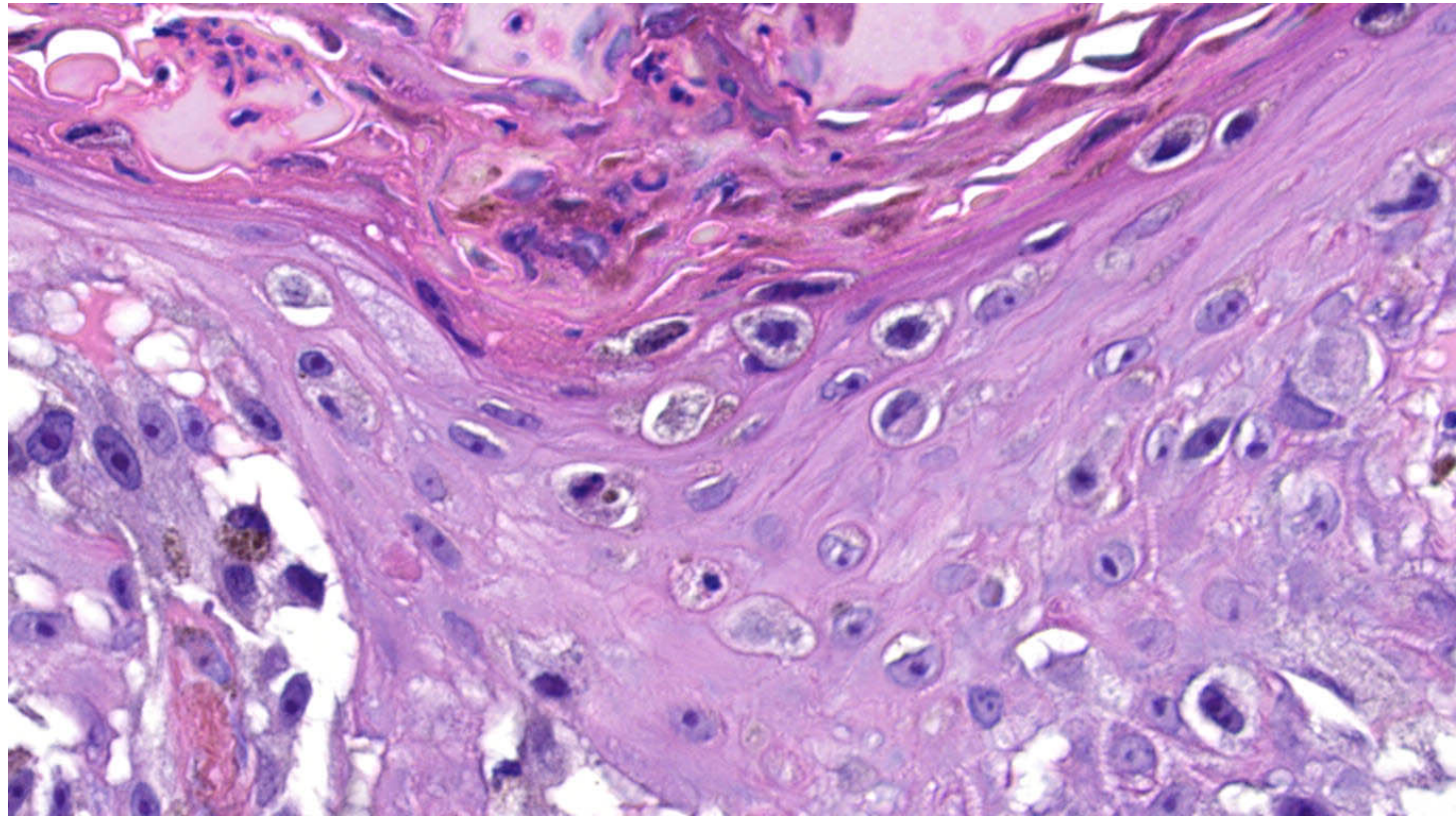
Histopathological Features

- Pagetoid spread
- Large epithelioid and plump spindle cells
- Nuclear enlargement, pleomorphism, prominent nucleoli



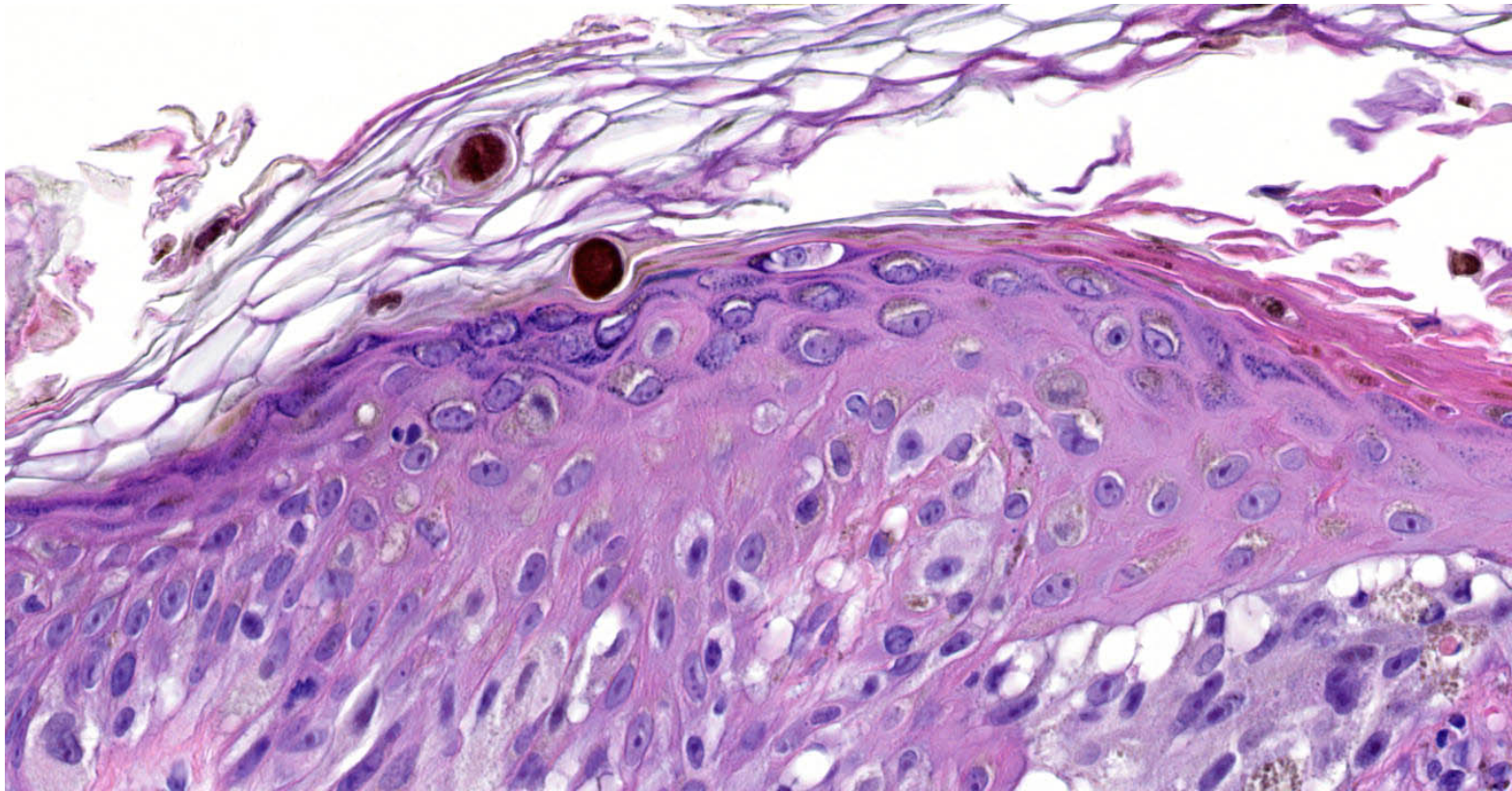
Histopathological Features

- Pagetoid spread
- Nuclear enlargement, pleomorphism, prominent nucleoli



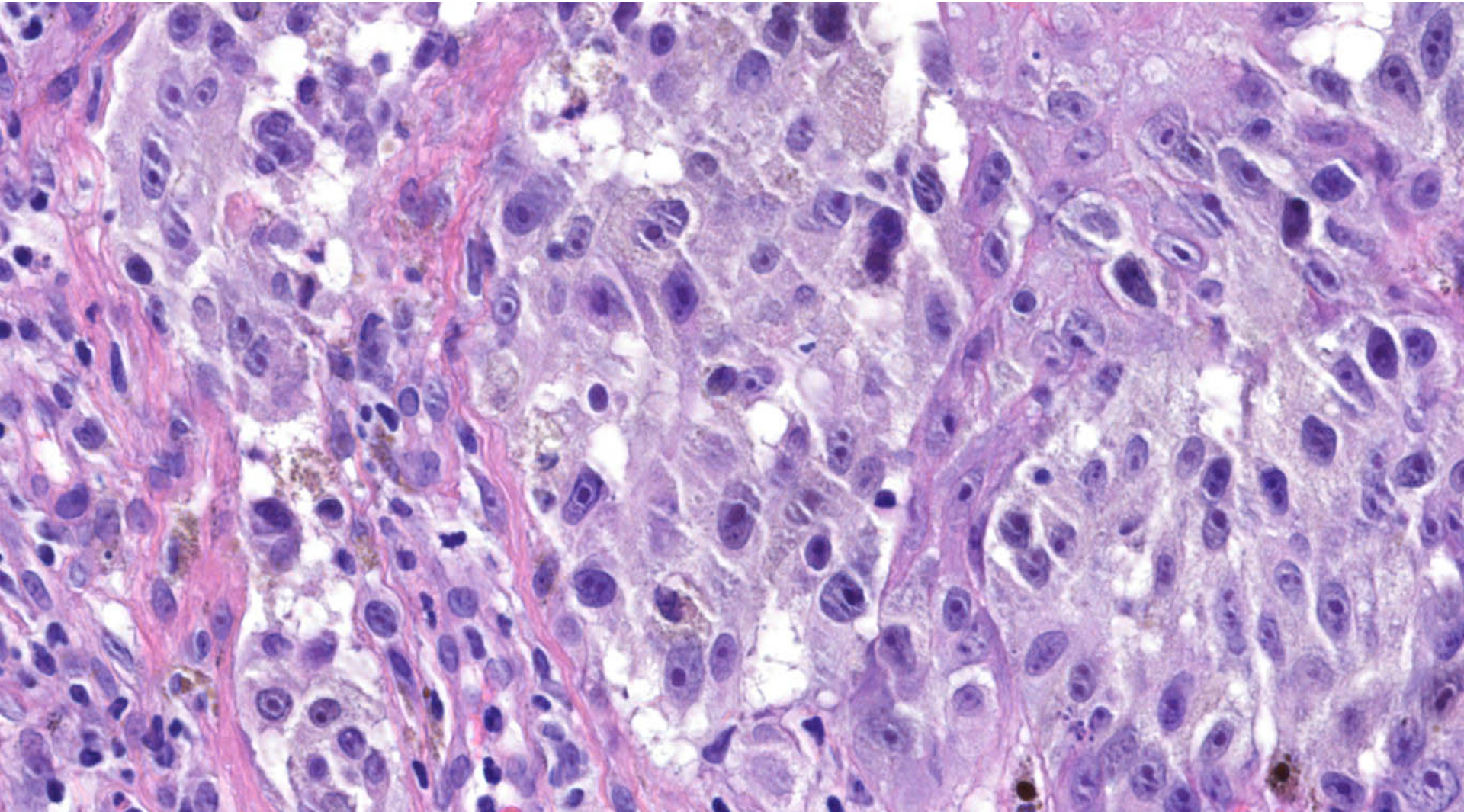
Histopathological Features

- Pagetoid spread



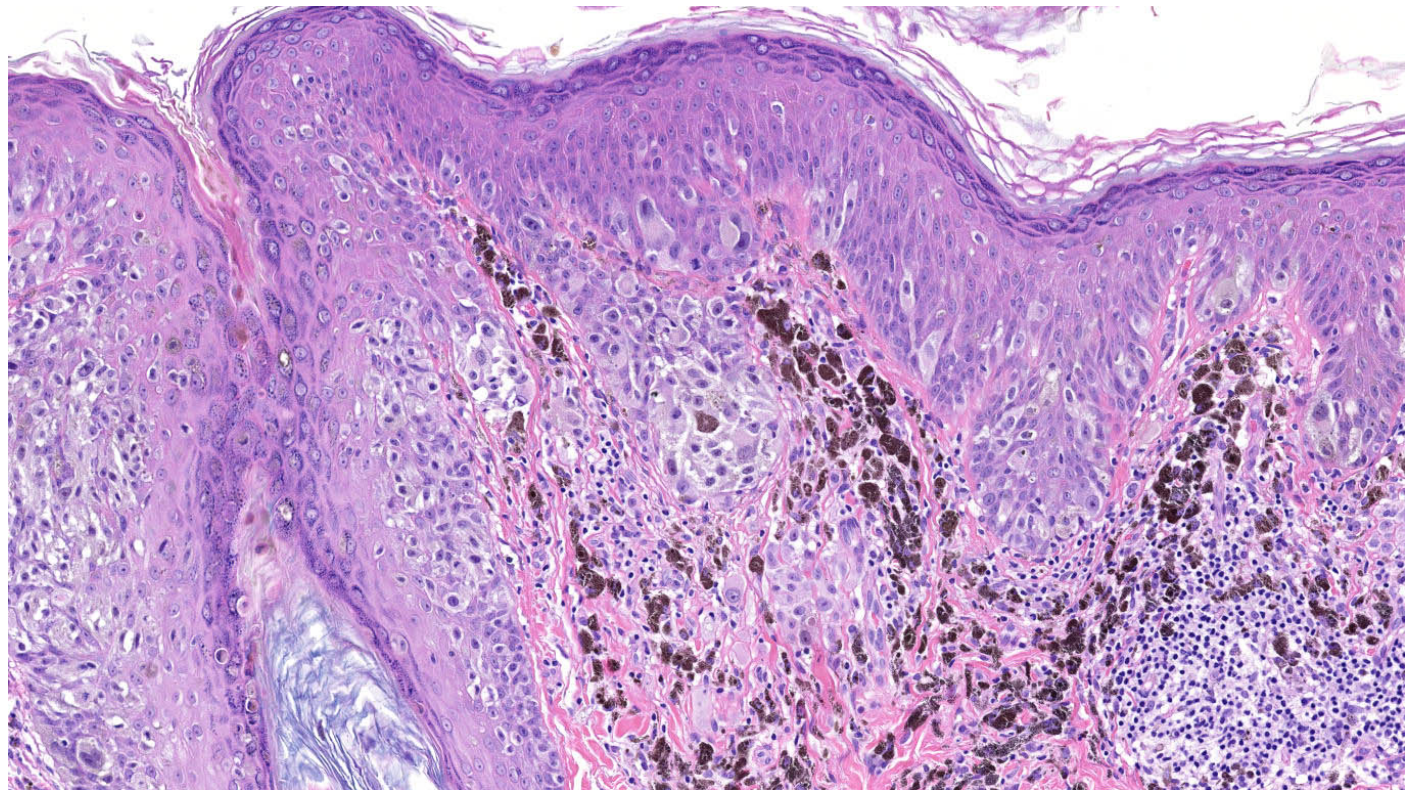
Histopathological Features

- Severe cytological atypia



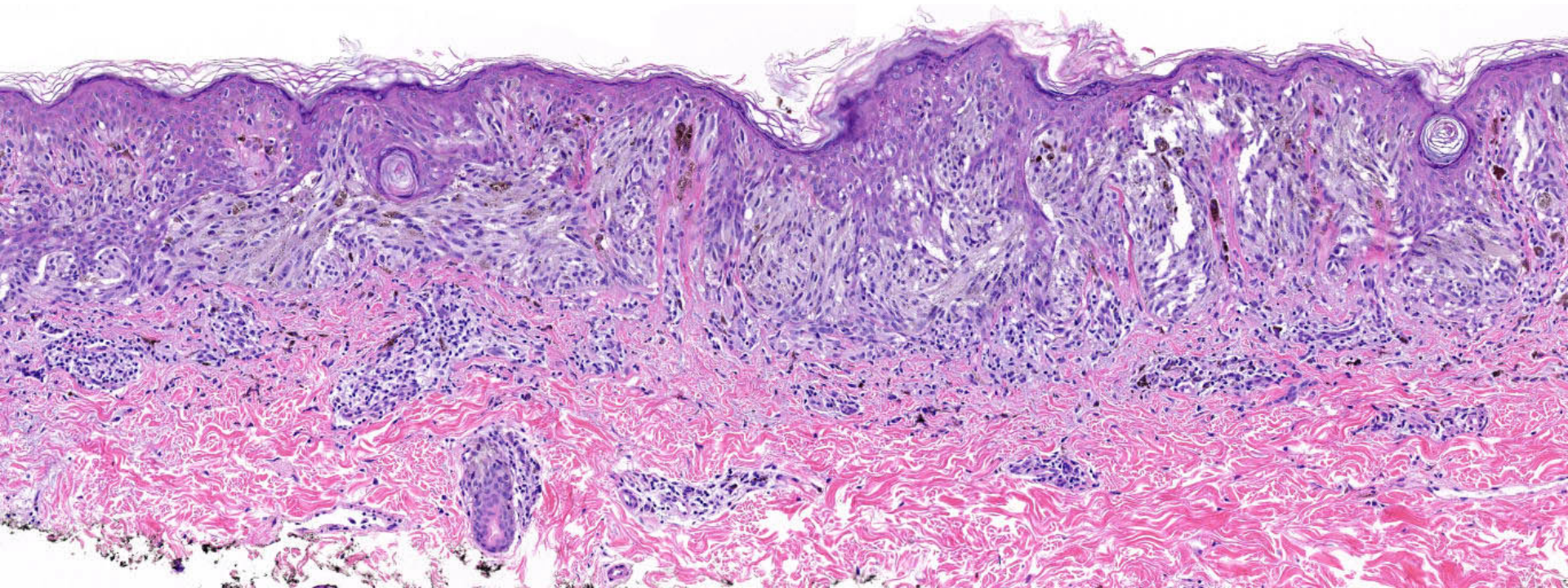
Histopathological Features

- Thickness: 0.50 mm
- Mitotic rate: 0 per per mm²
- No ulceration



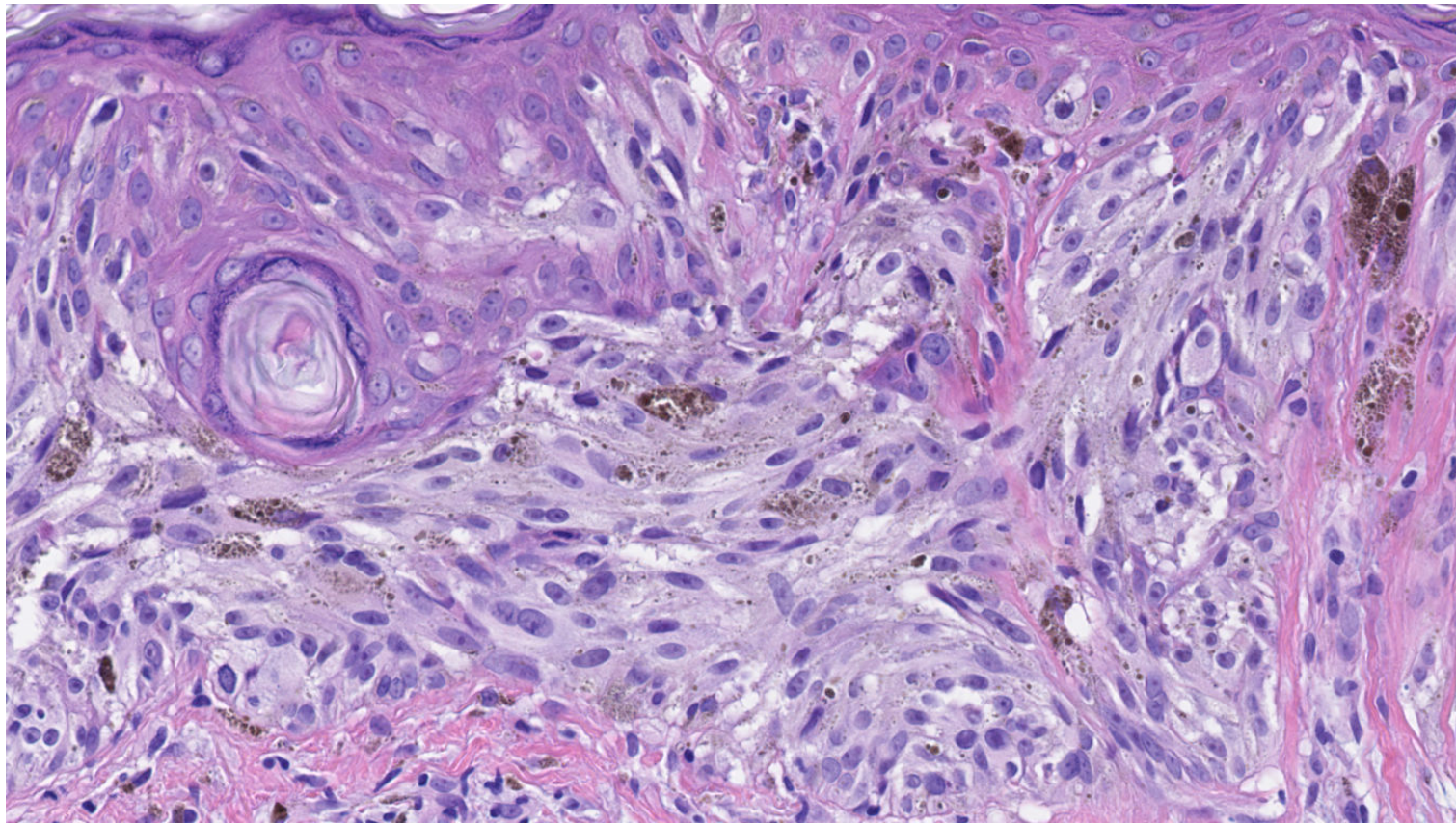
Histopathological Features

- Hypercellular fascicles and junctional nests of atypical pigmented spindled melanocytes



Histopathological Features

- Granular and dusty melanin
- Nuclear pleomorphism, hyperchromatism



1. What is the most likely diagnosis?

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

Expert Panel Consensus

- Mpath Class IV: Invasive Melanoma: Superficial Spreading

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 melanocytic 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 tumor
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 17			
		N	%
Class IV	Class Subtotal	19	50 %
	<u>Invasive Melanoma: Superficial Spreading **</u>	<u>10</u>	<u>26,3 %</u>
	Invasive Melanoma: Spitz	6	15,8
	MLUMP: Atypical Melanocytic Junctional	1	2,6
	Invasive Melanoma: Unclassifiable	1	2,6
	Invasive Melanoma: Spindle	1	2,6
Class III	Class Subtotal	13	34,2 %
	Spitzoid: Atypical Spitz	10	26,3
	Melanoma In Situ: Common	1	2,6
	Spitzoid: Atypical Spindle	1	2,6
	MLUMP: SAMPUS	1	2,6
Class II	Class Subtotal	4	10,5 %
	Nevus: Spitz Nevus	2	5,3
	Nevus: Pigmented Nevus	1	2,6
	Nevus: Blue Nevus: Epithelioid	1	2,6
Class V	Class Subtotal	2	5,3 %
	Invasive Melanoma: Superficial Spreading	1	2,6
	Invasive Melanoma: Nodular	1	2,6
Total		38	100 %

2. What ancillary study might be of most value for diagnosis?

- a. Mutation analysis for GNAQ, GNA11
- b. IHC for BRAF V600E
- c. IHC for kinase fusion
- d. SOX10 immunostain

2. What ancillary study might be of most value for diagnosis?

- a. Mutation analysis for GNAQ, GNA11
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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?