

tion, and the lipidized DF, with a homogeneous yellowish area.^{3,6}

Although initially considered rare, sebaceous structures are identified in more than 15% of DFs,^{4,5,7} even in multiple forms.⁸ This finding is typical in lesions localized in the anatomical area of the shoulder (shoulder, proximal region of the arm, upper back and deltoid region), being observed in more than 40% of these cases, particularly in DF with seborrhic keratosis-type epidermal hyperplasia or with a sclerotic pattern.⁴ The dermoscopic image shows yellowish globular structures due to the sebaceous component.⁶ Although growth factors and cytokines have been implicated,⁹ the etiology of sebaceous induction and the reason for its predilection for DF of the shoulder remain unknown.⁴

In this case, the differential diagnosis should include sebaceous tumors and tumors with sebaceous differentiation, such as sebaceous hyperplasia, sebaceous nevus, sebaceous adenoma, sebaceous carcinoma, and reticulated acanthoma or poroma with sebaceous differentiation, which can include yellowish structures in the dermoscopy image.¹⁰ Yellowish globules have also been identified in melanocytic nevi and balloon cell melanomas.

In conclusion, DF is a tumor with a marked variability of its clinical, histopathological, and dermoscopic presentation. A diagnosis of DF with sebaceous induction should be considered in lesions in the shoulder area with yellowish globules visible on dermoscopy.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Not as Good as it Looks[☆]



No es bueno todo lo que lo parece

To the Editor:

A 50-year-old man, skin phototype III, with no past medical history of interest and with no personal or family history of melanoma, was seen in dermatology outpatients for a lesion that had arisen a year earlier on the auricle of his right ear. After treatment with salicylic acid as if it were a wart,

the lesion initially disappeared, but subsequently returned. Dermatologic examination revealed an erythematous nodular lesion measuring 0.5 cm in diameter on the lower third of the auricle of the right ear (Fig. 1). Dermoscopy did not suggest a melanocytic lesion, and there were no palpable regional cervical lymph nodes. The lesion was excised and histopathology reported a well-defined polypoid lesion that, at low magnification, appeared to be a benign lesion; however, at higher magnification, a melanocytic lesion with cytologic atypia and mitoses was observed, with a lack of deep maturation. Pagetoid spread and lymphatic invasion were also observed (Fig. 2). Immunohistochemistry was positive for S100 and melan A and negative for HMB45 and p16, and a high Ki-67 cell proliferation index was also observed (Fig. 2).

Based on these findings, the patient was diagnosed with nevoid melanoma of 0.7 cm diameter, Clark level v and a Breslow thickness of 6.11 mm, with up to 3 mitoses per mm.²

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Figure 1 Erythematous nodule on the auricle of the ear.

No ulceration, lymphocytic response, signs of regression, or perineural invasion were present.

Positron emission tomography-computed tomography was performed, showing no viable tumor tissue with affinity for 18F-FDG. Widening of the surgical margins to 2 cm and selective sentinel lymph node biopsy (SLNB) were performed. After widening, the margins were free of tumor and the SLNB was negative. The patient was therefore diagnosed with melanoma stage T4b, N0, M0.

Nevoid melanoma, described by Schmoeckel et al.¹ in 1985, is a lesion with characteristics similar to a benign

nevus (symmetrical, dome-shaped lesion with cells that apparently mature). The main differential diagnosis is with intradermal melanocytic nevus (IDMN), and up to 50% of cases are referred for a suspected benign lesion.² Histologically, nevoid melanoma is differentiated from IDMN because IDMN does not present cytologic atypia, mitoses, pagetoid spread, lymphovascular invasion, or lack of deep maturation. Immunohistochemistry is very similar and cannot be used to differentiate between these 2 diseases. HMB-45 is positive in 80% to 86% of melanomas, but was negative in our patient. Loss of p16, as was found in our patient, correlates with aggressiveness and metastases.³

Regarding malignant lesions, nodular melanoma is a densely cellular, nodular tumor, with intense cytologic atypia, mitoses, and an absence of the radial growth phase. Signs of IDMN are almost always present in melanoma on nevus, and immunohistochemistry can help in such cases, as the expression of HMB-45 and Ki-67, which characterize the superficial region of IDMN, is lost in nevoid melanoma.

In minimal deviation melanoma, cell organization in the dermis facilitates differentiation, as the growth pattern is expansive and displaces adjacent structures, and remnants of the preexisting nevus, whether a Spitz nevus, congenital nevus, or blue nevus, almost always persist.^{3,4}

Nevoid melanoma is very rare, accounting for between 0.5%⁵ and 2.3% of cases. It is more common in men, with a mean age at presentation of 57 years, and tends to arise on the back and limbs.⁶ The largest series, with 43 patients, was published in 2015 by Idriss et al.⁷ Those authors described 2 architectural patterns (plaque and polypoid) and stated that

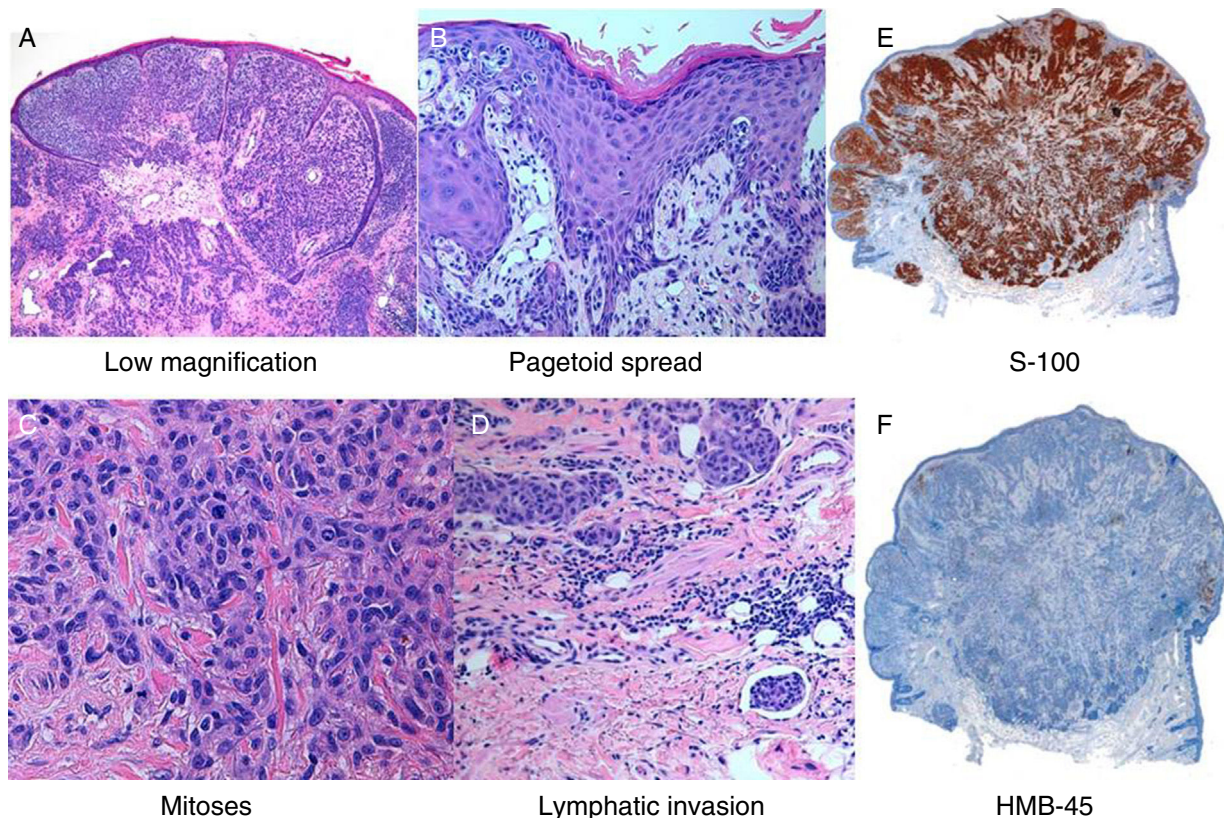


Figure 2 Histopathology.

81% of cases of nevoid melanoma presented nests arranged in a parallel theque pattern in the basal layer of the tumor, which could aid diagnosis. Genetic techniques including fluorescent in situ hybridization and comparative genomic hybridization (CGH) have been shown to be useful in the differentiation between melanoma and melanocytic nevus. In that study, CGH detected genetic changes in 7 of the 8 cases in which the test was performed.

Nevoid melanomas appear to carry a poorer prognosis than other types described in the different series, with metastasis rates of 15% to 37.5% and a mortality of between 25% and 37.5% (series by Schmoeckel et al.¹ and series by Idriss et al.⁷). In our patient, SLNB was performed despite the site being on the head and neck, which can make the technique more difficult, and, in accordance with the melanoma committee, local radiotherapy was administered.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Double Hatchet Flap For The Reconstruction Of Scalp Defects[☆]



Reconstrucción de defecto en cuero cabelludo mediante doble colgajo en hacha

To the Editor:

The scalp is a relatively common site for skin tumors. The lack of cutaneous elasticity and the high frequency of actinic damage can limit the choice of reconstruction techniques, particularly in medium-sized or large defects. One of the most widely used flaps is the double hatchet flap, which is a good option with excellent cosmetic results.

We present the case of a 62-year-old patient with a past history of hypertension and diabetes mellitus. He was referred to our outpatient clinic for a basal cell carcinoma measuring 3.4 × 3.5 cm in the right parietal region (Fig. 1A). After histological confirmation by biopsy, surgical excision under local anesthesia and sedation was scheduled.

The resulting surgical defect measured approximately 4.2 × 5.7 cm; the periosteum was intact. A bilateral hatchet flap was designed (Fig. 1B); the length of each flap was 1.5 times the diameter of the defect and the pedicle was a third of the length of the flap. Dissection was performed in the subgaleal plane (Fig. 1C), and the defect was closed by tissue planes, with placement of a drain posteriorly (Fig. 2A). The drain was removed the following day. The cosmetic result was excellent, with a minimal residual scar (Fig. 2B), and there were no signs of recurrence after a year of follow-up.

Tumors are not uncommon on the scalp, and can sometimes be large lesions that require laborious surgical techniques.

The options for reconstruction include closure by second-intention, which is possible when the periosteum is preserved.^{1,2} This is an acceptable option in small defects and in patients of advanced age or with comorbidities, although healing time is prolonged and the scar is depressed and alopecic. Another possibility is a graft, which usually achieves a poorer cosmetic result than a plasty, and leaves an area of alopecia.

Several flaps may be considered. Advancement, rotation, and transposition flaps are usually good options in defects that require special anatomical modifications. Specifically, advancement and transposition plasties are used less frequently, although they may be considered to be an option for reconstruction, depending on the size and site of the defect. The anatomical convexity makes rotation flaps and combined rotation-advancement flaps the most useful

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