**Skin Disorders**

**With Dysplastic Nevi, Pause Before You Biopsy**

**BY BETSY BATES**

Los Angeles Bureau

PORTLAND, Ore. — Dysplastic nevi, also known as nevi with architectural disorder, are “overbiopsied and overtreated” in what has become a money-making, “nevi-melanocytic industrial complex,” Dr. Terry Barrett asserted at the annual meeting of the Pacific Northwest Dermatology Society. Nevi with architectural disorder do not generally need to be excised unless severe cytologic atypia is present in a lesion that has been incompletely excised or if severe atypia extends to the margins, said Dr. Barrett, clinical professor of pathology and dermatology at the University of Texas Southwestern Medical Center in Dallas.

Confusion has reigned since 1978 when Dr. Wallace Clark first described what has become known as the dysplastic nevus, an entity clearly distinct from melanoma at one end of the spectrum and common acquired nevus at the other, he said. By 1992, a National Institutes of Health Consensus Statement tried to banish the term “atypical nevus,” preferring that clinicians and pathologists use the term “nevus with architectural disorder,” followed by a statement about the degree of cytologic atypia present.

Today, both terms are used, often with little agreement on their definitions or even what constitutes atypia, said Dr. Barrett, who is also director for the dermatopathology division of Dallas-based ProPath pathology services. “It has been a quagmire,” Physicians were confused. The general public was baffled, he said. Reported cases of patients looking for a second opinion because their dermatopathologists fought with one another. The histology formation can be gained by the knowledge that they show atypical features.

If they are biopsied, Dr. Barrett said, he believes that the degree of their atypia must be spelled out in a straightforward way and characterized as either “mild” or “severe” with an explanation of their significance attached.

His laboratory currently uses a modified version of Dr. Arthur R. Rhodes’ atypia grading system from Massachusetts General Hospital (Mod. Pathol. 1989;2:306-19), using the following definitions:

- **Mild atypia**: The nucleus is 1.5-2 times the diameter of the nucleus of the basilar keratinocyte. The nucleolus is not visible, or if visible, there is only one per cell.
- **Severe atypia**: The nucleus is more than twice the size of the nucleus of the basilar keratinocyte; there are multiple nucleoli per cell; or there is chromatin clumping or nuclear membrane notching. “It’s very simple. It’s reproducible,” Dr. Barrett said.

Excision is rarely necessary, and not justified in patients with absent or mild atypia, he asserted.

Patients should be followed up according to their degree of risk at 3- to 12-month intervals. They should be taught how to perform skin self-examination and sun protection strategies, and their blood relatives should be screened.

As always, any lesion suspected to be melanoma should be excised, and reexcision should be considered when a lesion appears to be becoming more atypical, he said.

**What to Look Out for, Clinically and Histologically**

In clinical appearance, nevi with architectural disorder tend to be macules, with or without a papule. If a papule is present, it is usually in the center of the macule. These nevi are generally symmetrical with regular, but fuzzy borders. Sharp angles and prominent notching should not be present. Color includes variations of tans and browns, but rarely black. Grey suggests regression and should not be present. Erthythema may be present. Histologically, the cellular components include lentigous junctional melanocytic proliferation, with lateral fusion of nests and shouldering, and epidermal hyperplasia with elongation of the rete ridges. The stromal reaction involves fibroblasts (concentric eosinophilic, lamellar) and inflammation. The cytologic atypia has large nuclei with variation of nuclear size, irregular nuclear membrane, variably stained chromatin, large eosinophilic nucleoli, and fine dusty melanin pigment in cytoplasm.

Source: Dr. Barrett

**First Nonmelanoma Skin Cancer May Flag Risk for Second**

**BY SHERRY BOSCHERT**

San Francisco Bureau

WINNIPEG, Man. — People who developed their first basal cell carcinoma or squamous cell carcinoma had a higher risk of developing and dying of a second primary cancer, data from a retrospective study of 43,275 patients showed. A first basal cell carcinoma quadrupled the relative risk for melanoma in men, tripled the risk for melanoma in women, and raised women’s risk for lip cancer fivefold. Men with a first primary squamous cell cancer had nine times the risk for salivary gland cancer, compared with men without the first cancer, Dr. Marni C. Wiseman said.

Death from esophageal cancer was seven times more likely in men and five times more likely in women if they’d had a first primary nonmelanoma skin cancer. A first squamous cell cancer increased the risk of death from Hodgkin’s lymphoma in men, death from genitourinary cancer was three to four times more common in women after a first primary basal or squamous cell carcinoma, the said at the annual conference of the Canadian Derma-

**Dysplastic nevi seem to represent a marker for melanoma risk, rather than precursors to the disease.**

ology at CancerCare Manitoba. Patients in the Manitoba Cancer Registry, which recorded other cancers but excluded second nonmelanoma skin cancers, were tracked. Of the first primary nonmelanoma skin cancers, 21% were squamous cell carcinoma, 74% were basal cell carcinoma, and 5% were other nonmelanoma skin cancers. Patients in the squamous cell cancer group, 16% developed a second primary nonmelanoma skin cancer, as did 17% of patients in the basal cell carcinoma group. Combined with people who had no history of nonmelanoma skin cancer, men diagnosed between the ages of 40 and 79 years and women diagnosed between the ages of 40 and 74 years with basal or squamous cell carcinoma had a higher risk for a second primary cancer. Overall, the risk increased for only 4 years following diagnosis of the primary nonmelanoma skin cancer, except in women originally diagnosed with squamous cell carcinoma, whose risk stayed elevated. For patients diagnosed with a first primary basal or squamous cell carcinoma at a young age (under 60 years), however, the risk of a second primary cancer was permanently elevated, ranging from a relative risk of 1.67 to 1.31 depending on sex and type of first cancer. In general, the lifetime risk of developing a first primary basal cell or squamous cell carcinoma is common—14% in men and 16% in women. Dr. Wiseman said it is not known why the risk for a second primary cancer and death is increased, but it is reasonable to think that in some patients, a nonmelanoma skin cancer may be a “first glimpse” of overall cancer-prone status.