INTRODUCTION

Lentigo maligna (LM) is used by clinicians and pathologists for melanoma “in situ”, confined to the epidermis, and lentigo maligna melanoma (LMM) when invades the dermis, there where invasion and metastasis are possible.(1) They represent a subclass of melanocytic malignancies (World Health Organization criteria).(2) They often present with a prolonged phase of slow growth but once invasion has occurred, the prognostic features are identical to all other melanomas. These lesions occur primarily on sun damaged skin, especially in the elderly (mean age 67 years), especially in women, on the head and neck where they evolve from areas of pigmented melanotic lesions (neoplasm confined to radial growth phase was proven staining to the more typical features identifiable with malignant melanomas and 10-26% of melanomas of the head and neck. Objectives: histopathological profile analysis, with emphasis on histopathological prognostic markers. They were studied the associations between histopathological markers. Method: Analysis of 28 histopathological reports having diagnosis of LMM/LMM from the archive of the Pathology Department - Colentina Clinical Hospital in Bucharest (from 2003 to 2013). Statistical analysis of data was done with SPSS 19.0. Graphs were made with Tableau 8.2. Results: In the study, there are 20 women and 8 men with a mean age of 66 years; 24 lesions are to the head; pT stages is as follows - pT is-7 cases, pT1-14 cases pT2 - 1 case and pT 3 and 4, 2 cases each. Mean tumour thickness is 1.03mm; The mitotic index is greater than 6 mitoses / HPF in two cases. Conclusions: 20/28 cases are diagnosed in early stages, curable surgically. Demographics such as age and female preponderance are similar to those described in the literature. Healthcare Provider organisations criteria). They often present with a prolonged phase of slow growth but once invasion has occurred, the prognostic features are identical to all other melanomas. These lesions occur primarily on sun damaged skin, especially in the elderly (mean age 67 years), especially in women, on the head and neck where they evolve from areas of pigmented melanotic lesions (neoplasm confined to radial growth phase was proven staining to the more typical features identifiable with malignant melanomas and 10-26% of melanomas of the head and neck. Objectives: histopathological profile analysis, with emphasis on histopathological prognostic markers. They were studied the associations between histopathological markers. Method: Analysis of 28 histopathological reports having diagnosis of LMM/LMM from the archive of the Pathology Department - Colentina Clinical Hospital in Bucharest (from 2003 to 2013). Statistical analysis of data was done with SPSS 19.0. Graphs were made with Tableau 8.2. Results: In the study, there are 20 women and 8 men with a mean age of 66 years; 24 lesions are to the head; pT stages is as follows - pT is-7 cases, pT1-14 cases pT2 - 1 case and pT 3 and 4, 2 cases each. Mean tumour thickness is 1.03mm; The mitotic index is greater than 6 mitoses / HPF in two cases. Conclusions: 20/28 cases are diagnosed in early stages, curable surgically. Demographics such as age and female preponderance are similar to those described in the literature.

PURPOSE

The aim of the study is to present our experience in analysing histopathological data, especially the prognostic variables of patients with LM/ LMM attending a reference level), tumoral thickness (Breslow depth) (4), regression (neoplasm confined to radial growth phase was proven incapable of generating metastatic events unless regression is seen (5), perivascular invasion, location (melanoma of the head and axial skeleton have a worse prognosis than do extremity based lesions), gender (women have a better prognosis than men in some but not all studies (6), age of 60, more than 6 mitoses /HPF. Ulceration not attributable to trauma, irrespective of the diameter of ulcer, represents an independent factor associated with a worse prognosis that is well consolidated in the literature.(7) Spindle cell vertical growth is usually seen in LMM; The presence of tumour infiltrating lymphocytes is a significant favourable prognostic factor, being proportional with surviving.(8) The presence of plasma cells and macrophages has been suggested to impact prognostic as well.(9)
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pathology department service in Bucharest, statistical data that could be useful as a basis for further studies and disease prevention in the region. A further aim was to identify the association of histopathological factors. Our data do not include recurrence and surviving analysis.

methods

This is a retrospective study of LM/ LMM patients diagnosed between 2003 and 2013. It is a monocentric study performed in Bucharest, Colentina Clinical Hospital, Pathology Department and was approved by the ethics review board. All pathology laboratory reports in the archive were studied and are included in this study all of them having diagnosis LM/LMM. Other medical documents were not available in order to achieve clinical data. The statistical analysis was performed using SPSS 19.0 and the graphics were realised using Tableau 8.2. The correlation between the categorical variables were studied with Pearson chi-square test or Fisher’s exact test and Gamma and correlation between the categorical variables were studied with a p value of less than 0.05 to be statistically significant. Data collected were patient characteristics (age, gender, tumour location, the clinical diagnosis and description of the lesion), surgical outcomes (clear surgical margins- depth and lateral), tumour stadialisation- Clark level, pT level, Breslow thickness and ulcerations).

Results

A total of 28 cases of LM/LMM were observed. There are 20 women and 8 men in our study. The mean age of onset is 66 years (Min.37 vs. Max 87). With regard to the topography, 24 lesions are located on the head (specifically to the cheek in both gender), 2 on the trunk and 2 on the limbs. Clark level distribution is: I- 12 cases; II- 8 cases; III-2 cases; IV- 5 cases; V- 1 case (figura nr. 1). The mean Breslow thickness is 1,03mm (mean depth for women being 1,34mm vs men 0,256). The mitotic index is less than 1/HPF in 9 cases, between 1-6 mitoses in 6b cases and more than 6 mitoses/ HPF in 2 cases. Mean size lesions is 1,59cm (median 1,5 cm, std dev=0,722; min= 0,3; max=3). Metastases and lymphadenopathy are not assessed so, a TNM staging is not complete. It is used a pT staging- pT is-7 cases, pT1-14 cases, pT2- 1 case and pT 3 and 4, 2 cases each. The presence of ulceration was identified in only 5/28 cases being in pT stadium 1b (1 case), 2b (1 case), 3b (1 case), 4b (2 cases). In all cases, the depth margins are free of invasion; ¾ of lateral margins are invaded (mean=1,82; median=0,45; std.dev=2,6; min=0,0; max=9,25); in one case the invasion could not be assessed because of artefacts.

Discussions

In Romania, official data about LM/LMM are scarce. Data from publications, in general, provide information about superficial spreading and acral lentiginos melanoma with less data on LM/LMM.(10) Given these considerations, one should not be surprised about low number of cases in this study. Another explanation for this is the known data that this type of melanoma is very common for I and II Fitzpatrick skin phenotype, while in Romania the majority is of type III. Epidemiological data identified in this study, as age of onset- the sixth decade and female preponderance are similar with those published.(11) It is remarkable that the older persons have wider and thicker lesions due to decreased immunity with ageing (10), but not proven statistically significant in our study (figure no. 2). Even if in our study there are more women with cheek located lesions, statistically this is not significant (p= 4,729) the association between location and gender. Association between Clark level and Breslow thickness is important but not statistically significant (figure no. 3) Admitting the UV radiation to be the most important risk factor for the lesion (12) and knowing that the nose is the most exposed part of the face, maybe other aspects should be considered as variation of anatomic structures. The mitotic index is greater than 6 mitoses/ HPF (high power field) in only 2 cases. The limit of 0,6 cm used for malignancy assessment of a melanocytic lesion is confirmed in all cases, except one. Predetermined margins can be inadequate because of subclinical spread, or can affect function when margins are adjacent to the eye or mouth.
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REFERENCES