

Frequently Asked Questions, with Dr Robert West

Q: Why does melanoma look different on the face compared to other body sites?

A: Facial skin lacks the classic dermal papillae seen elsewhere, so the typical reticular pigment network is absent. Instead, pigmentation appears as a pseudo-network around hair follicles, which alters the dermoscopic pattern and requires site-specific interpretation.

Q: What dermoscopic features should raise suspicion for melanoma?

A: Concerning features include:

- Multiple colors (brown, black, gray, blue, pink, white)
- Asymmetry
- Atypical or disrupted network
- Blue-white veil
- Shiny white lines
- Peripheral streaking
- Structural chaos

The greater the number of colors and architectural disorder, the higher the index of suspicion.

Q: What is meant by “regression” in melanoma?

A: Regression refers to immune-mediated destruction of melanoma cells. Dermoscopically, this appears as white scar-like areas or blue-gray granularity. On the face, regression can be difficult to interpret due to background sun damage.

Q: How does regression differ in benign nevi?

A: In benign lesions:

- Regression is typically symmetrical
- Blue-gray areas are fine and evenly distributed
- The overall structure of the nevus is preserved
- There are no melanoma-specific features

Symmetry remains a key discriminator.

Q: What is a halo nevus, and how does it differ from melanoma with regression?

A: A halo nevus is a benign mole surrounded by uniform depigmentation caused by immune-mediated melanocyte destruction. Unlike melanoma regression, halo nevi are symmetrical and lack chaotic dermoscopic features.

Q: What is lichen planus-like keratosis (LPLK), and why does it cause diagnostic difficulty?

A: LPLK represents an inflamed, regressing lesion (often a solar lentigo or seborrheic keratosis). It can display:

- Diffuse coarse gray granules
- Pink and white background
- Milia-like cysts

Inflammation may mimic regression seen in melanoma, particularly on sun-damaged skin.

Q: What dermoscopic features suggest lentigo maligna?

A: Key clues include:

- Pigment between follicles
- Rhomboidal or angulated lines
- Annular-granular pattern
- Asymmetrical follicular pigmentation

These reflect atypical melanocyte proliferation extending along follicular epithelium.

Q: Why can LPLK be confused with lentigo maligna?

A: Both may show grey granularity and facial involvement. However, lentigo maligna typically demonstrates specific follicular features and angulated lines, whereas LPLK tends to show more diffuse inflammatory change.

Q: How can pigmented actinic keratosis mimic lentigo maligna?

A: Pigmented actinic keratosis may show gray granules and follicular accentuation. The presence of scale, wider white follicular openings, and surface keratin can assist differentiation, though biopsy is often required when uncertainty persists.

Q: What is a collision lesion?

A: A collision lesion occurs when two distinct lesions coexist in close proximity or overlap. The most common benign partner is seborrheic keratosis. The clinical risk is anchoring on the benign component and overlooking a malignant focus.

Q: If part of a lesion looks like seborrheic keratosis, can melanoma still be present?

A: Yes. A benign-appearing seborrheic keratosis does not exclude an adjacent or underlying melanoma. Any atypical area within a lesion should be sampled.

Q: How should new blue lesions be approached?

A: Classic, longstanding blue nevi in younger patients may be monitored. However, any new blue nodule in a middle-aged or older patient warrants biopsy to exclude cutaneous metastatic melanoma.

Q: Why is past melanoma history so important when assessing new lesions?

A: A new pigmented or nodular lesion in a patient with previous melanoma significantly increases the likelihood of metastasis. Even benign-appearing dermoscopy does not override this clinical context.

Q: What vascular patterns are concerning for melanoma?

A: Suspicious patterns include:

- Polymorphous vessels
- Corkscrew vessels
- Vessels of varying caliber
- Deeper, out-of-focus vessels

Vascular chaos should prompt biopsy.

Q: What is the “priest in the snow” pattern?

A: This describes a dark central lesion surrounded by white regression. The white background represents regressed tumor, and the darker focus may represent residual melanoma. It is a pattern that should not be ignored.

Q: Can melanoma partially regress or appear to improve?

A: Yes. Some melanomas shrink or lighten due to regression. Clinical improvement does not imply benignity. Any lesion with concerning features should still be biopsied.

Q: How useful is serial digital dermoscopy imaging?

A: Serial imaging is highly valuable, particularly when biopsy is deferred. Subtle evolution in grey granularity, asymmetry, or spread may only become apparent on comparison and can alter management decisions.

Q: What biopsy techniques are appropriate for suspicious facial lesions?

A: For thin or in situ-appearing lesions, a deep shave into the papillary dermis is generally appropriate. Punch or excisional biopsy may be preferred depending on lesion size, location, and suspicion of invasion.

Q: How should “atypical melanocytic proliferation with regression” be managed?

A: This terminology reflects diagnostic uncertainty. In most cases, complete excision with appropriate margins is recommended to ensure melanoma is not missed.

Q: When should referral be considered?

A: Referral is appropriate when:

- The lesion is large or cosmetically complex
- Histopathology is equivocal
- There is extensive regression
- Invasive or metastatic disease is suspected
- There is clinical uncertainty

Early referral is a sign of sound clinical judgment, not failure.

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