Small cell malignant melanoma: a variant of naevoid melanoma. Clinicopathological features and histological differential diagnosis

K Blessing, J J H Grant, D S A Sanders, M M Kennedy, A Husain, P Coburn

Abstract

Aims—To describe the clinical and histopathological features of a rare variant of naevoid melanoma, small cell melanoma, and discuss the histological differential diagnoses.

Methods—The clinical and histological features of cases of malignant melanoma with the histological features of small (non-Merkel like) melanoma were reviewed and documented. In addition, five cases had available material for immunohistochemistry and this was performed using antibodies to the S100 protein and melan-A, and the HMB-45 antibody.

Results—There were 15 cases of small cell melanoma from 14 (10 female, four male) patients, aged between 30 and 77 (mean, 48.6) years. The trunk was the most common location. In more than half the cases, the provisional diagnosis was melanoma/borderline lesion. All shared similar histological appearances of an intraepidermal component of in situ melanoma and a dermal component of nests of cells with hyperchromatic nuclei and scanty cytoplasm, usually in tightly packed nests. All components (junctional and intradermal) of the lesions investigated by immunohistochemistry were positive both for S100 protein and melan-A. All junctional components were positive with HMB-45, but with variable staining of the dermal components with this antibody.

Conclusions—Small cell malignant melanoma is postulated to be a distinct histopathological entity and a rare variant of naevoid melanoma. Such lesions can be difficult to interpret and easily missed at scanning magnification because the cells of the dermal component mimic benign naevus cells.

Keywords: malignant melanoma; naevoid melanoma; small cell melanoma

Malignant melanoma is renowned for its heterogeneous histological appearance, including mimicking other malignant tumours and benign melanocytic lesions. Those malignant melanomas that mimic benign melanocytic lesions are now recognised as uncommon variants that one should be aware of overlooking in daily practice (table 1).1–12 Most could be termed naevoid (naevocytic) melanomas. They are uncommon and pose difficulties in diagnosis. We would like to add another rare variant of naevoid melanoma, called small cell melanoma, where the constituent cells are small melanoma cells. These cells resemble those frequently seen at the base of conventional melanoma. There have been several references to small cell melanoma but almost all refer to a highly malignant tumour composed of small, undifferentiated cells with a high mitotic rate, and mostly occurring in non-cutaneous sites. These small cell melanomas are Merkel cell like.13–14 There is, however, a small cell melanoma variant that is poorly described in the literature and which like the other variants listed in table 1 could easily be misdiagnosed either as a benign naevus or in situ melanoma.15 Our study describes the clinical and histological features of this entity and discusses its relation to naevoid and minimal deviation melanoma, and other potential differential diagnoses.

Patients and methods

The cases were from personal collections, including referred cases, of two authors (KB and DSAS). The criteria (table 2) were discussed with all the histopathologists in the study and based on the published criteria used in discriminating small melanoma cells and naevoid cells in conventional melanomas (fig 1).16–20 The haematoxylin and eosin stained sections were available for review in all cases. In addition, the blocks were available in five cases for immunohistochemical staining with antibodies to the S100 protein (Dako; 1/350 dilution) and melan-A

Table 1 Malignant melanomas that mimic benign melanocytic lesions (naevoid melanomas)

<table>
<thead>
<tr>
<th>Naevoid melanoma</th>
<th>Spitzoid melanoma</th>
<th>Regressed melanoma</th>
<th>Melanoma in stasis skin</th>
<th>Verrucocytic melanoma</th>
<th>Small cell melanoma</th>
</tr>
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</table>

Table 2 Histological criteria for the diagnosis of small cell melanoma

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Notes</th>
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<tbody>
<tr>
<td>(1)</td>
<td>An obvious intraepidermal component recognisable at low power in situ melanoma</td>
</tr>
<tr>
<td>(2)</td>
<td>An intradermal component composed entirely of small dark cells mimicking benign naevus cells, usually lying in tightly packed nests</td>
</tr>
<tr>
<td>(3)</td>
<td>The dermal nests composed of cells with hyperchromatic, slightly pleomorphic nuclei and scanty cytoplasm. There may be occasional prominent nuclei</td>
</tr>
<tr>
<td>(4)</td>
<td>A stromal response of proliferation of small blood vessels between the dermal nests and a variable lymphocytic infiltrate</td>
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</tbody>
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Novocastra; 1/10 dilution), and the HMB-45 antibody (Dako; 1/50 dilution). Anti-melan-A and HMB-45 required antigen retrieval by high temperature unmasking.

The clinical features documented were patient age, patient sex, anatomical location of the lesion, lesion size, and follow up. These were obtained from request forms and case notes where possible. Histologically, the Breslow depth, Clark level, histogenetic type, pre-existing melanocytic lesion, mitotic count, lymphocytic infiltrate (scored as, +, ++, and +++), and vascular response (scored as +, ++, and ++++) were assessed.

Results

There were 15 lesions identified from 14 (10 female and four male) patients, aged between 30 and 77 (mean, 48.6) years. Eight patients were aged 50 years or over. Seven lesions were from the trunk, three from the upper limb, and five from the lower limb. No lesion was from an acral or genital site. All lesions were cutaneous in origin. The lesions measured 4–12 (mean, 7.0) mm. One patient was described as having “multiple moles”, one patient clinically had the atypical mole syndrome (dysplastic naevus syndrome), and another patient developed two lesions at different sites and on separate occasions. These last two lesions were felt not to be metastases and to be two independent lesions. Four lesions were submitted as probable melanomas, three with a history of borderline lesion/melanoma, two as probable dysplastic naevi, two as dysplastic naevi/other, two were accompanied with a history of mole with recent change, and two lesions had no accompanying history.

Initially, three lesions had been called benign naevi (one lentiginous compound naevus, one compound naevus with atypia, and one just naevus); another one had been reported as in situ melanoma. On review, all were regarded as malignant melanoma (of the small cell type). The intraepidermal component was in situ melanoma either recapitulating superficial spreading melanoma or having a lentiginous pattern in non-atrophic skin (figs 2–5). On high power examination, the dermal nests were composed of cells with hyperchromatic nuclei, exhibiting mild to moderate nuclear pleomorphism, and scanty cytoplasm. These nests lacked maturation at the base of the lesion. Many of the nests showed an expansile growth pattern, with the outer rim of nuclei being...
Small cell malignant melanoma

There is increasing recognition of melanoma variants and we believe that small cell melanomas is an important, but uncommon, variant that could easily be dismissed as a benign naevus or an in situ melanoma because the dermal nests can mimic a benign naevus at scanning power. Unlike other naevoid melanomas, the constituent cells are small melanoma cells that are frequently seen at the base of otherwise conventional melanomas. This has been called apparent maturation\textsuperscript{11} or pseudonaevoid phenomenon,\textsuperscript{9} and describes the melanoma cells deep within a lesion that become smaller but retain nuclear atypia, hyperchromasia, prominent nucleoli, and a large nuclear to cytoplasmic ratio.\textsuperscript{11} These areas within conventional melanomas can cause problems of differentiating pre-existing naevus cells from small melanoma cells. Features cited as favouring melanoma include cells with hyperchromatic nuclei, prominent nucleoli, nuclei more than 10 \(\mu\)m in diameter, newly formed blood vessels, a lymphocytic infiltrate, and pronounced fibrosis.\textsuperscript{16–20} Mitotic figures obviously favour a diagnosis of melanoma, but Maize \textit{et al} state that they are seldom present.\textsuperscript{15} Elder and Murphy emphasise the need for careful evaluation of the epidermal component, and suggest that mitoses in the dermis although helpful are not necessary for the diagnosis.\textsuperscript{25}

One major problem with acceptance of the concept of melanomas of the small cell type as being malignant is that the constituent cells are small, and exhibit only mild cytological abnormalities. In addition, there have been no metastases from this series. The differential diagnosis must therefore include “atypical naevi” (dysplastic naevi) or in situ melanoma with atypical dermal nests. However, the existence of the former group of lesions is also extremely contentious.\textsuperscript{23–25} As with tumours in other organs, malignancy in melanocytic lesions can only be proved if metastasis occurs and, therefore, virtually all the evidence is indirect. The first line of evidence is the clinical features: the age of the patients, the size of the lesions, and the presenting history. Naevoid melanomas are favoured in preference to naevus when the patient is 40 years or older and the lesions are \(\geq 6 \text{ mm.}\textsuperscript{20} In addition, because most of the lesions were submitted with a suspicious clinical history, it would be considered unwise to interpret a junctional component with a lentigious or pagetoid growth pattern as seen in figs 2–5 as benign. The dermal component again is contentious, but conforms to most of the accepted published criteria for small melanoma cells. Also, the nests were frequently expansile, a feature more in keeping with melanoma than naevus. As noted earlier mitoses are not required. We agree with Maize \textit{et al} that mitotic figures are rarely or almost never found in these pseudo-naevoid nests at the base of conventional melanomas.\textsuperscript{18} It may be that this small cell melanoma variant has similarities to desmoplastic melanoma: that is, a distinctive dermal growth pattern, and this could be the result of epidermally derived growth factors.

Discussion

Figure 6 High power of the dermal nests as in fig 5. The constituent cells have scanty cytoplasm, mild nuclear pleomorphism, and occasional nucleoli.

Figure 5 Small cell melanoma. Lesion from the thigh of a 56 year old woman. No clinical history was supplied. There is a lentigious proliferation of melanocytes at the junction. There is a dermal component composed of expansile nests of small cells with hyperchromatic nuclei.
There are currently no reliable immunohistochemical techniques that readily allow the distinction between benign and malignant melanocyties. The fact, however, that some of the dermal nests stained with HMB-45 is slightly supportive of our interpretation of these lesions being malignant.21,22

There have been several other descriptions of small cell melanoma, some describing sheets of small hyperchromatic cells with a high mitotic rate (Merkel cell like), usually occurring in non-cutaneous sites.13–16 In these melanomas and their metastases, immunohistochemistry was required to exclude other malignant small round cell tumours. However, we believe that the term small cell melanoma should be reserved specifically for the lesions described in our study and one other publication.17

Whether or not this and other variants of naevoid melanoma are less aggressive remains to be confirmed or refuted by larger studies. Kossard et al studied the proliferative activity and nuclear morphology in an apparently similar group of lesions with small cell morphology and compared them with conventional naevi and typical melanomas. They showed that the average numbers of argyrophilic nucleolar organiser regions in each nucleus for small cell melanoma did not differ significantly from ordinary dermal naevus, but both groups differed significantly from conventional melanomas.18 However, they were uncertain as to whether these results indicated that small cell melanoma had a better prognosis than conventional melanomas. They also did not comment on the stage of their samples, and one was 2.3 mm and could have metastatised. One report describes metastasis of small cell melanoma to the stomach, but whether or not the primary lesion fulfilled the criteria for small cell melanoma used in the study of Kossard et al and our study is unclear.4

There is confusion over the use of the term “naevoid” and in some instances minimal deviation melanoma to describe this group of small cell melanoma. Naevoid means naevus like, and therefore it is a general term and could be used to describe all the variants of melanoma listed in table 1. Some of these variants have distinct histological features, but some of the reports of naevoid melanoma contain a heterogeneous group of lesions.19 Some have the cytological features of conventional melanomas (verrucous naevoid), whereas some have an intermediate cytology (“dome shaped lesions” described by Wong et al).31 It might be that the small cell melanoma is a subgroup of these dome shaped naevoid melanomas, with the constituent cells being small melanoma cells. Therefore, it is important to group only similar lesions together to assist in assessing prognostic implications and to enable comparisons of studies to be carried out.

Some authors believe that some of the “naevoid” melanomas listed in table 1 might also be called minimal deviation or borderline melanoma. These terms are used to describe a subgroup of melanomas thought to have a less aggressive clinical course and a vertical growth phase, which have been described as having less pronounced cytological atypia than conventional melanomas.23–27 The terminology has proved difficult and confusing for most practising pathologists to grasp. The principal problems are the lack of clearly defined criteria for making the diagnosis, with the result that it may encompass a heterogeneous group with all types of lesions, possibly including benign naevi. This makes it difficult to interpret prognostic studies. Describing multiple subtypes of this minimal deviation melanoma28 has further confused the concept. In addition, whereas minimal deviation melanomas are level IV by definition, the term borderline melanomas is given to similar lesions that reach only level III. Increasingly, dermatologists and pathologists are using the term borderline lesion to describe a pigmented lesion that is severely atypical and bordering on in situ melanoma. For these reasons, although small cell melanoma might have a less aggressive behaviour, we also believe that the terms minimal deviation and small cell melanoma are not interchangeable.

In conclusion, the term small cell melanoma should be used to describe an uncommon variant of melanoma that belongs to the larger family of naevoid melanomas, all of which can mimic benign melanocytic lesions. This variant of melanoma might have a better prognosis than conventional melanomas. These lesions should be distinguished from the Merkel like small cell melanoma, which is predominantly of non-cutaneous sites. Larger studies, including analysis of growth factor production, and further assessment using newer proliferation markers, are required to confirm or refute the malignant nature of this group of lesions, and to determine the prognostic importance of making this diagnosis.


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