LETTERS TO THE EDITOR

Dermal squamo-melanocytic tumour: metastasizing or not?

Editor

We read with great interest the case report by Amerio *et al.*[1] entitled 'Metastasizing dermal squamomelanocytic tumour'. In their case, a 32-year-old woman presented with a biphenotypic dermal-based neoplasm compatible with a squamomelanocytic tumour, which was 4.3 mm in Breslow depth. A sentinel lymph node biopsy was pursued and revealed a Melan-A-positive deposit (0.54 mm) purportedly within the capsular sinus that was consistent with a micrometastasis of melanoma. Neither immunostain results for HMB-45 or Ki-67 nor cytomorphology of the cells within this lymph node deposit were described.

The dermal squamomelanocytic tumour is an exceedingly rare and unusual, dermal-based tumour comprised of malignant-appearing squamoid epithelial and melanocytic components in intimate association.[2–4] Indeed, lymph node metastasis from a squamomelanocytic tumour has not been previously reported. Thus, it is generally believed that these tumours have an indolent biological behaviour, although the follow-up on these patients is quite limited.

The authors mention in their report that the patient's squamomelanocytic tumour may have arisen within a precursor naevus. Incidental naevus cell aggregates can often be found in lymph nodes removed in patients with melanoma.[5] Nodal nevi typically have comparatively small collections of monomorphic melanocytes within the fibrous capsule of the lymph node. While the diagnosis of micrometastasis proffered by Amerio *et al.* may be appropriate in their case, we strongly urge them to provide a more detailed microscopic description of the cytomorphological features of the cells in the lymph node deposit and a high-power image demonstrating these features in the haematoxylin and eosin stained sections. This would allow for a more conclusive distinction between a melanoma micrometastasis and a nodal naevus deposit, to help further substantiate their diagnosis. Cytochemical stains, such as reticulin or trichrome, may have also been useful in demonstrating the relationship of the cells to the fibrous capsule of the lymph node. Immunohistochemical stains for HMB-45 and Ki-67 would also provide greater sensitivity in comparison with Melan-A in distinguishing micrometastatic melanoma from a benign nodal naevus, especially in the absence of a high-power figure showing the histopathological features of the cells within the lymph node.[6]

We kindly encourage the authors of this case report to provide additional histopathological and immunophenotypic evidence that can more definitively confirm that the nodal deposit in this patient is in fact a melanoma metastasis and not a nodal naevus. We emphasize this point because such reports can potentially impact the treatment decision in subsequent patients with this rare and unusual tumour.

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Metastasizing dermal squamomelanocytic tumour: more evidences

Editor

We would like to thank Dr Fullen *et al.*[1] for the opportunity to better define and further characterize the presentation of a very unusual type of biphasic tumour.[2]

In the beginning, when we found the melanocytic lesion in the lymph node, we experienced the same doubts of Dr Fullen about the correct differential diagnosis between nodal naevus and melanoma micrometastasis for two main reasons: (i) it is always a

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