Review and Updates: Dermoscopy

• New criteria in intradermal nevi:
  • Peripheral brown halo (good clue to distinguish from basal cell carcinoma).

• Recurrent nevi:
  • Pigment never extends beyond the scar!
  • Excise if not access to previous pathology report

• Amelanotic melanomas: the most difficult to diagnose!
  • Nodular injuries (usually)
  • Remants of pigment
  • Polymorphus (atypical) vessels: may be tiny!
  • Pink color in background
  • Shiny white lines

• Melanoma metastasis:
  • Six groups (blue nevus, nevus like, nevus like non-globular, angioma like, vascular, inespecific).
Review and Updates: Dermoscopy

• Dermoscopy of basal cell carcinoma and non invasive treatments:
  • If blue-gray ovoid nests: 11.9 less chance for sBCC
  • If arborizing vessels: 3.2 less chance for sBCC
  • If ulceration: 2.1 less chance for sBCC
• BCC with microerosions: imiquimod will work well
• Dermoscopic predictors of good response in actinic keratoses to IMB:
  • Positive: red pseudopattern/face
  • Negative: microerosions
• Limits and pitfalls in dermoscopy:
  • Do not take nail biopsies in children!
  • Do not use dermoscopy out of context:
    • Age, phototype, UV exposure, pregnancy, growth dynamic...

Using Dermoscopy Criteria and Patient-Related Factors for the Management of Pigmented Melanocytic Nevi

Ires Zalaudek, MD, Giovanni Docimo, MD, and Giuseppe Argenziano, MD
Review and Updates: Dermoscopy

- An integrated clinical-dermoscopic risk scoring system for the differentiation between early melanoma and atypical navi: the iDScore (Dermoscopy/Age/Site/Diameter) (2018 European Academy of Dermatology and Venerology)

- Ugly Duckling Sign as a Major Factor of Efficiency in Melanoma Detection (Intrapatient comparative)
Review and Updates: Clinical oncology: Targeting the tumour environment

- Therapeutic targeting of tumor environment:
  - Only patients with T-cells in melanoma will benefit from check-point inhibitors
  - Successful cancer treatment needs to reprogramme tumor microenvironment.
  - Some of our therapies are targeting tumor microenvironment (eg T-VEC or check-point inhibitors, Cell 2017; 171: 934-949).
  - Best results achieved with combination therapy (check-point inhibitors plus chemotherapy and/or radiotherapy).
  - Cancer vaccines will have a future (T-VEC was only the beginning!).

- CTLA-4 or PD1/PD-L1 antagonists: their direct effect on tumor cells:
  - Mouse models: BRAF/MEKi increase PD1 on melanoma cells (traversal research: PD1 inhibitors may work).
Immunosuppressed patients are more likely to have SCCs.

If more than 10 SCC (invasive):
- Usually immunosuppressed (85%)
- Local recurrence (37%)
- Nodal metastasis (26%) -> do much worse (58% deaths)

Aggressive management:
- Chemoprevention of Basal and Squamous Cell Carcinoma With a Single Course of Fluorouracil, 5%, Cream: A Randomized Clinical Trial. JAMA Dermatol 2018:
  - Randomized, double-blind, placebo-controlled
  - At least 2 keratinocyte carcinomas in the last 5 years
  - Topical 5% fluorouracil twice daily for 2-4 weeks
  - Reduction of keratinocyte carcinomas in the first year
D1T06.3D Risks and behaviour of NMSC intrasplant patients. MD Chrysalyne Schmults (Boston – United States)

- Protocol in Dana Farber Cancer Center:
  - Treatment of clear obvious dermal disease (shaving/Mohs surgery)
  - Daily sunscreen (with DNA repair enzymes?)
  - Nicotinamide 500 mg bid 6-12 months
  - Topical treatment of epidermal disease:
    - 5-FU% bid
    - Dailylight photodynamic therapy
  - Addition of acitretin: 4 month dosage uptake
    - 20 mg target dose

PD-1 Blockade with Cemiplimab in Advanced Cutaneous Squamous-Cell Carcinoma