



Greetings from the University of Pennsylvania, founded by Ben Franklin in 1740

08.15 Introduction. [Raymond Barnhill](#)
08.20 Criteria for melanocytic lesions : an introduction.
[Raymond Barnhill](#)
08.50 Immunohistochemistry for pathologists. [Klaus Busam](#)
09.20 Molecular diagnostics for pathologists. [Boris Bastian](#)
10.00 Coffee Break
10.30 MPath classification. [Raymond Barnhill](#)
10.50 AJCC 8th edition guidelines. [David Elder](#)
11.10 Sentinel lymph nodes and prognostic factors in
melanoma, [Lyn Duncan](#)
11.30 Treatment recommendations for melanocytic lesions.
[David Elder](#)
12.00 Lunch
01.00 ^{PM} Classification of melanoma for pathologists. [Boris](#)
[Bastian](#)
01.30 ^{PM} Lentigo maligna melanoma. [Klaus Busam](#)
01.50 ^{PM} Ocular conjunctival and uveal melanocytic lesions:
Clinical aspects. [Denis Malaise](#)
02.10 ^{PM} Conjunctival melanocytic lesions: Pathological
aspects. [Ian Cree](#)
02.25 ^{PM} Uveal melanoma: Pathological aspects. [Raymond](#)
[Barnhill](#)
02.40 ^{PM} Angiotropic extravascular migratory metastasis.
[Claire Lugassy](#)
03.00 ^{PM} Coffee Break
03.30 ^{PM} Case presentations
(10 cases, 10 min/case with discussion)
05.45 ^{PM} Welcome cocktail

08.10 Acquired melanocytic nevi. [David Elder](#)
08.40 Spitz nevus, atypical Spitz tumor, Spitz melanoma.
[Raymond Barnhill](#)
09.10 Blue nevus and melanoma arising in blue nevus.
[Arnaud de la Fouchardière](#)
09.40 Site-specific nevi (including scalp, breast and milk-line,
flexural, perianal). [David Elder](#)
10.00 Coffee Break
10.30 Combined melanocytic nevi: BAP1, deep penetrating,
Pigmented epithelioid melanocytoma, etc [Arnaud de la](#)
[Fouchardière](#)
10.50 Pediatric melanocytic lesions. [Raymond Barnhill](#)
11.10 Acral melanocytic nevi and melanoma. [Richard Scolyer](#)
11.40 Melanoma of unknown primary: differential diagnosis,
[Lyn Duncan](#)
12.10 Lunch
01.10 ^{PM} Nevoid melanoma. [Klaus Busam](#)
01.30 ^{PM} Desmoplastic nevi and desmoplastic melanoma.
[Klaus Busam](#)
01.50 ^{PM} Oral and genital melanocytic lesions. [Ian Cree](#)
02.10 ^{PM} Sinonasal melanoma, [Lyn Duncan](#)
02.30 ^{PM} Gene expression profiling in melanocytic lesions: an
update, [Matthew Goldberg](#)
03.00 ^{PM} Coffee Break
03.30 ^{PM} Case presentations continued

AJCC 8th Edition Guidelines.

T1a Melanoma,
Overdiagnosis of Melanoma &
Melanocytic Neoplasms with Low Malignant Potential

Paris April 2024

20 min


Disclosures

None

AJCC 8th Edition

CA CANCER J CLIN 2017;00:00-00

Melanoma Staging: Evidence-Based Changes in the American Joint Committee on Cancer Eighth Edition Cancer Staging Manual

Jeffrey E. Gershenwald, MD ^{1†}; Richard A. Scolyer, MD^{2,3†}; Kenneth R. Hess, PhD^{4†}; Vernon K. Sondak, MD⁵;
Georgina V. Long, MBBS, PhD⁶; Merrick I. Ross, MD⁷; Alexander J. Lazar, MD, PhD⁸; Mark B. Faries, MD⁹;
John M. Kirkwood, MD¹⁰; Grant A. McArthur, MD, BS, PhD¹¹; Lauren E. Haydu, PhD¹²; Alexander M. M. Eggermont, MD, PhD¹³;
Keith T. Flaherty, MD¹⁴; Charles M. Balch, MD¹⁵; John F. Thompson, MD¹⁶;
for members of the American Joint Committee on Cancer Melanoma Expert Panel and the International Melanoma Database
and Discovery Platform

Breslow thickness, ulceration and sentinel node status are key elements of staging system

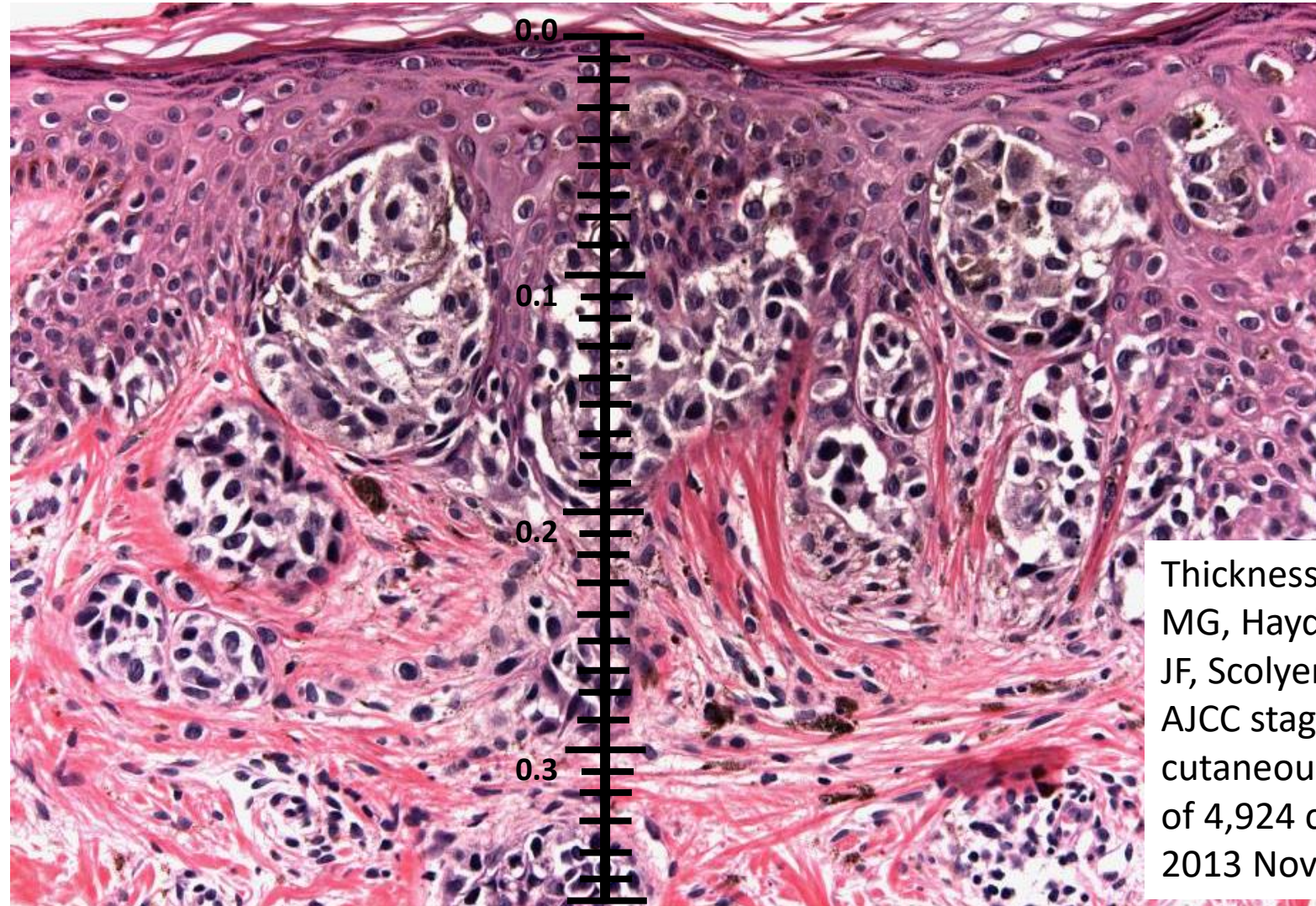
AJCC/UICC Staging Guides Therapy

- Breslow thickness is now measured to one decimal place – greater simplicity
- Cutoff of “< 0.8” (i.e. 0.7 or less) corresponds to original “Breslow number” of 0.76)
- Ulceration is a stage modifier in all T stages (T1a, T1b, T2a, T2b, etc
- Mitogenicity is no longer a stage modifier, however reporting of mitotic rate continues to be recommended
- Staging of the primary is dependent on Breslow thickness, ulceration, satellites
- Accurate staging requires SLNB

T Classification	
T1 ≤1.0mm	a. <0.8 mm without ulceration (i.e. 0.7 or less) b. <0.8 mm w/ulceration <u>or</u> 0.8-1.0 mm +/- ulceration
T2 >1.0-2.0mm (1.1-20.)	a. Without ulceration b. With ulceration
T3 >2.0-4.0mm (2.1-4.0)	a. Without ulceration b. With ulceration
T4 >4.0mm (4.1 or greater)	a. Without ulceration b. With ulceration
N and M Classification	
N1 1 node or in-transit, satellite, and/or microsatellite metastases with no tumor-involved nodes	a. Clinically occult* b. Clinically detected [†] c. Intralymphatic metastases [§] without regional lymph node disease
N2 2-3 nodes or in-transit, satellite, and/or microsatellite metastases with one tumor-involved node	a. Clinically occult* b. Clinically detected (at least 1) [†] c. Intralymphatic metastases [§] with 1 occult or clinically detected regional LN
N3 4 or more tumor-involved nodes or in-transit, satellite, and/or microsatellite metastases with two or more tumor-involved nodes, or any number of matted nodes without or with in-transit, satellite, and/or microsatellite metastases	a. ≥4 metastatic clinically occult nodes with no intralymphatic metastases b. ≥4 metastatic nodes (at least one clinically detected), or matted nodes (any number) with no intralymphatic metastases c. ≥2 clinically occult or clinically detected nodes and/or presence of matted nodes (any number) with intralymphatic metastases
M1a Distant skin, soft tissue (including muscle), and/or non-regional lymph nodes	+/- ↑LDH ^{&}
M1b Lung metastasis +/- M1a	+/- ↑LDH ^{&}
M1c Distant non-CNS visceral +/- M1a or M1b	+/- ↑LDH ^{&}
M1d Distant metastasis to CNS +/- M1a or M1b or M1c	+/- ↑LDH ^{&}
*Clinically occult tumor-involved regional lymph nodes are microscopically diagnosed after sentinel lymph node biopsy.	
[†] Clinically detected tumor-involved regional lymph nodes are defined as clinically evident nodal metastases confirmed on fine needle aspiration, biopsy, and/or therapeutic lymphadenectomy.	
[§] Intralymphatic metastases are defined by the presence of clinically apparent in-transit/satellite metastasis and/or histologically evident microsatellite metastases in the primary tumor specimen.	
^{&} Suffix: (0) LDH not elevated, (1) LDH elevated.	

Thickness measure to 1 decimal place –

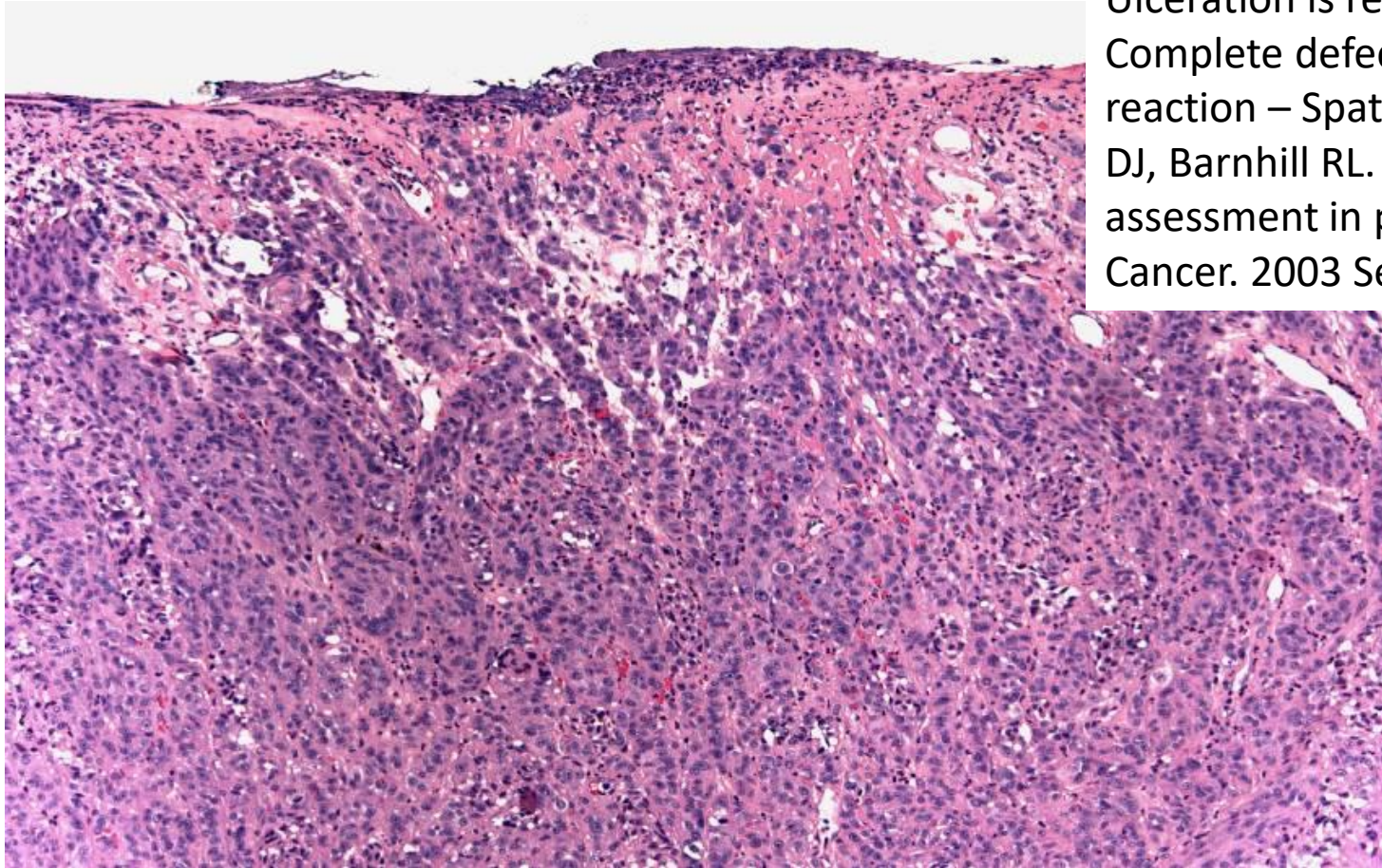
use 1/100ths or “eyeball”



0.75 rounds up to 0.8,
and so on ...

Thickness is reproducible - Niebling MG, Haydu LE, Karim RZ, Thompson JF, Scolyer RA. Reproducibility of AJCC staging parameters in primary cutaneous melanoma: an analysis of 4,924 cases. Ann Surg Oncol. 2013 Nov;20(12):3969-75.

Ulceration of a Melanoma



Ulceration is reproducible if criteria are followed – Complete defect of epithelium with a stromal/host reaction – Spatz A, Cook MG, Elder DE, Piepkorn M, Ruiter DJ, Barnhill RL. Interobserver reproducibility of ulceration assessment in primary cutaneous melanomas. Eur J Cancer. 2003 Sep;39(13):1861-5.

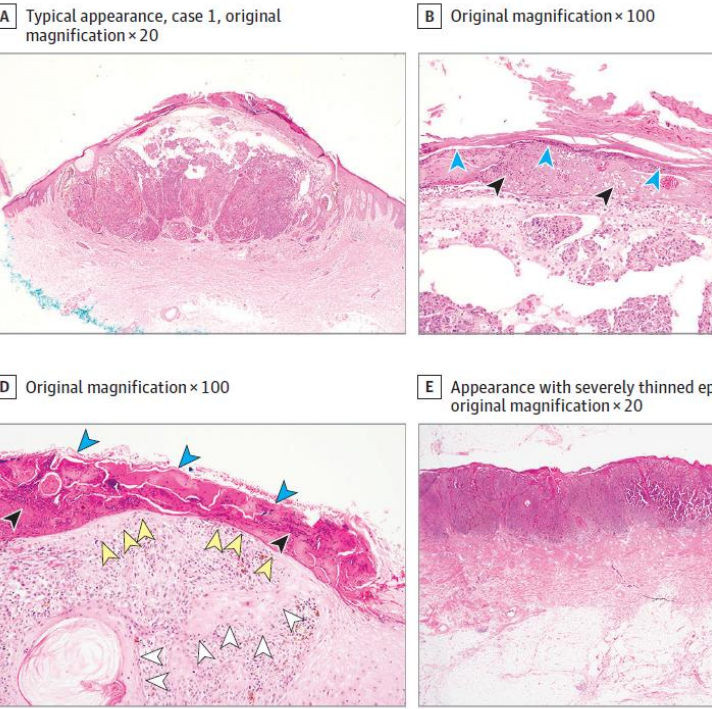
“Incipient Ulceration” recently described with intermediate survival curves – not yet standard of care but could be discussed in the pathology report

“Incipient Ulceration” is not the same as “Ulceration”

Prognostic Significance of Incipient Primary Cutaneous Melanoma

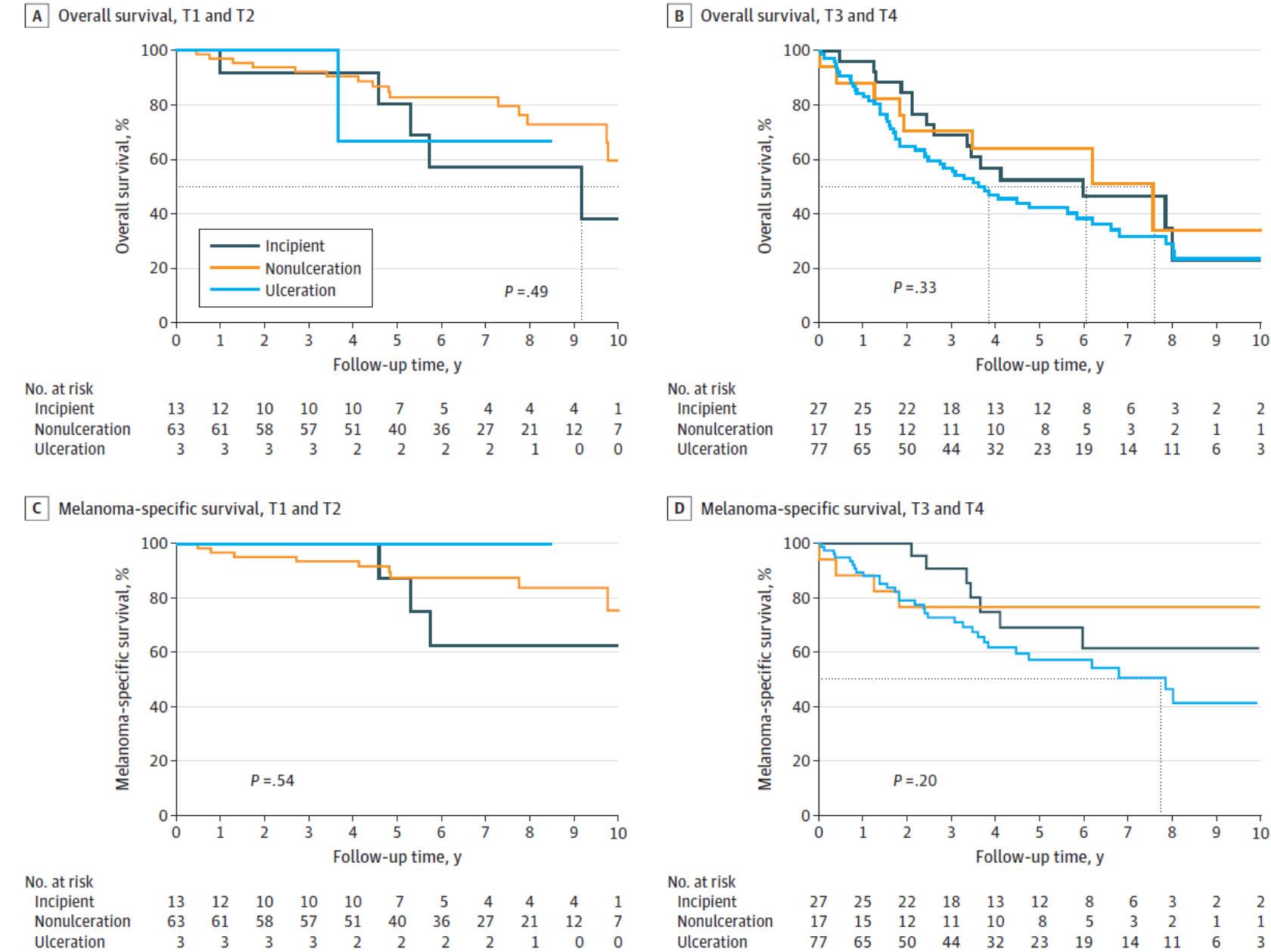
Elizabeth C Paver^{1 2 3}, Tasnia Ahmed¹, Hazel Burke¹, Ro Jonathan R Stretch^{1 4 5}, Andrew J Spillane^{1 4}, Kerwin F S David E Elder⁷, Serigne N Lo^{1 6 4}, John F Thompson^{1 4}

Figure 1. Histopathologic (Hematoxylin-Eosin Staining) Findings in 2 Typical Cases of Incipient Primary Cutaneous Melanoma

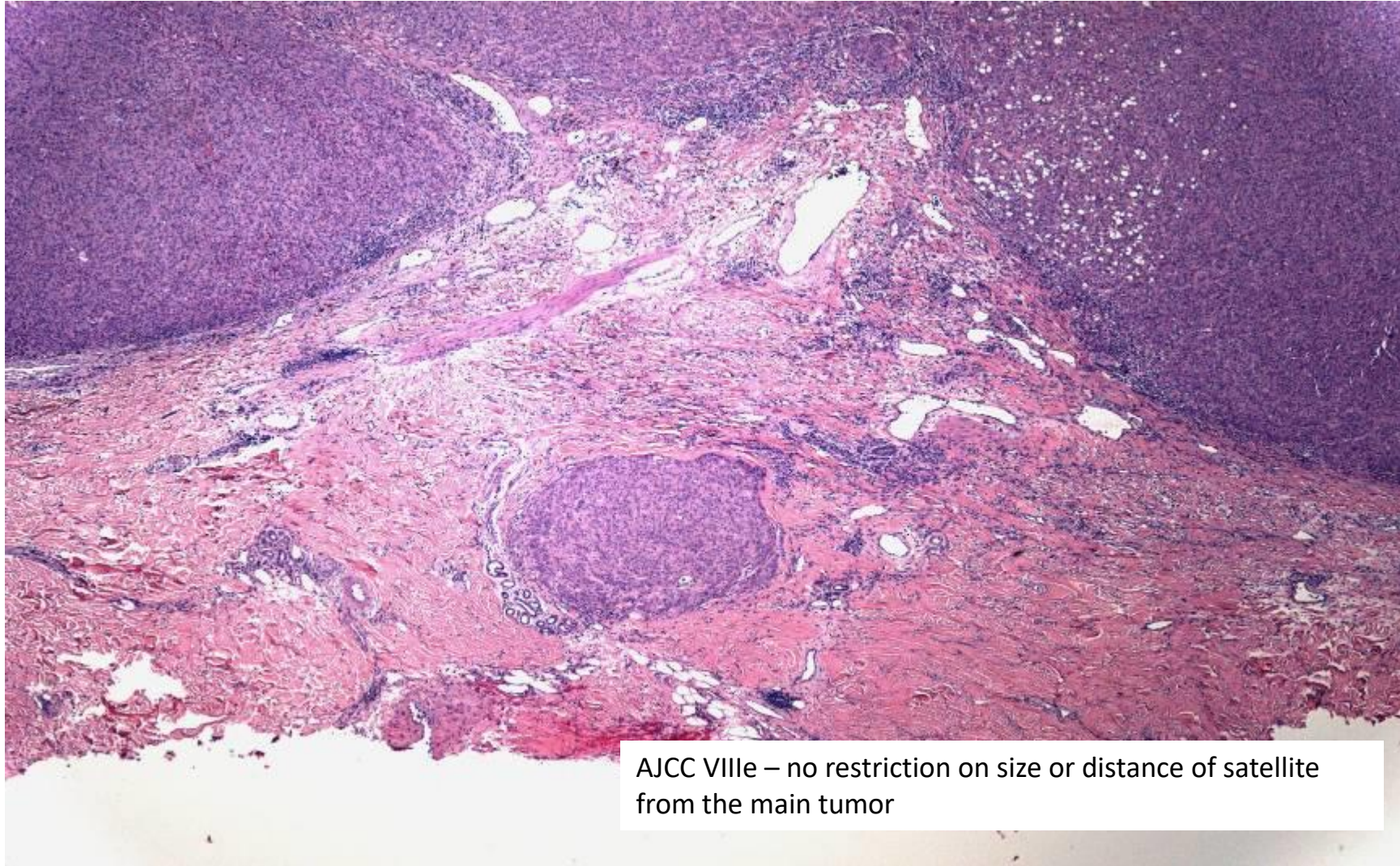


A and C, Expansile tumor nodule in the superficial dermis with a severely attenuated overlying epidermis in both cases 1 and 2. B, Higher power image of case 1 showing loss of the nucleated epidermis, with residual stratum corneum only (yellow arrowheads) and associated host response (serum with neutrophils shown by black arrowheads). D, Higher power image of case 2 showing severely thinned nucleated epidermis (yellow arrowheads) with adjacent epidermal hyperplasia (black arrowheads). E, Lower power image of case 2 showing an expansile tumor nodule in the superficial dermis with a severely attenuated overlying epidermis.

Figure 2. Overall Survival, Melanoma-Specific Survival, and Recurrence-Free Survival for Patients With Melanoma With Incipient Ulceration vs Nonulcerated and Ulcerated Control Groups, by Combined T-Stage Categories (T1 and T2 vs T3 and T4)



Satellite Beneath a Melanoma



AJCC VIII – no restriction on size or distance of satellite from the main tumor

AJCC Summary

- Staging applies to lesions diagnosed as melanoma, i.e. not to nevi
- Staging drives therapy
- AJCC Stage 1a melanoma lacks most characteristics of malignancy and might better be managed as for severely dysplastic nevi

Melanoma Diagnosis

- “The rising incidence of melanoma now exceeds the rates of increase of all other major cancers”
- But - many of these diagnoses may reflect “overdiagnosis”.
- “Overdiagnosis” is not the same as “Erroneous Diagnosis” but may (at least in part) reflect “UNCERTAINTY”

Overdiagnosis of Melanoma

Overdiagnosis MeSH Descriptor Data 2022

Details	Qualifiers	MeSH Tree Structures	Concepts
MeSH Heading	Overdiagnosis		
Tree Number(s)	E01.505 N02.421.562 N05.300.565		
Unique ID	D000088522		
RDF Unique Identifier	http://id.nlm.nih.gov/mesh/D000088522		
Scope Note	The labeling of a person with a disease or abnormal condition that would not have caused the person harm if left undiscovered, creating new diagnoses by medicalizing ordinary life experiences, or expanding existing diagnoses by lowering thresholds or widening criteria without evidence of improved outcomes. Individuals derive no clinical benefit from overdiagnosis although they may experience physical, psychological or financial harm.		
Entry Term(s)	Over-Diagnosis Pseudodisease, Over-Diagnosed Pseudodisease, Overdiagnosed		
Public MeSH Note	2022; see MEDICAL OVERUSE 2016-2021		
History Note	2022(2016)		
Date Established	2022/01/01		
Date of Entry	2021/07/09		
Revision Date	2021/05/10		

Chat GpT's Definition

- **Overdiagnosis** is the diagnosis of a medical condition that would never have caused any symptoms or problems. This kind of diagnosis can be harmful if it leads to psychological stress and unnecessary treatments. Broadly, overdiagnosis means making people patients unnecessarily, by identifying problems that were never going to cause harm or by medicalising ordinary life experiences through expanded definitions of diseases.
 - Overdiagnosis has two major causes: overdetection and overdefinition of disease.
-
- Brodersen J, Schwartz LM, Heneghan C, et al. BMJ Evidence-Based Medicine 2018;23:1–3

Overdetection of Melanoma

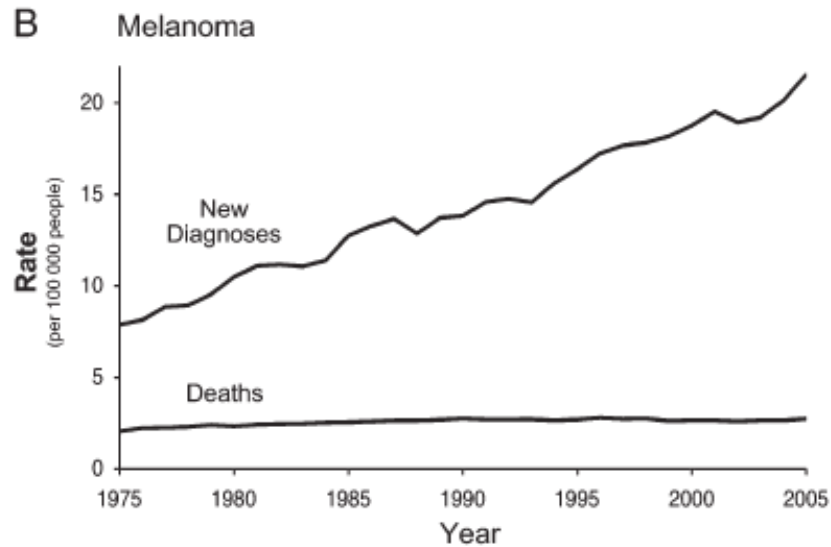
Overdiagnosis in Cancer

H. Gilbert Welch, William C. Black

... but they did not
mention Overdefinition!

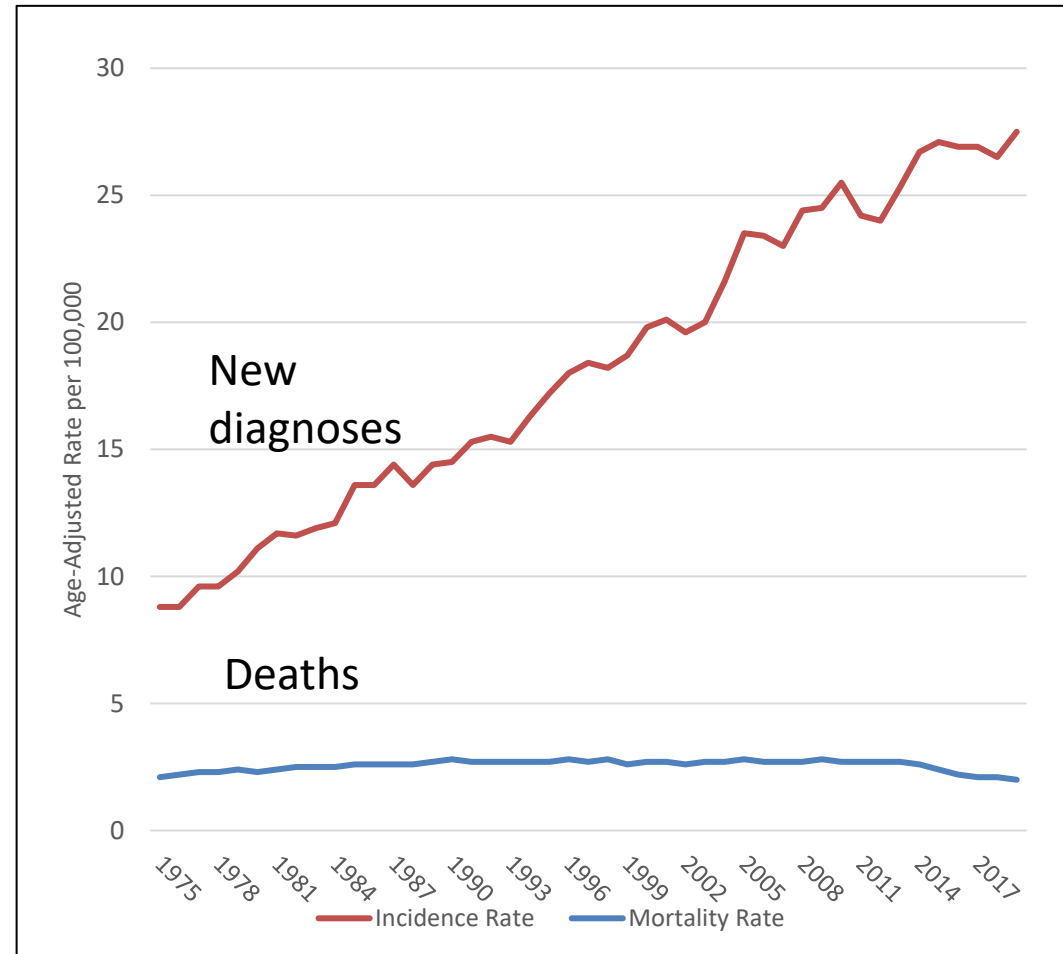
“We describe the two prerequisites for cancer overdiagnosis to occur: the existence of a silent disease reservoir and activities leading to its detection (particularly cancer screening)”.

Overdiagnosis



Welch et al, 2010

Overdiagnosis is the diagnosis as cancer of lesions that may meet current criteria but are not capable of causing symptoms (including death) in the lifetime of patients .

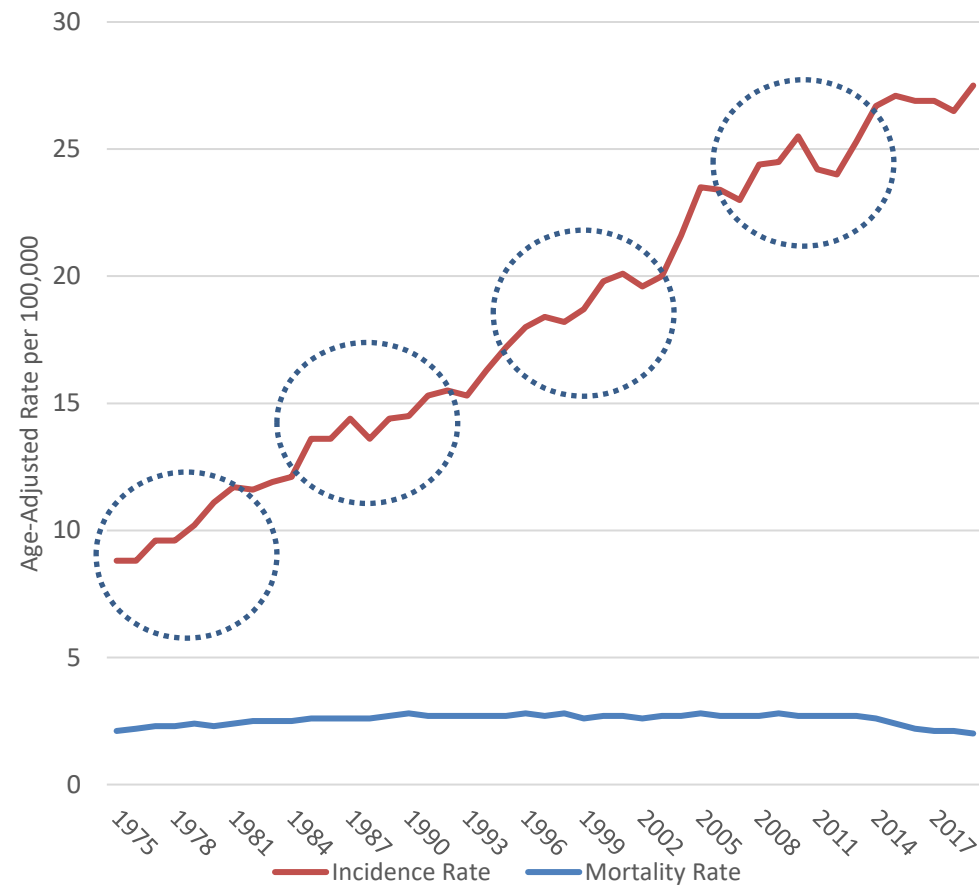


Megan Eguchi, M-
PATH Group, 2022

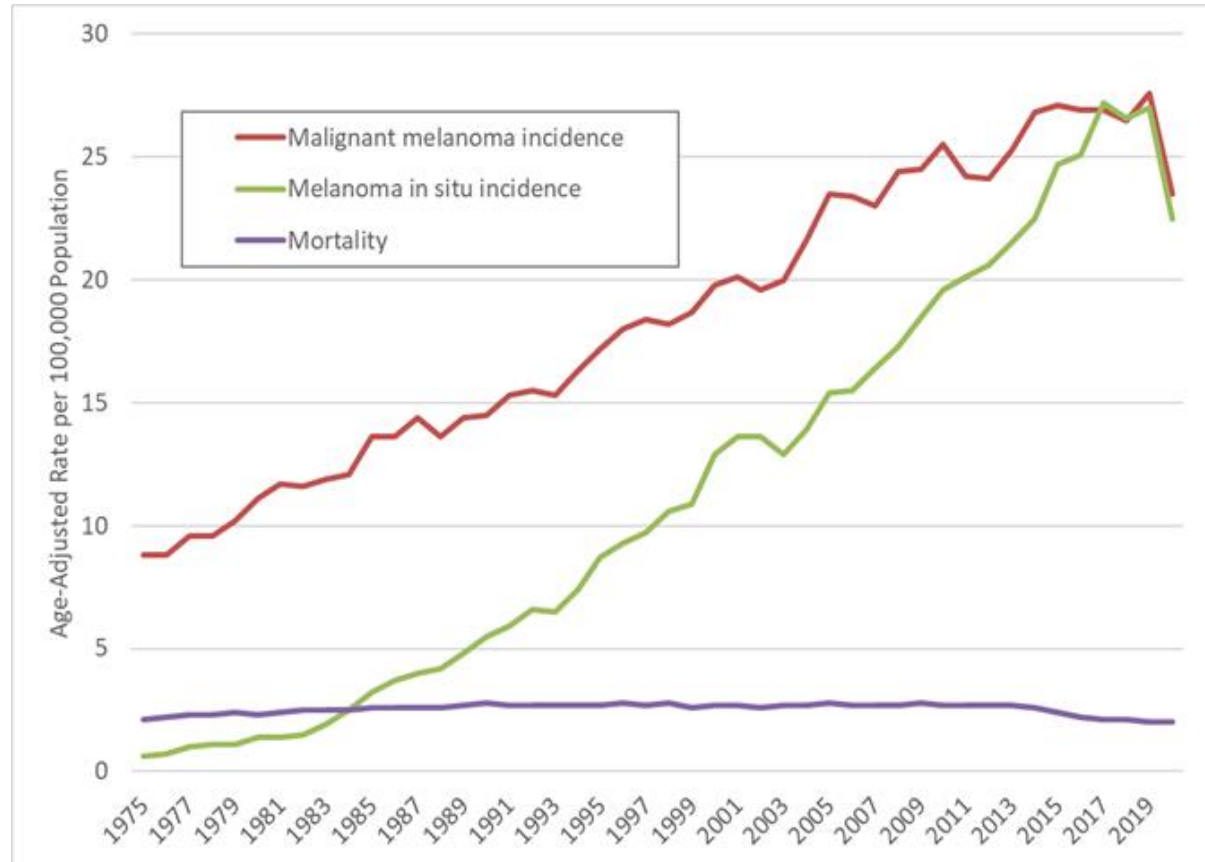
Overdiagnosis

- Can it be explained by treatment effects?

- All cases were treated by excision; therefore one might say “cured”.
- However, for every diagnosed case there must be a variable but probably large number of similar undiagnosed cases in the community.
- - a “fuzzy circle” about each point
- These should drag up the mortality curve – but we do not see this ...



In Situ Melanoma has the same trends as Invasive Melanoma



- Recent sharp fall, probably due to Covid.
- Earlier leveling off, perhaps due to primary prevention.

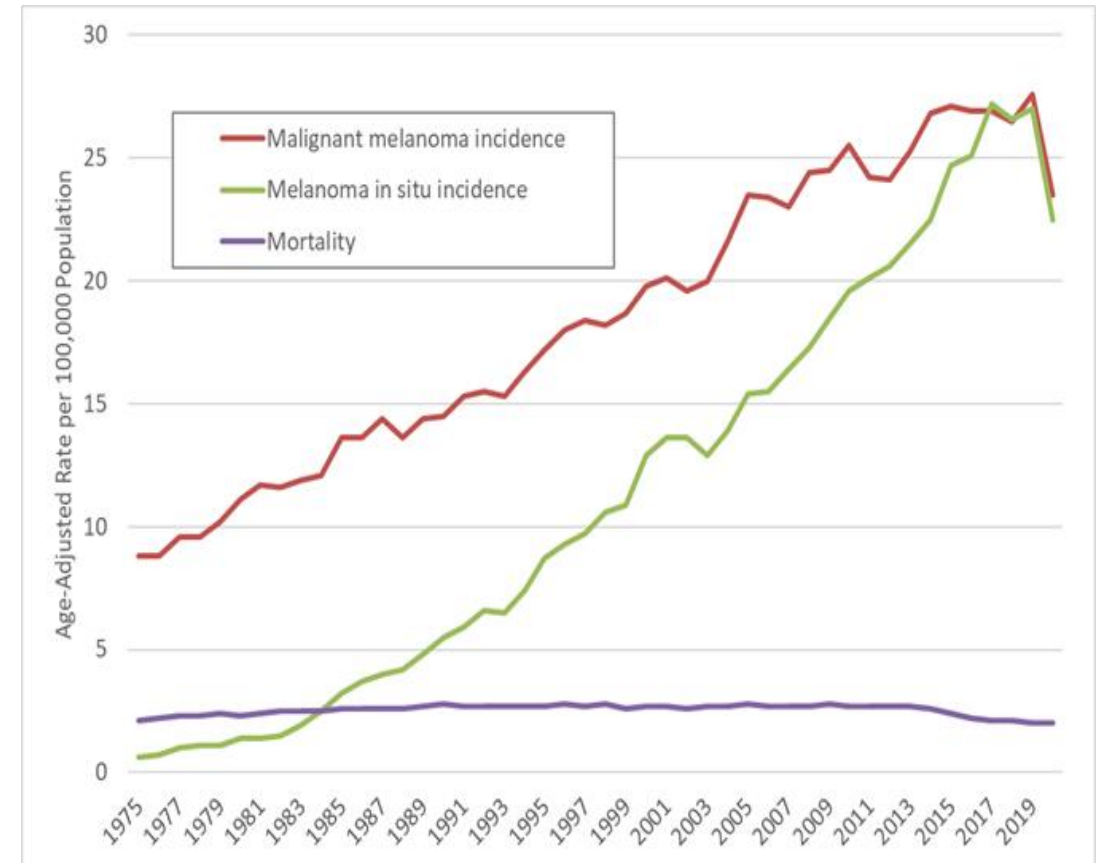
Incidence of Melanoma in Situ and Invasive Melanoma, and Mortality, SEER, 1975-2019.

Elder, Barnhill, Eguchi, et al. (In Press, Nov 2023)

Overdefinition of Melanoma

What are these Overdiagnosed Cases, Really? (If not Melanomas)

- Melanoma in Situ
- Benign albeit atypical nevi?
 - Dysplastic nevi
 - Atypical Spitz nevi
- Melanomas with a perfect prognosis? (oxymoron)
- “Slow melanomas?”
- “Pseudomelanomas?”
- ???



Eguchi, 2023 (September)

Increased diagnosis of thin superficial spreading melanomas: A 20-year study

Jason E. Frangos, MD,^a Lyn M. Duncan, MD,^b Adriano Piris, MD,^b Rosalynn M. Nazarian, MD,^b
Martin C. Mihm, Jr, MD,^d Mai P. Hoang, MD,^b Briana Gleason, MD,^c Thomas J. Flotte, MD,^f
Hugh R. Byers, MD,^g Raymond L. Barnhill, MD,^h and Alexa B. Kimball, MD, MPH^c
*Boston, Massachusetts; Sacramento, San Luis Obispo, and Los Angeles, California; and Rochester,
Minnesota*

JAAD, 2012

... a majority diagnosed melanoma in 4 of the 29 cases originally reported as dysplastic nevus with severe atypia (i.e. 14% of the nevus cases were upgraded)

- Interrater agreement over time was excellent (kappa 0.88) and fair (kappa 0.47) for cases originally diagnosed as melanoma and severely atypical dysplastic nevus, respectively.

Pathologist Characteristics Associated With Rendering Higher-Grade Diagnoses for Melanocytic Lesions

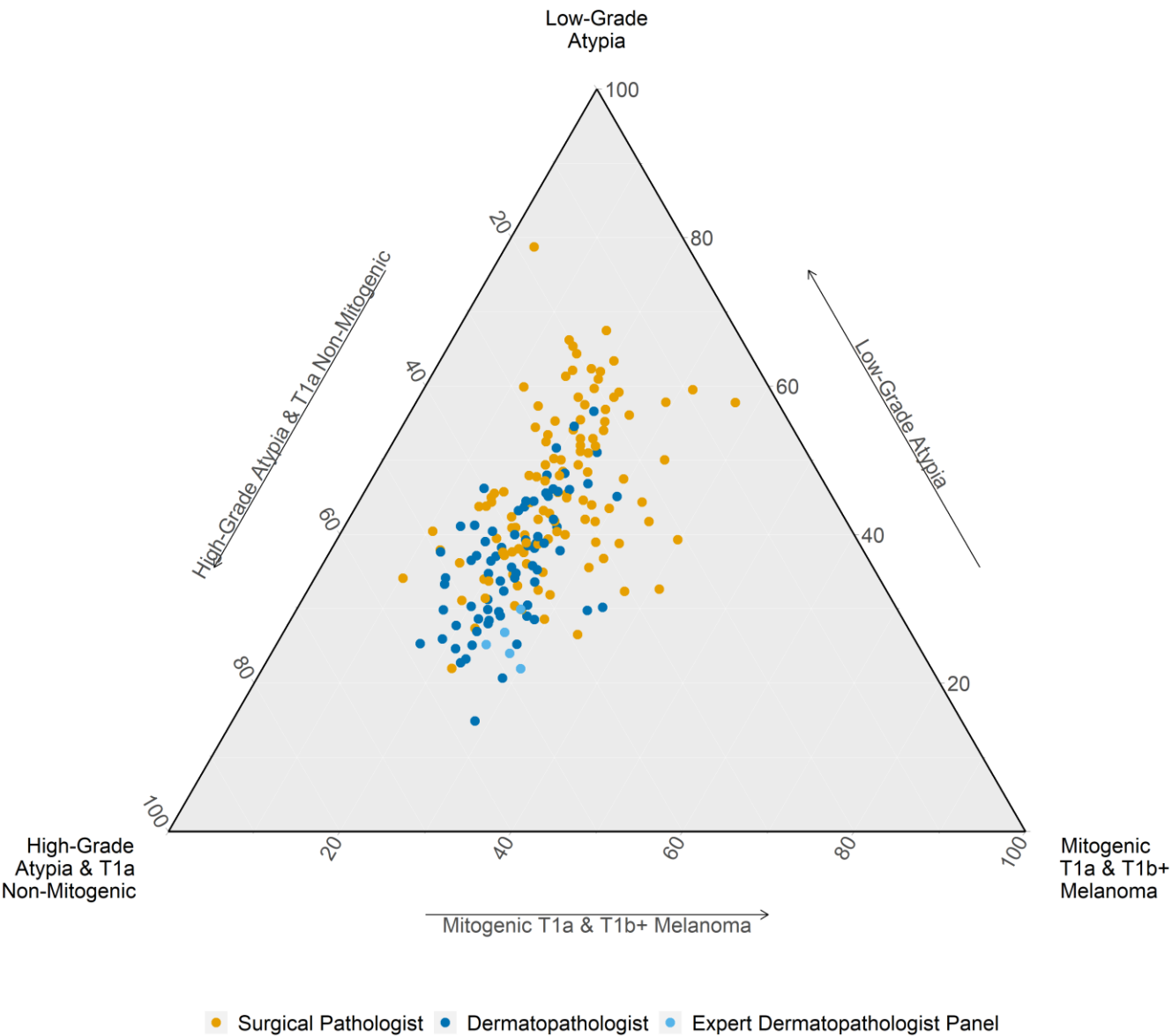
Kathleen F. Kerr, PhD; David E. Elder, MB, ChB; Michael W. Piepkorn, MD, PhD; Stevan R. Knezevich, MD, PhD; Megan M. Eguchi, MPH; Hannah L. Shucard, MS; Lisa M. Reisch, PhD; Joann G. Elmore, MD, MPH; Raymond L. Barnhill, MD

IMPORTANCE The incidence of melanoma diagnoses has been increasing in recent decades, and controlled studies have indicated high histopathologic discordance across the intermediate range of melanocytic lesions. The respective causes for these phenomena remain incompletely understood.

OBJECTIVE To identify pathologist characteristics associated with tendencies to diagnose melanocytic lesions as higher grade vs lower grade or to diagnose invasive melanoma vs any less severe diagnosis.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study used data from 2 nationwide studies (the Melanoma Pathology [M-Path] study, conducted from July 2013 to May 2016, and the Reducing Errors in Melanocytic Interpretations [REMI] study, conducted from August 2018 to March 2021) in which participating pathologists who interpreted melanocytic lesions in their clinical practices interpreted study cases in glass slide format. Each pathologist was randomly assigned to interpret a set of study cases from a repository of skin biopsy samples of melanocytic lesions; each case was independently interpreted by multiple pathologists. Data were analyzed from July 2022 to February 2023.

- Dermatopathologists compared to traditional pathologists appear to have evolved to use more sensitive criteria for melanoma, consistent with over definition and contributing to over diagnosis
- Supports reclassifying some lesions as “MNLMP” or even as nevi



Overdiagnosis due to Overdefinition

- Many lesions diagnosed as melanoma are not capable of causing death
- How to identify these?
- Known markers of low risk:
 - Lack of ulceration
 - Low or “thin” Breslow thickness
 - Clark level I or II
 - Lack of mitoses (nonmitogenic melanoma)
 - Lack of tumorigenic VGP (“nontumorigenic melanoma”)

**Highlighted attributes
are present in SEER
database after AJCC7
(introduced in 1989)**

ORIGINAL ARTICLE

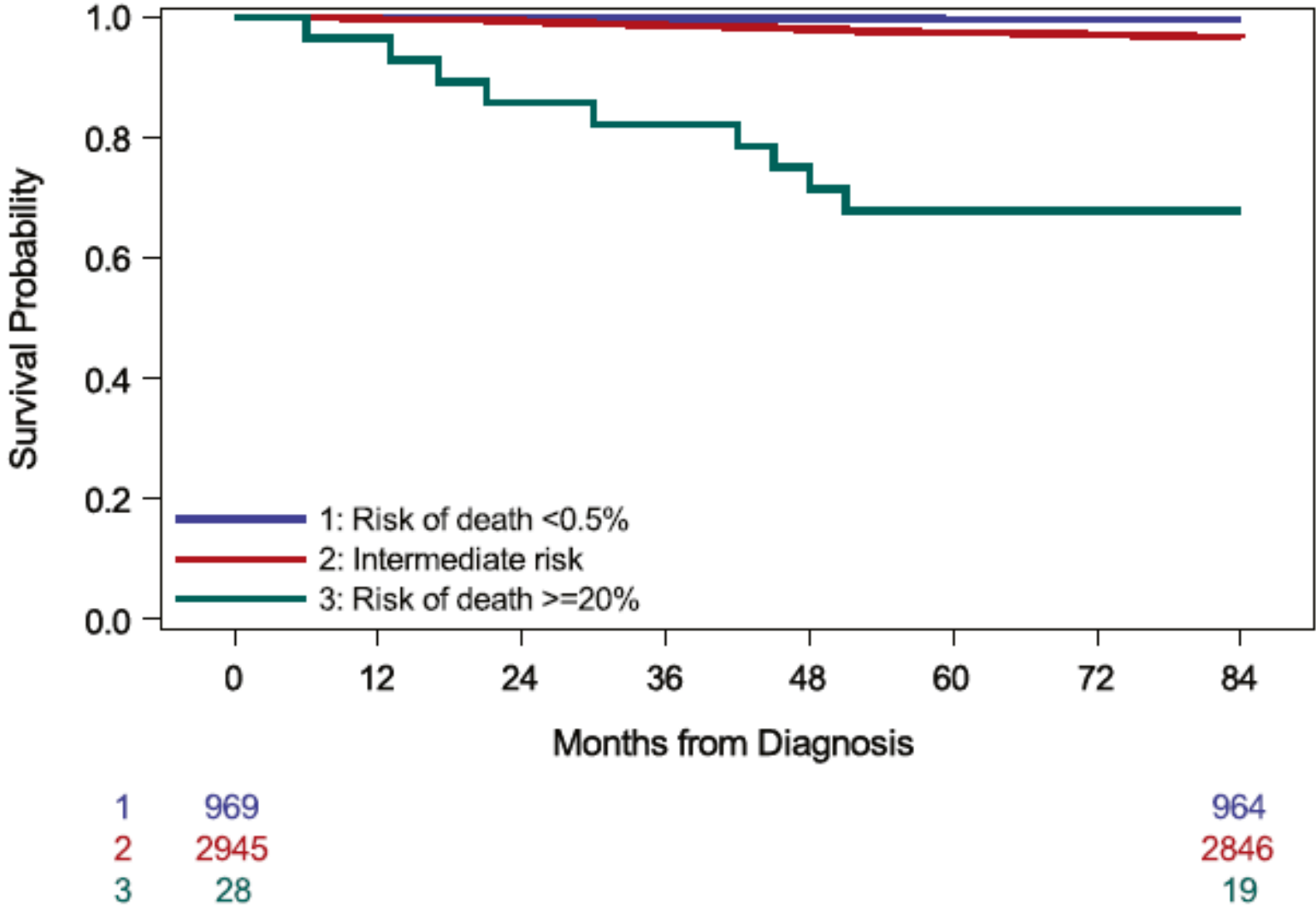
Prognostic modeling of cutaneous melanoma survival using cancer registry data identifies subsets with low melanoma mortality

Megan M. Eguchi MPH¹ | David E. Elder MB, ChB, FRCPA² |
Raymond L. Barnhill MD^{3,4} | Michael W. Piepkorn MD, PhD^{5,6} |
Stevan R. Knezevich MD, PhD⁷ | Joann G. Elmore MD, MPH¹ | K

Cancer. 2022;1–9.

Results:

- 11913 Cases all followed 7 years
- Compared to an overall 7-year mortality (from a large cancer database), a subset comprising 25% had a lower mortality
- Younger age at diagnosis and Clark level
- Breslow thickness below 0.4 mm, absence of ulceration, and female sex were also associated with lower risk
- A small subset of high-risk patients with



Conclusion: Patients with very-low risk of dying from melanoma within 7 years of diagnosis were identified. Such cases warrant further study and consensus discussion to develop classification criteria, with the potential to be categorized using an alternative term such as “**melanocytic neoplasms of low malignant potential** (or, in some cases, as “severe melanocytic dysplasia”, or even “compound nevus”)

969 Cases with T1 Clark level II melanoma, age < 43, with zero observed risk of death

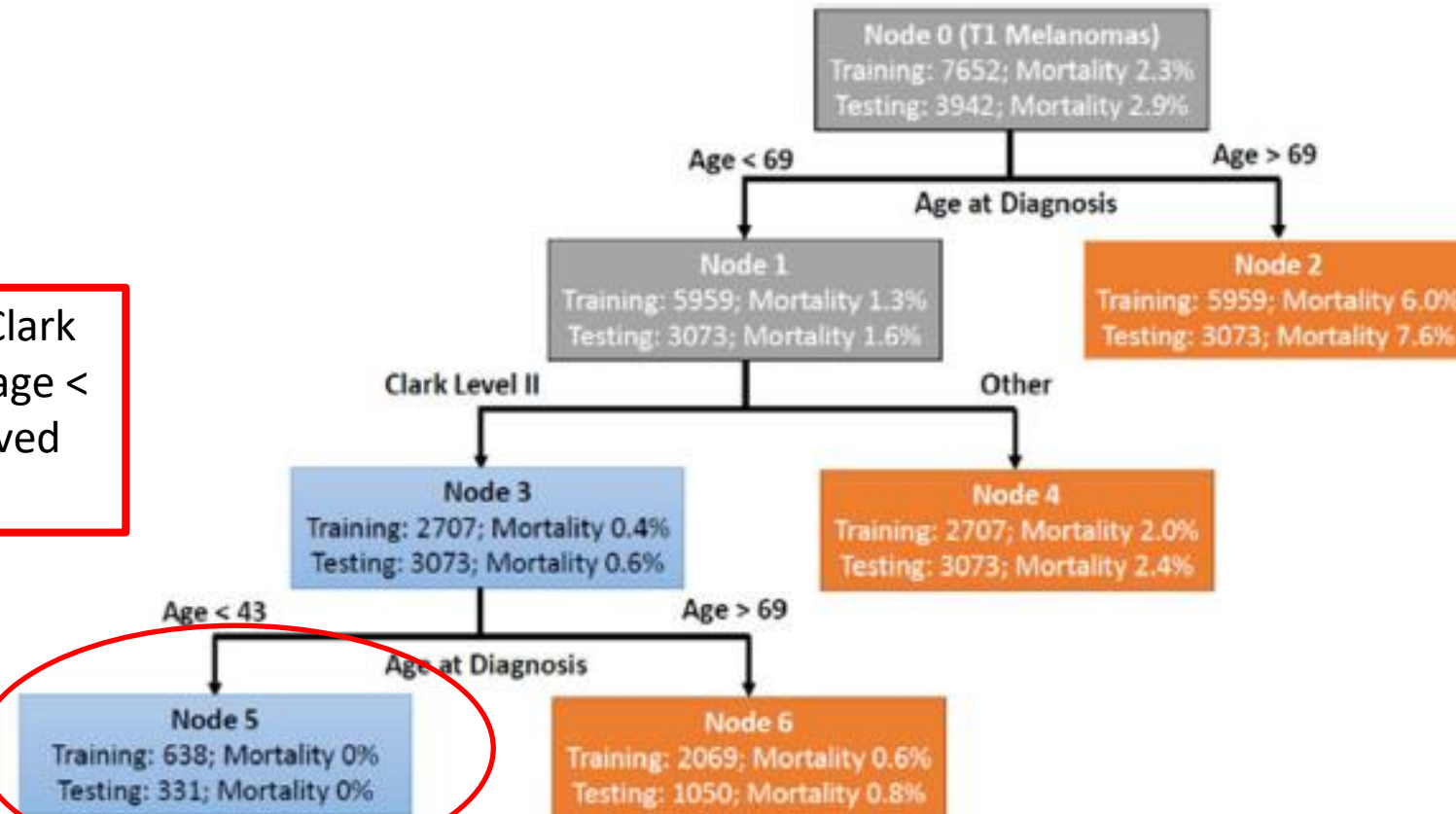


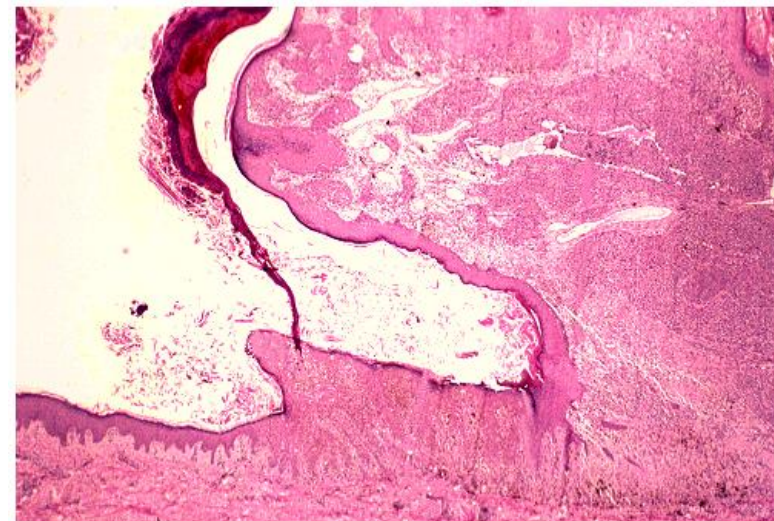
Fig. 2 Prognostic model for Stage I melanoma. The importance of Clark level II. The diagram displays the number of patients in each node and the proportion of patients in the node who died. Blue leaves indicate subsets of patients classified as at low risk of death and orange leaves indicate subset of patients classified as relatively higher risk of death. These models were constructed in the training dataset weighting patients who died within 7 years 160:1 compared to patients that survived. Data from Eguchi *et al.*⁴⁰

The Power of Clark level II
- A Surrogate for Lack of Vertical Growth Phase

Vertical Growth Phase

- morphologic features
 - balloon-like expansion forms nodule
 - often less pigmented than RGP (“HGP”)
 - ABCD criteria do not apply
 - VGP is often symmetrical
 - borders are often smooth
 - color is often quite uniform
 - diameter often less than 6 mm

– Clark WH Jr, Ainsworth AM, Bernardino EA, Yang CH, Mihm CM Jr, Reed RJ. The developmental biology of primary human malignant melanomas. *Semin Oncol.* 1975 Jun;2(2):83-103. PMID: 790575



Tumorigenic and/or Mitogenic Melanomas (VGP) – limiting case

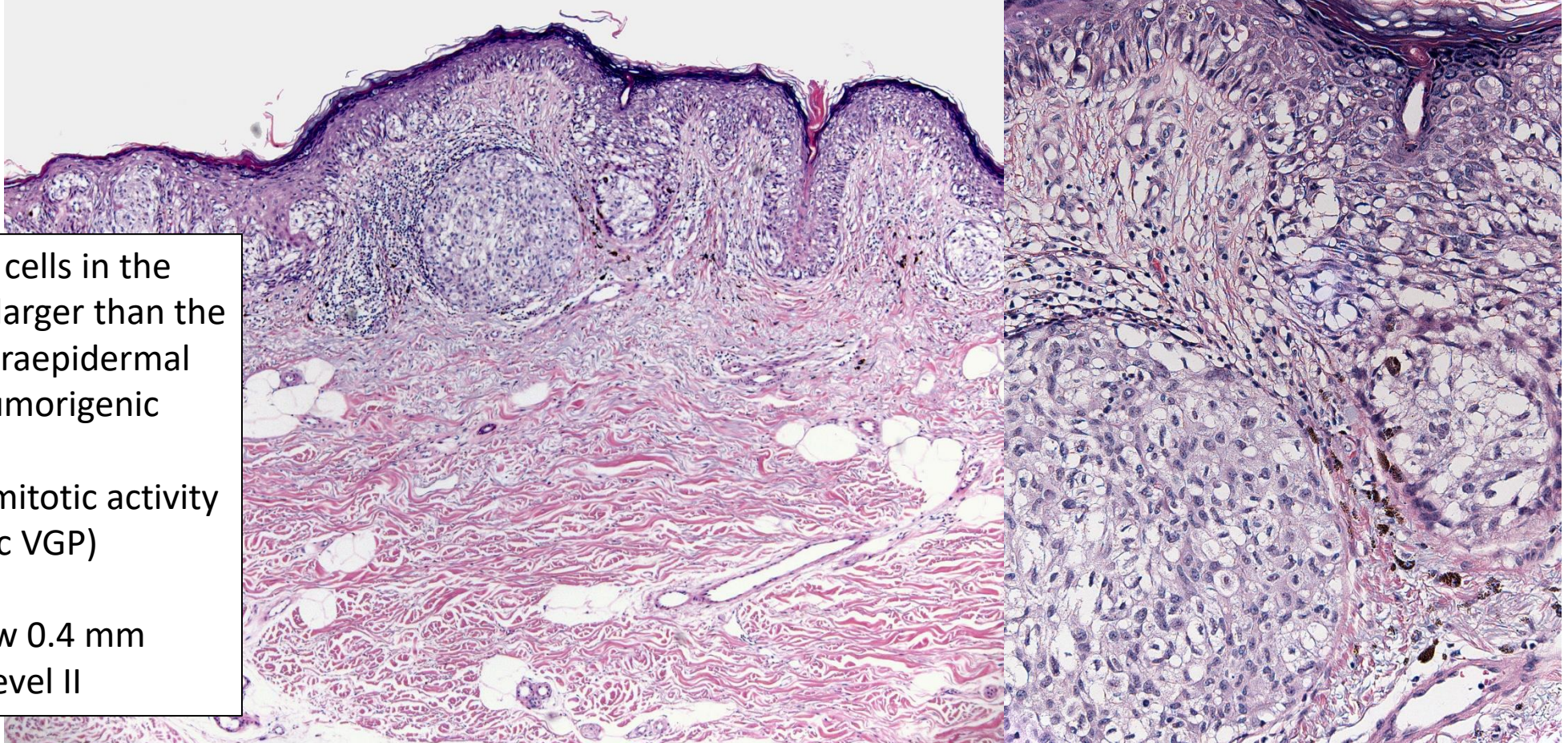
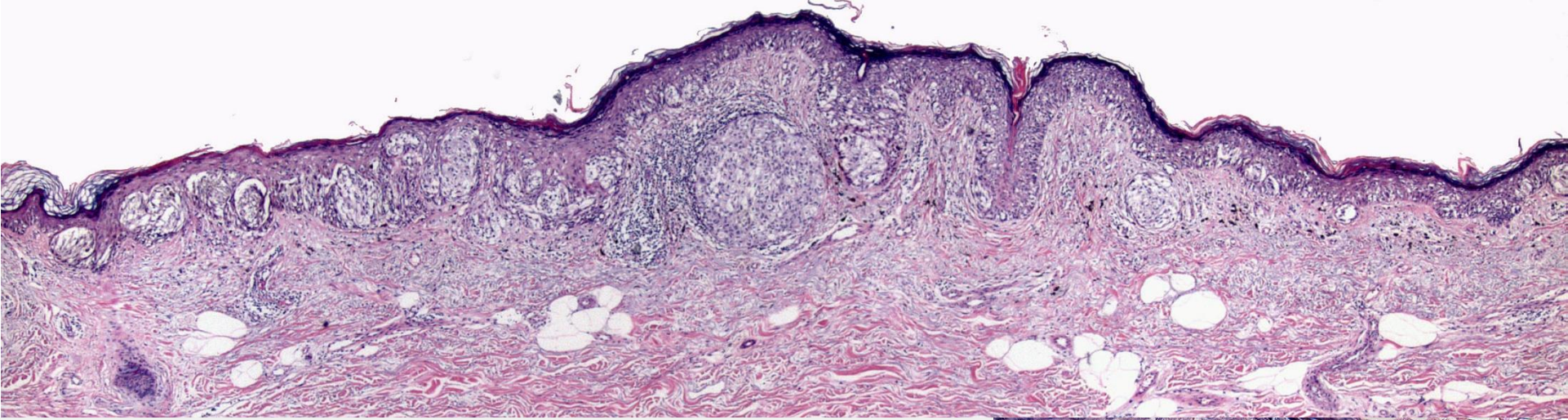
- Tumorigenic

- Defined as the presence of a mass in the dermis
- Limiting case – there is a cluster of cells in the dermis that is larger than the largest cluster in the epidermis

- Mitogenic

- Presence of any mitoses in the dermis

Either finding implies that the lesion has capacity for survival and growth in the dermis and defines it as a VGP melanoma



Cluster of cells in the dermis is larger than the largest intraepidermal cluster (tumorigenic VGP)
AND has mitotic activity (mitogenic VGP)

- Breslow 0.4 mm
- Clark level II

Invasive malignant melanomas lacking competence for metastasis

D E Elder, D Guerry 4th, M N Epstein, L Zehngebot, E Lusk, M Van Horn, W H Clark Jr. Am J Dermatopathol. 1984 Summer;6 Suppl:55-61.

- **Summary of Abstract**
- Recorded the presence or absence of VGP in 211 invasive cutaneous malignant melanomas.
-
- 5Y Disease-free survival after complete excision:
 - 146 patients with VGP: 63.7% survival
 - 65 patients whose neoplasms lacked VGP: 100% survival
- The data suggest that the absence of vertical progression of growth (RGP only melanoma) identifies a group of patients whose risk of metastasis is close to zero.

D.E. Elder E. Lusk
D. Guerry, IV M. Van Horn
M.N. Epstein* W.H. Clark, Jr.
L. Zehngebot

Invasive malignant melanomas lacking competence for metastasis

ABSTRACT Two stages of progression have been described in malignant melanomas, namely, the so-called "radial" and "vertical" phases of growth. We sought the presence or absence of vertical growth in 211 invasive cutaneous malignant melanomas. Disease-free survival in 146 patients with vertical growth was 63.7%, whereas 100% of 65 patients whose neoplasms lacked this feature survived 5 years or more after ablation of their lesions without evidence of recurrence or metastasis. Microstaging of patients with malignant melanoma by traditional means (level of invasion and thickness) identifies groups of patients at low and high risk of metastasis. Our data suggest that the absence of vertical progression of growth identifies a group of patients whose risk of metastasis is close to zero.

Am J Dermatopathol 6 (Suppl 1): 55-61, 1984.

From the Pigmented Lesion Study Group (D.E., D.G., M.V.H., W.H.C.); the Departments of Pathology and Laboratory Medicine (D.E.), Internal Medicine (D.G.), and Dermatology (D.E., W.H.C.); the Biostatistics Center, University of Pennsylvania Cancer Center (E.L.); University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania; the National Library of Medicine, National Institutes of Health, Bethesda, Maryland (M.N.E.); and the Department of Medicine, Albany Medical College, Albany, New York (L.Z.).
* Deceased.

In about 90% of cases, cutaneous malignant melanomas evolve through at least two stages of progression that have been termed the "radial" (plaque) and "vertical" (nodule) phases of growth.⁽¹⁾ The remaining 10% of cases progress directly to the vertical phase. Histologically, a plaque of malignant melanoma in the so-called radial phase may stay confined to the epidermis (*in situ*) or extend into the dermis in single or small groups of cells ("invasive"). Malignant melanomas *in situ* lack competence for metastasis (disease-free survival is 100%).⁽²⁾ Survival from invasive melanoma may be predicted for groups of patients by various microstaging criteria.⁽³⁾ The most important of these for prediction of low risk of metastasis are level (I or II) of invasion⁽⁴⁾ and "thickness" (less than 0.76 or 0.85 mm).^(5,6) We hypothesized that a malignant melanoma in invasive "radial" growth lacks competence for metastasis because clinical metastases are mass lesions that are not likely to be found in a neoplasm that lacks ability to generate a mass lesion (vertical growth) at its primary site. Our hypothesis implies that disease-free survival of patients solely with radial growth should be 100%. We further hypothesized that other methods of assessing low-risk disease like level and thickness tend to show 100% disease-free survival because a majority of patients identified by these methods have neoplasms that are solely in "radial" growth. Thus, these low-risk sets of patients identified by microstage may be separated into two subsets having different prognoses

Reproducibility of VGP Diagnosis

Our results show that although overall agreement for the growth phase is moderate, agreement between experienced observers is good. In fact, agreement for the growth phase among this group was equal to the agreement for Breslow thickness. Overall agreement for Breslow thickness also was good but for the Clark level was only fair. These findings suggest that if the predictive value of the vertical growth phase proves to be robust, it will be used with an acceptable level of accuracy in routine diagnostic practice.

*Nuala C. McDermott, MRCPATH, Donal P. Hayes, DipRCPath,
Mohammed H. Al-Sader, DipRCPath, JohnM. Hogan, FRCPath,
Caitriona Barry Walsh, FRCPath, Elaine W. Kay, MD, and Mary B. Leader, MD*

*From the Department of Pathology, Royal College of Surgeons in
Ireland, St Stephen's Green, Dublin, Ireland, and Department of
Pathology, Cork University Hospital, Cork, Ireland.*

*McDermott, N.C., et al., Identification of vertical growth phase in malignant melanoma. A study of interobserver agreement. Am. J. Clin. Pathol, 1998. **110**: p. 753-757.*

Overdiagnosis of Melanoma:

- Results from applying the term “melanoma” to lesions that do not have capacity for metastasis or causing death
- Due to Overdetection or Overdefinition
 - These lesions may be viewed as risk markers
 - Likely do not have potential for local persistence, recurrence and progression to “real melanoma”
 - Rare exceptions are possible
- Possible new term for these lesions:

Melanocytic Neoplasm of Low Malignant Potential “MNLMP”

MNLMP Definition (Provisional)

- DEFINITION
- Age ≤ 70
- Thickness ≤ 0.8 mm
- No mitoses
- No ulceration
- No VGP
- Clark level I or II
- No regression
- Clinical absence of dynamic changes (indicative of active clinical evolution e.g. “changing mole”)
- Mortality in cases so defined is vanishingly rare
- Achieving “zero-risk melanoma” will require incorporating VGP (absence of) into our reports ...
- Some cases with confirmed and validated “zero risk” may need to be reclassified as nevi

Significance of Overdiagnosis

- For patients:
 - Living unnecessarily with a cancer diagnosis.
- For Pathologists
 - Pressure to diagnose lesions as melanoma that do not have convincing attributes of malignancies, leading to increased uncertainty (overdefinition).
- For Clinicians:
 - Wasted effort in managing benign lesions as malignancies.
- For Clinicians and Epidemiologists

Failure to concentrate on detection of potentially lethal melanomas at the expense of Overdetection of actually benign lesions (Key may be to focus on Changing Lesions).
- For Scientists:
 - Studies of potentially lethal melanomas may be obscured by data from over detected and over defined benign lesions

MNLMP Summary

MNLMP are byproducts of screening, surveillance and education programs for early melanoma (“over-detection”), and also from changes in criteria (“over-definition”)

- Should not be considered to be melanomas
- Only lesions with VGP should be considered “true” melanomas
- Criteria will likely be expanded over time to further reduce overdiagnosis delta.
- Manage (currently) by complete local excision
- TRUE ZERO RISK “MELANOMAS” SHOULD BE CLASSIFIED AS MELANOCYTIC DYSPLASIAS (imo)



Up the Creek without a Paddle?

EDITORIAL

Perspectives and Strategies to Minimize Harm From Melanoma Diagnosis

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What can be done to reduce overdiagnosis? One way to change the records of melanoma incidence reports would be through changed tumor terminology. If, as suggested by Kerr et al,¹ nonmitogenic pT1a melanoma were reclassified as *melanocytic neoplasms of low malignant potential*, that could significantly reduce the number of newly diagnosed melanomas.

While there are merits to this proposal, there is concern that a change in the terminology would lead to diagnostic confusion and make it harder to monitor changes in overdiagnosis over time.

Furthermore, since the surgical treatment recommendations are similar irrespective of the chosen terminology, there is limited benefit for patients.