The degree and depth of skin trauma may be greater at the donor site, which may be responsible for the Koebner phenomenon. Many questions arise out of this observation. Is the degree of trauma important in precipitating the phenomenon? Is the activity lesion specific or generalized? What are the factors responsible for the survival of transplanted melanocytes? Are these patients vulnerable to recurrence or loss of pigment in the lesions treated with MKT? Long-term follow-up and collaborative research with immunologists and dermatopathologists may be helpful to elucidate the events and shed more light on the pathogenesis of vitiligo.

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Financial Disclosure: None reported.

Acknowledgment: We thank Smita S. Mulekar for helping with data compilation.


COMMENTS AND OPINIONS

Fast-Growing and Slow-Growing Melanomas

We read with great interest the article by Liu et al1 and the accompanying editorial by Lipsker2 on rapidly growing melanomas. Both articles point out that different types of melanomas exist in relation to their biological propensity to grow and metastasize. Based on patient recall, Liu et al1 calculated the rate of growth of 404 invasive melanomas (median tumor thickness, 1.3 mm) and found that almost a third of them grew 0.5 mm per month or more. These rapidly growing melanomas are more likely thick tumors associated with a high mitotic rate and more frequently found in older men with fewer melanocytic nevi and freckles. Furthermore, they usually lack the clinical ABCD features of melanoma (A, asymmetry; B, border irregularity; C, color variegation; D, diameter >5 mm), being frequently symmetric and amelanotic nodules. The authors conclude that the lack of the most important risk factors for melanoma (ie, large number of nevi and freckles) and the lack of the typical melanoma features (ie, ABCD criteria) make it more difficult for the physician to identify this subtype of rapidly growing melanoma.

To overcome these difficulties, Lipsker2 suggests a simple rule: each growing skin tumor that cannot be clearly diagnosed clinically must be rapidly excised. We applaud this message as being the simplest rule to apply in daily practice so as not to miss those melanomas that are responsible for most deaths attributable to melanoma. But will this recommendation be sufficient to decrease melanoma mortality? We do not believe so.

In our view there are 3 avenues to approach the task of reducing melanoma deaths: the first is to alter the tumor itself, particularly the subtype described by Liu et al1; the second is to modify patient behavior; and the third is to concentrate on what the physician can do. On which of the 3 actors should we concentrate our efforts? Unfortunately, nothing can be done to change the aggressive behavior of some melanomas, and it would be very difficult to teach the whole population how to recognize fast-growing melanomas early enough to prevent growth and metastases. Thus, the only way to reduce melanoma deaths is to focus our attention on the third actor, the physician; but our challenge is not only the recognition of fast-growing melanoma once we see it but, indeed, to get the chance to see it! How many times do we perform full-body skin examination when the patient is coming to us for hand dermatitis or cosmetic procedures? As a dermatologist, I have to confess, the answer is very rarely!

It is actually proven that although most patients with melanoma have at least 1 medical consultation in the year before diagnosis, only 20% report receiving a skin cancer examination.3 In a previous randomized trial, our research group4 demonstrated that a group of general physicians using dermoscopy performed 25% better triage of suggestive skin tumors than physicians who used naked-eye examination alone. At the beginning of that study, just a short dermoscopy course (only 2 hours) was given to general physicians. Thus, our research group speculated that the increased dedication of physicians to the patients, a sine qua non condition to perform dermoscopy, was in itself one of the main reasons for the increased detection rate of suspected skin malignancies. In summary, we would like to propose a modification of the simple message of Lipsker2: full-body skin examination should routinely be performed to detect growing skin tumors, which must be rapidly excised if they cannot be clearly diagnosed clinically.

Another point of discussion is the existence of different forms of melanoma as outlined by Lipsker2: (1) thin, slow-growing melanomas, with a strong increase in incidence across time and associated with intermittent sun exposure, a large number of nevi, and BRAF mutations; (2) thick, fast-growing melanomas, with stable incidence and presumably not associated with sun exposure, a large number of nevi, and BRAF mutations; and (3) classic lentigo maligna melanoma, with a more slowly increasing incidence and associated with continuous sun exposure but not with a large number of nevi and BRAF mutations. This categorization seems very plausible from an epidemiologic and biologic point of view. As noted by Lipsker,2 the striking increase in number of thin melanomas contrasts with the stable incidence of thick melanomas, and it is surprising that increased excision of thin melanomas had no effect on the number of thick melanomas in a region not subjected to significant population migration.
In our view, the only explanation for this epidemiologic phenomenon is that a high proportion of thin melanomas that are excised would never have become thick, at least within the range of our current life expectancy. As preliminary evidence of this, members of our research group\(^5\) studied a series of thin (\(<1\text{ mm}\)) invasive or in situ melanomas that were excised after long-term follow-up (1-10 years). All 5 cases in that study showed no features of melanoma at baseline, and the lesions were excised because of slight changes only visible in side-by-side comparisons of dermoscopic images. Remarkably, the changes were mainly structural (focal increase of pigment network irregularity and regression structures), with only slight or no increase in size was seen after 1 to 10 years of follow-up (Figure). Based on this preliminary observation, we propose to further divide the Lipsker\(^2\) category of thin melanomas into 2 subcategories: (1) slow-growing thin melanomas, and (2) very slow-growing thin melanomas.

In conclusion, there is growing evidence of increasing detection of a new spectrum of biologically "benign" melanomas. Given this development, dermoscopy and digital follow-up might be the key factors to improving our knowledge about the natural evolution of nevi, melanoma, and the spectrum of undefined melanocytic proliferations.

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Financial Disclosure: None reported.


In reply

We read with interest and support the comments of Argenziano et al regarding the spectrum of melanoma growth rates, the role for opportunistic screening at consultations undertaken for other reasons, and the potential for sequential digital dermoscopy to further evaluate growth rates, particularly among the slow-growing lesions. We would, however, draw attention to the limited role of dermoscopy in diagnosing nodular and rapidly growing melanomas because many of these lesions display little pigmentation or, if pigment is present, even color distribution and symmetry. Nevertheless, dermoscopy is useful in ruling out the vascular and pigmentary changes associated with

\(\begin{align*}
\text{Figure. Clinical (A) and dermoscopic views at baseline (B) and follow-up consultation (C) of a 0.45-mm-thick melanoma located on the abdomen of a 57-year-old man. The lesion was excised 4\frac{1}{2} \text{ years after the baseline consultation because of slight changes detected in side-by-side comparison of dermoscopic images. After such long-term follow-up, the lesion exhibits only a minor increase in size.}
\end{align*}\)