The patient was subsequently referred to our department. On clinical full body examination, despite a few nevi on the trunk, the lesion of concern appeared as a solitary, scaly, reddish plaque with small foci of bluish pigmentation and ill-defined borders measuring 3 × 2 cm (Figure 1A). There was no familial or personal history of melanoma.

Dermoscopic examination of the lesion (Figure 1B) revealed a marked asymmetry of colors and structures, with white to yellow surface scales, homogeneous blue to tan structureless areas, multiple brown dots and globules, and areas of regression, the latter consisting of white scarlike depigmentation and multiple blue-gray dots (pepperlike granules). In addition, a polymorphous vascular pattern composed of dotted, hairpin, and thick and irregular coiled “corkscrew” vessels (Figure 1, inset) was seen, as well as milky-red and red-blue globules and areas. This combination of features along with the clinical course raised suspicion for melanoma, and a punch biopsy specimen was taken from the bluish area encircled in Figure 1B. Prior to biopsy, microscopic examination of a skin
scraping was undertaken, which tested negative for dermatophytosis.

Histopathologic examination of the punch biopsy specimen revealed an atypical melanocytic proliferation (Figure 2). The lesion was completely excised, and a histopathologic diagnosis of invasive melanoma ensued (Clark level IV, Breslow thickness 2.5 mm).

Comment. Our case highlights the potential difficulties in differentiating eczemalike AHM from an inflammatory process. While the clinical appearance and even the dermoscopic features alone may be nonspecific and overlap with a large spectrum of inflammatory or tumoral skin disorders, the combination of clinical and dermoscopic findings in the context of the patient’s overall condition help to increase the level of suspicion for melanoma. Accordingly, the clinical course of a solitary, continuously enlarging lesion that exhibits dermoscopically a polymorphous vascular pattern with remnants of pigment should always raise a red flag for a malignant skin tumor and prompt biopsy.5

In conclusion, eczemalike AHM exhibits dermoscopic features that may help to identify this group of clinically featureless melanoma. This presumes, however, that physicians base their diagnosis and management on a combined approach, including a detailed anamnesis, a full body examination, and the application of dermoscopy on all (and particularly solitary) skin lesions, regardless of whether these lesions appear clinically suspect.

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Financial Disclosure: None reported.