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A common and deadly misunderstanding

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A 54-year-old man was referred to the dermatology clinic for evaluation of a lesion on his neck. The lesion had been present for an indeterminate period of time but was now becoming irritated by clothing. The patient had always spent a great deal of time outdoors, both in his job in construction and in other outdoor activities, including hunting and fishing. Except for the irritated lesion, he was reasonably healthy.

Physical examination revealed a tremendous amount of sun damage, including solar lentigines, actinic keratoses, weathering, and focal solar elastosis on the face. The lesion in question was a warty, traumatized-looking papule on the right anterolateral neck skin. It was highly consistent with an irritated seborrheic keratosis, and we treated it with liquid nitrogen. Looking elsewhere, we then saw a 1-cm, very irregularly pigmented and bordered, dark brown to black macule on the upper right trapezius area (see Figure 1). Biopsy was clearly indicated because the lesion was most likely a melanoma.

Which approach to biopsy would be entirely inappropriate?

- Multiple (2 or 3) 3- to 4-mm punch biopsies
- Saucerization of the entire lesion (deep shave, into superficial adipose tissue)
- Excision of the entire lesion with minimal margins
- A single 3-mm punch biopsy

Discussion

The correct answer is that a single 3-mm punch biopsy is the wrong choice: a single, small punch biopsy could easily miss the malignant portion of the lesion, thus falsely reassuring the patient and possibly allowing a malignancy to become dangerous. The other three choices are acceptable since they all result in adequate representation of any pathologic process, in horizontal as well as vertical planes. Obviously, excision of the entire lesion with minimal margins is the gold standard. Conversely, a superficial shave biopsy of the lesion—not one of the choices above—is easily the worst possible choice because the pathologist cannot assess the tissue

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FIGURE 1

The lesion that required the biopsy



from this type of biopsy for the vertical extent of the cancer, which is a key prognostic issue for melanoma.

Discussion and treatment There are probably many reasons why most primary care clinicians do not routinely perform biopsies of skin lesions. One important one is raised in this case: uncertainty over what type of biopsy to do. But the basic reason is that the clinician has to be able to accurately identify the lesions that need biopsy.

The lesion we were concerned about was much larger and far more worrisome than the one that brought the patient to our clinic, but this dangerous lesion—which did prove to be a melanoma in situ—was overlooked by the referring clinician, probably because it was totally flat. The common but erroneous belief that melanomas cannot be flat costs many lives that otherwise could have been saved. Making such a sweeping assumption can have dangerous consequences for the patient. In fact, about 75% of all melanomas are essentially flat (macular), with little if any raised component. Some melanomas are raised, but these are in the minority. This patient's lesion was reexcised with 5-mm margins. He was scheduled for follow-up four times a year for the first year and twice yearly thereafter. □