Dermatology Practical & Conceptual

A Rare Case of Superficial Spreading Melanoma with Prominent Folliculotropism: Dermoscopic and Histological Findings

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Introduction

Superficial spreading melanoma (SSM) is the most common subtype of invasive melanoma in fair-skinned individuals [1]. Histologically, it is characterized by atypical melanocytes along the dermal-epidermal junction, spreading in the suprabasal layers of the epidermis and into the dermis [2]. When present, follicular infiltration typically remains confined to the upper portion of the follicle (infundibulum and isthmus), in contrast to the often diffuse involvement observed in lentigo maligna melanoma (LMM).

Case Presentation

We present the case of an 84-year-old Caucasian male with phototype II followed at the dermatology oncology clinic every six months for multiple basal cell and squamous cell carcinomas. During a routine check-up, a pigmented lesion approximately 1 cm in diameter was identified in the left parietal region, absent six months earlier (Figure 1A). Dermoscopic examination revealed blue-violet globules of various sizes, some confluent, with perifollicular distribution in the central portion of the lesion, associated with peripheral structureless brown pigmentation (Figure 1B). Although the dermoscopic examination was not indicative of a melanocytic lesion, initially suggesting a basal cell carcinoma (BCC) or an angioma-like vascular lesion, the recent onset of the lesion justified urgent excision with histopathological examination. Histopathological examination revealed an SSM exhibiting marked folliculotropism with a Breslow thickness of 1.1 mm. Histologically, there was diffuse and prominent follicular invasion by atypical melanocytes, corresponding

to the globules with a perifollicular distribution observed in dermoscopy (Figure 2A-D).

Conclusion

Folliculotropism occurs in different morphological variants of melanoma, including follicular malignant melanoma (FMM), LMM, folliculotropic primary melanoma, and folliculotropic metastases. FMM is a primary cutaneous melanoma characterized by massive invasion of one or a few hair follicles, with a minimal epidermal component [3]; it may exhibit atypical features, presenting as a pigmented cyst or comedones mainly in photodamaged skin [4]. FMM must be distinguished from LMM with secondary follicular invasion, in which the lateral epidermal involvement is more extensive than the depth of the follicular structure [4], and from folliculotropic metastasis, characterized by secondary involvement of the hair follicle from another distant primary melanoma [5]. Folliculotropism in SSM is a rarely reported phenomenon. Recent studies suggest folliculotropism may represent an unfavorable prognostic factor correlating with increased Breslow thickness and a higher risk of metastatic progression [6].

This case highlights how marked folliculotropism is associated with distinctive dermoscopic features generally absent in melanocytic lesions and that it may mimic other entities such as BCC. In our case, dermoscopy revealed features resembling the ovoid nests typically seen in BCC. This resemblance is likely due to the presence of melanocytes extending downwards along pilosebaceous units as single cells but mostly as large nests, with occasional infiltration of the adjacent dermis. These large nests may appear as hyperpigmented ovoid structures under dermoscopy closely resembling those of BCC. Both folliculotropic melanoma and BCC may therefore exhibit deep dermal pigmentation, visible as bluish structures due to the Tyndall effect, complicating the differential diagnosis. These findings underscore the importance of an integrated diagnostic approach combining clinical evaluation, dermoscopy, and histopathology to improve diagnostic accuracy and guide patient management.

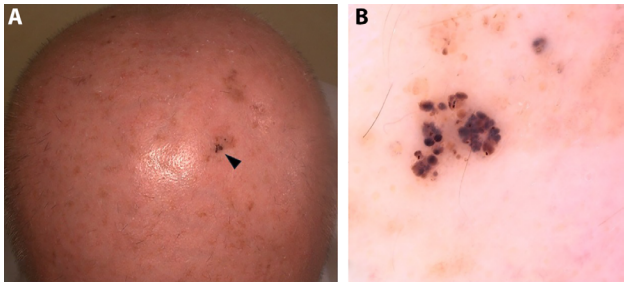

Figure 1. A) Clinical presentation of the pigmented lesion approximately 1 cm in diameter, located in the left parietal region (black arrowhead). B) Dermoscopic image of the lesion showing blue-violet globules of different sizes, some confluent, with a perifollicular distribution in the central portion and structureless brown pigmentation in the periphery.

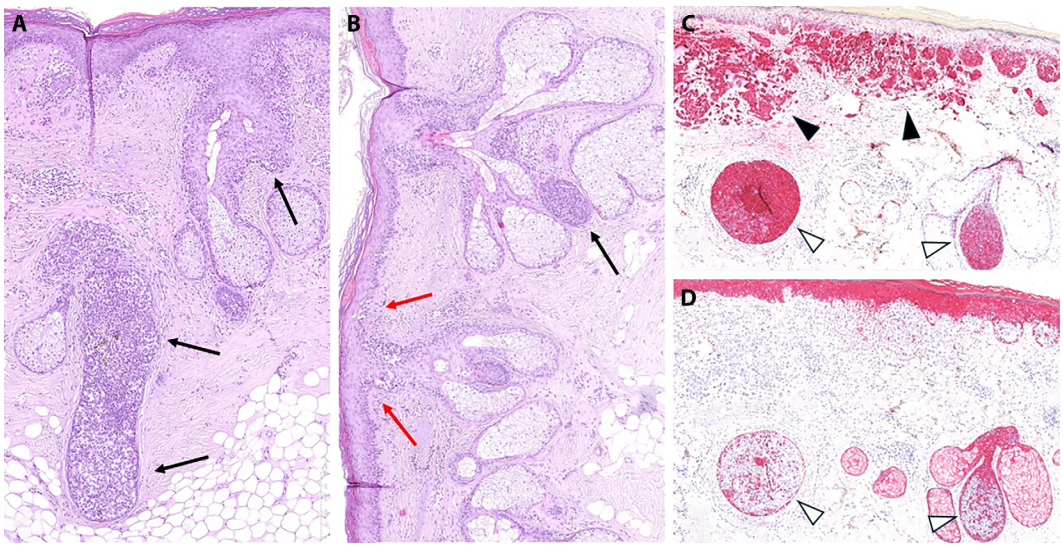

Figure 2. A) In this field, involvement of the hair follicles (black arrows) by a neoplastic proliferation is clearly visible. On the other hand, junctional and dermal involvement are harder to assess (hematoxylin and eosin; original magnification: 10x). B) In a different field, deep adnexal involvement (black arrows) is present together with more traditional junctional and infundibular proliferation (red arrows), pointing to the malignant melanocytic nature of this pathologic process (hematoxylin and eosin; original magnification: 10x). C-D) Immunostaining for HMB45 «C» confirms the diagnosis of melanoma and shows a dermal component of the lesion that retains positivity for the antigen (black arrowheads). Positivity in the deeper dermis (white arrowheads) is related to involvement of the adnexa and not to deep infiltration by melanoma cells, as demonstrated in «D» by positivity for CKAE1AE3 immunostaining in some residual cells. (immunostaining for HMB45 and CKAE1AE3; original magnification 10x).

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