Non-choroidal yellow melanoma showing positive staining with Sudan Black consistent with the presence of lipofuscin: a case report

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ABSTRACT

A case of a predominantly yellow primary superficial spreading melanoma arising on the back of a 44-year-old woman is presented. Possible causes of the clinical and dermatoscopic yellow color are discussed. Staining with the histochemical stain, Sudan Black, revealed a differential uptake compared to a closely matched control melanoma. We speculate that the clinical and dermatoscopic yellow color could be due to the presence of increased amounts of the pigment lipofuscin, which is known to produce subtle orange color in some choroidal melanomas.

Case report

A 44-year-old female patient presented to a dermatologist in Blanquefort, France for a routine check of her moles. There was no family or personal history of cutaneous malignancy and there was no history of any significant health problems or of any symptoms of disease. There had been a previous examination by the same dermatologist one year earlier, and nothing of concern had been noticed.

Examination revealed that the patient had skin of Fitzpatrick photo-type 3, with multiple ephelides as evidence of previous sun exposure. On the skin over her right scapula a raised, smooth, shiny, yellow and skin-colored lesion was observed (Figure 1). A dermatoscopic examination was performed (Figure 2), and the lesion was noted to be structureless, predominantly yellow. There was evidence of light melanin pigmentation with some areas of structureless gray interspersed between the dominant yellow areas and present...
Observation | Dermatol Pract Concept 2013;4(2):9

at one end of the lesion but not the other producing asymmetry of color. Polymorphous linear vessels (serpentine, looped and curved) were arranged randomly and densely over the surface of the lesion and there were a small number of dot vessels.

Immediate excision biopsy was performed. Dermatopathologically (Figures 3-7) the lesion presented as a nodular, well circumscribed proliferation of melanocytes (Figure 3). There was a proliferation of cytologically abnormal melanocytes and some confluent nests of melanocytes at the dermoepidermal junction (Figure 5), and the junctional proliferation did extend beyond the dermal proliferation for more than three rete ridges at one location at the periphery of the nodular component. In the dermis sheets of abnormal melanocytes, most as spindle cells (Figures 5, 6A & B) and others with plump oval nuclei, prominent nucleoli and abundant clear cytoplasm (Figure 6A, B, C, D), extended throughout the dermis with both nesting and evidence of melanin production all the way to the base of the lesion (Figures 4 and 6). Melanin was seen on hemotoxylin and eosin staining (Figure 6A), which was also verified by Masson Fontana stain that confirmed significant melanin extending to the base of the melanocytic proliferation. Evidence of a pre-existing nevus was present as a sheet of mature nevomelanocytes at the base of the lesion (Figure 6D). The diagnosis was rendered melanoma, superficial spreading subtype with a dominant nodule comprising the great majority of the lesion, Breslow thickness 2.4 mm with 4 mitoses per high power field.

Following this, in an attempt to clarify the cause of yellow color, two further stains were performed. A pearl’s stain confirmed the absence of hemosiderin. To test for the presence of the pigment lipofuscin, new sections were cut from the paraffin block, five microns in thickness and stained with Sudan Black. When this appeared to stain heavily, new sections of the same thickness were also cut from the paraffin block of another melanoma as a control and stained with Sudan Black. The control melanoma was a heavily pigmented superficial spreading melanoma, also with a dominant (pigmented) nodule, with a Breslow thickness of 2.2 mm, 2 mitoses per mm², and no ulceration. Figure 7 is a composite image of both the melanoma reported here (upper image) and the control (lower image), both stained with Sudan Black. Both images are taken at with the same 4x objective and with identical exposure and white-balance settings. Apart from cropping and identical resizing for publication, there has been no photo manipulation. It can be seen that there is dif-
Similarly, amelanotic/hypomelanotic melanomas (AHM) typically present with minimal clues due to melanin structures on which to base a diagnostic analysis [2]. The particular challenge, where a melanoma presents clinically as a hypomelanotic nodule, has been described as that of evaluating a rapidly enlarging pink tumor [3]. The melanoma reported here was a hypopigmented superficial spreading melanoma.

Conclusions

While pigmented melanomas usually display dermatoscopic disorganization and clues related to their chaotic evolution [1], amelanotic/hypomelanotic melanomas (AHM) typically present with minimal clues due to melanin structures on which to base a diagnostic analysis [2]. The particular challenge, where a melanoma presents clinically as a hypomelanotic nodule, has been described as that of evaluating a rapidly enlarging pink tumor [3]. The melanoma reported here was a hypopigmented superficial spreading melanoma.
(SSM) with a dominant nodule, which was notable because of its dominant structureless yellow color. In one series of four cases of AHM with dermatoscopic images, all cases had significant pink or red color and none had any yellow color [4]. Although this lesion fulfilled the definition of AHM, according to revised pattern analysis (RPA), the presence of any pigment should lead to a diagnostic analysis based on pigmented structures [5,6]. Applying the RPA algorithmic method for pigmented lesions, “Chaos and Clues” [1] this lesion was asymmetric by color and therefore was regarded as exhibiting chaos (defined as asymmetry of structure and/or color), and it had the clue of blue or gray structures so excision biopsy was indicated. In addition to these pigment clues, there were vascular dermatoscopic clues including an eccentric structureless pink area (Figure 2 upper pole) and a random arrangement of polymorphous vessels. Both milky red pink areas and linear irregular vessels are described as clues to AHM by Menzies et al. [7], and an eccentric structureless area (any color except skin color, including pink) and polymorphous vessels have been evaluated as clues to malignancy in RPA [8].

Dermatoscopic yellow color has also been attributed to keratin as seen in seborrheic keratosis [9] and congenital type nevus [10]. In a study of 400 BCCs Bellucci et al. found that 10% displayed yellow structures either as milia-like cysts (7.75%) or lobular structures (4.2%) [11], also presumably due to keratin. There was no accumulation of keratin to explain the yellow color in the melanoma reported here.

Structureless dermatoscopic yellow color has also been attributed to ulceration with surface serum exudate [6], and dermatoscopic structureless yellow color was described in the first case report of a balloon cell melanoma (BCM) with dermatoscopy [12], being attributed by the authors to ulceration. Considering the possibility that it may actually have been the balloon cells that caused the yellow color, the only other reported BSM with dermatoscopic images was a partially pigmented lesion with a dominant structureless white area and without any yellow color [13]. The case we report here did have two cell populations, including one with large cells with vacuolated cytoplasm resembling balloon cells (Figures 6 A, C, D), but it did not meet the criteria for diagnosis as a BCM which requires that the melanoma contain more than 50% of balloon cells, [14] and in fact the sheets of balloon cells were only present focally. With respect to ulceration as a reported cause of structureless yellow in one melanoma [12], there was no evidence of ulceration either clinically, dermatscopically or dermatopathologically in the case reported here.

Another published cause of dermatoscopic yellow is the presence of sebaceous structures in sebaceous hyperplasia [15], nevus sebaceous and sebaceous adenoma [16]. Bryden et al. attributed the yellow color in sebaceous hyperplasia to sebum accumulation by proliferation of sebaceous glands [15]. Sebum consists primarily of a complex mixture of lipids [17]. Ideally staining for lipids is performed on fresh unfixed tissue with stains such as Oil Red O. In this case all tissue had been fixed in formalin and blocked in paraffin.

Subtle orange pigment, attributed to the pigment lipofuscin, a derived lipid which is an accumulation of lysosomes [18], is described as one of the features that can help differentiate choroidal melanoma from choroidal nevus [19]. The histochemical stain Sudan Black can be used on formalin-fixed, paraffin-processed tissue to detect some phospholipids and also lipofuscin [18]. The melanoma reported here showed significant staining with Sudan Black compared to staining by a similar but deeply pigmented melanoma. This increased staining was present in varying intensity and uneven distribution throughout the dermal component of the melanoma consistent with the uneven presence of dermatoscopic structureless yellow (Figure 2).

The possible presence of the pigment lipofuscin in this melanoma is supported by positive staining by Sudan Black, and we speculate that the structureless yellow color displayed clinically and dermatoscopically may be due to the pigment lipofuscin, a pigment which has been previously described as a clue to choroidal melanoma.

References
1. Rosendahl C, Cameron A, McColl I, Wilkinson D. Dermatoscopy in routine practice—“Chaos and Clues.” Aust Fam Physician. 2012 Jul;41(7):482–7.
2. Chamberlain AJ, Fritschi L, Kelly JW. Nodular melanoma: patients’ perceptions of presenting features and implications for earlier detection. J Am Acad Dermatol. 2003 May;48(5):694–701.
3. Moloney FJ, Menzies SW. Key points in the dermoscopic diagnosis of hypomelanotic melanoma and nodular melanoma. J Dermatol. 2011 Jan;38(1):10–5.
4. Steglich RB, Meotti CD, Ferreira MS, Lovatto L, de Carvalho AVE, de Castro CGC. Dermoscopic clues in the diagnosis of amelanotic and hypomelanotic malignant melanoma. An Bras Dermatol. 2012 Dec;87(6):920–3.
5. Kistler H. Dermatoscopy: introduction of a new algorithmic method based on pattern analysis for diagnosis of pigmented skin lesions. Dermatopathology: Practical & Conceptual 2007;13:3.
6. Kistler H, Rosendahl C, Cameron A, Tschandl P. Dermatoscopy. Vienna, Austria: facultas.wuv, 2011.
7. Menzies SW, Kreusch J, Byth K, et al. Dermoscopic evaluation of amelanotic and hypomelanotic melanoma. Arch Dermatol. 2008 Sep;144(9):1120–7.
8. Rosendahl C, Tschandl P, Cameron A, Kistler H. Diagnostic accuracy of dermatoscopy for melanocytic and nonmelanocytic pigmented lesions. J Am Acad Dermatol. 2011 Jun;64(6):1068–73.
9. Berk DR, Bayliss SJ, Milia: a review and classification. J Am Acad Dermatol. 2008 Dec;59(6):1050–63.
10. Changchien L, Dusza SW, Agero AL, et al. Age- and site-specific variation in the dermoscopic patterns of congenital melanocytic nev: an aid to accurate classification and assessment of melanocytic nevi. Arch Dermatol. 2007 Aug;143(8):1007–14.
11. Bellucci C, Arginelli F, Bassoli S, Magnoni C, Seidenari S. Dermatoscopic yellow structures in basal cell carcinoma. J Eur Acad Dermatol Venereol. Epub 2013 Jan 18.

12. Inskip M, Magee J, Barksdale S, Weedon D, Rosendahl C. Balloon cell melanoma in primary care practice: a case report. Dermatol Pract Concept. 2013;3(3):6.

13. Maher J, Cameron A, Wallace S, Acosta-Rojas R, Weedon D, Rosendahl C. Balloon cell melanoma: a case report with polarized and non-polarized dermatoscopy and dermatopathology. Dermatol Pract Conc. (in press)

14. Kao GF, Helwig EB, Graham JH. Balloon cell malignant melanoma of the skin. A clinicopathologic study of 34 cases with histochemical, immunohistochemical, and ultrastructural observations. Cancer. 1992 Jun 15;69(12):2942–52.

15. Bryden AM, Dawe RS, Fleming C. Dermatoscopic features of benign sebaceous proliferation. Clin Exp Dermatol. 2004 Nov;29(6):676–7.

16. Enei ML, Paschoal FM, Valdés G, Valdés R. Basal cell carcinoma appearing in a facial nevus sebaceous of Jadassohn: dermoscopic features. An Bras Dermatol. 2012 Aug;87(4):640-2.

17. McMahon A, Lu H, Butovich IA. The spectrophotometric sulfophospho-vanillin assessment of total lipids in human meibomian gland secretions. Lipids. 2013 May;48(5):513–25.

18. Bancroft J, Stevens A. Bancroft’s Theory and Practice of Histological Techniques, 2nd ed. Edinburgh: Churchill Livingstone, 2012.

19. Shields CL, Furuta M, Berman EL, et al. Choroidal nevus transformation into melanoma: analysis of 2514 consecutive cases. Arch Ophthalmol. 2009;127(8):981-7.