Acréal melanoma (ALM) was described for the first time in 1976 by Reed. It is the fourth variant of cutaneous melanoma, differing from it in terms of different genetic etiology, namely the presence of a mutation in the Kit gene and not in the BRAF gene. It is a rare pathology in the white population, representing only 10% of all melanomas, but its incidence increases in Asian population to 50–58% and in black-skinned population to 60–70%. From the clinical point of view, its distinctive feature is to be a great pretender; anything but infrequently, it adopts clinical faces, simulating skin conditions that make the healthcare provider diagnose it as a benign disease of the palms, soles, and ungual regions. We present a case of a hyperkeratotic acral melanoma that has been misdiagnosed and that has led to an amputation of the thumb. (Plast Reconstr Surg Glob Open 2015;3:e377; doi: 10.1097/GOX.0000000000000336; Published online 17 April 2015.)

**Summary:** Acréal melanoma is a great pretender; anything but infrequently, it adopts clinical faces, simulating skin conditions that make the healthcare provider diagnose it as a benign disease of the palms, soles, and ungual regions. We present a case of a hyperkeratotic acral melanoma that has been misdiagnosed and that has led to an amputation of the thumb. (Plast Reconstr Surg Glob Open 2015;3:e377; doi: 10.1097/GOX.0000000000000336; Published online 17 April 2015.)

A 78-year-old white woman presented at our clinic with a skin lesion of the distal phalanx of the left thumb, which was of several months of evolution (Figs. 1–3). It had been previously treated with cryotherapy based on the suspicion of a wart, showing no response to treatment but only a local progression. Physical examination revealed a hyperkeratotic plaque of 20mm with a nondefined, asymmetric border. The lesion extended proximally to the distal third of the nail bed, causing nail detachment.

**CLINICAL CASE**

A 78-year-old white woman presented at our clinic with a skin lesion of the distal phalanx of the left thumb, which was of several months of evolution (Figs. 1–3). It had been previously treated with cryotherapy based on the suspicion of a wart, showing no response to treatment but only a local progression. Physical examination revealed a hyperkeratotic plaque of 20mm with a nondefined, asymmetric border. The lesion extended proximally to the distal third of the nail bed, causing nail detachment.

An incisional biopsy of the lesion was performed, and the diagnosis of ALM was established. According to Breslow depth (5.8mm), radical excision was planned as an en bloc amputation of the distal...
phalanx with sentinel lymph node dissection, followed by radical axillary node dissection after 10 days. After 1 year, the oncological follow-up was negative.

**DISCUSSION AND CONCLUSION**

ALM may frequently adopt clinical characteristics simulating less serious skin conditions, such as benign lesions, leading, as we said earlier, to delayed and/or inadequate treatment. The knowledge of the atypical characteristics of presentation of acral lesion allows to reduce the incidence of misdiagnosis of melanoma and consequently to have a better prognosis. Recently, authors have discussed about the real benefit of the sentinel lymph node biopsy in the prognosis of the ALM, concluding that it could be really helpful only in the patients with thick melanoma (>1 mm) and that it is a very important prognostic factor if associated with ulceration in the primary tumor.\(^5\)

Finally, considering ALM and its presentation as an amelanotic, hyperkeratotic lesion, which is just as rare as deceptive, it is absolutely mandatory both to document the cases as much as possible and to remember that whenever a hyperkeratotic lesion resistant to treatments for common warts is encountered, melanoma should always be ruled out.

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