

Lentigo maligna: European style



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In daily practice, we all encounter patients with hyperpigmented macules on sun-exposed skin. When managing such a patient, what would you do to rule out a lentigo maligna (LM)? Do you take a biopsy, do you perform skin-mapping or an incision biopsy? And if it is an LM, what kind of treatment do you choose? For example, surgical excision or local immunotherapy? By talking to our international colleagues, we noticed that there is a lack of consensus regarding the management of LM patients in Europe.

To answer these questions we submitted a study proposal and received an EADV grant to study the management of LM among EADV members in Europe.

LM is a premalignant form of lentigo maligna melanoma (LMM). It is treated

to prevent progression to LMM. A rise in the incidence of LM has been reported^{1,2}. Recently, Greveling *et al* reported that the progression rate of LM to LMM is 2-2.6% over the course of 25 years. The relative survival has been reported to be 99% for LM patients and 104% for LMM patients³. The current European guidelines state that local excision with a 5mm margin is the gold standard of treatment. Alternative treatments such as radiotherapy and local immunotherapy with imiquimod are barely mentioned. There is no standard protocol for management of LM patients⁴.

To evaluate how LM patients are managed internationally we sent out a survey highlighting every aspect of the clinical process, from diagnosis, to treatment and finally follow-up. We also explored what kind of aspects clinicians take into account when they choose a treatment strategy.

A survey consisting of 29 questions was sent to 3308 members of the European Academy of Dermatologists and Venereologists (EADV). Most questions were multiple choice, and multiple answers could be ticked per question. A total of N = 415 (12.5%) completed surveys were included in the analysis. A combination of clinical diagnosis (65.7%), dermatoscopy (83.4%) and histopathology (88.2%) was used by most respondents to diagnose LM. Only a minority of the respondents used confocal microscopy (5.5%) for diagnostic purposes. Tissue for histopathological evaluation was collected using either a punch biopsy in 61% of cases, an incisional biopsy in 27.7%, an excisional biopsy in 31.9% and/or skin-mapping in 19.1%. The most common treatment for LM patients <60 years of

age is surgery (97.6%). For LM patients >70 years of age, 66.8% of the respondents preferred surgical treatment. However, non-surgical options such as radiotherapy (17.0%), topical imiquimod (30.6%), watchful waiting (19.6%) or cryotherapy (20.4%) were used more often in these elderly patients.

So, when you feel hesitant about the options for a patient with a brown macule which you suspect of being an LM, you are not alone. The results of this study show an absence of consensus on the diagnosis and management of LM around Europe.

We would recommend that further studies compare the different treatment options such as surgery, local imiquimod and radiotherapy in a randomised controlled setting. These alternative treatment options could be of value for patients who do not qualify, or do not opt for surgical treatment. The manuscript of the full article has been submitted for publication in the *JEADV*. ●

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