or obese. One of the 2 patients not overweight or obese at onset showed a steep BMI percentile gain within 1 year after onset (from 56th to 83rd percentile) and was overweight 1 year after onset (90th percentile); the other’s BMI increased from the 75th (onset) to the 94th percentile at 1 year after onset and then to the 95th percentile 2 years after onset. Timing of onset of psoriasis vs excess adiposity did not correlate with being overweight vs obese, birthweight, scalp or nail involvement, history of arthritis, or family history of psoriasis or hyperlipidemia. However, children with familial obesity developed psoriasis earlier than those without (mean age, 7.0 vs 10.3 years at onset, respectively; \( P = .02 \)). After psoriasis onset, 2 patients showed a decline in BMI percentile, one from the 90th to 85th percentile and the other from the 97th to 94th percentile.

Discussion | In our pilot study, being overweight or obese preceded psoriasis by at least 2 years in 93% of children with psoriasis. While chronically elevated circulating proinflammatory cytokines (eg, interleukin 6 and tumor necrosis factor) and adipokines characterize both obesity and psoriasis, the reason for the delayed psoriasis onset (mean, 4.6 years) remains unclear. We also demonstrate that children with psoriasis with increased adiposity have a high percentage of immediate family members with obesity (48%) and psoriasis (41%), which occurs in 34% and 30%, respectively, of children overall with psoriasis.1 Weight-loss programs are more successful in children 6 to 12 years old than in adolescents and when healthy diet and physical activity become a family activity. We recommend early lifestyle counseling of families with psoriasis (especially those with obesity). Whether weight control reduces pediatric psoriasis severity also deserves investigation.

This pilot study was limited by being retrospective. A prospective, collaborative study between local pediatricians and pediatric dermatologists (eg, the Pediatric Dermatology Research Alliance) is warranted to further address the temporal relationship of psoriasis and obesity. Given the latency period of 2 or more years between obesity and psoriasis onset and uncommon occurrence of pediatric psoriasis (<1% of children2–3 and <40% having excess adiposity4), a cohort of more than 10,000 children in a 5-year longitudinal analysis would be required to capture data for 27 overweight or obese children with psoriasis.

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OBSERVATION

Giant Primary Melanoma With No Apparent Metastases: A Report of 2 Cases

Large primary cutaneous melanomas convey an ominous risk of metastases. The finding of large-scale melanomas without regional or distant metastases suggests a less aggressive biology for this type of tumor.

Report of Cases | Case 1. A man in his 60s presented with a 2-year history of a bleeding mass on his left thigh. Examination revealed a 6.0 × 8.2-cm fungating tumor with a 4-mm palpable left inguinal node. The patient underwent wide excision with clear margins. Histologic examination of the excision revealed an expansive proliferation of epithelioid neoplastic cells with abundant cytoplasm and prominent nuclei. The tumor extended into the subcutaneous tissue to a depth of 6 cm. The tumor cells were positive for Mart-1 and S-100 immunostains. An in situ component and ulceration were identified. Five mitoses/mm² were identified, and there was no evidence of lymphovascular invasion. Fine-needle aspiration biopsy of the enlarged lymph node identified no malignant cells. One sentinel lymph node in the left inguinal region was negative for metastasis, and whole-body positron emission tomography (PET)/computed tomography (CT) scan showed no evidence for metastatic disease. He declined chemotherapy and was disease free at last follow-up, 4 years after diagnosis.
Case 2. A man in his 60s presented with a 1-year history of an 8 × 7-cm tumor on his left back associated with fever and left axillary lymphadenopathy (Figure). Histologic sections of the surgical resection revealed a nodular proliferation of atypical and epithelioid melanocytes that extended into the reticular dermis to a depth of 2.4 cm. Sixteen mitoses/mm² were identified, and the margins were negative. Two sentinel lymph nodes in the left axilla were negative for metastasis by S-100 stain and epithelioid melanocytes that extended into the reticular dermis. Subsequent whole-body PET scan were negative for metastatic disease. The patient died 4 months after diagnosis due to chronic cardiac disease.

Discussion | Cases of giant primary melanoma, defined as lesions at least 10 cm in diameter or 48 mm in thickness, are almost exclusively associated with extensive metastatic disease. To our knowledge, only 2 other cases of giant primary melanoma without extensive metastasis have been described in the literature. 

Studies have illustrated that certain primary melanoma subtypes are associated with favorable prognostic outcomes. Desmoplastic melanoma is a rare variant with variable presentation that is marked histologically by fusiform melanocytes in a sclerotic stroma. Investigators have found that patients with pure desmoplastic melanoma (desmoplasia found throughout the tumor) have a more advanced Breslow depth and less regional metastasis than patients with conventional melanoma. Primary dermal melanoma, a more recently described variant that is confined to the dermis and may histologically resemble cutaneous metastasis, also appears to have improved survival compared with metastatic melanoma or primary nodular melanoma of equal Breslow thickness.

These cases challenge the current belief that large primary cutaneous melanomas of long duration connotes extensive metastatic disease and/or rapid death. Although our conclusions are somewhat limited by the inability to assess long-term outcomes in patient 2, both patients reported a prolonged duration of symptoms and had negative findings on metastatic workup, suggesting a less aggressive biology for these tumors. With the discovery of various genetic mutations in primary melanomas, there has been a recent movement to reclassify melanoma subtypes based on genetic profile, which may predict pathologic behavior and therefore outcome more accurately than histopathologic features. We propose that these cases may represent a distinct genetic subtype of giant melanoma that, while locally aggressive, lacks propensity for metastasis.

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Spindle Cell Squamous Carcinoma During BRAF Inhibitor Therapy for Advanced Melanoma: An Aggressive Secondary Neoplasm of Undetermined Biologic Potential

Secondary cutaneous squamous cell carcinomas (cSCCs) are adverse effects of BRAF inhibitor targeted therapy for advanced melanoma. The histologic type most commonly reported during vemurafenib and dabrafenib mesylate BRAF inhibitor therapy is well-differentiated keratoacanthoma-like cSCC (cSCC-KA). Lesions of cSCC-KA in BRAF inhibitor therapy are considered to have a low biologic potential (ie, infrequent metastasis or recurrence). Whereas the early follow-up (<3 years) in most patients seems to support this claim, it is unproven. Furthermore, optimal intervention for secondary BRAF inhibitor cSCC is not established. We report multiple biphasic...