p-16: immunohistochemical staining to differentiate an inflamed atypical nevus

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A 45-year-old white female with a history of metastatic melanoma to the left supraclavicular lymph node from an unknown primary melanoma on nivolumab presented to clinic.

There was a new pink papule with irregular vascularity on her right upper arm. (Fig 1)

Histopathology revealed small nests of melanocytes in the dermis with a brisk lymphocytic infiltrate and rare dermal mitotic figures, (Fig 2) consistent with either an inflamed atypical intradermal nevus secondary to immunotherapy or a cutaneous metastatic melanoma site.

Although histopathology is the gold standard for melanoma diagnosis, distinguishing between these two entities in this clinical setting requires further investigation.

The new papule on the arm demonstrated preservation of p16, while the previous melanoma showed a loss of p16.

Thus, this helped confirm that the new lesion was an inflamed melanocytic nevus secondary to treatment with nivolumab.

In the monitoring of patients who have had metastatic melanoma, repeat skin exams at specific intervals is a crucial screening tool to prevent recurrence.

At many of these visits, suspicious melanocytic lesions are biopsied to determine if they represent a return of the patient’s melanoma.

Here, we present a case of a suspicious atypical melanocytic nevus discovered during a skin exam following diagnosis of metastatic melanoma to a lymph node from an unknown primary lesion.

To determine whether this lesion was melanoma, p16 immunohistochemical staining was performed of both the lymph node biopsy and the nevus, and provided a reliable means for determining the nature of the nevus.

This information would be helpful to readers who care for patients with a history of melanoma who require differentiation of atypical nevi from recurrence of melanoma.