

We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

6,900

Open access books available

186,000

International authors and editors

200M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?
Contact book.department@intechopen.com

Numbers displayed above are based on latest data collected.
For more information visit www.intechopen.com



Acral Melanoma: Clinical, Biologic and Molecular Genetic Characteristics

Minoru Takata

*Department of Dermatology, Okayama University Postgraduate
School of Medical, Dentistry, and Pharmaceutical Sciences
Japan*

1. Introduction

Acral melanomas (AM) is a distinct subtype of melanoma affecting the palms, soles and nail apparatuses. It is mostly identical to acral lentiginous melanoma according to Clark's classification (Clark et al., 1986), but it may also include nodular melanoma and superficial spreading melanoma that developed on glabrous skin and nail apparatus (Curtin et al., 2005). While AM is the least frequent subtype of cutaneous melanoma overall in Caucasians, it is the most prevalent type of melanoma in people of color. Prognosis of AM is generally poor, which may be in part due to delay in diagnosis (Bradford et al., 2009).

The distinct histological and phenotypic characteristics suggest that AM might differ biologically from other types of cutaneous melanomas. Recent molecular genetic studies characterized AM as a unique type of melanoma showing higher frequency of chromosomal aberrations, especially focused amplifications of particular chromosome regions (Bastian et al., 2000; Curtin et al., 2005). Furthermore, recent discovery of frequent mutation or amplification of *KIT* gene in AM and mucosal melanoma has led to the molecular targeted therapy by approved drugs targeting KIT, such as imatinib, for advanced cases (Curtin et al., 2006). This would represent a first decisive step toward the individualized treatment of melanoma (Garrido & Bastian, 2010).

2. Epidemiology

Although AM accounts for 5% of all melanomas in the United States (Markovic et al., 2007)(Table 1), it is a predominant form of melanoma in individuals with darker skin (ie, Blacks, Asians and Hispanics) (Cormier et al., 2006). The proportion of AM among all melanoma subtypes is greatest in blacks followed by Asians/Pacific islanders and Hispanic whites (Bradford et al., 2009). The nation-wide survey in Japan shows that AM accounts for 41% of all melanomas (Ishihara et al., 2008)(Table 1), the rate being almost the same in Chinese (Chi et al., 2011). However, the absolute incidence of AM in darker-skinned individuals is similar to that in whites (Stevens et al., 1990; Bradford et al., 2009), who have a much higher incidence of melanoma overall due to the strong susceptibility to sunlight (Cormier et al., 2006). Thus, carcinogens other than ultraviolet light (UVL) equally affecting all ethnic groups or endogenous mutagenesis may play a role in the development of AM. Trauma may have a role in AM development, since 13% to 25% of patients with AM reported prelesional trauma, such as puncture wounds, friction blisters and stone bruises (Coleman et al., 1980; Phan et al.,

2006). The mean age at diagnosis of AM is 62.8 years, compared with 58.5 years for cutaneous melanoma overall. Incidence of AM significantly increases with each year of advancing age, which is seen across the different racial groups (Bradford et al., 2009).

Type of Melanoma ¹⁾	United States (Markovic et al., 2007)	Japan (Ishihara et al., 2008)
SSM	70%	17%
NM	5%	20%
LMM	4~15%	7%
ALM	5%	41%
Unknown	5~11%	13%

¹⁾SSM, superficial spreading melanoma; NM, nodular melanoma; LMM, lentigo maligna melanoma; ALM, acral lentiginous melanoma

Table 1. Comparison of melanoma types between the United States and Japan.

Although acral volar skin and nail beds constitutes only a few % of skin surface, the fact that nearly half of cutaneous melanomas arise on these anatomical sites in darker-skinned individuals indicates that these are predilection sites of melanomas not causally related to UVL exposure. The melanocyte density in palmoplantar skin is five times lower than that found in nonpalmoplantar sites. Furthermore, the growth and differentiation of palmoplantar melanocytes are suppressed by dickkopf 1 (DKK1) secreted from dermal fibroblasts through the down-regulation of microphthalmia-associated transcription factor (MITF) and beta-catenin (Yamaguchi et al., 2004). The reason why such growth-suppressed melanocytes in palmoplantar skin are more susceptible to melanoma development is currently unknown.

3. Clinical features

Clinically, AMs on palms and soles begin with irregularly pigmented macular lesions. The soles of the feet are most commonly involved. Morphological characteristics of early AM lesions include variable shades of brown from tan to black color, irregular and asymmetric shape often accompanied by notching at the periphery, and over 7mm in diameter (Saida, 1989) (Fig. 1a).

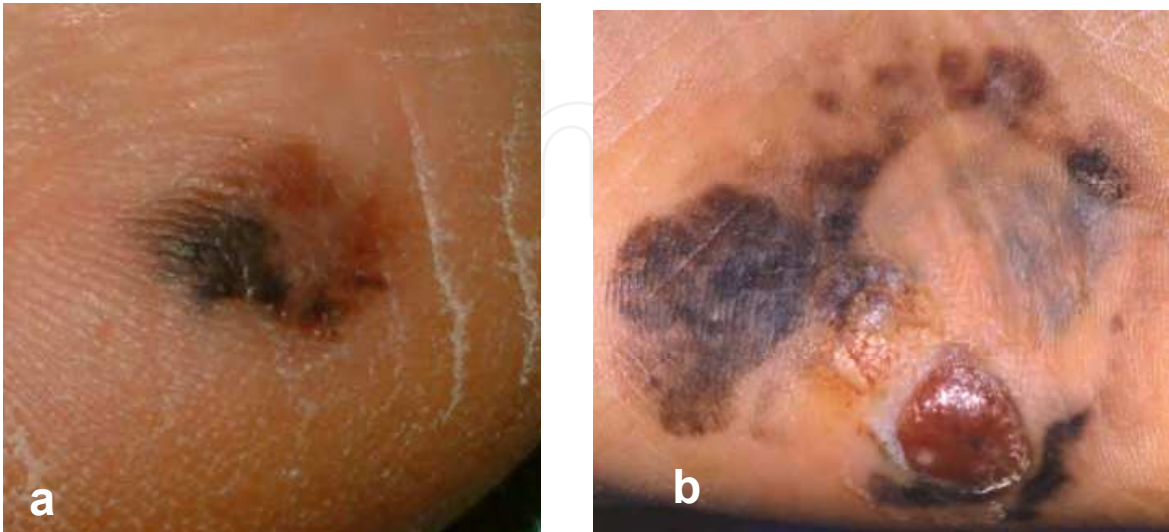


Fig. 1. Clinical pictures of radial growth phase (a) and tumorigenic vertical growth phase (b) of AM.

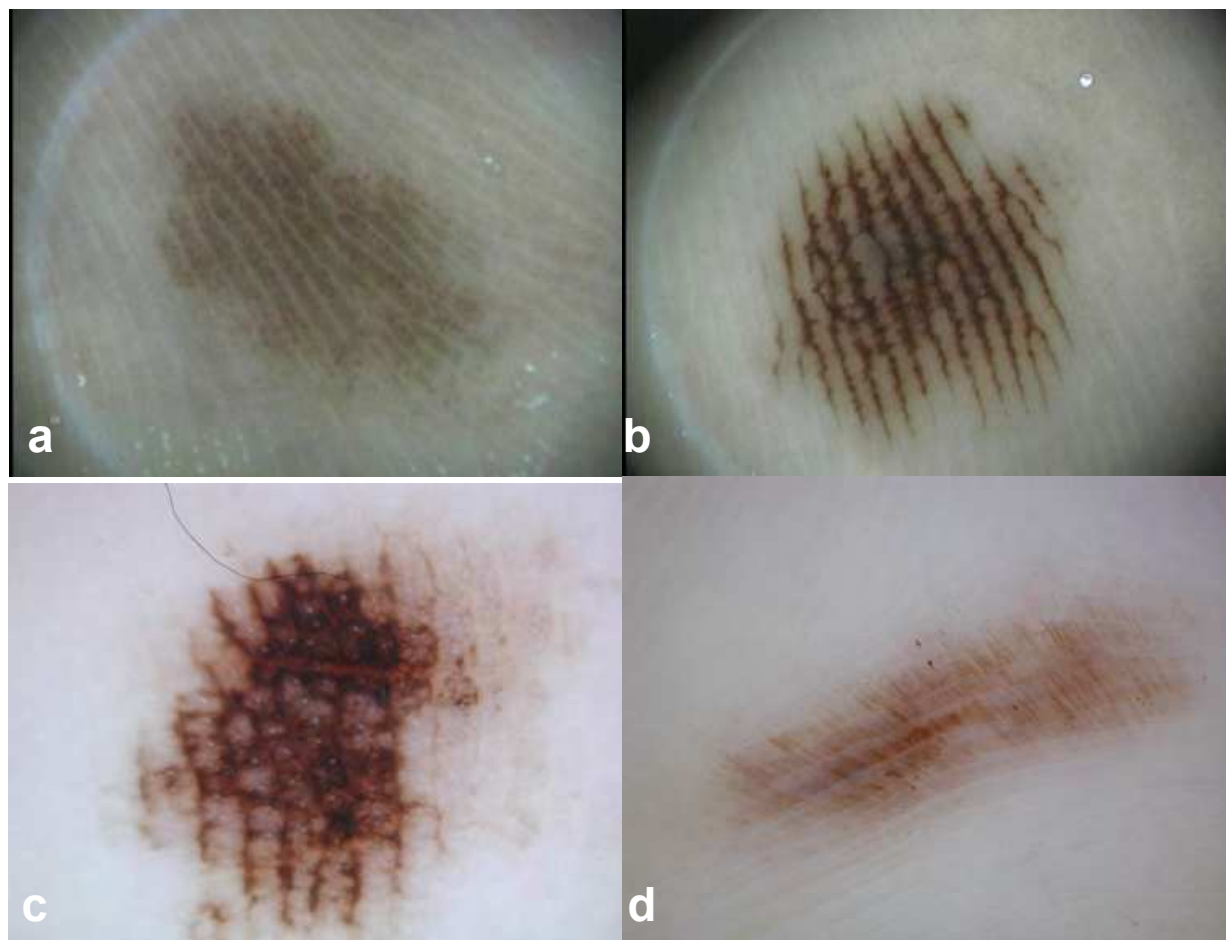


Fig. 2. Dermoscopy of early AM (a) and melanocytic nevus on acral volar skin (b, c, and d). a, parallel ridge pattern; b, parallel furrow pattern; c, lattice-like pattern; d, fibrillar pattern.

Dermoscopic observations of these early lesions show band-like pigmentation on ridges of the skin markings, designated as a “parallel ridge pattern” (Fig. 2a). This is in sharp contrast to the dermoscopic patterns in acral melanocytic nevi, which show parallel linear pigmentation along the sulci of the skin markings, designated as a “parallel furrow pattern” (Fig. 2b) and its variants “lattice-like pattern” (Fig. 2c) and “fibrillar pattern” (Fig. 2d) (Oguchi et al., 1998; Miyazaki et al., 2005). The sensitivity and specificity of the parallel ridge pattern in diagnosing early AM is 86% and 99%, respectively (Saida et al., 2004). A simple three-step algorithm effectively discriminating early AM from acral melanocytic nevi has been proposed (Fig. 3) (Saida et al., 2011). This algorithm classifies acquired pigmented lesions on acral volar skin by the dermoscopic findings and the maximal diameter, and recommends three management options including “no need to follow-up”, “periodic follow-up”, and “excision of the lesion for histopathological evaluation”.

In contrast to the palmoplantar melanoma, nail apparatus melanoma more often affects fingers than the toes. The digits most commonly affected are the thumb followed by the great toe. If the AM is situated in the nail matrix, a longitudinal pigmented band of the nail plate is the earliest sign (Fig. 4a). As melanocytic nevi of the nail matrix also typically accompany longitudinal melanonychia, identifying early nail matrix melanoma is challenging. Dermoscopy again provides useful information for this differentiation. The suspicious dermoscopic features of early nail matrix melanoma are irregular lines on a

brown background, pigmentation of the cuticle (micro-Hutchingson’s sign), a wide pigmented band, and triangular pigmentation on the nail plate (Fig. 4b) (Koga et al., 2011).

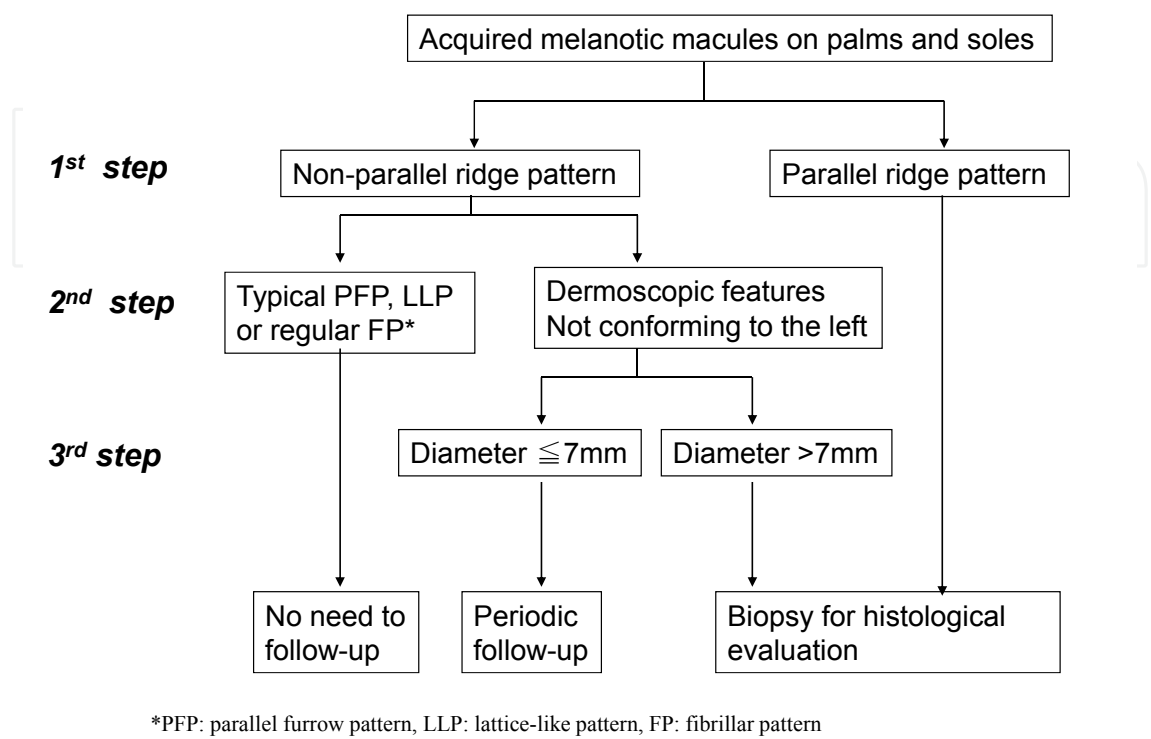


Fig. 3. Three-step algorithm for the management of acquired pigmented lesions on plams and soles (Adapted from Saida et al., 2011, with permission).

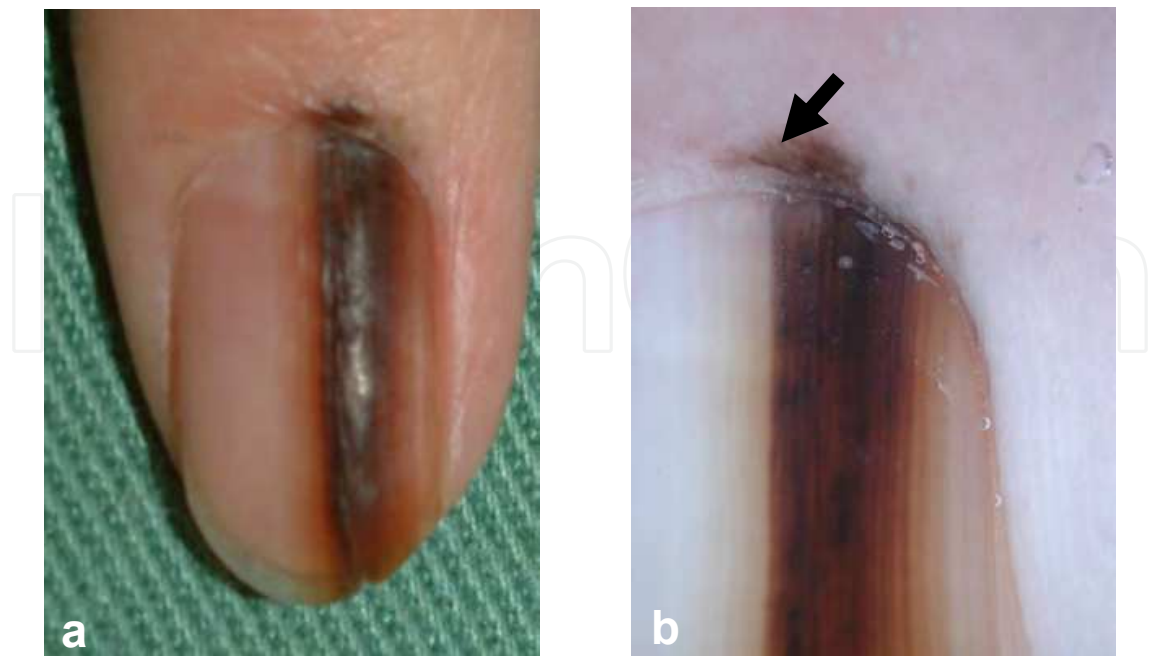


Fig. 4. Clinical (a) and dermoscopic (b) photographs of early nail matrix melanoma. The arrow indicates micro-Hutchingson’s sign.

The tumorigenic vertical growth phase of palmoplantar melanoma is characterized by the development of a nodule often associated with ulceration (Fig. 1b). The development of a subungual tumor and the destruction of the nail plate are observed in the vertical growth phase of nail apparatus melanoma.

4. Histopathology

Histopathology of the earliest lesions of palmoplantar melanoma shows proliferation of solitary arranged slightly atypical melanocytes mainly detected in the crista profunda intermedia, the epidermal rete ridge underlying the ridges of the skin markings (Ishihara et al., 2006). In early nail apparatus melanoma, slightly atypical melanocytes proliferate in the epidermis of nail matrix. Eventually, large atypical melanocytes, frequently with prominent pigmented dendrites, proliferate as single cells in the basal layer of the hyperplastic epidermis while some tumor cells can be found in the upper layer of the epidermis. Nesting of melanocytes is not prominent, and tends to occur at the tips of the rete ridges. Brisk lichenoid lymphocytic infiltrate that may obscure the dermal-epidermal junction is common. In the vertical growth phase, atypical tumor cells are often spindle-shaped. Desmoplastic change is not uncommon (Clark et al., 1986).

5. Molecular genetics

There exists clinical heterogeneity in cutaneous melanoma with different susceptibility to UVL, which may be explained by differences in somatic genetic changes. Recent molecular genetic investigations have revealed that melanomas from intermittently sun-exposed skin, most of which are located on trunk and extremities, show frequent mutations in either *BRAF* or *NRAS* gene. In contrast, *BRAF* or *NRAS* mutations are rather infrequent in melanomas arising from sun-protected areas, such as acral skin, nail apparatus and mucosa (Table 2). Instead, these types of melanomas show a higher degree of chromosomal aberrations; specifically, genomic amplifications involving small portions of chromosome arms (Curtin et al., 2005). In AM, the most frequently amplified region is chromosome 11q13 which contains the *cyclin D1* gene. Narrow amplifications of other chromosome regions, including 4q12, 5p15, 11q14 and 22q11-13, are also found (Bastian et al., 2000). Target genes of 4q12 and 11q14 amplifications appear to be *KIT* and *GAB2*, respectively (Curtin et al., 2006; Chernoff et al., 2009).

	Acral melanomas	Melanomas from intermittently sun-exposed skin	Reference
<i>BRAF</i>	23% mutated	59% mutated	(Curtin et al., 2005)
<i>NRAS</i>	10% mutated	22% mutated	(Curtin et al., 2005)
<i>KIT</i>	14% mutated 24% amplified	0% mutated 0% amplified	(Curtin et al., 2006)
<i>Cyclin D1</i>	44% amplified	5% amplified	(Sauter et al., 2002)
<i>GAB2</i>	19% amplified	3% amplified ^a	(Chernoff et al., 2009)

^a including one melanoma on face

Table 2. Comparison of somatic genetic changes between acral melanomas and melanomas from intermittently sun-exposed skin.

Cyclin D1 positively regulates the activity of cyclin dependent kinases, leading to phosphorylation of retinoblastoma protein promoting entry into mitosis, and acts as an oncogene (reviewed in (Tashiro et al., 2007)). Interestingly, while gene amplifications are usually found in association with disease progression in other cancers, *cyclin D1* gene amplifications in AM are detected early in the radial growth phase (Bastian et al., 2000). Furthermore, copy number increase of *cyclin D1* gene was observed even in normal-looking melanocytes in the epidermis beyond the histopathologically recognizable margin of melanoma (Bastian et al., 2000; North et al., 2008), as well as in very early acral melanoma *in situ* lesions, which shows slight increase of non-atypical melanocytes in the basal cell layer of the epidermis (Yamaura et al., 2005). These genetically aberrant cells with normal morphology are “field cells” (Bastian, 2003), which represent a latent progression phase that precedes the stage of atypical melanocyte proliferation in the epidermis. These observations suggest that amplification of the *cyclin D1* gene might be one of the earliest events in AM development. The presence of amplifications, however, indicates that other aberrations likely cause genomic instability (North et al., 2008). Investigations in a radial growth phase AM cell line SMYM-PRGP harboring *cyclin D1* amplification (Fig. 5) suggest that overly expressed cyclin D1 protein may act as a survival factor (Murata et al., 2007). While the progressive increase of the *cyclin D1* copy number from normal-looking melanocytes to the *in situ* portion to the invasive melanoma was observed, suggesting that the increased *cyclin D1* gene dosage confers a growth advantage during later stages of tumor progression (North et al., 2008), this may simply reflect the increase of genomic instability associated with melanoma progression (Takata et al., 2010).

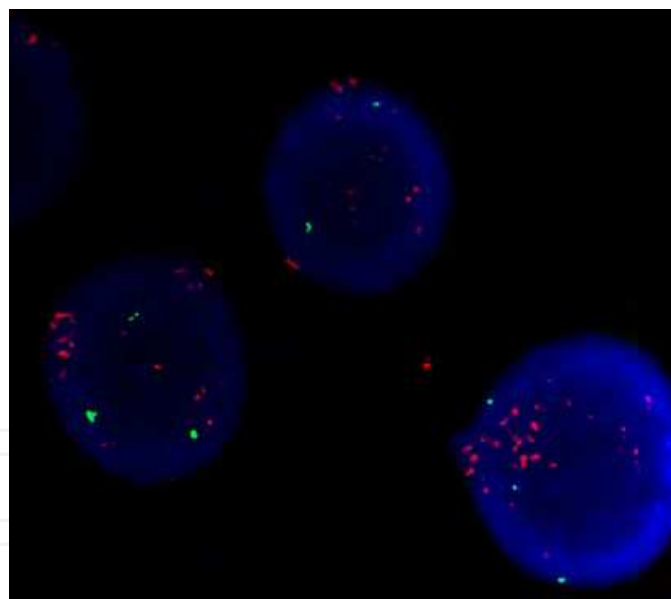


Fig. 5. Amplification of the *cyclin D1* gene in radial growth phase acral melanoma cell line SMYM-PRGP (Murata et al., 2007). Green signals, chromosome 11 centromere; red signals, *cyclin D1*.

While mutations of the *BRAF* and *NRAS* genes are infrequent in AM, a substantial number of AM harbor mutations or amplifications of the *KIT* gene encoding a receptor tyrosine kinase (Curtin et al., 2006). Recent studies have revealed *KIT* mutations and amplification in 14% and 24% of AMs, respectively (Table 2) (Woodman & Davies, 2010). About 30% of the tumors with *KIT* mutations also show increased copy number/amplification of *KIT*. The *KIT*

mutations identified in AM differ from those found in gastrointestinal stromal tumors (GIST). The majority of *KIT* mutations in GIST are deletions or insertions, whereas those found in melanoma are substitution mutations. In addition, *KIT* mutations are not present in exon 9, which is the location of 15% of *KIT* mutations in GIST. More than half of *KIT* mutations in melanoma are found in exon 11, which encodes juxtamembrane domain of *KIT* receptor, whereas mutations are also found in exons 13, 17 and 18 encoding kinase domains (Woodman & Davies, 2010).

GAB2 is a scaffolding protein that mediates interactions with various signaling pathways including RAS-RAF-ERK and PI3K-AKT signaling, and is a critical molecule for melanoma progression (Horst et al., 2009). A recent study found GAB2 amplification in 5 of 23 (19%) AMs, while amplifications were rare in other types of cutaneous melanomas (Table 2). The majority of GAB2 amplification occurred independent from genetic alterations in *BRAF*, *NRAS*, *KIT* and *cyclin D1*, suggesting a critical role of GAB2 in a subset of AM (Chernoff et al., 2009).

6. Molecular targeted therapy

Since *KIT* mutations are detected in ~15% of AM, *KIT* is a promising molecular target of metastatic AM. Several *in vitro* experiments using melanoma cell lines harboring *KIT* mutations have actually shown significant growth suppressive effects of small molecular *KIT* inhibitors, such as imatinib, which are already approved for other cancers. Imatinib dramatically decreased proliferation, and was cytotoxic to a mucosal melanoma cell line demonstrating a highly amplified *KIT* exon 11 V559D mutation (Jiang et al., 2008). In contrast, cell viability of another melanoma cell line with *KIT* exon 11 L576P mutation, the most common *KIT* mutation in melanoma (34%) (Woodman & Davies, 2010), was not reduced by imatinib. However, dasatinib reduced cell viability of this cell line at concentrations as low as 10nM. Molecular modeling studies found that the L576P mutation induces structural changes in *KIT* that reduce the affinity for imatinib but not for dasatinib (Woodman et al., 2009). An acral melanoma cell line with non-amplified *KIT* exon 17 D820Y was also resistant to imatinib treatment. The *KIT* D820Y mutation usually arises as a secondary mutation in the setting of imatinib treatment in GIST, which was shown to be sensitive to sunitinib. As expected, treatment of the *KIT* D820Y cell line with 1 μ M of sunitinib showed modest reduction in cell proliferation. (Ashida et al., 2009).

Clinically, dramatic response to imatinib therapy has been observed in several sporadic cases with metastatic acral and mucosal melanomas with *KIT* mutations, such as exon 13 K642E, 7-codon duplication in exon 11, and exon 11 V599A (Hodi et al., 2008; Lutzky et al., 2008; Terheyden et al., 2010). However, gene amplification and overexpression of wild-type *KIT*, which is frequently present in acral and mucosal melanomas (Woodman & Davies, 2010), did not translate into clinical efficacy of imatinib (Hofmann et al., 2009). Consistent with an *in vitro* study, metastatic melanoma patients with the *KIT* L576P mutation showed marked reduction (>50%) and elimination of tumor F18-fluorodeoxyglucose (FDG)-avidity by positron emission tomography (PET) imaging after dasatinib treatment (Woodman & Davies, 2010). Partial response by dasatinib was also observed in a patient with the *KIT* exon 13 K642E mutation (Kluger et al., 2010).

Three phase-II trials of imatinib in unselected metastatic melanomas were mostly disappointing, and highlighted the importance of proper patient selection (Ugurel et al., 2005; Wyman et al., 2006; Kim et al., 2008). There are currently three ongoing clinical trials

prospectively testing imatinib in selected patients with melanoma showing *KIT* mutations or amplifications (mostly acral and mucosal melanomas)(Table 3). The NCT00470470 trial selected stage III or IV patients with somatic mutations in *KIT*. Of the 12 evaluable patients, 2 demonstrated a complete response. Of note, these two patients had both amplification and mutation of *KIT*. A partial response was observed in two patients. All but two, who had mutations known to be resistant to imatinib in GIST, of the remaining patients had stable disease (Carvajal et al., 2009). In another phase-II trial of imatinib in patients with advanced melanoma from acral skin, mucosa or chronically sun-damaged skin (NCT00424515), five of ten patients with *KIT* mutations demonstrated a partial response. In contrast, none of the ten patients who had wild-type/amplified *KIT* showed a clinical response (Fisher et al., 2010). In the NCT00881049 trial which recruited Chinese patients with metastatic melanoma harboring *KIT* aberrations, a rate of 20% partial response and 40% stable disease was achieved, with 60% overall disease control rate (Guo et al., 2010). These results show clinical benefit of imatinib in a proportion of molecularly selected patients.

	Phase	NCT number	<i>KIT</i> aberrations required for eligibility
Imatinib	2	00470470	Mutation or amplification
Imatinib	2	00424515	Mutation or amplification
Imatinib	2	00881049	Mutation or amplification
Imatinib and temozolomide	1/2	00667953	Mutation
Nilotinib	2	00788775	Mutation or amplification
Nilotinib and dacarbazine	3	01028222	Mutation
Sunitinib	2	00631618	Mutation or amplification
Sunitinib	2	00577382	None
Dasatinib	2	00700882	None
Dasatinib and dacarbazine	1/2	00597038	None

Table 3. Clinical trials of *KIT* inhibitors for melanoma (Modified from Romano et al., 2011).

Nilotinib is a second-generation tyrosine kinase inhibitor of *KIT*, *PDGFR* and *BCR-ABL*. Nilotinib is potent as imatinib against mutant *KIT*, and is significantly more potent than imatinib against wild-type *KIT*. A phase-II trial of nilotinib in patients with melanoma characterized by a *KIT* mutation or amplification is ongoing, and a randomized phase-III, open-label study to compare the efficacy of nilotinib versus dacarbazine for treatment of patients with metastatic melanoma harboring a *KIT* mutation has been initiated. Phase-II trials testing other tyrosine kinase inhibitors targeting *KIT*, such as sunitinib and dasatinib, for melanoma are also ongoing (Table 3).

7. Conclusions

It is now clear that melanoma arises from multiple pathways, with initiating and promoting factors differing for each. Melanomas on intermittently sun-exposed skin preferentially affect Caucasians who have an inherently high propensity for melanocyte proliferation characterized by high nevus counts (Whiteman et al., 2003). Exposure to intense bursts of UVL radiation,

especially in childhood, is the major risk factor. This type of melanomas may arise from pre-existing melanocytic nevus, and the mutation of the *BRAF* gene may be a key initiating somatic genetic event (Michaloglou et al., 2008). By contrast, AM arises *de novo*, and equally affects all ethnic groups. The first genetic aberration affecting normal melanocytes in acral volar skin would be one that disrupts the maintenance of genomic integrity. This would lead to the amplification of *cyclin D1* and the selection for clonal expansion of affected melanocytes. Then, acquiring activating mutations in oncogenes, such as *KIT* (Curtin et al., 2006), may be a crucial step inducing proliferation of transformed melanocytes (Takata et al., 2010). Understanding molecular pathogenesis in different types of melanomas will lead to the development of effective prevention and treatment strategies for individual patients.

8. Acknowledgments

The author's works were supported by the Grants-in-Aid for Cancer Research from the Ministry of Health, Labor, and Welfare of Japan (15-10 and 21S-7), Grants-in-Aid for Scientific Research from the Japan Society for the Promotion of Science (17659336 and 20591318), and a Management Expenses Grant from the Japanese Government to the National Cancer Center (21S-7(6)). I thank many colleagues who worked with me at the Department of Dermatology, Shinshu University, Japan, for their contributions to the studies of acral melanoma.

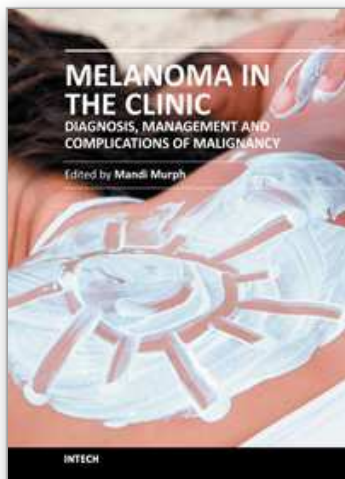
9. References

- Ashida, A., Takata, M., Murata, H., Kido, K. & Saida, T. (2009). Pathological activation of *KIT* in metastatic tumors of acral and mucosal melanomas. *Int J Cancer*, Vol. 124, No. 4, pp. 862-868, ISSN 1097-0215
- Bastian, B. C. (2003). Understanding the progression of melanocytic neoplasia using genomic analysis: from fields to cancer. *Oncogene*, Vol. 22, No. 20, pp. 3081-3086, ISSN 0950-9232
- Bastian, B. C., Kashani-Sabet, M., Hamm, H., Godfrey, T., Moore, D. H., 2nd, Brocker, E. B., LeBoit, P. E. & Pinkel, D. (2000). Gene amplifications characterize acral melanoma and permit the detection of occult tumor cells in the surrounding skin. *Cancer Res*, Vol. 60, No. 7, pp. 1968-1973, ISSN 0008-5472
- Bradford, P. T., Goldstein, A. M., McMaster, M. L. & Tucker, M. A. (2009). Acral lentiginous melanoma: incidence and survival patterns in the United States, 1986-2005. *Arch Dermatol*, Vol. 145, No. 4, pp. 427-434, ISSN 1538-3652
- Carvajal, R. D., Chapman, P. B., Wolchok, J. D., Cane, L., Teitcher, J. B. & Lutzky, J. (2009). A phase II study of imatinib mesylate (IM) for patients with advanced melanoma harboring somatic alterations of *KIT*. *Proceedings of the American Society of Clinical Oncology*, Orlando, May-June, 2009.
- Chernoff, K. A., Bordone, L., Horst, B., Simon, K., Twadell, W., Lee, K., Cohen, J. A., Wang, S., Silvers, D. N., Brunner, G. & Celebi, J. T. (2009). *GAB2* amplifications refine molecular classification of melanoma. *Clin Cancer Res*, Vol. 15, No. 13, pp. 4288-4291, ISSN 1078-0432
- Chi, Z., Li, S., Sheng, X., Si, L., Cui, C., Han, M., & Guo, J. (2011). Clinical presentation, histology, and prognosis of malignant melanoma in ethnic Chinese: A study of 522 consecutive cases. *BMC Cancer*, Vol. 11, pp. 85-94, ISSN 1471-2407

- Clark, W. H., Jr., Elder, D. E. & Van Horn, M. (1986). The biologic forms of malignant melanoma. *Hum Pathol*, Vol. 17, No. 5, pp. 443-450, ISSN 0046-8177
- Coleman, W. P., 3rd, Loria, P. R., Reed, R. J. & Krementz, E. T. (1980). Acral lentiginous melanoma. *Arch Dermatol*, Vol. 116, No. 7, pp. 773-776, ISSN 0003-987X
- Cormier, J. N., Xing, Y., Ding, M., Lee, J. E., Mansfield, P. F., Gershenwald, J. E., Ross, M. I. & Du, X. L. (2006). Ethnic differences among patients with cutaneous melanoma. *Arch Intern Med*, Vol. 166, No. 17, pp. 1907-1914, ISSN 0003-9926
- Curtin, J. A., Busam, K., Pinkel, D. & Bastian, B. C. (2006). Somatic activation of KIT in distinct subtypes of melanoma. *J Clin Oncol*, Vol. 24, No. 26, pp. 4340-4346, ISSN 1527-7755
- Curtin, J. A., Fridlyand, J., Kageshita, T., Patel, H. N., Busam, K. J., Kutzner, H., Cho, K. H., Aiba, S., Brocker, E. B., LeBoit, P. E., Pinkel, D. & Bastian, B. C. (2005). Distinct sets of genetic alterations in melanoma. *N Engl J Med*, Vol. 353, No. 20, pp. 2135-2147, ISSN 1533-4406
- Fisher, D. E., Barnhill, R., Hodi, F. S., Herlyn, M., Merlino, G., Medrano, E., Bastian, B., Landi, M. T. & Sosman, J. (2010). Melanoma from bench to bedside: meeting report from the 6th international melanoma congress. *Pigment Cell Melanoma Res*, Vol. 23, No. 1, pp. 14-26, ISSN 1755-148X
- Garrido, M. C. & Bastian, B. C. (2010). KIT as a therapeutic target in melanoma. *J Invest Dermatol*, Vol. 130, No. 1, pp. 20-27, ISSN 1523-1747
- Guo, J., Si, L., Kong, Y., Xu, X. w., Flaherty, K. T., Corless, C. L., Zhu, Y. Y., Li, L. & Li, H. F. (2010). A phase II study of imatinib for advanced melanoma patients with KIT aberrations. *Proceedings of the American Society of Clinical Oncology*, Chicago, June, 2010.
- Hodi, F. S., Friedlander, P., Corless, C. L., Heinrich, M. C., Mac Rae, S., Kruse, A., Jagannathan, J., Van den Abbeele, A. D., Velazquez, E. F., Demetri, G. D. & Fisher, D. E. (2008). Major response to imatinib mesylate in KIT-mutated melanoma. *J Clin Oncol*, Vol. 26, No. 12, pp. 2046-2051, ISSN 1527-7755
- Hofmann, U. B., Kauczok-Vetter, C. S., Houben, R. & Becker, J. C. (2009). Overexpression of the KIT/SCF in uveal melanoma does not translate into clinical efficacy of imatinib mesylate. *Clin Cancer Res*, Vol. 15, No. 1, pp. 324-329, ISSN 1078-0432
- Horst, B., Gruvberger-Saal, S. K., Hopkins, B. D., Bordone, L., Yang, Y., Chernoff, K. A., Uzoma, I., Schwipper, V., Liebau, J., Nowak, N. J., Brunner, G., Owens, D., Rimm, D. L., Parsons, R. & Celebi, J. T. (2009). Gab2-mediated signaling promotes melanoma metastasis. *Am J Pathol*, Vol. 174, No. 4, pp. 1524-1533, ISSN 1525-2191
- Ishihara, K., Saida, T., Otsuka, F. & Yamazaki, N. (2008). Statistical profiles of malignant melanoma and other skin cancers in Japan: 2007 update. *Int J Clin Oncol*, Vol. 13, No. 1, pp. 33-41, ISSN 1341-9625
- Ishihara, Y., Saida, T., Miyazaki, A., Koga, H., Taniguchi, A., Tsuchida, T., Toyama, M. & Ohara, K. (2006). Early acral melanoma in situ: correlation between the parallel ridge pattern on dermoscopy and microscopic features. *Am J Dermatopathol*, Vol. 28, No. 1, pp. 21-27, ISSN 0193-1091
- Jiang, X., Zhou, J., Yuen, N. K., Corless, C. L., Heinrich, M. C., Fletcher, J. A., Demetri, G. D., Widlund, H. R., Fisher, D. E. & Hodi, F. S. (2008). Imatinib targeting of KIT-mutant oncoprotein in melanoma. *Clin Cancer Res*, Vol. 14, No. 23, pp. 7726-7732, ISSN 1078-0432
- Kim, K. B., Eton, O., Davis, D. W., Frazier, M. L., McConkey, D. J., Diwan, A. H., Papadopoulos, N. E., Bedikian, A. Y., Camacho, L. H., Ross, M. I., Cormier, J. N., Gershenwald, J. E., Lee, J. E., Mansfield, P. F., Billings, L. A., Ng, C. S.,

- Charnsangavej, C., Bar-Eli, M., Johnson, M. M., Murgo, A. J. & Prieto, V. G. (2008). Phase II trial of imatinib mesylate in patients with metastatic melanoma. *Br J Cancer*, Vol. 99, No. 5, pp. 734-740, ISSN 1532-1827
- Kluger, H. M., Dudek, A. Z., McCann, C., Ritacco, J., Southard, N., Jilaveanu, L. B., Molinaro, A. & Sznol, M. (2010). A phase 2 trial of dasatinib in advanced melanoma. *Cancer*, Vol. 117, No. 10, pp. 2202-2208 ISSN 0008-543X
- Koga, H., Saida, T. & Uhara, H. (2011). Key point in dermoscopic differentiation between early nail apparatus melanoma and benign longitudinal melanonychia. *J Dermatol*, Vol. 38, No. 1, pp. 45-52, ISSN 1346-8138
- Lutzky, J., Bauer, J. & Bastian, B. C. (2008). Dose-dependent, complete response to imatinib of a metastatic mucosal melanoma with a K642E KIT mutation. *Pigment Cell Melanoma Res*, Vol. 21, No. 4, pp. 492-493, ISSN 1755-1471
- Markovic, S. N., Erickson, L. A., Rao, R. D., Weenig, R. H., Pockaj, B. A., Bardia, A., Vachon, C. M., Schild, S. E., McWilliams, R. R., Hand, J. L., Laman, S. D., Kottschade, L. A., Maples, W. J., Pittelkow, M. R., Pulido, J. S., Cameron, J. D. & Creagan, E. T. (2007). Malignant melanoma in the 21st century, part 1: epidemiology, risk factors, screening, prevention, and diagnosis. *Mayo Clin Proc*, Vol. 82, No. 3, pp. 364-380, ISSN 0025-6196
- Michaloglou, C., Vredeveld, L. C., Mooi, W. J. & Peeper, D. S. (2008). BRAF(E600) in benign and malignant human tumours. *Oncogene*, Vol. 27, No. 7, pp. 877-895, ISSN 1476-5594
- Miyazaki, A., Saida, T., Koga, H., Oguchi, S., Suzuki, T. & Tsuchida, T. (2005). Anatomical and histopathological correlates of the dermoscopic patterns seen in melanocytic nevi on the sole: a retrospective study. *J Am Acad Dermatol*, Vol. 53, No. 2, pp. 230-236, ISSN 1097-6787
- Murata, H., Ashida, A., Takata, M., Yamaura, M., Bastian, B. C. & Saida, T. (2007). Establishment of a novel melanoma cell line SMYM-PRGP showing cytogenetic and biological characteristics of the radial growth phase of acral melanomas. *Cancer Sci*, Vol. 98, No. 7, pp. 958-963, ISSN 1347-9032
- North, J. P., Kageshita, T., Pinkel, D., Leboit, P. E. & Bastian, B. C. (2008). Distribution and Significance of Occult Intraepidermal Tumor Cells Surrounding Primary Melanoma. *J Invest Dermatol*, Vol. 128 No. 8 pp. 2024-2030, ISSN 1523-1747
- Oguchi, S., Saida, T., Koganehira, Y., Ohkubo, S., Ishihara, Y. & Kawachi, S. (1998). Characteristic epiluminescent microscopic features of early malignant melanoma on glabrous skin. A videomicroscopic analysis. *Arch Dermatol*, Vol. 134, No. 5, pp. 563-568, ISSN 0003-987X
- Phan, A., Touzet, S., Dalle, S., Ronger-Savle, S., Balme, B. & Thomas, L. (2006). Acral lentiginous melanoma: a clinicoprognostic study of 126 cases. *Br J Dermatol*, Vol. 155, No. 3, pp. 561-569, ISSN 0007-0963
- Romano, E., Schwartz, G. K., Chapman, P. B., Wolchock, J. D. & Carvajal, R. D. (2011). Treatment implications of the emerging molecular classification system for melanoma. *Lancet Oncol*, Vol. No. pp. ISSN 1474-5488
- Saida, T. (1989). Malignant melanoma in situ on the sole of the foot. Its clinical and histopathologic characteristics. *Am J Dermatopathol*, Vol. 11, No. 2, pp. 124-130, ISSN 0193-1091
- Saida, T., Koga, H. & Uhara, H. (2011). Key points in dermoscopic differentiation between early acral melanoma and acral nevus. *J Dermatol*, Vol. 38, No. 1, pp. 25-34, ISSN 1346-8138
- Saida, T., Miyazaki, A., Oguchi, S., Ishihara, Y., Yamazaki, Y., Murase, S., Yoshikawa, S., Tsuchida, T., Kawabata, Y. & Tamaki, K. (2004). Significance of dermoscopic patterns

- in detecting malignant melanoma on acral volar skin: results of a multicenter study in Japan. *Arch Dermatol*, Vol. 140, No. 10, pp. 1233-1238, ISSN 0003-987X
- Sauter, E. R., Yeo, U. C., von Stemm, A., Zhu, W., Litwin, S., Tichansky, D. S., Pistrutto, G., Nesbit, M., Pinkel, D., Herlyn, M. & Bastian, B. C. (2002). Cyclin D1 is a candidate oncogene in cutaneous melanoma. *Cancer Res*, Vol. 62, No. 11, pp. 3200-3206, ISSN 0008-5472
- Stevens, N. G., Liff, J. M. & Weiss, N. S. (1990). Plantar melanoma: is the incidence of melanoma of the sole of the foot really higher in blacks than whites? *Int J Cancer*, Vol. 45, No. 4, pp. 691-693, ISSN 0020-7136
- Takata, M., Murata, H. & Saida, T. (2010). Molecular pathogenesis of malignant melanoma: a different perspective from the studies of melanocytic nevus and acral melanoma. *Pigment Cell Melanoma Res*, Vol. 23, No. 1, pp. 64-71, ISSN 1755-148X
- Tashiro, E., Tsuchiya, A. & Imoto, M. (2007). Functions of cyclin D1 as an oncogene and regulation of cyclin D1 expression. *Cancer Sci*, Vol. 98, No. 5, pp. 629-635, ISSN
- Terheyden, P., Houben, R., Pajouh, P., Thorns, C., Zillikens, D. & Becker, J. C. (2010). Response to imatinib mesylate depends on the presence of the V559A-mutated KIT oncogene. *J Invest Dermatol*, Vol. 130, No. 1, pp. 314-316, ISSN 1523-1747
- Ugurel, S., Hildenbrand, R., Zimpfer, A., La Rosee, P., Paschka, P., Sucker, A., Keikavoussi, P., Becker, J. C., Rittgen, W., Hochhaus, A. & Schadendorf, D. (2005). Lack of clinical efficacy of imatinib in metastatic melanoma. *Br J Cancer*, Vol. 92, No. 8, pp. 1398-1405, ISSN 0007-0920
- Whiteman, D. C., Watt, P., Purdie, D. M., Hughes, M. C., Hayward, N. K. & Green, A. C. (2003). Melanocytic nevi, solar keratoses, and divergent pathways to cutaneous melanoma. *J Natl Cancer Inst*, Vol. 95, No. 11, pp. 806-812, ISSN 1460-2105
- Woodman, S. E. & Davies, M. A. (2010). Targeting KIT in melanoma: a paradigm of molecular medicine and targeted therapeutics. *Biochem Pharmacol*, Vol. 80, No. 5, pp. 568-574, ISSN 1873-2968
- Woodman, S. E., Trent, J. C., Stemke-Hale, K., Lazar, A. J., Pricl, S., Pavan, G. M., Fermeiglia, M., Gopal, Y. N., Yang, D., Podoloff, D. A., Ivan, D., Kim, K. B., Papadopoulos, N., Hwu, P., Mills, G. B. & Davies, M. A. (2009). Activity of dasatinib against L576P KIT mutant melanoma: molecular, cellular, and clinical correlates. *Mol Cancer Ther*, Vol. 8, No. 8, pp. 2079-2085, ISSN 1538-8514
- Wyman, K., Atkins, M. B., Prieto, V., Eton, O., McDermott, D. F., Hubbard, F., Byrnes, C., Sanders, K. & Sosman, J. A. (2006). Multicenter Phase II trial of high-dose imatinib mesylate in metastatic melanoma: significant toxicity with no clinical efficacy. *Cancer*, Vol. 106, No. 9, pp. 2005-2011, ISSN 0008-543X
- Yamaguchi, Y., Itami, S., Watabe, H., Yasumoto, K., Abdel-Malek, Z. A., Kubo, T., Rouzaud, F., Tanemura, A., Yoshikawa, K. & Hearing, V. J. (2004). Mesenchymal-epithelial interactions in the skin: increased expression of dickkopf1 by palmoplantar fibroblasts inhibits melanocyte growth and differentiation. *J Cell Biol*, Vol. 165, No. 2, pp. 275-285, ISSN 0021-9525
- Yamaura, M., Takata, M., Miyazaki, A. & Saida, T. (2005). Specific dermoscopy patterns and amplifications of the cyclin D1 gene to define histopathologically unrecognizable early lesions of acral melanoma in situ. *Arch Dermatol*, Vol. 141, No. 11, pp. 1413-1418, ISSN 0003-987X



Melanoma in the Clinic - Diagnosis, Management and Complications of Malignancy

Edited by Prof. Mandi Murph

ISBN 978-953-307-571-6

Hard cover, 310 pages

Publisher InTech

Published online 23, August, 2011

Published in print edition August, 2011

This book provides an excellent overview of how melanoma is treated in the clinic. Since oncologists and clinicians across the globe contributed to this book, each area also explores the unique burdens that geographical areas experience from melanoma subtypes and how these are treated in different settings. It also includes several chapters that illustrate novel methods for diagnosing melanoma in the clinic using new technologies, which are likely to significantly improve outcomes. Several chapters cover surgical techniques and other present very rare or challenging clinical cases of melanoma and how these were treated. The book is geared towards informing clinicians and even patients how melanoma arises, what tools are available and which decisions need to be made by patients and their families in order to treat this devastating disease.

How to reference

In order to correctly reference this scholarly work, feel free to copy and paste the following:

Minoru Takata (2011). Acral Melanoma: Clinical, Biologic and Molecular Genetic Characteristics, Melanoma in the Clinic - Diagnosis, Management and Complications of Malignancy, Prof. Mandi Murph (Ed.), ISBN: 978-953-307-571-6, InTech, Available from: <http://www.intechopen.com/books/melanoma-in-the-clinic-diagnosis-management-and-complications-of-malignancy/acral-melanoma-clinical-biologic-and-molecular-genetic-characteristics>

INTECH
open science | open minds

InTech Europe

University Campus STeP Ri
Slavka Krautzeka 83/A
51000 Rijeka, Croatia
Phone: +385 (51) 770 447
Fax: +385 (51) 686 166
www.intechopen.com

InTech China

Unit 405, Office Block, Hotel Equatorial Shanghai
No.65, Yan An Road (West), Shanghai, 200040, China
中国上海市延安西路65号上海国际贵都大饭店办公楼405单元
Phone: +86-21-62489820
Fax: +86-21-62489821

© 2011 The Author(s). Licensee IntechOpen. This chapter is distributed under the terms of the [Creative Commons Attribution-NonCommercial-ShareAlike-3.0 License](https://creativecommons.org/licenses/by-nc-sa/3.0/), which permits use, distribution and reproduction for non-commercial purposes, provided the original is properly cited and derivative works building on this content are distributed under the same license.

IntechOpen

IntechOpen