

**Reply to “Comment on ‘Association of subungual melanoma and subungual squamous cell carcinoma: A case series’”**



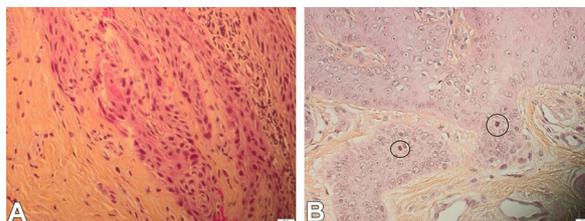
*To the Editor:* We would like to thank the authors for their comments<sup>1</sup> on our article “Association of subungual melanoma and subungual squamous cell carcinoma: A case series.”<sup>2</sup> The presence of onycholemmal cysts near a subungual melanoma is possible and not unusual. Like the authors, we have analyzed and described them numerous times.

Nevertheless, we do not think that onycholemmal cysts associated with a subungual melanoma is the diagnosis in our published series because of the presence in all our patients of architectural and cellular atypia, dyskeratotic cells, and mitoses. These modifications might not be evident on photographs at low magnification but are more evident on high-magnification photographs. We hope these features are seen more clearly on these additional images (Fig 1).

Moreover, in our series, most cases had a dermoscopic semiology of melanoma (irregular pattern of parallel microlines on a brown background [5/7]), and associated squamous cell carcinoma (SCC) was a histopathologic incidental finding. In several other cases, the situation was the opposite, with clinical and dermoscopic features suggestive of subungual SCC with incidental histopathologic findings in favor of an associated acral lentiginous melanoma. For example, case 6 involved erythronychia with the presence of blood spots with atypical vessels, distal triangular plate erosion, and localized hyperkeratosis (Fig 2), and case 7 involved an irregular pattern of parallel microlines on a gray background (see clinical and dermoscopic images in the original article).<sup>2</sup> Longitudinal melanonychia is also not uniquely associated with subungual melanoma, as it is also a frequent finding in subungual SCC (present in 27.3% of cases).<sup>3</sup>

Therefore, we continue to stand by our diagnosis of subungual melanoma associated with a SCC, but we agree that the interpretation of pathologic and histologic images can be subjective.

If there was sufficient material to do so, it would be interesting to further investigate this issue and microdissect the part we interpreted as SCCs in our published case series and perform RNA sequencing. We could then compare the results with RNA sequencing performed on other microdissected onycholemmal cysts and isolated subungual SCCs to evaluate if the RNA sequencing profile of our published patients is closer to that of an onycholemmal cyst or a subungual SCC.



**Fig 1.** Two histologic images of samples from patients in our case series with SSCC subungual melanoma. **A**, SSCC showing architectural and cytologic atypia. **B**, SSCC showing architectural atypia and mitoses (circled). (Original magnification:  $\times 40$ .) SSCC, Subungual squamous cell carcinoma.



**Fig 2.** Clinical and dermoscopic aspect of patient 6. Monodactyl erythronychia with the presence of blood spots with atypical vessels and distal triangular plate erosion.

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