Dysplastic Nevus
Panel Discussion

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Stanford Dermatopathology Service

Joshua Schulman, MD
Director of Dermatopathology, Sacramento Veterans Affairs Medical Center
Definitions, Diagnostic criteria
Dysplastic nevus

- Major criteria (required)
  - basilar proliferation of atypical melanocytes extending 3 rete ridges beyond a dermal component (if present) i.e. “shoulder”
  - intraepidermal melanocytic proliferation (lentiginous or epithelioid)

- Minor criteria (≥ 2)
  - fusion of rete ridges
  - concentric/lamellar eosinophilic fibrosis
  - inflammatory host response
  - neovascularization

Atypical nevus/mole

- Usually 4-12 mm
- Asymmetry
- Irregular pigmentation
- Irregular border
- Ill-defined border
- Macular component, usually peripheral

Dysplastic nevus syndrome
atypical mole syndrome, B-K mole syndrome, familial melanoma syndrome, familial atypical multiple mole-melanoma (FAMMM)

• OMIM #155600

**NIH Consensus criteria**
- Occurrence of melanoma in ≥1 first- or second-degree relatives
- Large number of nevi (often >50), some of which are clinically atypical
- (and) Nevi with certain distinct histologic features

**Dutch working group criteria**
Sporadic dysplastic nevus syndrome
- Melanoma and ≥1 severely clinically atypical nevi

Familial dysplastic nevus syndrome
- Two close relatives with melanoma (with or without atypical nevi)
- 1 relative with atypical nevi

**Revised (British group) dysplastic nevus syndrome score**
- ≥ 100 nevi of size >2 mm (≥50 if <20 or >50 years of age)—1 point
- ≥ 2 atypical nevi—1 point
- ≥1 nevus on buttocks—1 point
- ≥2 nevi on the dorsa feet—1 point

If total score is >2, the patient has dysplastic nevus syndrome
How small can a dysplastic nevus be?

- Small diameter is < 4 mm
- N=261 small nevi
- 72% exhibited diagnostic histologic features of DN/NAD
- Conclusion: small nevi should be classified as DN/NAD, regardless of small diameter.

Dysplastic nevi
how special are they?

Founder
Convert
Skeptic
Agnostic
Atheist

Wallace H. Clark Jr MD
(1924-1997)

A. Bernard Ackerman MD
(1936-2008)
Origin of Familial Malignant Melanomas From Heritable Melanocytic Lesions

'The B-K Mole Syndrome'

Wallace H. Clark, Jr, MD; Ronald R. Reimer, MD; Mark Greene, MD; Ann M. Ainsworth, MD; Michael J. Mastrangelo, MD

- Distinctive melanocytic moles are described in 37 patients from six melanoma families. Among the family members examined by the authors, 15 of 17 patients with melanoma and 22 of 41 non-melanoma relatives had the unique moles. The clinical and histological features of these moles have been designated the “B-K mole syndrome.” The clinical features of the syndrome include the presence of <10 to >100 moles prominent on the upper trunk and extremities, and variability of mole size (5 mm to 15 mm), outline, and color combination. Histologically, B-K moles show atypical melanocytic hyperplasia, lymphocytic infiltration, delicate fibroplasia, and new blood vessels that occur within a compound nevus or de novo. The transformation of two B-K moles into malignant melanomas was documented photographically.

(Arch Dermatol 114:732-738, 1978)
Defining melanocytic dysplasia
Clark WH, et al. 1978

• “Histology is required for diagnosis of B-K moles. . . The intraepidermal component is similar to that of ordinary melanocytic nevi. The dermal component is uniformly cellular, is limited to the papillary dermis, and does not show evidence of neurotization. Some of the large moles, usually those with pink areas and an irregular outline, will show the microscopic changes distinctive for the B-K mole syndrome. Such changes are superimposed upon the compound melanocytic nevus and include atypical melanocytic hyperplasia, mesenchymal changes in the papillary dermis, and a lymphocytic infiltrate. The term ‘atypical melanocytic hyperplasia’ as used by us, is synonymous with melanocytic dysplasia, i.e., individual melanocytes or small clusters of melanocytes that have some of the structural features of malignant melanocytes, but whose potential for development into obvious melanoma is obscure. The situation is precisely analogous to cervical dysplasia”

Defining melanocytic dysplasia

Clark WH, et al. 1978

• “The atypical melanocytes may be isolated in the basilar epidermal area or may be disposed in irregular, ellipsoidally shaped nests, the long axis of which tends to parallel the dermal-epidermal interface. The individual melanocytes are large and relatively pale; mitotic figures may be observed. The cells are frequently spindled in form, but they may be epithelioid. The cytoplasm is abundant and filled with fine, "dusty" melanin granules. In foci where one sees atypical melanocytes, mesenchymal changes and an infiltrate of lymphocytes and macrophages. The papillary dermis is widened because of delicate fibroplasia and new blood vessel formation. Virtually indistinguishable from the histology of regression commonly seen in malignant melanoma, The atypical melanocytes of B-K moles are present focally within nevi. Multiple sections may be necessary to demonstrate them.”

Defining melanocytic dysplasia
Clark WH, et al. 1984

“... atypical melanocytes may appear in the area of persistent melanocytic growth at the shoulder of a nevus (aberrant differentiation). Such atypical cells vary from one nevus to another, but two forms are apparent. The first is seen within a prominent area of lentiginous melanocytic hyperplasia. Characteristically, it appears as a large, hyperchromatic nucleus surrounded by a rather sparse amount of cytoplasm, frequently showing artifactual shrinkage. We have described this type of atypia as lentiginous melanocytic dysplasia. The second form of atypical melanocyte is larger, owing to an abundance of cytoplasm, and usually contains finely divided pigment. This cytoplasm rarely shows artifactual shrinkage and surrounds a large nucleus that tends to be spherical and somewhat less chromatic than those of lentiginous melanocytic atypia. We have termed this second type of atypia epithelioid melanocytic dysplasia. These atypical cells may be mixed with areas of lentiginous melanocytic atypia, or they may be present as isolated cells at the shoulder of a nevus or in the epidermis over the central region of a nevus... In this paper we use the term melanocytic dysplasia to include both persistent lentiginous melanocytic hyperplasia and melanocytic nuclear atypia. However, the sine qua non of melanocytic dysplasia remains melanocytic nuclear atypia.”
Fig 9.—Atypical melanocytic hyperplasia at dermoepidermal interface. Higher magnification of area near right margin of Fig 7 (hematoxylin-eosin, x 608).

FIG. 5.5 (Original fig. 9) At very high magnification, cells of even normal structures can be seen to have nuclei that are slightly pleomorphic. That surely is true of abnormal cells, such as the melanocytes that compose a melanocytic nevus. Because the melanocytes pictured here are not strikingly large or pleomorphic, we do not regard them as atypical.


• Minimal histologic criteria?
  • Clark: “... About 4 mm in width.”
Dyplastic congenital nevus? 
“an undefined number of cases . . .”

A small congenital nevus in which junctional nests extend beyond the dermal component and bridge adjacent rete

Clark: “Of the difficult situations presented, this one has given me the greatest problems. Sometimes I cannot distinguish these from dysplastic nevus.”

Nevus w dysplastic and congenital features
Dysplastic nevus
Overlapping cytology with common nevus
Interobserver variation: DN or not?

• **92% concordance**

• **Interobserver concordance “fair”**

**TABLE 1. Histopathologic criteria for dysplastic nevi**

<table>
<thead>
<tr>
<th>Features</th>
<th>Elder</th>
<th>Maize</th>
<th>Friedman/Heilman</th>
<th>Sagebiel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymmetry of the melanocytic lesion</td>
<td>Minor</td>
<td>Major</td>
<td>Major</td>
<td>Major</td>
</tr>
<tr>
<td>Poor circumscription of the lesion</td>
<td>Minor</td>
<td>Major</td>
<td>Major</td>
<td>Major</td>
</tr>
<tr>
<td>Lateral extension of the epidermal component beyond the dermal component (i.e., &quot;shoulders&quot;)</td>
<td>Major</td>
<td>Major</td>
<td>Major</td>
<td>Major</td>
</tr>
<tr>
<td>Variation in size and shape of junctional melanocytic nests</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>Nests of melanocytes along lateral aspects of rete ridges</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>Bridging of adjacent nests of melanocytes</td>
<td>Major</td>
<td>Minor</td>
<td>Minor</td>
<td>Major</td>
</tr>
<tr>
<td>Parallel orientation of some of the junctional nests of melanocytes with the surface epithelium</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
<td>Major</td>
</tr>
<tr>
<td>Presence of epidermal cytologic atypia (i.e., melanocytes having large, hyperchromatic, pleomorphic nuclei)</td>
<td>Major</td>
<td>Minor</td>
<td>Consist. (random)</td>
<td>Consist.</td>
</tr>
<tr>
<td>Presence of melanocytic mitotic figures within the epidermis (no. per hpf)</td>
<td>Inconsist.</td>
<td>Consist. (≤1/10 hpf)</td>
<td>Consist. (1–2 rarely)</td>
<td>Inconsist.</td>
</tr>
<tr>
<td>the dermis (no. per hpf)</td>
<td>Inconsist.</td>
<td>Inconsist.</td>
<td>Consist. (rarely)</td>
<td>Inconsist.</td>
</tr>
<tr>
<td>Presence of fibrosis</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>Lamellar fibrosis</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>Eosinophilic or nonspecific fibrosis</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
<td>Minor</td>
</tr>
<tr>
<td>Presence of inflammation</td>
<td>Major</td>
<td>Minor</td>
<td>Consist.</td>
<td>Minor</td>
</tr>
<tr>
<td>Bandlike</td>
<td>Consistent</td>
<td>Minor</td>
<td>Consist.</td>
<td>Minor</td>
</tr>
</tbody>
</table>
2014

“There is no gold standard for the diagnosis of a dysplastic nevus.”

In this issue of the Journal, Rosendahl et al (1), sacrifice yet a few more trees in the ongoing, seemingly never-ending controversy surrounding the so-called “dysplastic” nevus. Is this latest sacrifice going to make significant changes in how these lesions are named and treated or is this yet another quixotic tilting at windmills? There is an almost religious zeal that has burned hotly and brightly about this issue virtually since the description of this new cancer syndrome was published in 1978 by Wallace Clark and his coworkers. (2) Rosendahl et al have
### What are the minimal criteria?

<table>
<thead>
<tr>
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<tr>
<td>Nuclear atypia</td>
<td>✓</td>
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<td></td>
<td></td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Shoulder</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Bridging</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Lamellar/ concentric fibrosis</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Host response</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>SK-like epidermal changes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spitz-nevus like</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Congenital pattern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
Grading
Interobserver variation: grading

• 35-58% concordance among experienced dermatologists

• dysplasia can be reproducibly graded statistically
  • pairwise exact agreement 63%
Atypical nevus clinical criteria

• Assessment of clinical atypia: slight to fair agreement
• Clinical-path correlation: fair/moderate

Clinical-path correlation

- Nevi ≤ 3mm as likely to have histologic dysplasia as those larger


- Histologic dysplasia occurs in clinically benign nevi.

Dysplastic nevus

• To grade or not to grade . . . ?
  • What grading scale to use?
    • 2-tier
    • 3-tier (mild/mod/severe)
  • What to grade:
    • Cytologic features only?
    • Architectural + cytologic features together?
    • Each separately?
Grading Dysplastic Nevi: Easy as Present or Not

BY DOUG BRUHK
San Diego Barretts

SAN DIEGO — There's no need to grade the level of architectural disorder when assessing dysplastic nevi. Just acknowledge if it's present or not.

"It doesn't matter how much architectural disorder is there; it only matters that it's present or absent," Dr. Terry L. Barretts said at an update on melanoma sponsored by the Scripps Clinic. "It's like being pregnant. Every single person in the world can be divided into one of two categories: You're either pregnant or you're not."

His minimal criterion for defining the presence of architectural disorder in a lesion is a well-defined junctional nevus with nests at the base of the rete and lentigines proliferation. Concentric eosinophilic fibroplasia and amelanotic fibroplasia are commonly seen.

In addition to architectural disorder, dysplastic nevi may or may not have cytologic atypia, which may include large nuclei with variation of nuclear size; irregular nuclear membrane; variably staining chromatia; large eosinophilic nucleoli; and fine dusty melanin pigment in cytoplasm.

Some experts recommend that cytologic atypia be graded as mild, moderate, or severe, but Dr. Barrett does not use the term moderate. "If there's none, there's none, but if there's some cytologic atypia it's either mild or severe," said Dr. Barrett of the departments of pathology and dermatology at the University of Texas, Dallas.

He favors a modified version of Dr. Arthur R. Rhodes' atypia grading system (Mod. Pathol. 1992;5:396-399). Cytologic atypia is considered mild if the size of the nucleus of the melanocyte is 1.5-2 times the size of the nucleus of the keratinocyte and if nucleoli are not present; if they are present, there should be no more than one per cell, he explained.

"I can tell that in 2 microscords," Dr. Barrett said. "It's very easy." Cytologic atypia is severe if there are multiple nucleoli per cell, or if the nucleus is more than two times the size of the basal keratinocyte nucleus, or if there is chromatin clumping or nuclear membrane notching.

"I can tell that very quickly," said Dr. Barrett, who also directs an outpatient pathology group in Dallas. "Whatever melanoma is a patient who has one dysplastic nevus and nothing else is the about the same as someone who has red or blond hair. "Not everybody with red or blond hair is going to get melanoma, but they are at an increased risk," he said.

Dr. Barrett likened dysplastic lesions to amoebae.
Discordance between skilled observers in the application of the published criteria [for DN] remains a currently intractable issue.

“What to one participant at the Workshop denoted high-grade cytologic or architectural dysplasia was to another participant a variation on the theme of histologic normality in a nevus.”

Prognosis
Melanoma risk

- 5 vs zero atypical nevi $6.36x$
- 101-120 vs <15 common nevi $6.89x$
- “... poor concordance between the diagnosis of atypical naevi using the clinical phenotype and the histological criteria.”

• 6725 NAD
• Patients with “severe” atypia nearly 3x more likely to report personal hx of melanoma

Grading of Atypia in Nevi: Correlation with Melanoma Risk

Montserrat Arumi-Uria, M.D., Ph.D., N. Scott McNutt, M.D., Bridget Finnerty, M.S.

Dermatopathology Division, Departments of Pathology and Dermatology, Weill Medical College of Cornell University, New York, New York

Nevi with architectural disorder and cytologic atypia of melanocytes (NAD), aka “dysplastic nevi,” have varying degrees of histologic abnormalities, which can be considered on a spectrum of grades of atypia. Somewhat controversial and subjective criteria have been developed for grading of NAD into three categories “mild,” “moderate,” and “severe.” Grading involves architectural and cytological features, which often correlate with each other. Architectural criteria were intraepidermal junctional extension beyond any dermal component, complex distortion of rete ridges, and dermal fibrosis. Cytological criteria were based on nuclear size, dispersion of chromatin, prominence of nucleoli, hyperchromasia and variation in nuclear staining. Few measure of association between NAD and personal history of melanoma, shows an odds ratio of 4.08 (2.91–5.7) for NAD-severe versus NAD mild, odds ratio 2.81 (2.3–95) for NAD-severe versus NAD-moderate and odds ratio 1.45 (1.13–1.67) for NAD moderate versus NAD-mild. These data show that the probability of having personal history of melanoma, for any given NAD patient, correlates with the NAD grade. Likewise, the risk of melanoma is greater for persons who tend to make nevi with high grade histological atypia.

KEY WORDS: Atypia, Dysplastic nevus, Malignant melanoma.

Mod Pathol 2003;16(8):764–771
Does histologic dysplasia predict melanoma risk?

- Histologic grade cannot be used to assess risk of melanoma


Melanoma risk

- Size matters . . . more than atypia
- Threshold: 4.4 mm

Xiong MYH et al. Diameter of dysplastic nevi is a more robust biomarker of increased melanoma risk than degree of histologic dysplasia: a case control study. *J Am Acad Dermatol* 2014;41:28-44.
DN as a melanoma precursor

“It is highly unusual that DN themselves eventuate into melanoma.”


“Melanoma in situ does arise in ‘dysplastic’ nevi but, in our view, only occasionally.”

“...the proposition that the DN, defined histologically, represents a risk indicator and a potential precursor lesion of melanoma is significantly contentious.”

Results

Ten recurrent problems were identified:
1. Nodular melanoma misdiagnosed as melanocytic nevus without explanation
2. Nodular melanoma with the low power architecture of melanocytic nevus, but the cytologic features of melanoma (nevomelanoma)
3. Claims involving partial biopsies (shave or punch biopsies)
4. Superficial spreading melanoma misinterpreted as chronically inflamed nevus
5. Melanoma misdiagnosed as Spitz nevus
6. Unrecognized desmoplastic melanoma
7. Melanoma presenting as a lymph node metastasis, misdiagnosed as lymphoma
8. Melanoma misdiagnosed as “dysplastic nevus”
9. Spindle cell melanoma misdiagnosed as spindle cell squamous carcinoma
10. Patients presenting with metastatic melanoma without a known primary, and a history of having a skin lesion removed and presumably discarded without microscopic examination

Am J Surg Pathol • Volume 27, Number 9, September 2003

Management
Table 2. Reasons for Reexcising Incompletely Removed Dysplastic Nevi*

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the dysplastic nevus has additional atypical clinical or histologic features</td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td></td>
</tr>
<tr>
<td>Recurrence</td>
<td>2</td>
</tr>
<tr>
<td>Histologic</td>
<td></td>
</tr>
<tr>
<td>Mild to moderate atypia (or worse)</td>
<td>1</td>
</tr>
<tr>
<td>Moderate atypia (or worse)</td>
<td>30</td>
</tr>
<tr>
<td>Severe atypia</td>
<td>3</td>
</tr>
<tr>
<td>Pagetoid upward scatter of melanocytes</td>
<td>1</td>
</tr>
<tr>
<td>Architectural disorder, severe</td>
<td>1</td>
</tr>
<tr>
<td>When the pathologist recommends additional therapy</td>
<td>64 (44)</td>
</tr>
</tbody>
</table>

*Includes 167 responses from 145 participants.

**RESULTS: Chicago Derm Study**

- **Virtual unanimity** in two scenarios:
  - Do not re-excite mildly atypical DN with positive margins
  - Do re-excite severely atypical DN with positive margins
- Margin status did **not** greatly influence proposed management of:
  - Mildly atypical DN
  - Severely atypical DN
- Margin status strongly influenced management of **moderately** atypical nevi:
  - Negative margins: **Do not** re-excite
  - Positive margins: **Do** re-excite
Dysplastic nevus management

- Survey of Canadian dermatologists
- N=179 (of 613)
- Majority do not reexcise nevi with mild to moderate atypia even if margins are positive.

Standardized margin comments for mild-mod DN: ↓ excision rate?

- N=584 (histologically DN)
- No margin comment: 51.8%
- With margin comment: 39.4%
- Regardless of margin status

Non-grading approach to Clark (dysplastic) nevi: ↓ excision rate?

- Diagnostic uncertainty rate: 11.1%
- Rate of change to melanoma: 2%
- Non-grading approach results in lower excision rate

Mild-moderate DN

- N=115 HDN (histologically DN) extending within 0.2 mm of border and not re-excised
- 17.4 years avg F/U; no melanomas
- Routine re-excision of mild-mod DN not necessary


Mild-moderate DN

- Clinical monitoring of margin-positive mild-moderate DN may be warranted.
  - Low histopathologic yield

- Only rare clinically significant change in dx
- Risk of transformation “very low”

Mild-moderate-severe DN

- 590 had + margin
- 191 re-excised
  - 1 MIS arose from moderate DN
- 399 observation
  - 6/304 (2%) developed melanoma at same site, 1 thin
- 9% developed new primary melanoma elsewhere
- Observation is reasonable for mild-moderate DN

Severe DN

- 2/451 had melanoma in the re-excision
- 7/451 had metastatic melanoma
- Clinical follow up ≥ 5 years
- Re-excising all severe DN may not be necessary

Terminology

'Dysplastic' debate: Terms continue to confuse
Derm feels integrity questioned
Publish date: Oct 1, 2007
By: Michael H. Coverman, M.D.
Source: DermatologyTimes

Battle of words: Response to 'dysplastic' debate
Terms continue to confuse
Publish date: Oct 1, 2007
By: Craig Burkart, M.D. M. Ph.
Source: DermatologyTimes

Defining terms: Dysplastic debate continues
Publish date: Dec 1, 2007
By: Gary N. Fox, M.D.
Source: DermatologyTimes
<table>
<thead>
<tr>
<th>Term</th>
<th>Date</th>
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<tbody>
<tr>
<td>B-K mole</td>
<td>(Clark 1976)</td>
</tr>
<tr>
<td>Atypical mole/nevus</td>
<td>(Clark &amp; 1978)</td>
</tr>
<tr>
<td>Dysplastic nevus</td>
<td>(Clark &amp; 1980)</td>
</tr>
<tr>
<td>Clark’s nevus</td>
<td>(Ackerman 1986)</td>
</tr>
<tr>
<td>“Nevus with melanocytic dysplasia of the type which may be seen in patients with the familial dysplastic nevus syndrome” or “melanocytic dysplasia of the type which may be seen in the DNS (when there is no associated nevus)”</td>
<td>(Clark, 1989)</td>
</tr>
</tbody>
</table>
Dysplastic nevus: more terms

6) Nevus with architectural disorder and [presence, degree] cytologic atypia (NIH, 1992)

7) LEJC-BFV nevus (Glusac 2004)

8) The clinically atypical nevus (Barnhill & 1994)

9) The histologically atypical nevus (Barnhill & 2007)
1992

- NIH Consensus: “Nevus with architectural disorder” with statement regarding *presence* and degree of atypia

<table>
<thead>
<tr>
<th>Term</th>
<th>No. (%)</th>
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<tbody>
<tr>
<td>Atypical nevus</td>
<td>62 (42.8)</td>
</tr>
<tr>
<td>Dysplastic nevus</td>
<td>58 (40.3)</td>
</tr>
<tr>
<td>Nevus with architectural disorder</td>
<td>21 (14.6)</td>
</tr>
<tr>
<td>Clark nevus</td>
<td>6 (4.2)</td>
</tr>
<tr>
<td>No preference</td>
<td>3 (2.1)</td>
</tr>
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</table>

*Includes 150 responses from 145 participants.


<table>
<thead>
<tr>
<th>Nomenclature</th>
<th>ASDP members (n = 522) (%)</th>
<th>AAD members (n = 483) (%)</th>
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</thead>
<tbody>
<tr>
<td>Dysplastic nevus (with or without qualifiers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysplastic nevus with mild, moderate, or severe dysplasia</td>
<td>204 (39.1)</td>
<td>301 (62.3)</td>
</tr>
<tr>
<td>Dysplastic nevus (without grading of degree of dysplasia)</td>
<td>175 (33.5)</td>
<td>289 (59.6)</td>
</tr>
<tr>
<td>Nevus with architectural disorder (with or without qualifiers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nevus with architectural disorder and cytologic atypia</td>
<td>29 (5.6)</td>
<td>12 (2.5)</td>
</tr>
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<td>Nevus with architectural disorder (no comment on cytologic atypia)</td>
<td>148 (28.3)</td>
<td>75 (15.5)</td>
</tr>
<tr>
<td>Nevus with architectural disorder and cytologic atypia</td>
<td>132 (25.3)</td>
<td>73 (15.1)</td>
</tr>
<tr>
<td>Nevus with architectural disorder (no comment on cytologic atypia)</td>
<td>16 (3)</td>
<td>2 (0.4)</td>
</tr>
<tr>
<td>Clark’s nevus (with or without qualifiers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clark’s (dysplastic) nevus</td>
<td>51 (9.8)</td>
<td>26 (5.4)</td>
</tr>
<tr>
<td>Clark’s nevus (with no qualifiers)</td>
<td>17 (3.3)</td>
<td>12 (2.5)</td>
</tr>
<tr>
<td>Clark’s nevus (with no qualifiers)</td>
<td>34 (6.5)</td>
<td>14 (2.9)</td>
</tr>
<tr>
<td>Atypical nevus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atypical nevus (with no qualifiers)</td>
<td>22 (4.2)</td>
<td>26 (5.4)</td>
</tr>
<tr>
<td>Compound nevus (with no qualifiers)</td>
<td>14 (2.7)</td>
<td>2 (0.4)</td>
</tr>
<tr>
<td>Compound nevus with lateral extension of junctional component</td>
<td>8 (1.5)</td>
<td>5 (1.0)</td>
</tr>
<tr>
<td>Atypical melanocytic hyperplasia</td>
<td>5 (1.0)</td>
<td>8 (1.6)</td>
</tr>
<tr>
<td>Other terms written in by respondents</td>
<td>43 (8.2)</td>
<td>15 (3.1)</td>
</tr>
<tr>
<td>More than one term selected</td>
<td>27 (5.2)</td>
<td>25 (5.2)</td>
</tr>
</tbody>
</table>