

# NOT ALL HALOES ARE HOLY: THE IMPORTANCE OF CORRELATION WITH HISTORY

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## CLINICAL PRESENTATION

18-year old female student

6-month history of a non-tender pink plaque on right inner thigh

Became more raised and deeper red over the past month

No history of skin disease

Family history of melanoma (grandmother)

On examination: 7mm x 7mm well-demarcated pink plaque with surrounding halo of hypopigmentation





MACROSCOPIC IMAGES



# DERMOSCOPIC IMAGES



Non-polarized



Polarized

# DIFFERENTIAL DIAGNOSIS

Halo naevus

Spitz naevus with  
halo

Amelanotic  
melanoma with  
halo

# MANAGEMENT

1

- Elliptical excision with 2mm margins to subcutaneous fat.

2

- Closed with 4.0 vicryl (deep) and 4.0 prolene (superficial) sutures.

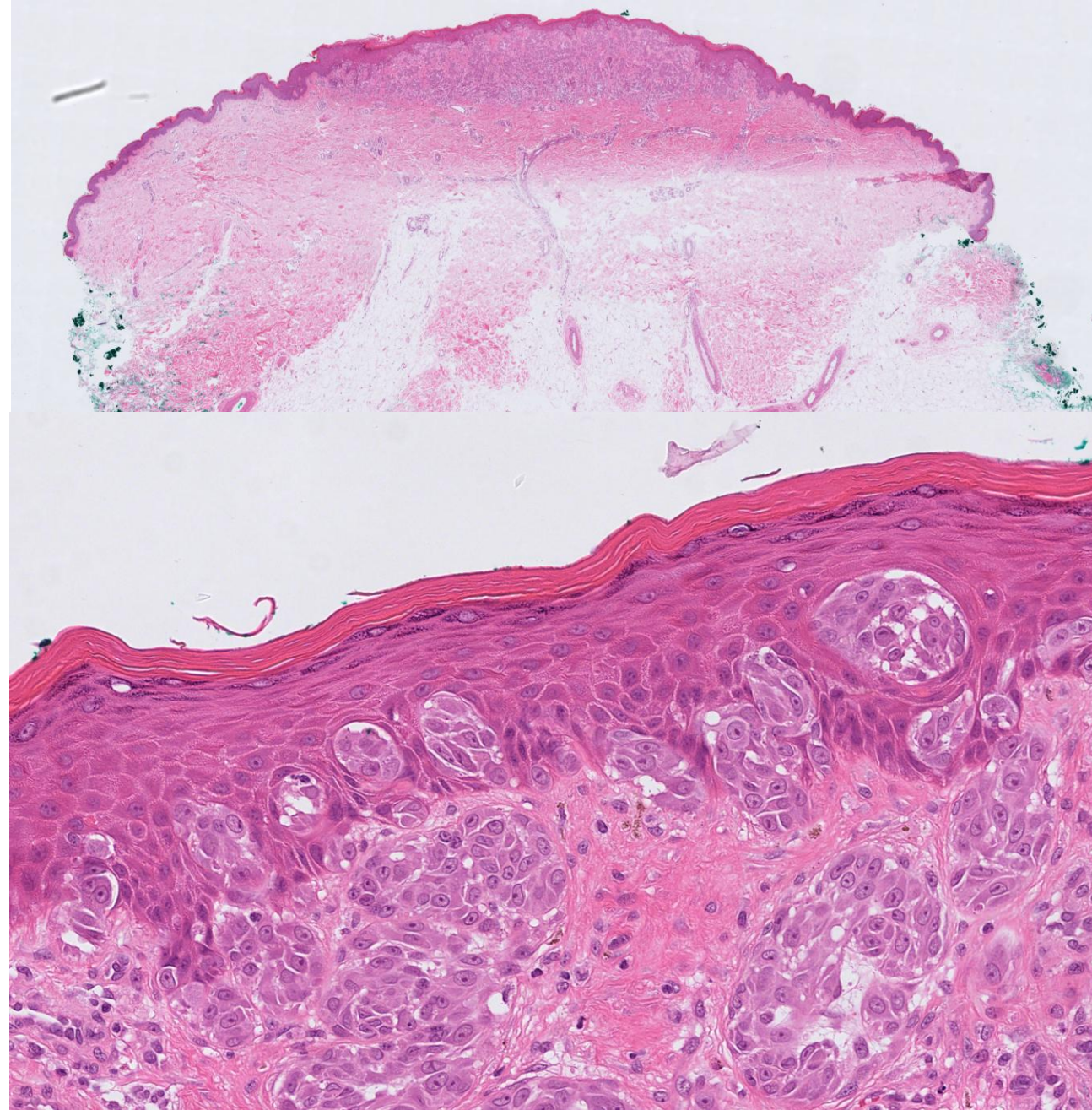
3

- Histological analysis with H&E staining.



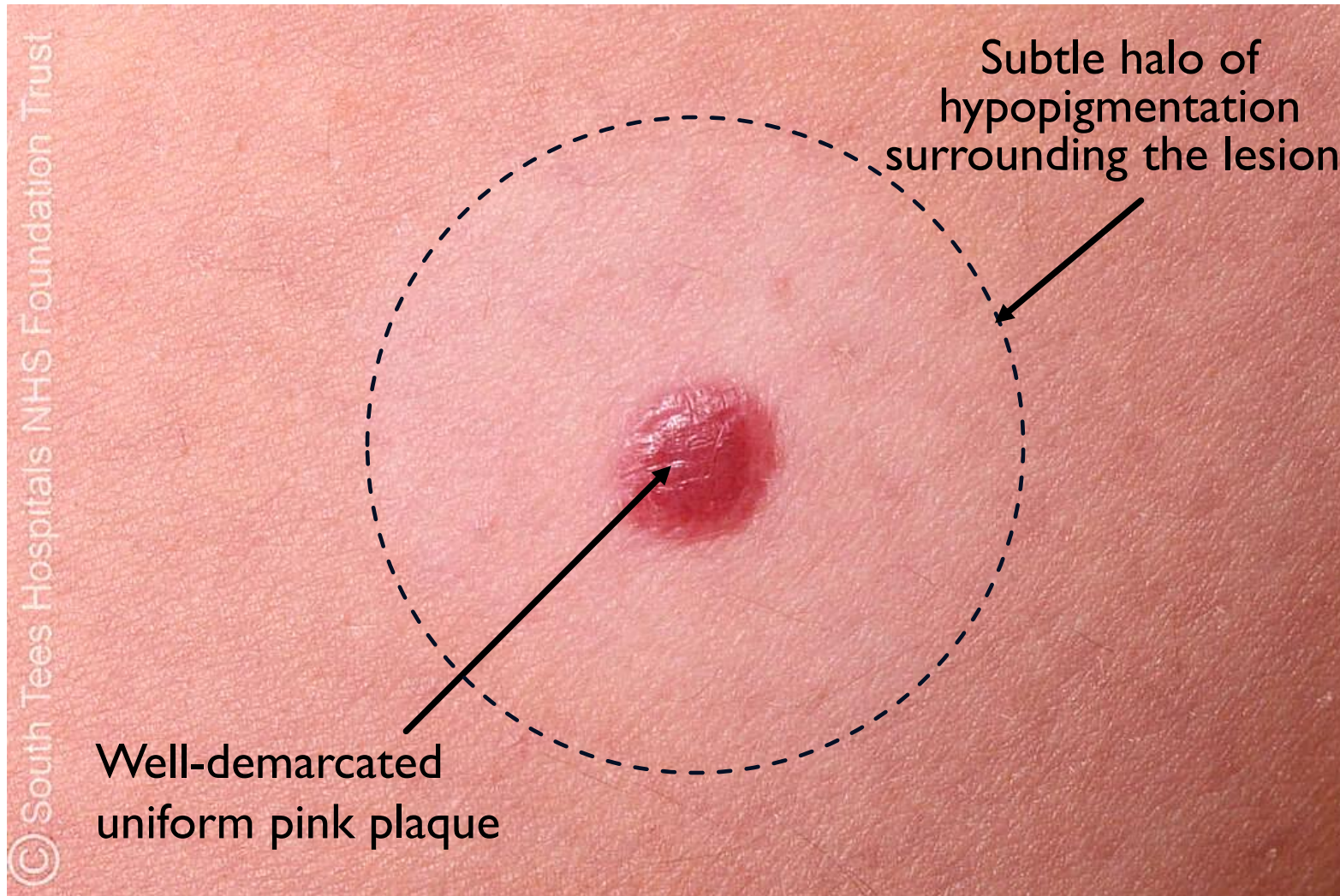
# Histology

- Excision with 2mm margins
- Symmetric melanocytic lesion
- Epithelioid and spindled melanocytes formed nests at dermo-epidermal junction and superficial dermis
- No cytologic atypia or mitosis
- No lymphocytic infiltrate
- **Diagnosis: compound Spitz naevus**





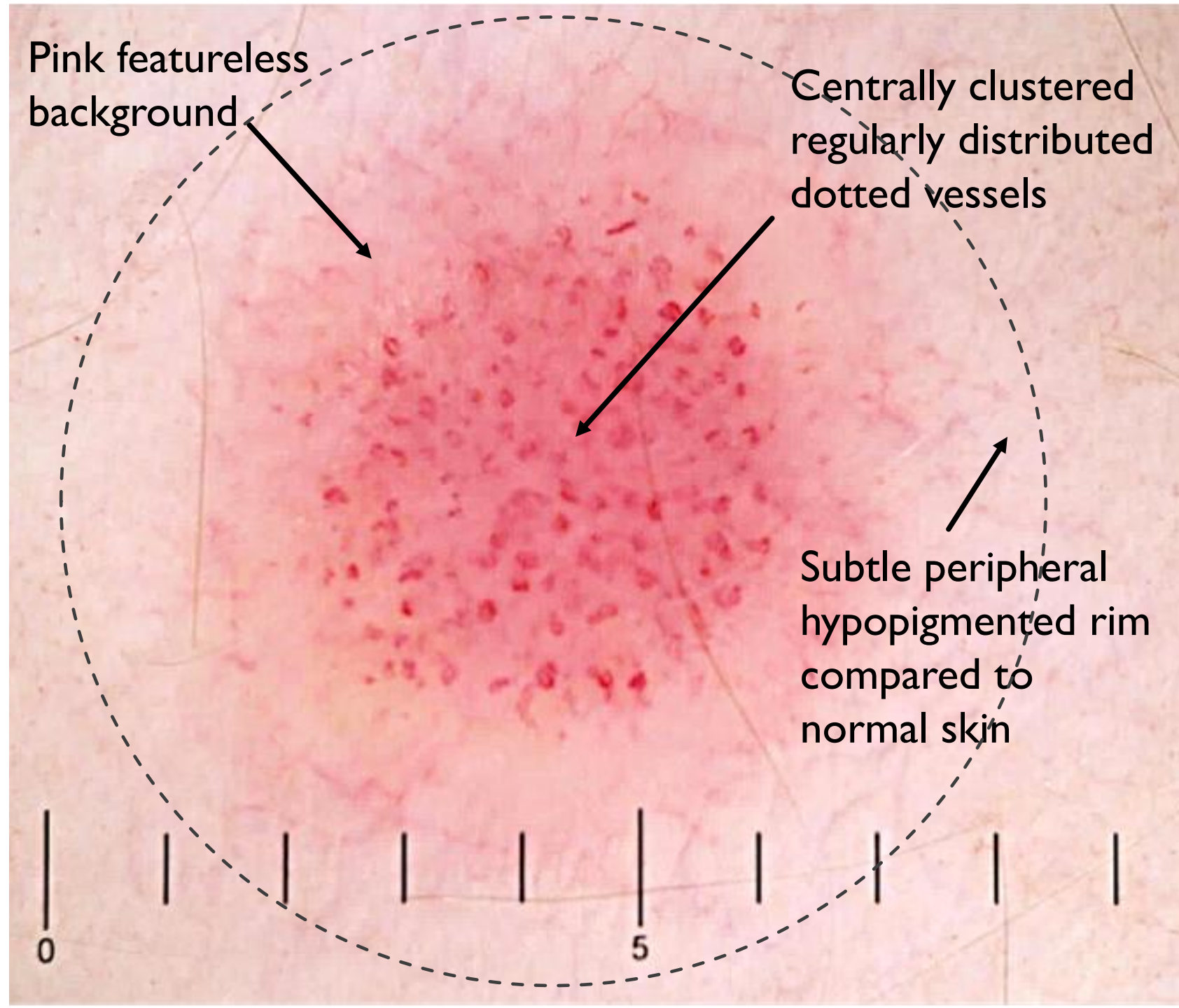
# MACROSCOPIC IMAGES WITH ANNOTATIONS





## DERMOSCOPIC IMAGES WITH ANNOTATIONS

- Centrally clustered regularly distributed dotted vessels
- Pink featureless background
- Subtle peripheral hypopigmented rim compared to normal skin



# FALSE-HALO SECONDARY TO PLASTER APPLICATION

On further questioning it became apparent that the patient had been applying a plaster to protect the lesion whilst using artificial tanning product that caused a **false halo effect**.

**Halo** is a term for an annular area of depigmentation surrounding a lesion caused by melanocyte destruction. Most commonly associated with melanocytic naevi but can occur in Spitz naevi or melanoma with regression.

**Pseudo-halo** has been used to describe an artifactual phenomenon observed secondary to external factors such as application of sunscreen to a lesion.

**Spitz naevi** are benign melanocytic lesions which most commonly occur in younger people and Fitzpatrick skin types I & II, most often on the face or lower limbs. They undergo rapid initial growth phase then become static.

Typically present as a firm brown-red papule but pigmented variants can range from brown to black (Reed's naevus).

## LEARNING POINTS

Observation of a white rim surrounding a lesion does not equate to halo naevus.

Haloes can cause difficulty in differentiating benign lesions from primary malignant melanoma with regression.

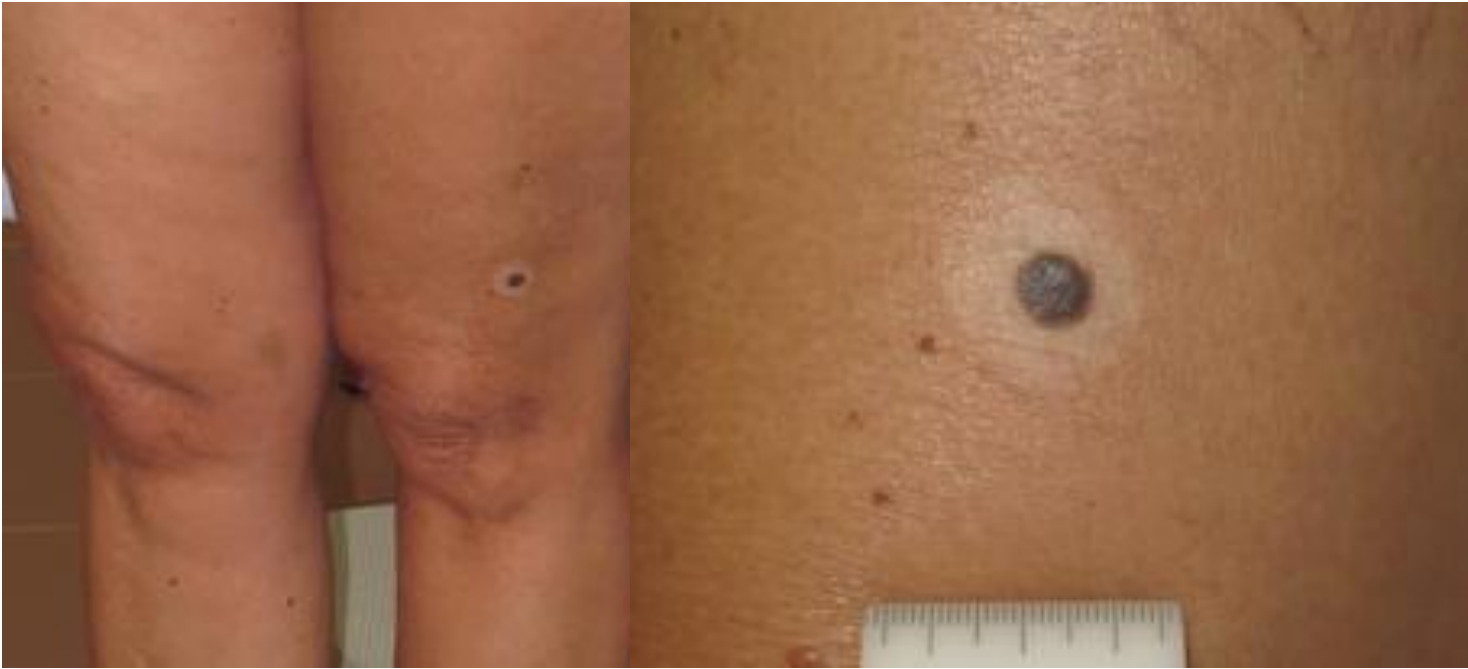
Beware that round plasters or sun-screen application can lead to false impression of halo phenomenon around lesions.

Careful history taking is pertinent when examining lesion(s) with halo effect.

Accurate histological examination requires adequate clinical information.



# PSEUDO-HALO LESIONS



1. Pseudo-melanoma – patient had applied sunscreen to protect the “mole” <sup>3</sup>



2. Artifactual “pseudo-halo nevi” secondary to sunscreen application. <sup>4</sup>

## REFERENCES

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2. P. Rubegni, N. Nami, M. Risulo, D. Tataranno, M. Fimiani, Melanoma with halo, *Clinical and Experimental Dermatology*, Volume 34, Issue 6, 1 August 2009, Pages 749–750, <https://doi.org/10.1111/j.1365-2230.2008.03030.x>
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5. Luo S, Sepehr A, Tsao H. Spitz nevi and other Spitzoid lesions part I. Background and diagnoses. *J Am Acad Dermatol*. 2011 Dec;65(6):1073-84. doi: 10.1016/j.jaad.2011.04.040. PMID: 22082838; PMCID: PMC3217183.