Correspondence

Duodeno-jejunal adenocarcinoma and coeliac disease

We read with interest the report by MacGowan *et al* of two cases of duodeno-jejunal adenocarcinoma representing a first presentation of coeliac disease.[1] We have recently encountered a similar case of coeliac disease presenting initially as a periampullary adenocarcinoma, in which changes of severe villous atrophy and an associated lymphocytic gastritis were present in the Whipple's resection specimen.

A 42 year old woman presented with symptoms and signs of intermittent obstructive jaundice. Endoscopic retrograde cholangiopancreatography revealed a duodenal tumour, biopsies of which confirmed adenocarcinoma. Pancreaticoduodenectomy and cholecystectomy were performed and histology confirmed a poorly differentiated periampullary adenocarcinoma with four positive lymph nodes. In addition, histology of the duodenal mucosa not involved by tumour showed severe villous atrophy with crypt hyperplasia and increased intraepithelial lymphocytes typical of untreated coeliac disease. Histology of the antral portion of the resection specimen showed features of an active lymphocytic gastritis.

The patient subsequently developed profuse malabsorptive diarrhoea with reduced levels of vitamin B12 and folate. She was put on a gluten free diet and significant weight gain ensued. Repeat distal duodenal and gastric biopsies have shown a marked improvement in villous architecture and resolution of the lymphocytic gastritis.

Of particular interest in this case was the additional finding of a lymphocytic gastritis within the antral gastric component of the Whipple's resection specimen. It is recognised that there is a significant association between coeliac disease and both lymphocytic colitis[2] and lymphocytic gastritis,[3] possibly representing a manifestation of gluten sensitivity at different levels of the gastrointestinal tract. Although it is recognised that the changes of lymphocytic gastritis may be focal, it is possible that resolution of the lymphocytic gastritis in this case represents a response to gluten free diet and this phenomenon merits further study.

This case is an additional example of coeliac disease presenting with a small bowel carcinoma and the findings further highlight the association between coeliac disease and lymphocytic gastritis. The possibility of occult coeliac disease should be considered in patients presenting with small bowel carcinoma or showing the gastric biopsy appearances of lymphocytic gastritis.

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1 MacGowan DJL, Hourihane D O'B, Tanner WA, O'Morain C. Duodeno-jejunal carcinoma as a first presentation of coeliac disease. *J Clin Pathol* 1996;**49**:602–4.
2 Wolber R, Owen D, Freeman H. Colonic lymphocytosis in patients with celiac sprue. *Hum Pathol* 1990;**21**:1092–6.
3 Wolber R, Owen D, DelBuono L, Appelman H, Freeman H. Lymphocytic gastritis in patients with celiac sprue or sprue-like intestinal disease. *Gastroenterology* 1990;**98**:310–15.

Diagnosis of thin melanoma

I read with interest Professor Mooi's editorial "Diagnosis of thin melanoma".[1] His comments included a hypothesis arguing for the development occasionally of melanoma from the superficial dermal component of a melanocytic lesion. This may well be theoretically plausible but in practice the number of primary cutaneous invasive melanomas without an epidermal or junctional component is vanishingly small. This by no means refutes the hypothesis that actual acquisition of aggressive features of melanoma arises in stages including an intermediate superficial dermal invasion without metastatic potential (microinvasion).[2 3] However, it is not clear how this can be used against the concept of melanocytic intraepidermal neoplasia (MIN).[3 4] MIN was not a concept devised to explain the biological sequence of melanoma development, it was a response to an unnecessary diagnostic dilemma based on the excessive numbers of diagnostic categories applied to preinvasive atypical melanocytic lesions.

The term MIN has been demonstrated to reduce diagnostic discordance and at the same time remove the label melanoma (in situ) from a number of lesions that, if excised, are known not to present subsequent problems of recurrence or metastasis.

Professor Mooi is right that small atypical melanocytic lesions are common and the difficulty for pathologists is identifying those which have an entirely favourable prognosis. The CRC group believed that if such cases could be confidently recognised it would be beneficial to refer to them in a different way.

Professor Mooi makes the wrong assumption that MIN does not apply to junctional naevi. The papers describing MIN[3 4] were definitely intended to include both junctional and compound melanocytic lesions. His other criticisms of the words intraepidermal and neoplasia are appropriate. It could be argued that the small number of cases showing adnexal extension of melanocytes makes the term intraepithelial more exact.

The term neoplasia applies to most melanocytic tumours and was chosen to make the term more memorable by analogy with CIN rather than for semantic accuracy. The term melanocytic intraepithelial neoplasia in its entirety refers to melanoma in situ and severely dysplastic melanocytic naevi, to emphasise the futility of attempting to separate them. I am grateful for the generally supportive comments in the rest of the editorial.

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1 Mooi WJ. Diagnosis of thin melanoma [editorial]. *J Clin Pathol* 1997;**50**:179–80.
2 Elder DE, Murphy GF. Melanocytic tumours of the skin. Washington: Armed Forces Institute of Pathology, 1991:110.
3 Cook MG, Clark TJ, Humphreys S, Fletcher A, McLaren KM, Smith NP, *et al*. The evaluation of diagnostic and prognostic criteria and the terminology of thin cutaneous melanoma by the CRC Melanoma Pathology Panel. *Histopathology* 1996;**28**:497–512.
4 CRC Melanoma Pathology Panel. A nationwide survey of observer variation in the diagnosis of thin cutaneous malignant melanoma including the MIN terminology. *J Clin Pathol* 1997;**50**:202–5.

Professor Mooi comments:

I thank Dr Cook for his interest in my recent editorial, which commented on the CRC Melanoma Pathology Panel paper on thin cutaneous melanoma.

Two points need, perhaps, further clarification. My problem with the term MIN being applicable to junctional naevi is the fact that it is applicable to all junctional naevi, regardless of the presence or absence of atypia. Thus, the distinction between the categories "benign" and "MIN with no microinvasion", as evident from fig 1 in the CRC Panel paper, would not be entirely appropriate.

Perhaps more important than this question of terminology is the more basic biological issue of the concept of invasion in melanocytic tumours. The remarks made in my editorial were not aimed specifically at the CRC Panel's paper. My point can be summarised as follows: as the precursor lesion of invasive melanoma is most commonly a naevus with an intradermal (as well as an intraepithelial) component, the pathogenesis of some melanomas is bound to be different from that of epithelial neoplasms, unless we assume, without proof, that the intradermal component of the naevus is always an innocent bystander, and never plays a role in the pathogenesis of the tumour. Perhaps we have to reconsider the current dogma, which dictates that cutaneous melanoma always arises in the epidermis and that its presence in the dermis results from invasive growth. The fact that the number of purely intradermal primary melanomas is "vanishingly small" does not prove that the intraepithelial component was always first, and the intradermal component develops as a result of "invasive growth".

I feel that we are well advised to exercise some caution when using the concept of early malignancy and early invasion of epithelial neoplasms as the template on which we mould our terminology of melanocytic neoplasms. We have discontinued the use of the term melanocarcinoma, commonly used a few decades ago, but in some ways our concept of melanocytic tumours continues to be related to epithelial neoplasms to a degree that is not really supported by solid data.

As indicated above, this is not a criticism specifically aimed at the paper by the CRC Panel, it is aimed at most of us, including myself! However, I am sure we all agree that in science it is never too late to reconsider critically one's beliefs and assumptions.

MIN terminology

"Rolling stones gather no moss". Similarly, despite increased verbal support for the term melanocytic intraepidermal neoplasia (MIN), the subject has received little formal published appraisal. For this reason, Professor Mooi's editorial on the diagnosis of thin melanoma is of particular importance.[1] Astutely, he highlights several significant conceptual and practical drawbacks associated with the term MIN. I share his overall reservations and propose that other considerations should be added to his list.

First, it is essential that adoption of the term MIN only follows extensive international discussion and agreement. The United Kingdom must not go it alone and become isolated.

Second, the scientific and diagnostic basis for radial and vertical growth phases in melanoma must be established beyond rea-