Table II. Patient-reported outcomes for home narrowband ultraviolet B phototherapy

Outcome	Respondents (N = 31)
Currently using home phototherapy, n (%)	14 (45.2)
Currently using for >1 year, n (%)	10 (71.4)
Stopped using home phototherapy, n (%)	17 (54.8)
How long used before stopping, n (%)	
<1 month	5 (29.4)
1 month to 1 year	3 (17.6)
>1 year	9 (52.9)
Frequency of use, n (%)	
Once per week or less	3 (9.7)
2-4 times per week	21 (67.7)
>4 times per week	4 (12.9)
Unknown	3 (9.7)
Consistent use (without breaks), n (%)*	17 (56.7)
Kept logs, n (%)	14 (45.2)
Total number of treatments, n (%)	
1-49	8 (25.8)
50-99	4 (12.9)
100-200	8 (25.8)
≥200	4 (12.9)
Unknown	7 (22.6)
Duration of treatment session per area, minutes, n (%)	
<5	14 (45.2)
5-10	6 (19.4)
>10	5 (16.1)
Unknown	6 (19.4)
Confidence when starting, median (IQR)†	8 (5.5-9.5)
How well treatment worked, median (IQR)‡	4 (1-7)
Level of satisfaction, median (IQR)§	6 (1.5-10)
Complications, n (%)	
None	25 (80.6)
Mild erythema	5 (16.1)
Severe erythema	1 (6.3)
Currently seeing a dermatologist, n (%)	26 (83.9)
Received adequate follow-up,‖ n (%)	20 (71.4)

IQR, Interquartile range.
*A *break* was defined as missed dose for 2 or more consecutive sessions; 1 patient declined to answer.
†Scale of 1 (not confident) to 10 (very confident).
‡Scale of 1 (no improvement) to 10 (best improvement imaginable).
§Scale of 1 (no satisfaction) to 10 (complete satisfaction).
‖Three patients declined to answer.

excessive use, at times with inadequate follow-up; (3) failure to initiate use; and (4) discontinuation before response could be evaluated. Studies enhancing patient counseling should be explored to prevent treatment underuse and overuse. These observations highlight opportunities for quality improvement addressing compliance, effectiveness, and complications.

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Dermoscopic predictors to discriminate between in situ and early invasive lentigo maligna melanoma: A retrospective observational study

To the Editor: Lentigo maligna (LM) accounts for 4% to 15% of all melanomas.[1] Unlike other melanoma subtypes, partial/incisional biopsies are often performed for LM diagnosis, but they may underestimate Breslow thickness in case of microinvasion.[2] The optimal management is wide surgical excision,

Table I. Dermoscopic features of 104 lesions of lentigo maligna and results of the univariate analysis

Dermoscopic criteria	In situ LM (n = 82), n (%)	Invasive LM (n = 22), n (%)	OR (95% CI)	*P* value
Structures				
Gray dots	54 (65.8)	14 (63.6)		
Gray circles/semicircles*	50 (61)	8 (36.3)	0.37 (0.13-0.97)	.043
Target-like pattern/circle within circle	40 (48.8)	13 (59.1)		
Angulated lines*	71 (86.6)	14 (63.6)	0.27 (0.09-0.79)	.017
Rhomboid structures	74 (90.2)	7 (31.8)		
Obliterated folicles*	26 (31.7)	12 (54.5)	2.59 (0.99-6.74)	.05
Irregular hyperpigmented areas	65 (79.2)	16 (72.7)		
Irregular blotch*	5 (6.1)	9 (41)	10.66 (3.08-36.88)	<.001
Shiny white streaks	10 (12.2)	2 (9.1)		
Atypical vessels/high-density vessels	48 (58.5)	14 (63.6)		
Erased areas	48 (58.5)	16 (72.7)		
Colors				
Gray	67 (81.7)	16 (72.7)		
Blue	9 (11)	5 (22.7)		
Red	55 (67)	19 (86.3)		
Light brown	81 (98.8)	22 (100)		
Dark brown	59 (72)	15 (68.2)		
Black	15 (18.3)	10 (45.4)	3.72 (1.35-10.20)	.011

CI, Confidence interval; *LM*, lentigo maligna; *OR*, odds ratio.
*Variables that were statistically significant predictors of invasive LM after the univariate analysis. Obliterated follicles, irregular blotches, and black color were positive predictors of invasive LM, whereas gray circles/semicircles and angulated lines were negative predictors of invasive LM.

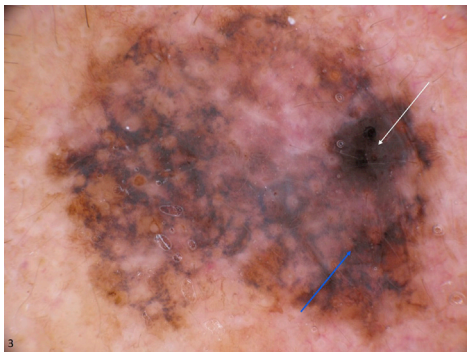

Fig 1. Invasive lentigo maligna. Dermoscopy reveals follicles that have been completely obliterated by black pigment, resulting in the loss of visible adnexal openings that would be expected within a pseudonetwork (blue arrow). An eccentric black blotch is also present (white arrow). Both features, along with the black color in general, are highly predictive of an invasive tumor.

whereas nonsurgical modalities, such as radiotherapy and imiquimod, may be considered for patients with in situ LM in who refuse surgery or are poor surgical candidates.[3] However, these options presuppose that the tumor is purely intraepidermal, which cannot be fully elucidated with partial sampling. Although the dermoscopic criteria of LM have been exhaustively investigated, to our knowledge, no study has attempted to discriminate in situ from early invasive LM.

We aimed to identify dermoscopic criteria that help predict the presence of an invasive component in LM, conducting a retrospective analysis of dermoscopic images of in situ and early invasive (up to 1 mm of Breslow thickness) tumors, diagnosed after excisional biopsy. Crude and adjusted odds ratios were calculated by univariate and multivariate logistic regression.

Of 104 LMs included, 82 were in situ and 22 invasive. In the univariate analysis, gray circles/semicircles and angulated lines were negative predictors of invasive LM, and obliterated follicles, irregular blotches, and black color positively predicted invasive LM (Table I). After the multivariate analysis, angulated lines remained a negative predictor and irregular blotch a positive predictor of invasive LM.

The dermoscopic predictors found in our study are consistent with the classic progression model of LM.[4] Gray circles/semicircles and angulated lines typify intraepidermal LM, corresponding to melanocytes that tend to surround the follicular unit but still respect the basement membrane. In contrast, the presence of obliterated follicles, irregular blotches, and black color may all reflect a massive invasion of the hair follicle, with melanocytes probably no longer respecting the basement membrane (Fig 1).

Our findings might be particularly relevant when a partial/incisional biopsy is selected to obtain a

sample for histopathologic diagnosis. Several studies have shown that incisional biopsies for melanoma diagnosis may underestimate the presence of an invasive component in up to 50%.[2] In this context, identifying dermoscopic features that predict microinvasion might accurately target the area to be biopsied. This becomes even more relevant when alternative nonsurgical treatment modalities are considered and an invasive component needs to be previously excluded.

Our study has some limitations. First, it was a single-center study with a limited sample and, therefore, the results cannot be extrapolated to other populations before being confirmed by further studies. Second, the retrospective design did not allow a targeted histopathologic correlation of dermoscopic structures and, therefore, our findings can be considered as only indicatory. A direct correlation between dermoscopic and histopathologic criteria by future studies might confirm or modify our results. Third, we did not assess the usefulness of confocal microscopy, which might be very helpful in the assessment of LM.[5]

In conclusion, our results indicate that dermoscopy might enhance the discrimination between in situ and microinvasive LM. However, histopathologic analysis of the completely excised tumor remains the criterion standard for diagnosing LM and assessing the occurrence of microinvasion.

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The risk of myocardial infarction, stroke, and revascularization among patients with psoriasis treated with apremilast compared with biologics and disease-modifying antirheumatic drugs: A cohort study in the US MarketScan database

To the Editor: The cardiovascular safety of apremilast is understudied.[1,2] We conducted a study to quantify the risk of myocardial infarction, stroke, and revascularizations in people with apremilast-treated psoriasis compared with other systemic psoriasis treatments.

We conducted a cohort study of patients with psoriasis treated with apremilast, tumor necrosis factor inhibitor biologics, interleukin 17 or 12/23 biologics, or conventional disease-modifying antirheumatic drugs in the US MarketScan database. Cohort entry was date of first study drug after March 21, 2014. Cases were patients with myocardial infarction, stroke, or revascularization after cohort entry. We calculated incidence rates and incidence rate ratios for psoriasis treatments, alone or in combination, categorized by presence of concomitant corticosteroid use, among all patients and among patients with no history of serious cardiovascular disease. (See Supplemental Methods for more details, including sensitivity analyses, available via Mendeley at https://data.mendeley.com/datasets/h7bf4p8p98/1).