

Table II. Median Patient Satisfaction Questionnaire 18 scores by study group

Grouping	Median (interquartile range)/no. missing		P value
	Intervention, n = 62	Control, n = 61	
General satisfaction	5.0 (5.0-5.0)/0	4.5 (4.5-5.0)/1	<.001
Technical quality	5.0 (5.0-5.0)/0	4.8 (4.3-4.8)/1	<.001
Interpersonal manner	5.0 (5.0-5.0)/0	5.0 (4.5-5.0)/1	.003
Communication	5.0 (5.0-5.0)	4.5 (4.5-5.0)	<.001
Financial aspects	3.5 (3.0-3.5)/0	3.5 (3.0-3.5)/1	.806
Time spent with doctor	5.0 (5.0-5.0)/0	4.0 (4.0-4.5)/1	<.001
Access and convenience	4.0 (3.8-4.3)/0	3.8 (3.4-4.0)/1	.012
Overall score	4.6 (4.5-4.7)	4.3 (4.1-4.4)	<.001

manner ($P = .003$). Most patients in both groups reported positive satisfaction scores (strongly agree or agree) for the genital-specific statements. However, these were significantly higher in the experimental group ($P < .001$).

Our results suggest that by offering a deodorizing wipe we were able to increase privacy and examination satisfaction. This finding mirrors results of a prior study, in which offering a wrap skirt to increase privacy significantly improved patient experience.³ Second, offering a wipe not only increased satisfaction of the genital examination itself but also of the entire appointment. Last, this intervention improved patients' perception of time spent with the provider, a key predictor of patient satisfaction.^{4,5}

Limitations of our study include the use of a single study site and small sample size. Furthermore, determining whether patients actually used the wipes offered was not possible, making it unclear whether self-cleaning with the wipe or simply receiving the wipe as an act of kindness contributed to the improved patient satisfaction scores.

In summary, our findings suggest that the simple, low-cost intervention of offering patients a deodorized ~2-cent wipe before their genital examination has the ability to not only increase their satisfaction with the genital examination but also their overall experience.

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Acral melanoma with eccrine involvement: Comments and controversies



To the Editor: Acral lentiginous melanoma (ALM) accounts for approximately 5% of all melanomas. Its occurrence is similar across all racial and ethnic groups, peaking around the seventh decade of life. It typically occurs on the palms and soles or in and around the nail apparatus. These areas, which lack hair follicles but contain abundant eccrine sweat glands, are susceptible to developing melanoma without ultraviolet light exposure.¹

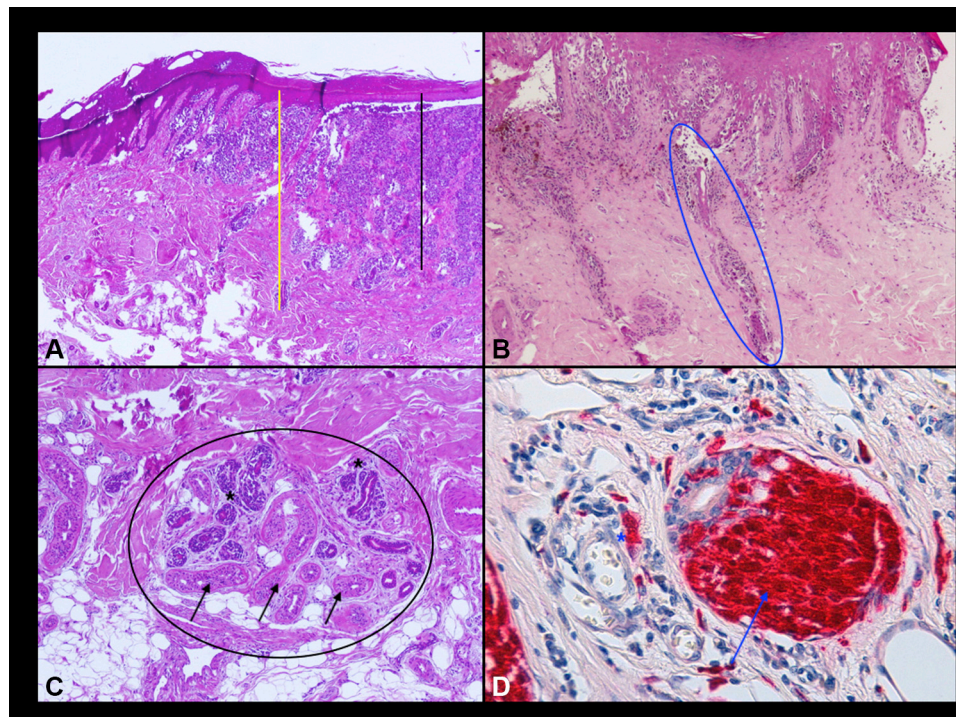


Fig 1. **A**, Breslow depth (black line) and syringotropic Breslow depth (yellow line). (Original magnification: $\times 10$.) **B**, Acrosyringeal involvement (blue circle). (Original magnification: $\times 10$.) **C**, Glandular secretory unit (black circle), where the involvement of the ductal portion (asterisk) is observed, leaving the secretory portion spared (arrow). **C**, Eccrine invasion in the form of nests (blue arrow) (original magnification: $\times 20$), and **(D)** individual cells (blue asterisk) were observed with the MelanA stain (original magnification: $\times 40$).

The eccrine unit is composed of a secretory gland section (secretory coil) and a duct component. The secretory coil lies in the lower reticular dermis. This area is surrounded by a discontinuous myoepithelial cell layer. The transition from the distal portion of the secretory coil to the proximal fragment of the duct component is abrupt, with a loss of the myoepithelial cell layer in the ductal portion.²

The ductal component of the eccrine unit is composed of 2 parts: the intradermal duct and the intraepidermal component (acrosyringium). The intradermal ductal component is coiled in the lower parts, mixing with the secretory coil in routine histologic sections.³

Patients diagnosed with ALM involving any portion of the eccrine glands from October 1999 to October 2018 in our Department of Dermatology were selected from our pathology database. All cases were re-examined for the purpose of this study and had disease-free margins. Fig 1 illustrates some of these variables.

Overall, 20 samples of distinct ALM lesions of 11 patients were analyzed. Table I summarizes the main clinical and histopathologic characteristics of the cases. Seven patients had no recurrences of any

melanoma subtype after the initial excision, although the follow-up period for 2 of them was <12 months. Local recurrences developed in 2 patients. One of these patients experienced 2 recurrences, the first developing 17 years after excision and the second 5 years later. The other patient had 5 local recurrences, the first occurring 3 years after the initial excision. Recurrences developed as acral satellitosis (stage III disease) in 2 patients.

In 5 cases, the initial Breslow index was <0.8 mm, with a syringotropic Breslow depth of >0.8 mm. Of the 20 anatomopathologically analyzed samples, 7 (35%) corresponded to stage III disease, 4 due to sentinel lymph node invasion, and 3 presented with microsattelitosis. In our series, there was a statistically significant association between stage III disease and the presence of glandular coil involvement ($P = .015$) and with an increased syringotropic Breslow depth (4.5 mm vs 2.5 mm, $P = .008$).

That unknown melanocyte precursors (melanoblasts) may exist in sweat glands has been suggested, and in fact, Okamoto et al³ identified melanocyte stem cells in the secretory portion of murine eccrine sweat glands in volar skin. These cells could be the anatomic niche not only for those melanoblasts but

Table I. Clinical and histopathologic data of the analyzed population

Data*	Sample number
Patients	(n = 11)
Man	7 (64)
Woman	4 (36)
Age at diagnosis	70.6 ± 12
Primary ALM location	
Heel	4 (36.4)
Base of the toe	2 (18.2)
Nail bed (foot)	2 (18.2)
Nail bed (hand)	1 (9.1)
Thenar eminence (hand)	1 (9.1)
Sole	1 (9.1)
Patients with local recurrences	2 (18.2) [†]
Recurrence in the form of satellitosis	2 (18.2)
Histopathologic samples	(n = 20)
Breslow depth, mm	1.9 ± 1.6
Syringotropic Breslow depth, mm	3.2 ± 1.7
Clark level	
I	4 (20)
II	4 (20)
III	5 (25)
IV-V	7 (35)
Acrosyringium involvement	20 (100)
Glandular unit involvement	12 (60)
Duct involvement	11
Secretory coil portion involvement	0
Duct and secretory coil portion	1
Formation of eccrine melanoma nests	11 (55)
Diameter of nests, mm	0.3 ± 0.1
Microsatellitosis	2 (10)

*Continuous data are presented as the mean ± SD and categorical data as number (%).

[†]Patients experienced 2 and 5 local recurrences, respectively.

also for early human melanoma precursors.³ Zembowicz et al⁴ reported 7 syringotropic melanomas, 1 of which was an ALM. These authors suggested that melanoma spreading within the eccrine apparatus can infiltrate deeper into the reticular dermis or subcutis than conventional melanomas.⁴ Other authors have reported several cases of syringotropic ALM.⁵

Studies and reports published so far do not differentiate between the involvement of the secretory and the ductal coil portions within the glandular coil. In our series, invasion of the glandular coil seems to predict a poorer prognosis, with advanced disease development being more frequent than in cases not involving the glandular coil. In addition, the ductal component is predominantly affected, whereas the secretory coil is mostly spared. One explanation for this is that myoepithelial cells could

act as a barrier, hindering the infiltration of melanoma cells into these secretory areas.

Moreover, we believe the syringotropic Breslow depth should be taken into account in clinical practice, because in our series it was also associated with advanced disease. Further, the syringotropic Breslow depth in 5 of the 20 samples would modify the T category from T1 to T2, thus changing therapeutic management from a wide local excision to a wide local excision with sentinel lymph node biopsy.

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Optimizing presentation of expected treatment outcomes



To the Editor: Patients struggle with starting medications for various reasons, including inadequately understanding the direct personal benefits of