I share Bernie Ackerman’s dislike for handouts, for the same reasons that he articulated with his customary verve in one of his editorials \(^1\). I also agree with him that if one cannot escape from the task of delivering such a product (which, alas, in my predicament on this occasion), it is best for that handout to be brief and to the point, in the sense of simply listing the main ideas that will be developed in the lecture.

With that premise, and considering the fact that the title of my lecture was framed (not by me) in the form of a set of sequential questions, I thought of limiting this handout to the answering of those questions and of using my allotted conference time to provide the rationale behind those answers. The basic question is whether I believe or not in the concept of equivocal/borderline melanocytic lesions (tumors), and my answer is a qualified yes. The qualification stems from two considerations. The first is that I believe in the concept of equivocal/borderline lesions not only for the narrow field of melanocytic tumors but for the entire gamut of tumor types, i.e., epithelial, mesenchymal, neural, lymphoid, and germ cell.
The second qualifier refers to the fact that I agree with the concept of “borderline tumor” (of whatever cell type) not in the sense of believing in the existence of a distinct tumor type located exactly in the middle (i.e., at the border line) between a distinct benign tumor and an equally distinct malignant tumor of the same cell type, but rather as an indicator of the fact that the time-honored practice of sharply dividing human tumors into benign and malignant types is a gross oversimplification of a very complex issue. Admittedly, as indicators go, “borderline” is a rather crude one. It would be much more sensible and accurate to think of tumors of a given cell type as lesions spanning the entire span from the wholly indolent and clinically insignificant to the highly aggressive and often fatal. The result would be a graded scale of tumors of increasing aggressiveness, in which ideally the position of each member would be indicated by a set of values that would provide the clinician with the information needed to treat the condition in the most efficient and rational fashion. Terms such a “borderline”, “equivocal”, “minimal deviation”, “of low malignant potential”, “of uncertain malignant potential”, “aggressive”, and “atypical”, as they have been proposed at various sites, including the melanocytic system, are imperfect in more ways than one, but in my opinion they represent small steps in the right direction. Of all the terms listed above, the one I like the best is that of “melanocytic tumor of uncertain malignant potential” (MELTUMP), as coined by David Elder, perhaps because it comes closer in words and spirit to the terms we have proposed to deal with a similar situation in the thyroid gland. I am concerned, however, about the snail pace at which this paradigmatic shift is proceeding. Hopefully, it will pick up speed in the near future, perhaps buoyed by the many exciting molecular genetic studies that are being carried out on these lesions.
REFERENCES


2) Elder DE, Murphy GF: Melanocytic tumors of the skin, Atlas of Tumor Pathology, Third Series, fascicle 2, Armed Forces Institute of Pathology. 1191, pp 182-185.


