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Agminated Acquired Melanocytic Nevi of the Common and Dysplastic Type

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Dear Editor:

'Agminated' refers to circumscribed grouping of lesions confined to a localized area of the body. Pigmented lesions that have been described as agminated includes melanocytic nevi[1], Spitz nevi[2], nevi spilus[3], blue nevi[4], and multiple lentigines[5]. However, the presence of acquired common and dysplastic nevi (ACDN) arranged in an agminated pattern has not been well-established. Herein, we describe a patient with multiple agminated acquired melanocytic nevi, several of that were histologically characterized as dysplastic nevi.

A 16-years-old female presented with multiple irregular moles on her right inguinal area (Fig. 1A). Her parents reported that this cluster of nevi developed at the age of 6 years, and continuously increased in numbers and sizes. No family history of melanoma or multiple moles was present. Physical examinations revealed more than 40 melanocytic nevi clustered in a 5×5 cm skin area on her right inguinal area, where several of these nevi were irregular with variegation of color and a diameter greater than 5 mm (Fig. 1A). No background pigmentation within or surrounding the cluster was noted clinically or even with Wood's light examination. Dermoscopy of the clustered nevi revealed a diffuse patchy reticulation (Fig. 1B). A biopsy from a clinically atypical nevus demonstrated a lentiginous, compound-melanocytic nevus with architectural disorder in the epidermis. In the dermoepidermal junction, the nests of nevus cells were profused in

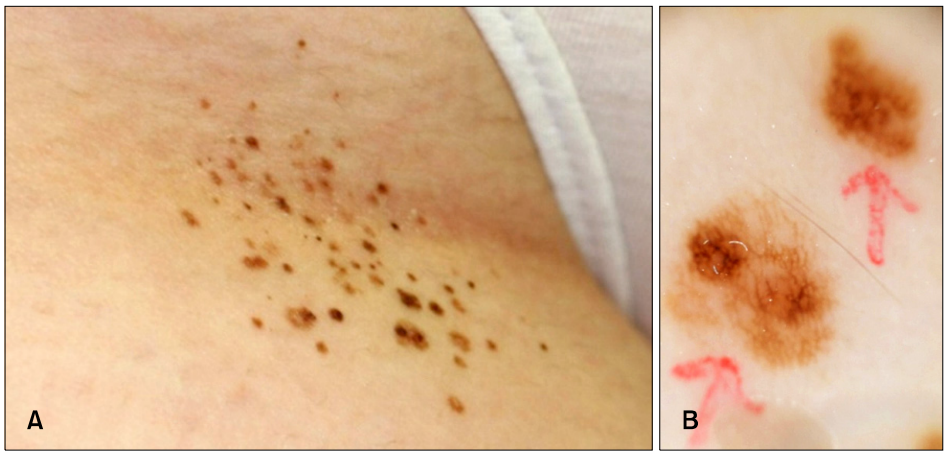

Fig. 1. (A) Asymmetric, multiple, grouped, irregular, flat, dark brownish papules and macules on the inguinal area. (B) Dermoscopic features showing a patchy reticulated network.

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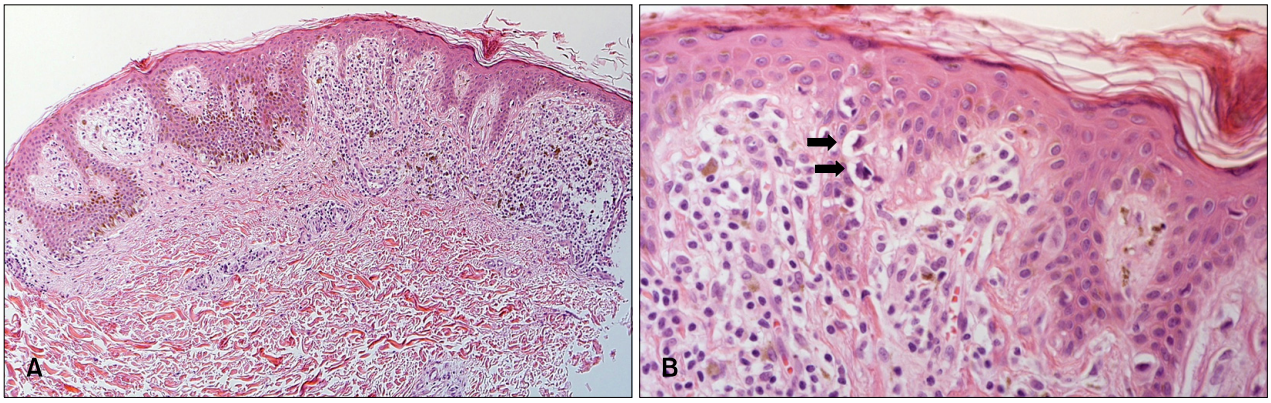

Fig. 2. (A) There was elongation of rete ridges and increase in the number of junctional melanocytes, arranged in a nest. In the dermoepidermal junction, nests of nevus cells were profused on the tips and sides of elongated rete ridges. There were also scattered single cells in a lentiginous array without continuous proliferations. (B) Several melanocytes contained abnormally large nuclei, and the nuclei had irregular contours (arrows) (H&E; A: ×40, B: ×400).

the tips and sides of elongated rete ridges. In the center of the nevus, nests of melanocytes are present in the papillary dermis (Fig. 2A). There were scattered single cells in a lentiginous array without continuous proliferations (Fig. 2A). A few atypical melanocytes with large, irregularly shaped, hyperchromatic nuclei lay individually or within a small group (Fig. 2B). The diagnosis of dysplastic nevi was confirmed by the presence of an architectural disorders and cytologic atypia. Several nevi within the cluster had clinical, dermoscopic, and histologic features which are commonly attributed to dysplastic nevi.

Dysplastic nevi have been the subject of ongoing controversy regarding its definition and use of more than 20 years[6]. It is argued that dysplastic nevi are both acquired and common, and they should be regarded as nothing but common nevi. However, when considering a review article from Elder[6], theses lesions have been only significant in relation to melanoma, as stimulants of melanoma, as markers of risks for melanoma, and as potential and occasional actual precursors of melanoma. Therefore, clinical and histological classifications of nevi have the most important purpose of categorizing these lesions so that dysplastic nevi can be distinguished, clinically and histologically, from melanoma. In our patient, the diagnosis of dysplastic nevi was based on the clinical, dermoscopic and histologic features.

Agminated dysplastic lesions, similar to our case should be distinguished from other forms of dysplastic nevi, which show a segmental distribution without a definite clustering. Two cases of dysplastic nevi with segmental distributions have been previously reported in the literature[7,8]. Both of the cases are not being described as agminated, because multiple dysplastic nevi were distributed throughout the patients' upper left quadrant. One thing that deserves the attention of clinicians is that malignant melanoma developed within the lesions of both cases.

There still exists much controversy about the presence of agminated ACDN. Marghoob et al.[9] and Bragg et al.[10] previously reported 5 cases of agminated ACDN. Unlike our case, however, agminated lesions were superimposed on an underlying dysplastic nevus syndrome phenotype in 4 out of 5 cases. In the 2 cases of the 5 reported as agminated ACDN, malignant melanoma did not developed within the agminated lesion, but within the underlying dysplastic nevus syndrome phenotype. The authors believed that agminated ACDN were a new, previously not described, clinical variant of dysplastic nevi. In conclusion, the uncertainty in the biological behaviors of agminated ACDN suggests a strict follow-up for this unusual entity.

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Medallion-Like Dermal Dendrocyte Hamartoma: Differential Diagnosis with Congenital Atrophic Dermatofibrosarcoma Protuberans

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Dear Editor:

Medallion-like dermal dendrocyte hamartoma (ML-DDH) is a recently described congenital benign dermal lesion, which was first reported by Rodríguez-Jurado et al.[1] Clinically, ML-DDH presents as a solitary, several centimeter-sized, round or oval, erythematous to yellow-brown, atrophic plaque on the neck or upper trunk. Histopathologically, ML-DDH is characterized by a proliferation of $CD34^+$ spindle-shaped cells or ovoid cells mainly in the reticular dermis and extending into the subcutis in some cases. Only a small number of ML-DDH has been reported in English literature[1-3]. Herein, we report a case of ML-DDH that was initially misdiagnosed as congenital atrophic dermatofibrosarcoma protuberans (DFSP).

A 6-year-old girl presented with symptoms of intermittently pruritic and painful, solitary, depressed, and erythematous to yellowish plaque along with fine wrinkles on her posterior neck (Fig. 1). The oval-shaped, 4.0×2.5 cm sized plaque had been present since birth. Other personal and family history was unremarkable. Routine laboratory tests were normal. The clinical impression was a scar or congenital atrophic DFSP. After obtaining an informed consent from the patient and her parents, a punch biopsy was performed on the depressed lesion. The skin biopsy specimen revealed dermal proliferation of spindle-shaped cells in a storiform-like pattern (Fig. 2A, B). The lesion was diffusely positive for CD34, but negative for S-100 protein on immunohistochemistry. Thus, the lesion was initially diagnosed as congenital atrophic DFSP. The patient was sent to a plastic surgeon for complete removal of the

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