INTRODUCTION

Agminated nevi are infrequent pigmented lesions. ‘Agminated’ is derived from the Latin word ‘agmen’, meaning ‘aggregation’ and refers to a clustered or circumscribed grouping of lesions confined to a localized area of the body. It should be distinguished from other forms of segmental distribution lacking a definite clustering.1

Pigmented lesions that have been described in the literature as agminated include blue nevi, multiple lentigines, Spitz nevi, congenital melanocytic nevi, acquired melanocytic nevi, and lesions within nevi spili.2-5 No hyperpigmented lesions described as agminated include xanthogranuloma, angiofibromas and neurilemomas.6

Most cases reported in the literature corresponded to Spitz or blue nevi, with only few descriptions of melanocytic congenital agminated nevi. Only a few cases of congenital agminated melanocytic nevi have been described in literature.4,7 One of these cases presented with a “blaschkoid” pattern following Blaschko lines on the abdomen.8

The main differential diagnosis is nevus spilus. This nevus commonly appears during late infancy or early childhood, leading to the belief that they are a type of congenital nevus.3,6 A tan lentiginous background patch on which more darkly pigmented macules and papules are distributed characterizes the lesion. The nevus spilus usually presents as lentigo simplex on the histological analysis whereas agminated nevus generally shows a junctional or compound melanocytic nevus.9

The association of melanoma with agminated nevus was initially described by Marghoob et al, in a patient with atypical mole syndrome, a pre-existent...
melanoma and a dysplastic agminated nevus on the arm that first appeared during puberty. Later were described two cases of melanoma arising directly from agminated melanocytic lesions. The first one, published by Corradin et al, described the development of an invasive melanoma in an acquired agminated nevus that appeared after thermal and solar burn. Most recently Rezze et al reported the case of a patient affected by atypical mole syndrome and with personal history of melanoma who presented an agminated nevus on the anterior chest since puberty. Some nevi within the agminated lesion presented clinical and dermoscopic criteria of atypical nevus. The whole lesion was excised and the histopathological analysis showed an in situ melanoma, some areas of severe dysplasia and other areas corresponding to junctional, intradermal and compound nevi.

CASE REPORT

A nine-year-old male patient, phototype V, student, was referred to the dermatology clinic for evaluation of multiple pigmented lesions on his left thigh. He was accompanied by his father, who informed that the child had had a cluster of melanocytic lesions since birth. The cluster increased in size following the growth of the patient and the minor lesions became somewhat closer together over the years. The family background of skin cancer was negative. The father has a history of congenital nevi on the face and left lumbar region. The patient presented epilepsy and was in treatment with carbamazepine, imipramine and risperidone.

On physical examination, the patient had a cluster of approximately 20 maculopapular, lightly palpable blackened lesions of different sizes on the anterior part of his left thigh, forming a cluster of nevi (Figures 1 and 2). The diameter of the total lesion was 9.2cm x 7.6cm. The largest isolated lesion measured 2.6 cm x 1.3cm. Dermoscopy revealed predominantly homogeneous pattern with diffuse brownish areas, regular network at the periphery and numerous regularly distributed small dots (Figure 3). No background pigmentation was noted on clinical or dermoscopic examination between lesions.

A single lesion was excised for histological evaluation with a 2 mm border of normal skin. The histopathological findings revealed an intradermal melanocytic nevus without histological melanocytic hyperplasia or hyperpigmentation in clinically normal peripheral skin (Figures 4 and 5).

Considering the clinical and histopathological diagnosis of the lesion and treatment limitations due to the size of the total lesion, it was decided to keep dermoscopic monitoring of the patient every 4 months. It has enhanced to the family the importance of sun protection and guidance for the observation of changes such as modification of color, palpation (such as nodularity), shape and rapid growth.
DISCUSSION

Agminated nevus is a rare lesion and its incidence is unknown. In this case the patient has a congenital agminated nevus, a rare condition.

The patient presented a cluster of melanocytic lesions in the anterior part of the left thigh. There were no dysplastic or malignant changes on clinical examination, dermoscopy or histology. It can be differentiated from nevus Spilus by the absence of brown macular background in the clinical examination and histopathology.

The association between epilepsy and agminated melanocytic nevus is to the best of our knowledge not found in the literature. There is an established relationship between big and giant congenital melanocytic nevi with neurocutaneous melanosis, in which the occurrence of epilepsy is common. In this case there was no suspicion of indication for investigation for cutaneous melanosis.

The decision to follow or excise this particular and rare presentation of compound nevus should be individualized. We decided to monitor the patient since the lesion was large and without atypical clinical, dermoscopic and histological findings. Long-term follow-up is recommended due to the possibility of malignant transformation, even if this probability is at the moment not exactly defined.

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