D|vided nevus, which is also known as “kissing nevus,” is a rare congenital dermatological abnormality that occurs on adjacent parts of the body that are separated during embryogenesis.1 Such lesions were first described by Von Michael in 1908 and named by Fuchs in 1919, describing a congenital melanocytic nevus that occurred on opposing margins of upper and lower eyelids and appeared to be a single lesion when the eye was closed.1 A similar interesting process of congenital divided nevus has also been described elsewhere in the body, including the penis, fingers,2 and mast cell tumors3; however, this is much less common than the eyelid. Divided nevus of the penis is exceedingly rare. Desruelles et al4 reported the first divided nevus on the penis in 1998, and since then, only 17 cases have been reported in the English language literature.5–15 Now, we present 1 new case of divided nevus of the penis, along with histopathological findings and follow-up result of the patient.

**REPORT OF A CASE**

In July 2014, a 14-year-old Chinese boy who was referred to our department presented with a 7-year history of asymptomatic black and dark brown macules on the ventral side of the glans and the adjacent area underneath the foreskin. He was healthy and had no history of trauma or circumcision. The size and color of the penile lesion had not changed since his parents first noticed it. On physical examination, a macule, 15 × 20 mm in size and black to dark brown in color, was seen on the left ventral portion of the glans penis, and a macule, 10 × 18 mm sized, was seen underneath the foreskin (Fig. 1A). The coronal sulcus was exempt from melanocytic pigmentation. The lesions overlapped each other when the prepuce was retracted. The 2 lesions appear to have mirror symmetry with respect to the coronal sulcus. Although the clinical diagnosis of the black macules was divided nevus of the penis, the lesions showed malignant properties, such as color variegation and ill-defined border; thus, surgical excision was performed for the

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prevention of carcinoma after dermatologic consultation and parental discussion. The patient underwent surgical excision of the lesion underneath the foreskin with a safety margin of 2 mm and wound was directly sutured. The excision of the lesion of the glans was performed with a safety margin of 1.5 mm, and the glans was reconstructed by a full-thickness skin graft using remnant foreskin. The preputial skin and the lesion on the glans were sent for histopathological evaluation.

Histopathologic examination of pigmented patch on inner surface of prepuce revealed that groups of melanocytic nevus cells can be found at the dermoepidermal junction and the papillary dermis, typical of a compound nevus. Mitoses and atypia were absent from the nevus cells (Fig. 2A).

Histopathologic examination of pigmented macule on glans revealed uniform nests of normal melanocytes located in the papilla layer of the dermis; the epidermis appeared normal, junctional activity was absent, and mitoses and atypia were absent from the nevus cells. Final pathology of the patch on the glans was determined to be an intradermal nevus (Fig. 2B).

Six months after the operation, the patient showed no deformity of the glans or loss of sensation (Fig. 1B). The lesion on the glans can be successfully reconstructed using the remnant foreskin with satisfactory aesthetic and functional outcome. This method is desirable with minimal donor-site morbidity and inconspicuous donor-site scars.

**DISCUSSION**

The term “divided” or “kissing” nevus was first suggested by Fuchs in 1919 when describing a congenital melanocytic nevus on adjacent parts of the upper and lower eyelid. This phenomenon is very rare and can be seen only on those parts of the body that separate at some point during embryogenesis. In addition to melanocytic lesions, other types of divided nevus have been reported, including mast cell tumors and epidermal nevus on the fingers and divided nevus of the penis. Kissing nevi of the penis are extremely rare. Desruelles et al reported the first divided nevus on the penis in 1998. Since then, only 17 cases have been reported in the English-language literature. The penis lesion may originate from a single lesion in the embryo that is then divided during development of the external genitalia from the 11th to the 14th gestational week, which has been suggested by Desruelles et al and Kono et al. Desruelles et al hypothesized that the problem is caused by the migration of the melanoblasts and melanocytes before completion of the invagination of the preputial epithelial placode. In contrast, Kono et al suggested that the migration of the melanoblasts occurs just after embryological separation of the glans from the prepuce, which occurs at 12 weeks. Malignant melanoma of the penis is very rare and accounts for less than 2% of all primary penile malignant lesions. Most frequently, it is located on the glans (55%), followed by the prepuce (28%), penile shaft (9%), and urethral meatus (8%). Most reported cases of malignant melanoma of the penis have occurred in the sixth and seventh decade of age. Almost all divided nevi lesions of the penis are benign melanocytic nevus, except one case reported by Egberts et al in 2007. So, aesthetics and functionality of the penis are the primary considerations.
in the treatment plan. Surgical excision and reconstruction by skin grafting using oral mucosa of the lower lip⁸ or remnant foreskin¹¹ have been recently performed and showed satisfactory outcomes. However, in cases in which nevi are large, as these lesions, surgical excision may cause a scar and deformity of the glans penis. Yun et al¹² treated divided nevus of penis with Nd:YAG laser. In our cases, the divided nevus of the penis was treated with circumcision and free inner prepuce grafting. Remnant foreskin is available for skin grafting, the color and texture of which are ideal for reconstruction of deformity of the glans. This method has yielded positive results with little scarring and no loss of sensation.

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