Sir,
An 18-year-old female presented with an asymptomatic raised pigmented swelling over the scalp since birth. On inquiry, the family revealed that the lesion had focal hair loss until 5 years ago, when the mass started rapidly enlarging and covered whole of the back of the scalp, with appearance of hair over it. There was no history of trauma to head, spontaneous bleeding, or oozing from the lesion. None of the family members had any similar complaints.

On examination, there was the presence of a well-defined plaque of around 12 cm × 5 cm protruding out from the occipital area, with thick folds separating it from uninvolved skin, and the presence of spare terminal hair, with a coarser consistency than those on uninvolved skin [Figure 1]. There was the presence of multiple dark brown-to-blue hyperpigmented papules dispersed all over the lesion, as well as over the surrounding skin, covering the entire occiput posteriorly and crown up to the mid vertex transition point. The involved body surface area was around 2%–3%. The lesion was firm and nonpulsatile with no transillumination (ruling out neural tube defect). No developmental anomalies were detected. There was no local lymphadenopathy. Routine investigations were

![Figure 1: Giant pigmented nevus of the scalp](image1)

![Figure 2: Trichoscopy revealing islands of multifocal globules (green arrow) and dots (red arrows) along with central hyperpigmentation (yellow arrow) (Dermlite, ×10)](image2)

![Figure 3: Nevus cells arranged in sheets and nests extending from reticular dermis to subcutis with few melanophages (H and E, x100)](image3)

![Figure 4: (a) Type-B (lymphocytoid) nevus cells in intermediate dermis, (b) Type-C (neuroid) nevus cells in deep dermis, (c) Type-C nevus cells in subcutis (H and E, x400)](image4)
unremarkable. Computed tomography, magnetic resonance imaging, and ultrasonography scalp did not reveal any central nervous system or bony invasion. The differential diagnoses considered were congenital nevus, nevus lipomatosus superficialis, fibrolipomatous hamartoma, cutis verticis gyrata, and neurofibroma.

On trichoscopy, there was the presence of multifocal globules and dots along with central hyperpigmentation. Such patterned lesions were dispersed throughout the enlarged mass, as well as surrounding skin [Figure 2]. Histopathological examination revealed abundant nevus cells arranged in sheets extending from reticular dermis to subcutis and few melanophages. There were mature Type-B lymphocytoid nevus cells arranged in nests with visible melanin pigment and pale nuclei. In deeper dermis and subcutis, there were sheets of spindle-shaped Type-C neuroid nevus cells which also surrounded the pilosebaceous structures [Figures 3 and 4]. No cellular atypia was detected. The lesion was, therefore, diagnosed as a giant congenital melanocytic nevus (GCMN). The patient was referred to the plastic surgery department and advised complete resection, which she denied to.

Congenital melanocytic nevus (CMN) is a neural crest disorder with varied size and macroscopic and microscopic pictures. They are often present since birth, either flat or raised, and may present with satellite nevi (tardive satellites), nodularity, or hypertrichosis. According to Zaal et al., Giant congenital melanocytic nevus (GCMN) is defined to cover 1% body surface area on the face and neck or 2% on rest of the body.[1] Keeping in view the expected growth rate, another definition defines a CMN measuring at least 6 cm on the trunk and 9 cm on the head in a neonate as GCMN.[2] Histologically, three types of dermal nevi cells can be seen: type-A (epitheloid) nevus cells mature into Type-B (lymphocytoid) nevus cells which in turn mature into Type-C (neuroid) dermal cells during progressive downward migration. Type-C cells are often found with adipocyte or neural metaplasia.[3]

The differential diagnoses considered in our patient were turban tumor, connective tissue hamartoma, pachydermoperiostosis, ectopic meningoeipithelial hamartoma, and amyloidosis, all ruled out by histopathology. Complications of giant CMV include malignant melanoma in 2%–31% cases, while those on head and neck may be complicated by neurocutaneous melanosis (i.e., abnormal pigmentation of skin and meninges), which presents with seizures, developmental delay, or malignant melanoma of meninges.[4,5] Indications of excision in a giant CMN include age of patient (old age), proximity to vital structures, and presence of neurocutaneous melanosis (seen in 2.5%–45% cases of CMN). Owing to the premalignant potential coupled with additional neurological involvement, all giant CMN on the scalp should go a through investigative workup and surgical excision must be practiced in all cases. Although several cases of GCMN on the scalp have been described in the past, its dermascopic evaluation has been seldom reported. Presence of atypical or negative network, streaks, dots, and globules in three or more colors (i.e., brown, black, red, white, and/or blue-grey) on dermoscopy could supplement histology in an early diagnosis and treatment of malignant transformation in CMN.[6]

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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REFERENCES

1. Zaal LH, Mooi WJ, Sillevis Smitt JH, van der Horst CM. Classification of congenital melanocytic naevi and malignant transformation: A review of the literature. Br J Plast Surg 2004;57:707-19.
2. Marghoob AA, Schoenbach SP, Kopf AW, Orlov SJ, Nossa R, Bart RS. Large congenital melanocytic nevi and the risk for the development of malignant melanoma. A prospective study. Arch Dermatol 1996;132:170-5.
3. Xavier-Júnior JC, Ocanha-Xavier JP, Camilo-Júnior DJ, Dávila SC, Mattar NJ. Interesting overlooked findings in melanocytic nevi. Surg Exp Pathol 2019;2:19.
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4. Maize JC, Foster G. Age-related changes in melanocytic naevi. Clin Exp Dermatol 1979;4:49-58.
5. Turkmen A, Isik D, Bekerecioglu M. Comparison of classification systems for congenital melanocytic nevi. Dermatol Surg 2010;36:1554-62.
6. Deinlein T, Arzberger E, Zalaudek I, Massone C, Garcias-Ladaria J, Oliveira A, et al. Dermoscopic characteristics of melanoma according to the criteria “ulceration” and “mitotic rate” of the AJCC 2009 staging system for melanoma. PLoS One 2017;12:e0174871.

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