

“A Mole No More”- Case Series on Management of Intradermal Nevus of Face

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Abstract

A nevus is a benign melanocytic neoplasm and is the most common type of skin tumour. Intradermal nevus is considered to be a form of benign cutaneous tumours and referred to the group of common acquired nevocytic nevi. Common acquired nevi may be papillomatous, dome shaped, pedunculated or flat-topped and are usually flesh-coloured, pink or pigmented. Acquired melanocytic nevi can be expected to change with age in overall size and shape and in their colour and surface characteristics. There is regional variation in the time sequence of their evolution. Most congenital melanocytic nevi grow in proportion to growth of a given anatomic site. The treatment of intradermal nevus is surgical removal. In this article, we have reported 2 cases of intradermal melanocytic nevus of facial region.

Keywords : Nevus, Intradermal nevus, Melanocytic pigmented nevi, Acquired nevi

Introduction

A nevus is a benign melanocytic neoplasm and is the most common type of skin tumor. Intradermal nevus is considered to be a form of benign cutaneous tumours and referred to the group of common acquired nevocytic nevi. Common acquired nevi may be papillomatous, dome-shaped, pedunculated or flat-topped and are usually flesh-coloured, pink or pigmented. Acquired melanocytic nevi can be expected to change with age in overall size and shape and in their colour and surface characteristics. There is regional variation in the time sequence of their evolution. Most congenital melanocytic nevi grow in proportion to growth of a given anatomic site. The treatment of intradermal nevus is surgical removal. In this article we have reported 2 cases of intradermal melanocytic nevus of facial region.

Case Reports

Case 1 : A 30 years old woman presented with history of a slow-growing mass in the nasal bridge region since childhood associated with cosmetic discomfort. She denied any previous medical history. Physical examination revealed a protruding mass covered with grey desquamated keratin

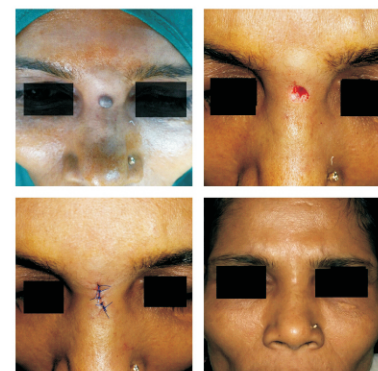
arising from the nasal bridge region in the midline (Figure 1). It showed a 6x8 mm sized dark brownish, dome-shaped, pedunculated mass. During the palpation with forceps, it was firm, non-tender mass. Although, the lesion was completely asymptomatic, she underwent excision for aesthetic reason only.

Under local anaesthesia, complete tumourexcision was performed. An elliptical incision was made around the base of the mass with adequate margins. The lesion was completely removed (Figure 1). Intraoperative finding showed well-demarcated mass covered with normal overlying skin. The skin closure was done with 5-0 proline suture material (Figure 1) and applied with antibiotic ointment. Following surgical excision, the patient experienced an uneventful recovery. Cutaneous wound healing occurred with complete re-epithelialization by regular dressing.

Histopathologic analysis revealed nevus cells presented in dermis in aggregates extending up to the depth at which skin appendages were located. Most nevus cells were round in shape containing melanin pigments in their cytoplasm. At the 3 months follow-up after operation, there was no sign of recurrence (Figure 1).

Diagnosis: Intradermal melanocytic nevus

Fig. 1



Case 2 : A 31 years old woman had a pedunculated mass on the left side of face just lateral to lateral margin of left eye since childhood. About 15 years previously she noticed a pigmented papule on the face lateral to left eye that gradually increased in size and became pedunculated. Physical examination revealed a flesh-coloured, lobulated tumour with central pigmentation, 6x8mm in size (Figure 2).

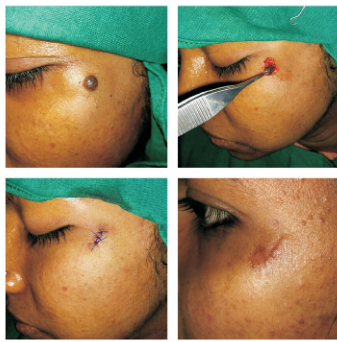
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Histopathologic analysis revealed pigmented cells in the basal layer of epidermis representing the basal keratinocytes. Dermis shows clusters of nevus cells. The nevus cells were round in shape containing the melanin pigment. At the 3 months follow-up after operation, there was no sign of recurrence (Figure 2).

Diagnosis: Intradermal melanocytic nevus

Fig. 2



Discussion

Nevi are pigmented benign tumours formed by proliferation of melanocytes from dermo-epidermal junction. Proliferated cells form nests and migrate to dermis where they can get together to elements derived from Schwann cells. They are considered developmental defects type hamartomas. Melanocytic nevi present different clinical expressions, normally sharing pigmentation and presence of nevus cells.⁷

Clinically, five macroscopic types of melanocytic nevi may be recognized⁸:

1. Flat lesions: flat pigmented spots = junctional nevus
 2. Slightly elevated lesions: slight sensation of elevation over the skin = compound
 3. Halo: elevated lesions with pigmented macular ring around it = compound
 4. Verrucous lesions: pigmented lesions covered by fine excrescence = intradermal (some are junctional nevi)
 5. Dome-like lesion: smooth, forming globous type elevation = intradermal
- Histologically, Melanocytic Nevus is

recognized by the presence of nevus cells, which, although they are melanocytes, differ from ordinary melanocytes by being arranged at least partially in cluster or nests and has been classified into three subtypes depending on the distribution of the melanocytes. A collection of nevomelanocytes located along the junction of the epidermis and the underlying dermis or remain in contact with the lower epidermis can be classified as a junctional nevus, situated in the upper dermis only and no longer contact the epidermis as intradermal nevus, and a mixture which display the features of both junctional and intradermal proliferation in both areas as a compound nevus.⁹

The nevus evolved by a process of nevus cells from the epidermis "dropping down" into the dermis. Melanocytic Nevus in adults is primarily of the intradermal type, and Melanocytic Nevus in children is primarily of the junctional type.¹⁰ Some authors asserts that overexposure to ultraviolet light from the sun may play a role in the skin damage that can lead to melanoma and the formation of acquired Melanocytic Nevus.¹¹

Melanocytic Nevus should be considered to be early diagnosed and to be managed with early complete surgical resection for aesthetic, functional and preventive purposes. The possibility of malignancy should be excluded all the time. The prognosis of Melanocytic Nevus is substantially favourable; however, the risk of progression to malignancy in benign melanocytic lesions was recently studied in a meta-analysis¹², which revealed a 2% incidence for melanoma, especially for congenital nevi >40 cm located on the trunk.¹³ The role of the pathologist is critical in the diagnosis, as recurrent nevi can be interpreted as malignant lesions.¹⁴

CONCLUSION:

The treatment of intradermal nevus is surgical removal. Surgical methods are shaving technique and complete excision. Hairless intradermal nevi may be removed using the shaving technique. Surgical excision gave good results for lesions on the face in both the cases. The procedure is simple, fast, efficient, and of low cost and low risk for the patient. However, the results depend on the experience and ability of the surgeon.

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