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Introduction

Different types of melanocytic nevi do exist in relation to their epidemiology, evolution, morphology, genetics, and their associated melanoma risk. The introduction of dermoscopy has opened a new morphologic dimension of melanocytic nevi; this along with recent progresses in our understanding of the molecular pathways involved in the formation of nevi opened new ways to classify nevi.

Although there are many different classification schemes depending on the method to obtain the morphologic information, the most

widely used scheme divides melanocytic nevi according to their clinical history into congenital and acquired nevi [1]. Per definition, congenital melanocytic nevi develop in utero and are present at birth; according to their maximum diameter, they are further classified into small (<1.5 cm), intermediate (1.5–20 cm), and large (>20 cm) nevi, with the risk of malignancy appearing to be proportional to size. Size is, however, irrelevant in the histopathologic classification of congenital nevi, which is based on more or less typical cytologic and architectural criteria (e.g., nevus cells preferentially following adnexal structures, fascicles of nevus cells growing down into the reticular dermis or subcutaneous fatty tissue).

Based on the definition of a congenital nevus, the group of acquired nevi encompasses basically all other benign melanocytic proliferations with development after birth. In contrast to congenital nevi, not the size but the number and clinical variability of acquired nevi are the most important risk factors for the development of melanoma [2].

Given the wide morphologic heterogeneity of this group, it is not a surprise that the classification of acquired nevi is controversial; the best known example is the unsolved discussion related to the definition of common, Clark, dysplastic, and atypical nevi and their role as precursors of or as risk markers for melanoma [3, 4]. Furthermore, considerable confusion arises in differentiating small congenital nevi from acquired nevi as many nevi with histopathologic criteria suggestive of small congenital nevi are actually not

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present at birth [1]. Just to add to confusion, even though Spitz and blue nevi commonly develop after birth, they are generally considered as separate entities with the latter being classified at times as congenital [3].

Based on our limited ability to clinically differentiate between various types of nevi, histopathology remains the gold standard for the diagnosis and classification of melanocytic nevi. However, histopathology relies on selection bias, permits little information about the nevus constellation in a given patient, and provides a mere cross-sectional view of nevus evolution at one point in time.

Dermoscopy is an *in vivo* technique for assessment of morphologic features of nevi; the fact that dermoscopy allows the recognition of features not visible with the clinical eye and that most dermoscopic features are well correlated with histopathologic criteria made dermoscopy a valuable method to observe the morphologic diversity of nevi and their changes over time without need to biopsy. Not surprisingly, dermoscopy and digital dermoscopic follow-up allowed new knowledge about the epidemiological and morphological diversity of nevi [5, 6].

There is no doubt that the assertion is true that for decades new knowledge has been stacked up and interwoven, while no consistent classification of melanocytic nevi based on reliable clinical-histopathologic criteria has resulted. Perhaps it is the role of dermoscopy to be the intersection of the microscopic and macroscopic worlds and lead to integration.

Dermoscopic Criteria of Melanocytic Nevi

Dermoscopy allowed clinicians to observe colors and structures within melanocytic nevi that are otherwise not visible to the unaided eye. The dermoscopic diagnosis of nevi relies on four basic criteria, each of them typified by four variables: (1) color (black, brown, gray, and blue), (2) pattern (globular, reticular, starburst, and structureless blue pattern), (3) body site-specific pattern

(face, acral, nail), and (4) pigment distribution (multifocal, central, eccentric, and uniform) (Tables 2.1 and 2.2; Fig. 2.1)[6].

Genetic Alterations of Melanocytic Nevi

Research on the molecular pathways aberrant in nevi has furthered our understanding of pathways involved in the formation of nevi; oncogenic BRAF is common among acquired and small congenital nevi. In contrast, intermediate to large congenital nevi, Spitz nevi, and blue nevi display mutations in other genes, including the NRAS, HRAS, or GNAQ, respectively. The fact that these different types of nevi display very different clinical and dermoscopic patterns suggests that morphology correlates well with genetics [7].

Classification of Melanocytic Nevi Integrating Dermoscopic Morphology and Molecular Biology

The recent improvements in our understanding of genetic alterations associated with different dermoscopic nevus morphologies and the factors influencing these nevus subtypes have led to a new proposal of nevus classification (Table 2.3) [8, 9]. The most significant difference between the new and traditional classification of nevi is that – with the exception of large and intermediate size congenital nevi – the new classification no longer differentiated between nevus types based on history. Instead, nevi are summarized into categories based on common epidemiological and morphologic features. Basically, five main categories can be differentiated, which are globular, reticular, mixed (complex), starburst, and structureless blue pattern, of which each corresponds to specific histopathologic substrate [8]. Besides these main groups, the dermoscopic classification further distinguishes between three specific subgroups, which are nevi of special body sites (including facial, acral, and subungual nevi), nevi with special features (halo nevus, Meyerson nevus, traumatized targetoid

Table 2.1 Dermoscopic structures, colors, and their pathologic correlates associated with melanocytic skin lesions

| Color | Anatomic level within the skin | Pathologic correlate |
|----------------------|---|--|
| Black | Melanin either in keratinocytes or melanocytes | Stratum corneum |
| Brown | Melanin either in keratinocytes or melanocytes | Dermo-epidermal junction |
| Gray | Melanin in melanocytes or melanophages | Superficial papillary dermis |
| Blue | Melanin in melanocytes or within melanophages | Papillary dermis or reticular dermis |
| Pattern | Description | Pathologic correlate |
| Reticular-network | Network of brownish interconnected lines over a background of tan diffuse pigmentation. *In facial skin, a peculiar pigment network, also called pseudonetwork, is typified by round, equally sized network holes corresponding to the preexisting follicular ostia | Regularly elongated, notably pigmented rete ridges with increased melanocytes in the basal layer and nests of melanocytes at the tips of the rete ridges |
| Globular-cobblestone | Numerous, variously sized, round to oval structures with various shades of brown and gray-black *Large, closely aggregated, somehow angulated globule-like structures resembling a cobblestone | Black dots correspond to circumscribed accumulations of melanocytes or melanin pigment in the cornified layer Brown globules correlate to nests of melanocytes at the dermo-epidermal junction or in the papillary dermis |
| starburst | These have been previously described separately as pseudopods and radial streaming but are now combined into one term. They are bulbous and often kinked or fingerlike projections seen at the edge of a lesion. They may arise from network structures but more commonly do not. They range in color from tan to black | Well-demarcated junctional nests of pigmented melanocytes The longitudinal shape of the streaks leads one to assume that the junctional melanocytic nests form strand-like structures parallel to the skin surface |
| Structureless blue | Structureless blue pigmentation in the absence of pigment network or other distinctive local features | Diffuse infiltrate of dendritic melanocytes and melanophages in the papillary and/or reticular dermis |

Table 2.2 Dermoscopic patterns of nevi located on special body sites

| Site | Dermoscopy |
|-------|---|
| Face | Pseudonetwork pattern intermingled by hairs |
| Acral | Parallel pigmented lines within the furrows or perpendicular to the furrows |
| Nail | Small pigmented band composed by parallel lines of uniform color and width |

hemosiderotic nevus, cockade nevus, combined nevus, and recurrent nevus), and unclassifiable melanocytic proliferations.

Large and Intermediate-Sized Congenital Melanocytic Nevi

Size is a sufficient criterion to make the diagnosis of large and intermediate congenital melanocytic nevi with high confidence; neither dermoscopy

nor genetic analyses (mostly NRAS mutations) add much to the clinical diagnosis [8, 10] (Fig. 2.2).

Globular Nevi

The definition of globular nevi includes all benign melanocytic lesions dermoscopically characterized by a globular, cobblestone, or structureless light brown pattern correlating histopathologically to variable large, predominantly dermal nests of melanocytes with or without congenital features (Fig. 2.3) [5].

Globular nevi can be present at birth (traditionally known as small “true” congenital nevi) but commonly develop during childhood (known also as tardive congenital nevi or early acquired nevi) [5, 11–17].

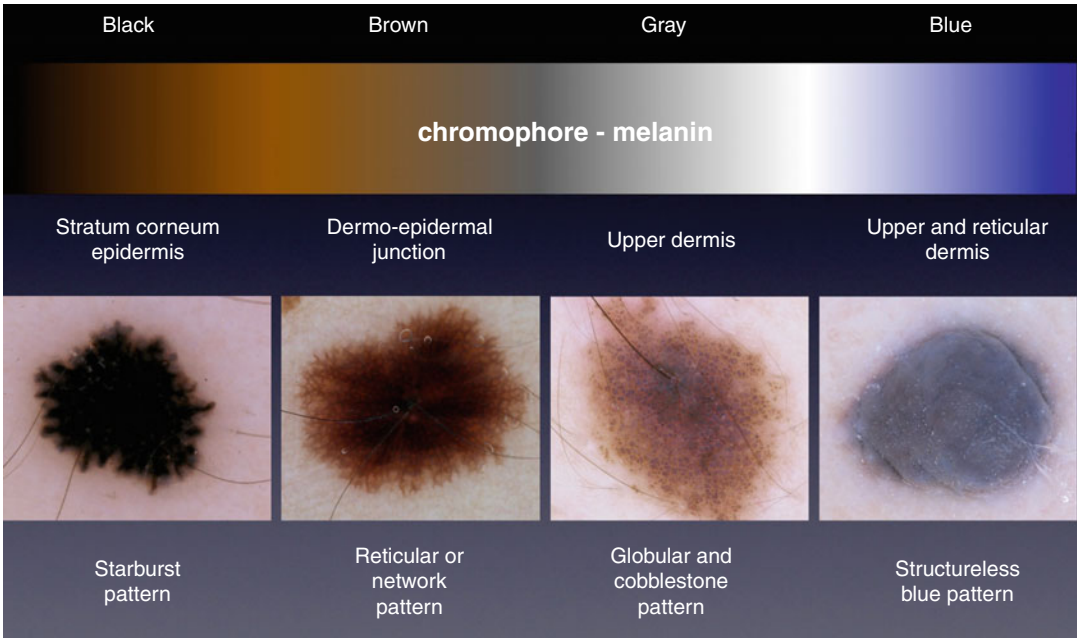


Fig. 2.1 The dermoscopic diagnosis of melanocytic nevi relies on their colors and patterns. The most important chromophore in melanocytic nevi is melanin within melanocytes or keratinocytes. Understanding the histopathologic correlates of colors and patterns of melanocytic nevi explains also why nevi with predominant epidermal involvement (i.e., reticular and starburst nevi) usually reveal a black to brown color, whereas nevi with predominant dermal involvement will often show shades of gray and blue

Table 2.3 New classification of nevi based on etiologic, epidemiologic, clinico-dermoscopic, and histopathologic features and their related risk for melanoma

| Pattern | Globular | Reticular | Mixed-complex | Starburst | Homogeneous blue |
|-----------------|-------------------------------------|-------------------------|-------------------------------|-----------------------|-------------------------------------|
| Pathway | Endogenous (genetically determined) | Exogenous (UV exposure) | Endogenous (growth hormones?) | Unknown | Endogenous (genetically determined) |
| Origin | Dermal | Epidermal | Dermal-epidermal | Epidermal | Dermal |
| Development | Childhood | Puberty | Puberty | Childhood–adolescence | Childhood–adolescence |
| Natural history | Persistence | Involution | Involution | Involution | Persistence |
| Melanoma risk | Precursor | Indicator | Precursor and indicator | Simulator | Simulator |
| Mutation | BRAF | None | In growth phase BRAF | HRAS | GNAQ |

From a histogenetic, clinical, dermoscopic, or histopathological perspective, distinguishing between true small congenital nevi and early acquired nevi is often impossible but is irrelevant because both types share the same morphologic features. The common pathway of globular nevi is further supported by molecular studies showing a comparable (high) frequency of BRAF mutations among these nevi,

irrespective whether being present since birth or not [10, 18].

Globular nevi are the most prevalent nevus type in children with a fair to intermediate skin type. However, they can be seen in few numbers at any age and in any skin type [19, 20]. This has led to the concept that globular nevi persist for most of the lifetime and eventually acquire the stereotypical appearance of a dermal nevus in the elderly [9].

Fig. 2.2 The clinical criterion “size” alone allows for the diagnosis of large (i.e., >20 cm) and intermediate congenital nevi (>1.5 cm) straightforward

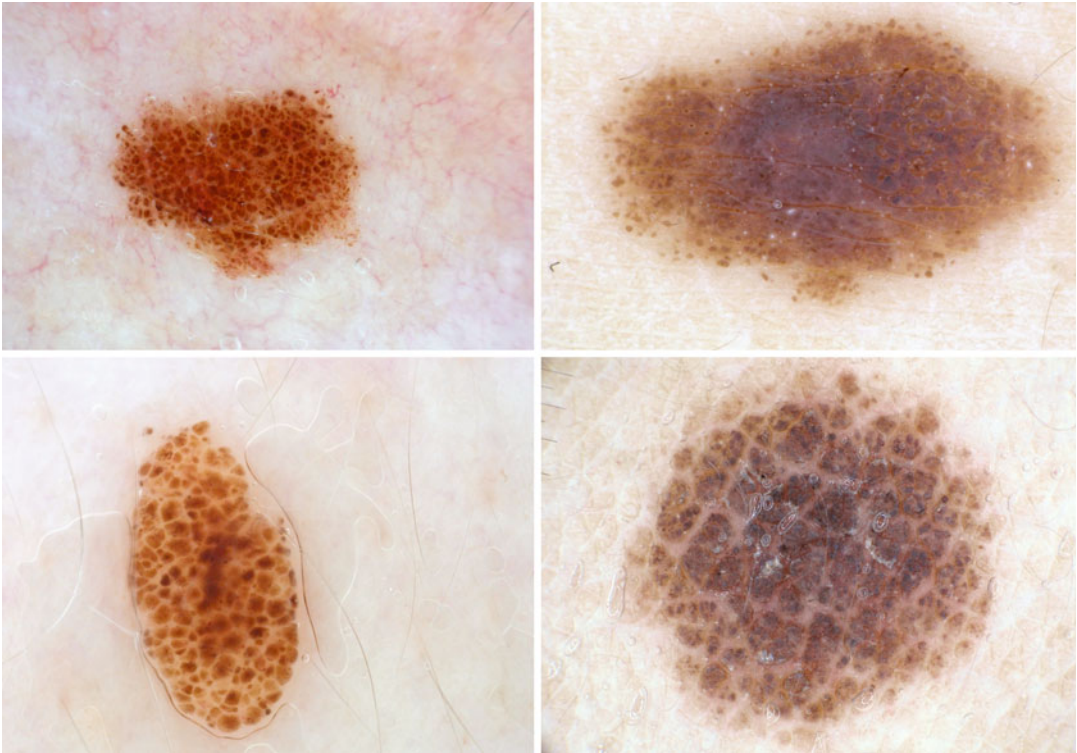
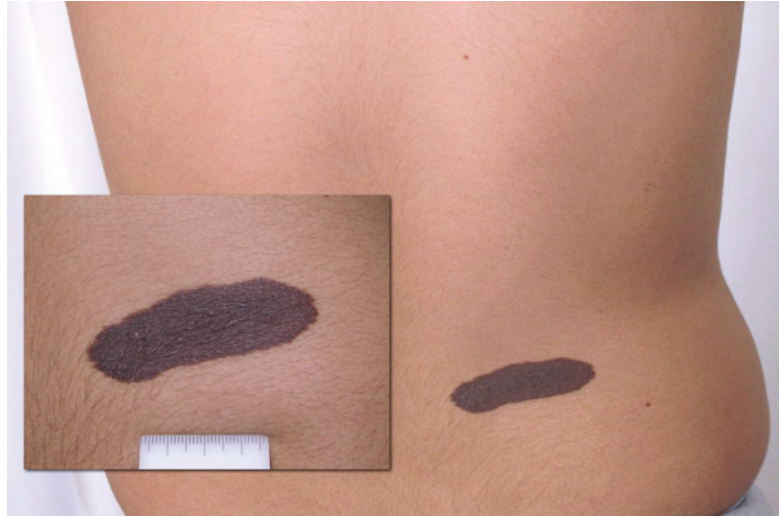


Fig. 2.3 Examples of nevi showing dermoscopically a globular and cobblestone pattern

Reticular Nevi

The histopathologic correlates of nevi with a dermoscopic reticular pattern reveal either single

melanocytes along the basal layer or small junctional nests of melanocytes at the tips of elongated rete ridges (i.e., lentiginous or junctional nevi) (Fig. 2.4). At times, superficial

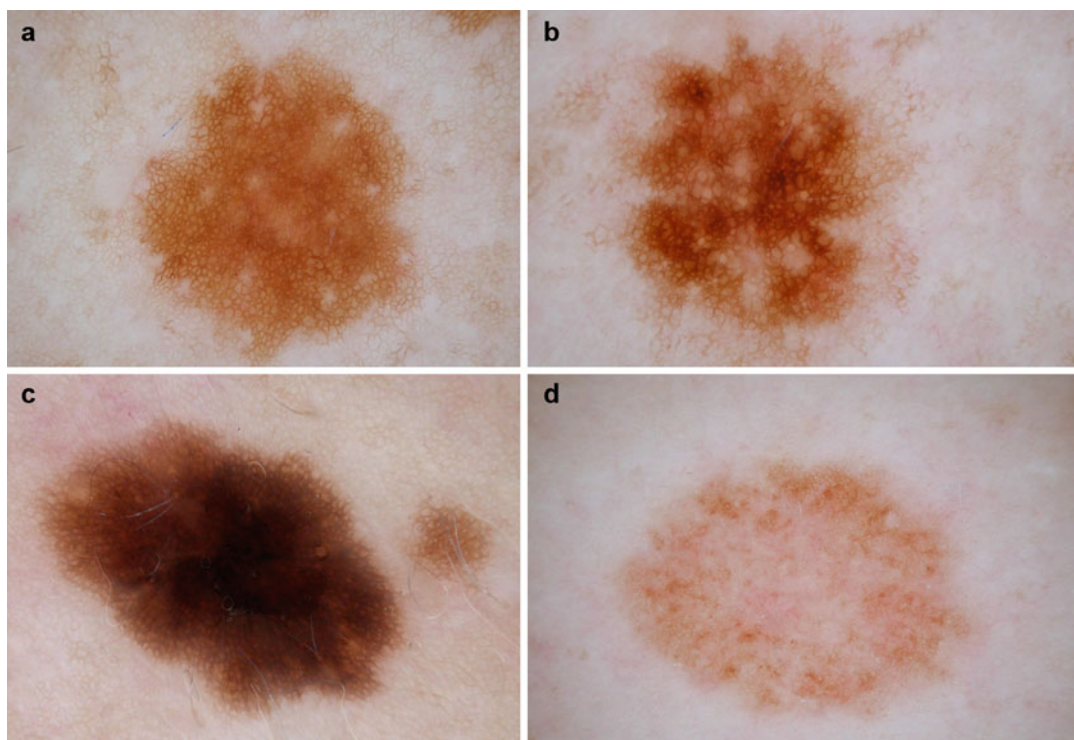


Fig. 2.4 Examples of nevi showing dermoscopically a reticular pattern with uniform pigmentation (a), multifocal hyper and hypopigmentation (b), central hyperpigmentation (c), and central hypopigmentation (d)

compound nevi may also show a reticular pattern. Reticular nevi of the lentiginous or junctional type rarely show mutations in any of the known genes [18, 21].

Reticular nevi are generally small (<6 mm) and are the most common nevus type in adults. In contrast to globular nevi, reticular nevi are almost never seen on the head/neck area of adults but appear randomly distributed on the trunk. They are the most prevalent nevus type on the lower extremities [6, 11, 12, 22].

In persons with a fair skin type, reticular nevi often reveal an evident and pronounced orange network at times associated with overlying brown dots [23]. In contrast, reticular nevi of persons with a dark skin type display a dark brown color and show typically a central black blotch. This black blotch is related to pigmented parakeratosis of the junctional nevus. Reticular nevi tend to vanish or regress over time, especially after the sixth decade of life [20, 24–26].

Mixed (Complex) Pattern Nevi

Mixed (complex) pattern is defined as the presence of more than one pattern [27] (Fig. 2.5). According to the distribution of different patterns within the nevus, basically two main subtypes of mixed pattern can be differentiated: (1) centrally located structureless brown-gray areas or network patterns which are surrounded by a peripheral rim of small brown globules and (2) centrally located structureless brown pattern or areas of hypopigmentation or globules which are surrounded by a peripheral network. Histopathologically, nevi with either mixed pattern are of the compound type in which the prevailing peripheral pattern corresponds to either larger (i.e., globules) or smaller (i.e., network) junctional nests of melanocytes (also called junctional “shoulders”). Notably, the former pattern represents a time-related variant of the latter pattern and is only seen during the active growth phase of the nevus. At times, compound nevi may

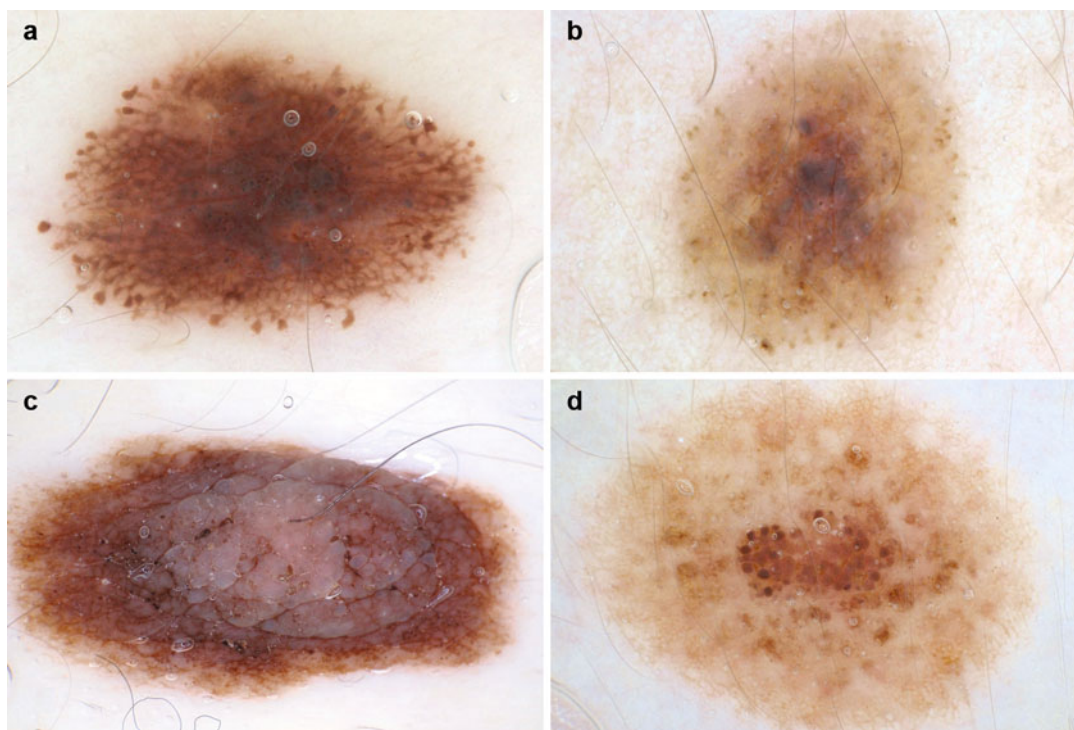


Fig. 2.5 Examples of nevi with a mixed pattern. (a) Nevus showing a central reticular pattern surrounded by a rim of small brown globules. (b) Nevus showing a central structureless pattern surrounded by a rim of small brown globules. Both (a and b) patterns are well-recognized fea-

tures of evolving compound nevi. (c) Nevus showing an elevated, central structureless brown pattern surrounded by a peripheral network. (d) Nevus showing a central globular pattern surrounded by a network pattern

also show only a reticular pattern; this is the case when more melanocytes or melanin is present at the dermo-epidermal junction [28].

Nevi with mixed pattern are commonly seen in persons with multiple and large nevi (i.e., also known as dysplastic nevus syndrome); they have been associated with an increased risk for melanoma development (mostly *de novo*) [27]. Evolving compound nevi are commonly seen in young adults and easily recognized because of their characteristic feature of peripheral brown globules. During follow-up, nevi will enlarge until the final disappearance of the brown globules indicates that stabilization of growth has been reached. At this stage, the nevus will show an elevated central area showing a structureless-hypopigmented-globular pattern and a flat area with a reticular pattern. After a variable time of months to years, an increasing proportion of nevi with mixed pattern will tend to disappear via

involution which is typified by a progressive fading of pigment from the periphery towards the center.

Genetic studies suggest that the frequency of BRAF mutations among compound nevi depends on the growth phase and the location of melanocytes in the skin (i.e., being higher among growing nevi or predominantly dermal than stable and predominantly epidermal subtypes) [18, 29].

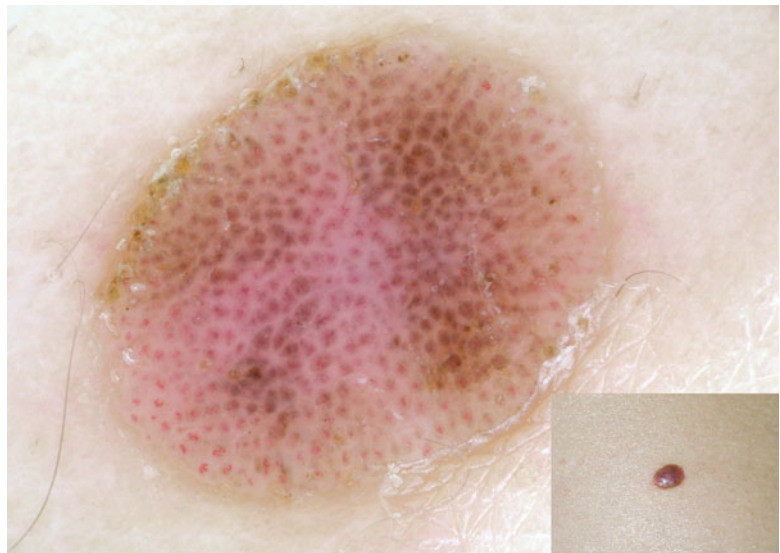
Starburst Nevi

Starburst, Spitz/Reed nevi are peculiar melanocytic nevi, usually acquired, that are seen in both children and adults [30–32]. Like reticular or reticular-mixed nevi, starburst nevi are rarely seen in elderly patients and tend to involute over the patient's lifetime [33–35]. Although initial descriptions defined Spitz nevi as non-pigmented lesions, more recent studies suggest that Spitz/Reed nevi are brown to black in about 70–90 %

Fig. 2.6 Typical examples of a starburst nevus showing peripheral streaks arising from a heavily pigmented center



Fig. 2.7 Classical example of a hypopigmented Spitz nevus showing dotted vessels and reticular depigmentation



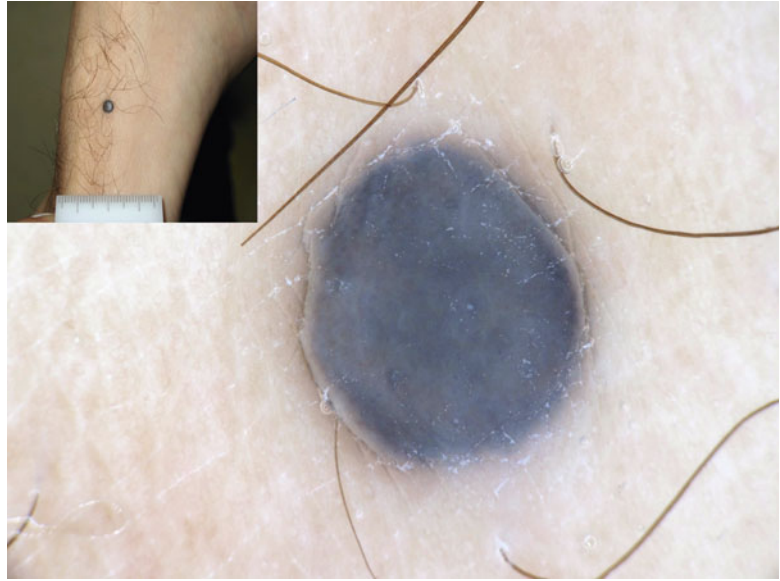
of histopathologically examined cases [32]. Such a high frequency of pigmented variants in surgical series could be the result of a better clinical recognition due to dermoscopy.

Clinically, pigmented Spitz/Reed nevi are brown to black, flat to slightly elevated, symmetrical lesions showing a relative preference for certain locations, including face, limbs, and buttocks. The most relevant and peculiar feature is the starburst pattern seen by dermoscopy (Fig. 2.6). This is typified by multiple streaks of pigmentation or large globules arranged symmetrically

at the periphery of the lesion in a radiating pattern like that of a star. Dotted vessels and reticular depigmentation are seen in nonpigmented lesions [36, 37] (Fig. 2.7).

Histopathologically, starburst nevi are junctional or compound neoplasms composed of heavily pigmented, highly cohesive spindle and/or epithelioid melanocytes, parallel and/or perpendicular to the skin surface with variable epidermal hyperplasia. The demarcation between the epidermis and the junctional nests of melanocytes is either sharp (with half-moon-shaped clefts: “capping”) or barely

Fig. 2.8 Stereotypical appearance of a blue nevus typified by a structureless blue pattern



discernible. A periadnexal junctional component is often evident, and a band-like dermal infiltration of melanophages is a common ancillary feature.

Classical Spitz nevi are plaque- or dome-shaped lesions that are typically symmetrical and sharply demarcated. Classical Spitz nevi are made up of large spindle and/or epithelioid cells that are mainly arranged in nests. Pigmentation is usually sparse or may even be absent. The dermal component often has desmoplasia encircling single melanocytes (“desmoplastic Spitz nevus”).

It should be noted that melanoma might rarely exhibit a type of starburst pattern, especially in lesions undergoing change in adults. In these circumstances, excision of lesions with a starburst pattern should be contemplated [38].

Blue Nevus

Blue nevi can be either congenital or acquired and usually persist throughout the patient’s life. By naked eye examination, they are flat to elevated, blue to black papules, plaques, or nodules of variable size [39] Dermoscopically, blue nevi are typified by a structureless, uniform blue coloration (Fig. 2.8). The histopathological pattern of the common blue nevus is defined as dendritic-sclerotic. This pattern is typified by the presence of heavily pigmented

dendritic melanocytes interspersed with some melanophages among thickened bundles of collagen in the mid- and the upper dermis. A thick grenz zone usually separates the lesion from the unaffected epidermis. Not uncommonly, some areas of otherwise typical blue nevi are populated by oval melanocytes almost devoid of any pigment (“hypochromic” blue nevi, either “hypomelanotic” or “amelanotic”). On dermoscopy, most of these “hypochromic” lesions appear as “white” blue nevi. Pigment loss in blue nevi is most commonly observed in blue nevi of the limbs and is likely to be a site-related phenomenon, rather than a consequence of aging.

Special Nevi

Several melanocytic nevi may exhibit special clinical features, often with a targetoid appearance. This group of special nevi includes halo nevi, Meyerson or eczematous nevi, irritated nevi, cockade nevi, combined nevi, and recurrent nevi.

Halo Nevus

Halo nevi, also termed Sutton’s nevi or leukoderma acquisitum centrifugum, are benign melanocytic nevi surrounded by a rim of

depigmentation, resembling a halo. Halo nevi are common in children and young adults, with an average age of onset of 15 years. Halo nevi may undergo progressive regression with subsequent disappearance of the nevus. Halo phenomenon commonly occurs typically in nevi with significant dermal component including dermal, compound nevi and congenital melanocytic nevi. Accordingly, the central nevus component typically exhibits a globular and/or homogeneous pattern, which is surrounded by a variable rim of a white scar-like depigmentation (Fig. 2.9). Depending on the clinical stage, the central nevus component may not be visible, and in these cases, a reddish depigmentation revealing visible vessels from the dermal vascular plexus may be present [40].

Meyerson Nevus

Meyerson nevus is characterized by the development of an eczematous halo around one or more pigmented nevi. Clinical features are the appearance of erythematous halo with overlying yellow scales sometimes accentuated at the periphery of the erythematous zones. This process can be confined to one, a few or all nevi in an individual. Slight pruritus is a feature in most lesions. The eczematous lesions become desquamative and

clear spontaneously or resolve with topical corticosteroid treatment. Dermoscopically, the Meyerson nevus pattern appears blurred due to the overlying superficial yellowish serous crust [41, 42] (Fig. 2.10). The nevi, once the eczematous reaction has resolved, return back to their baseline dermoscopic morphology.

Hemosiderotic Targetoid (Traumatized Nevus)

The occurrence of traumatic changes is frequent in melanocytic nevi, particularly in those that are elevated or exophytic (globular or mixed pattern nevi). Mechanical irritation by clothing and shaving or scratching and accident are the most common causes of injury. Typically, patients report a sudden change of pigmentation in the nevus, and they often do not recollect the trauma that lead to the irritation. Tenderness and itching are common symptoms. The typical clinical feature of traumatized nevus is the sudden development of an asymptomatic ecchymotic, violaceous halo around an existing nevus, which often has a central elevated component, causing a target-like phenomenon to appear (Fig. 2.11a, b). In traumatized nevi, dermoscopy is helpful to differentiate blood from melanin pigmentation. Hemosiderotic targetoid nevi typically show

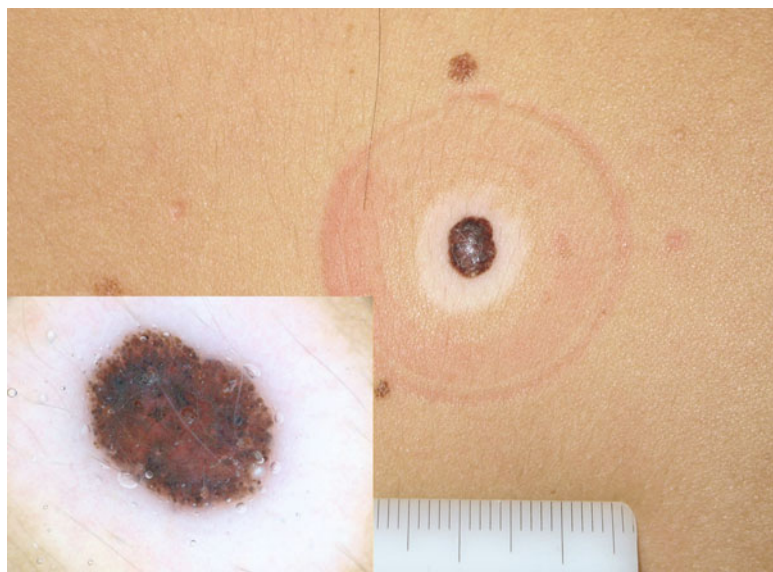


Fig 2.9 Example of a Sutton nevus showing the white halo surrounding a nevus with a globular pattern

Fig. 2.10 Clinical and dermoscopic features of Meyerson nevus; note on the right image the yellowish serocrusts

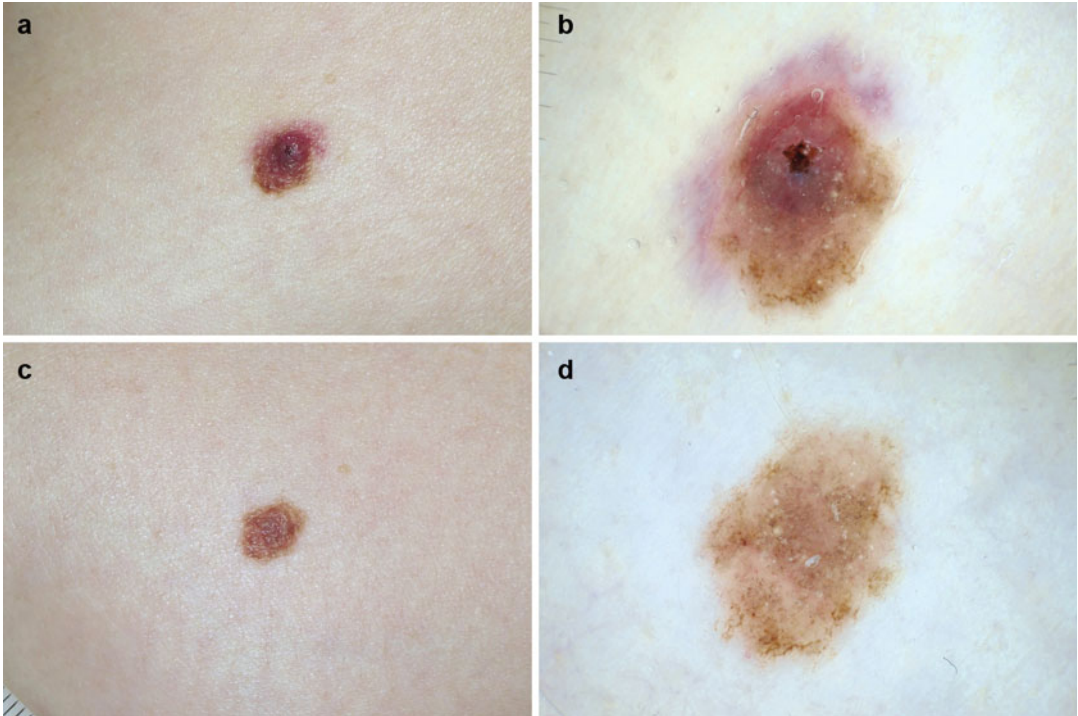
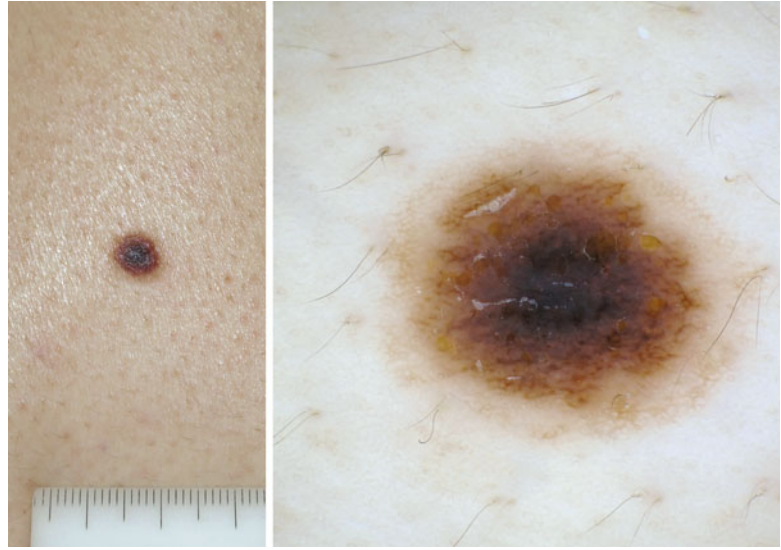


Fig. 2.11 Typical example of a targetoid hemosiderotic nevus showing a purple rim around the central brown nevus component (a and b). Figures (c) and (d) show the same nevus one month after the trauma. Once the healed,

the nevus reverts back to its original pattern, which in this particular case is a mixed pattern nevus with central structureless areas and peripheral network

features of globular nevi with vascular-hemorrhagic (red to purple or black) changes superimposed on and/or surrounding the nevus and particularly surrounding it. These color changes

often appear as irregularly sized and shaped patches, manifesting a violaceous to black color and comma-shaped vessels can often also be seen. The targetoid halo demonstrates a pale,

ill-defined inner area surrounded by a homogeneous reddish zone with peripheral-jagged margins.

Although irritated nevi including hemosiderotic targetoid nevi usually return to their baseline normal clinical appearance 7–14 days after the trauma (Fig. 2.11c, d), in some cases, a persistent scar characterized by white scar-like depigmentation may remain. In some of these cases pigment may reappear within the scar and then the lesion is referred to as recurrent or persisting nevus [42–44].

Recurrent Nevus

Recurrent nevi are benign melanocytic nevi that regrow or repigment after incomplete surgical removal or traumatic injury (Fig. 2.12a, b). Recurrent nevi are biologically benign without a documented risk of malignant progression, but they pose diagnostic problems

because they can morphologically resemble melanoma. Accordingly, they are also commonly referred to as “pseudomelanomas.” The typical feature observed in such recurrent nevi is a roundish to oval scar revealing in its center atypical network structures, globules, and/or irregular streaks with heterogeneous pigmentation (Fig. 2.12c, d). In cases with a previous histopathologic confirmation of a nevus and if the pigmentation is confined to within the scar then no further treatment is usually necessary. In cases for which a previous histopathologic diagnosis is not available, complete excision should be contemplated [45–48].

Cockade Nevus

This nevus is characterized by a central pigmented, often papular portion that is surrounded by an inner depigmented and outer pigmented rim. There

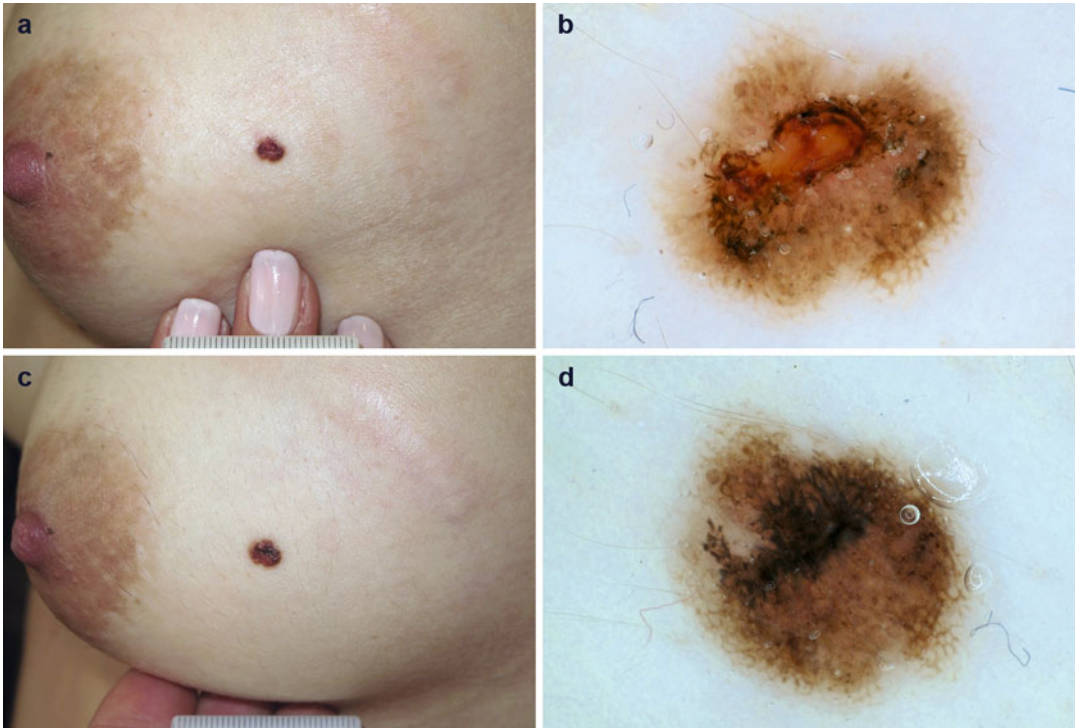


Fig. 2.12 Typical example of a traumatized nevus showing an erosion (a and b). Recurrent pigmentation appeared 2 weeks after the trauma and reveals a focus of black to

brown irregular pigmentation corresponding to the previous site of trauma (c and d)

Fig. 2.13 Typical example of cockade nevus showing a central hyperpigmented area surrounded by an inner lighter and outer darker rim of pigmentation

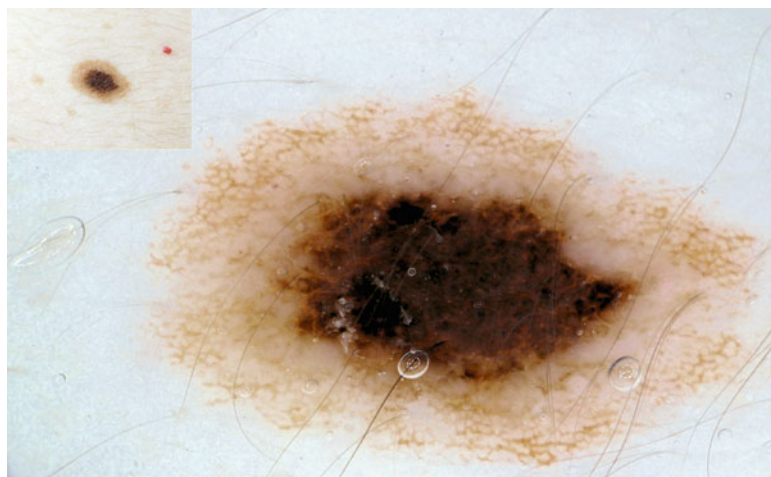
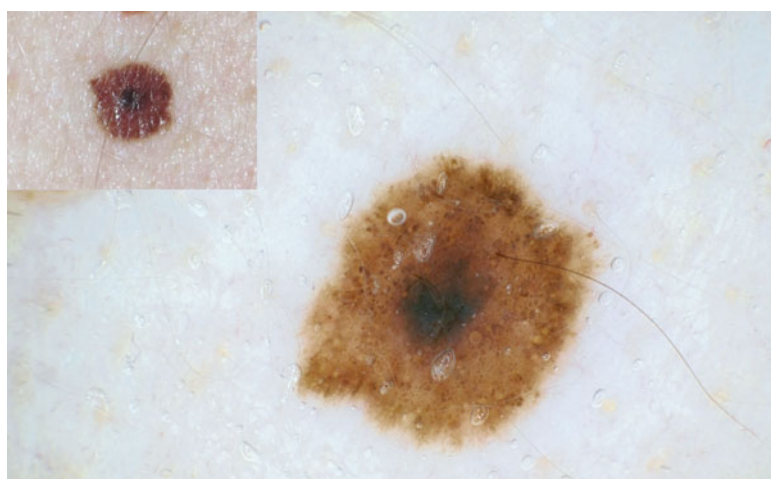


Fig. 2.14 Stereotypical appearance of a combined nevus (blue nevus and congenital nevus) showing a central blue-gray area surrounded by a brown part showing globules and reticular pattern



are only few reports in the literature reporting on cockade nevus, and accordingly this nevus is considered rare [49–55]. In our experience, this nevus occurs more commonly than suggested in the literature (Fig. 2.13) [49].

Combined Nevus

Combined melanocytic nevi are defined as the histopathological presence of two different types of melanocytic neoplasms. Combined nevi may be composed of variable histologic types of nevi; most commonly they consist of a blue nevus in combination with Spitz nevi, acquired melanocytic nevus, or congenital melanocytic nevus

[53]. Because of the presence of two nevus populations, color variegations or more than one structure is often seen. Depending on the dominant histopathologic component, combined nevi may appear clinically as blue nevi or common nevi, but typically they reveal a central blue papule or plaque (blue nevus) surrounded by a brownish new (Fig. 2.14).

Dermoscopically, the most classic type (blue nevus associated with reticular or globular nevus) is characterized by a delicate reticular pattern and/or globular pattern surrounding a central homogeneous blue pigmented area. Combined nevi lacking a blue nevus component often reveal less specific features and are difficult to diagnose by clinical-dermoscopic examination [56].

Nevi on Special Body Sites

Nevi located on the face, palms and soles, and subungual areas exhibit peculiar dermoscopic features that are related to the specific anatomy of the skin of these locations. Such nevi are therefore also referred to as nevi of special body sites and show a pseudonetwork pattern when located on the face (Fig. 2.15), parallel furrow pattern when located on volar skin (Fig. 2.16), and regular small band-like pattern when subungual (Fig. 2.17) [57–65].

Unclassifiable Melanocytic Lesions

Melanocytic nevi may show conflicting diagnostic criteria from a clinico-dermoscopic and/or a histopathologic point of view. A diagnostic gray zone exists where the boundary between benign and malignant are not clear cut. The extent of this “gray zone” differs clinically, and dermoscopically and histopathologically, being larger with the naked eye examination and smaller with the histopathologic examination.

Fig. 2.15 Typical example of a small flat facial nevus located on the cheek of a 6-year-old boy. Dermoscopically, a pseudonetwork pattern and some globules are seen

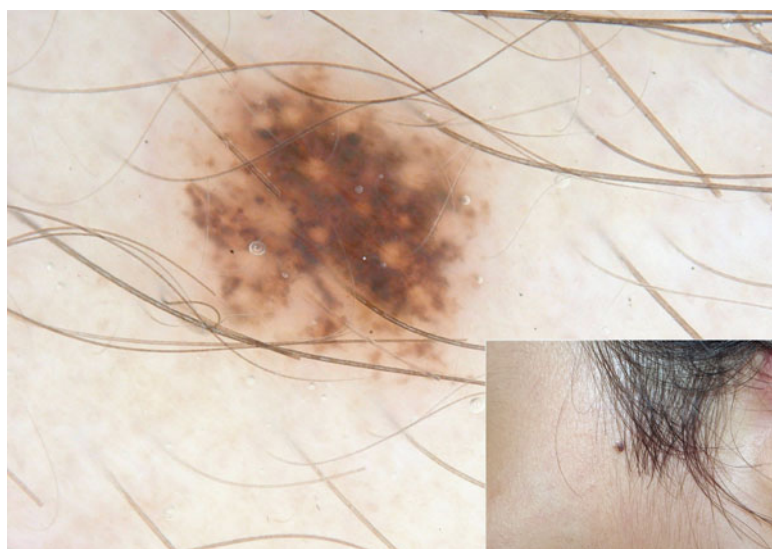


Fig. 2.16 Classical appearance of an acral nevus showing a parallel furrow pattern

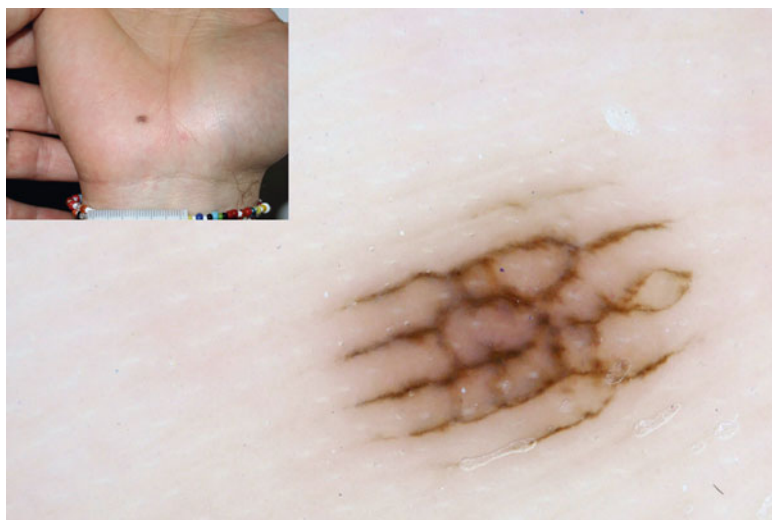
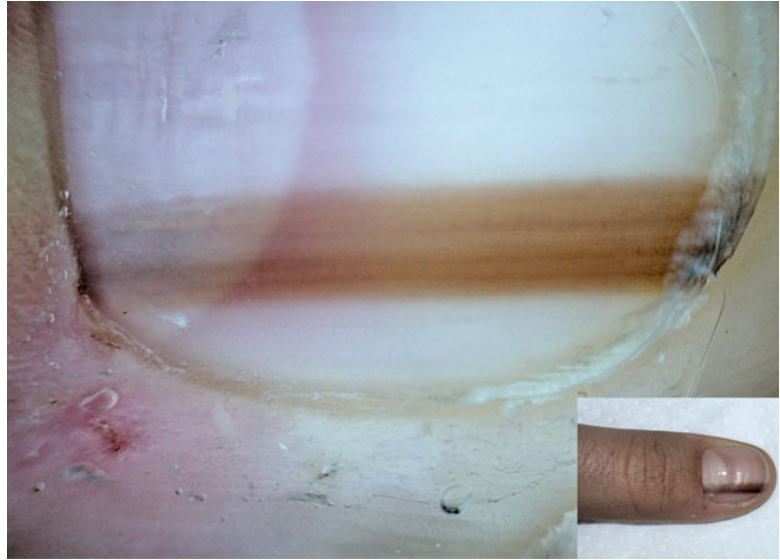


Fig. 2.17 Subungual nevi appear clinically and dermoscopically a small (usually less than 4 mm) uniform brown band-like pigmentation extending from the proximal to the distal nail



From a clinico-dermoscopic point of view, atypical melanocytic lesions often show an irregular distribution of patterns and colors that falls in none of the aforementioned nevus subtype categories. Importantly, no global definition of “atypical” exists and the interpretation of atypical features depends on the observers’ expertise. Accordingly, the cutoff point between typical and atypical is highly variable between different observers [8].

Conclusion

Different types of nevi do exist in relation to their epidemiology, morphology, evolution, genetic, and melanoma risk. The classification of nevus subtypes based on dermoscopy, which provides a bridge between clinical and histopathologic criteria, may improve the diagnosis, classification, management, and risk assessment of the heterogeneous spectrum of benign melanocytic proliferations encountered in normal human skin.

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