



Figure 3 Photograph showing pinkish lichenoid plaques on the scrotum of patient #2.

These eruptions were reported prior to the introduction of penicillin, i.e., when arsenic-based compounds were still being used as the treatment of choice for syphilis, and it was assumed that these compounds were responsible for the lichenoid appearance of the lesions. Similar lesions, however, continued to be observed when they were replaced with penicillin.⁷ Serology, together with histologic findings, has an important diagnostic role, with positive results shown by both treponemal and nontreponemal tests. Most patients with HIV infection have normal serology, although they may present false-positive nontreponemal responses and higher-than-expected titers in the absence of reinfection. It should also be noted that delayed positives and false negatives are also possible with nontreponemal tests.

The treatment of secondary syphilis in patients with HIV infection has generated some controversy. The latest edition of the Sexually Transmitted Diseases Treatment Guidelines from the Centers for Disease Control⁸ recommends a single dose of intramuscular benzathine penicillin G 2.4 million units, regardless of whether the patient has concomitant HIV infection or not, as additional doses have not proven to be more effective.

Although the literature contains reports of secondary syphilis mimicking lichen planus, our cases are interesting in that the lesions were exclusively genital. We found only 2 similar cases in our literature search.⁹ Both clinicians and pathologists should be aware of the highly variable clinical

and histologic features of secondary syphilis to ensure prompt diagnosis and treatment.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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N. Jiménez-Gómez,^{a,*} Á. Hermosa-Gelbard,^a
R. Carrillo-Gijón,^b P. Jaén^a

^a *Servicio de Dermatología, Hospital Universitario Ramón y Cajal, Madrid, Spain*

^b *Servicio de Anatomía Patológica, Hospital Universitario Ramón y Cajal, Madrid, Spain*

* Corresponding author.

E-mail address: natjgomez@gmail.com
(N. Jiménez-Gómez).

Nevus Spilus Associated With Agminated Blue Nevus: A Rare Combination[☆]



Nevo spilus asociado a nevus azul agminado: una combinación infrecuente

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To the Editor:

Nevus spilus, also known as speckled lentiginous nevus or zosteriform lentiginous nevus, is a melanocytic lesion that presents as a light-brown circumscribed background macule or patch that contains numerous more darkly pigmented macules or papules within its borders. Histologically, the background macule is due to lentiginous melanocyte hyperplasia at the dermoepidermal junction, while the more intensely pigmented lesions are melanocytic junctional nevi or combined nevi. Nevus spilus can be congenital but is

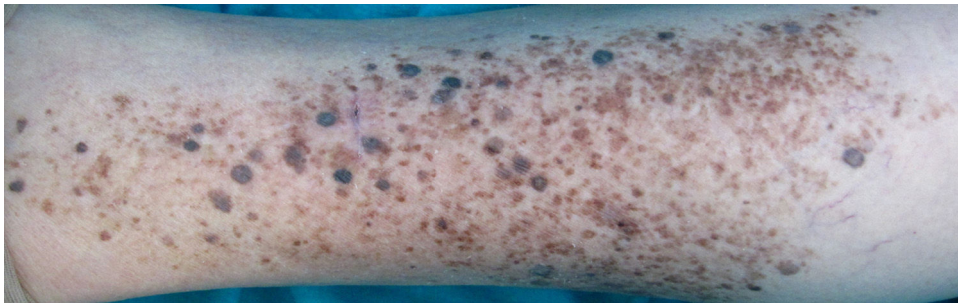


Figure 1 Pigmented lesion measuring 10 × 6 cm on the posterior surface of the right lower leg. The lesion was formed of a background of a light-brown macule that contained multiple dark-brown macules and papules within its borders, together with various bluish lenticular elements.

more commonly an acquired lesion; it has a benign behavior, though a few cases of melanoma arising on a nevus spilus have been reported.¹ Blue nevi are bluish-colored lesions formed by an intradermal proliferation of melanocytes. They usually present as a single, acquired lesion, but very rarely can arise as multiple lesions grouped in a well-defined area, not usually larger than 10 cm in diameter; they are then called agminated blue nevi.² The combination of agminated blue nevi and nevus spilus is rare.³

A 79-year-old woman was seen for an asymptomatic pigmented lesion that had been present on the posterior surface of her right lower leg since birth (Fig. 1). Physical examination revealed a 10 × 6 cm plaque formed of a light-brown macule that contained numerous dark-brown papules and bluish lenticular lesions within its borders. Dermoscopy of the brownish papules showed a globular melanocytic pattern, while the bluish papules presented a homogeneous blue pattern (Fig. 2).

Histology of the different biopsies taken from the pigmented plaque revealed a lesion with a combined pattern

(Fig. 3). A proliferation of spindle-shaped melanocytes with no atypia was observed in the dermis, accompanied by melanophages, a characteristic finding in blue nevus. Melanocyte proliferation with a lentiginous pattern was also seen at the dermoepidermal junction; this correlated clinically with the background light-brown macule. Finally, a third component formed of nests of melanocytes with correct maturation and with no architectural atypia was observed in the superficial dermis. These nests produced the dark-brown macules and papules of the nevus spilus.

The definitive diagnosis was nevus spilus associated with agminated blue nevi. The patient stated that the nevus spilus had been present since birth, whereas the bluish lesions had appeared progressively throughout her life, with a significant increase in the number of blue nevi in recent years.

Blue nevus usually arises as a solitary lesion, although it can rarely occur in clusters in an agminated pattern.⁴ Nevus spilus can be associated with blue nevus, with common melanocytic nevus, or with Spitz nevus. The association of nevus spilus and agminated blue nevi is a rare combination, with few cases reported in the literature.^{3,5} Kawamura⁵

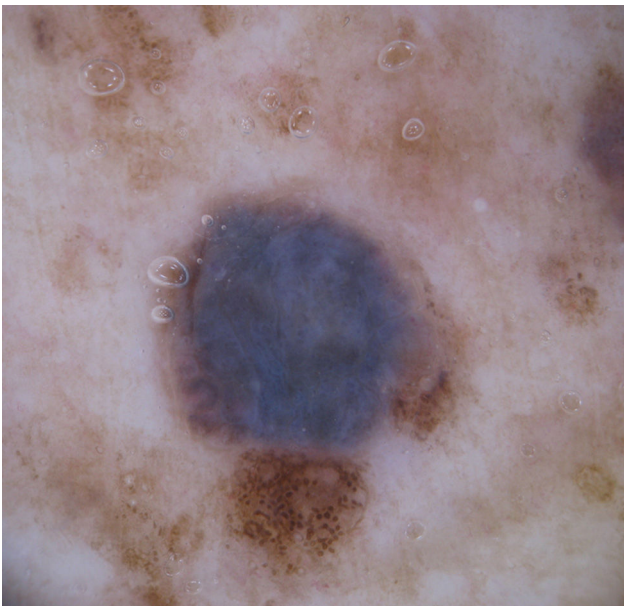


Figure 2 Dermoscopy image showing the collision of a blue nevus (presenting a homogeneous blue pattern) with several melanocytic nevi (showing a typical globular pattern).

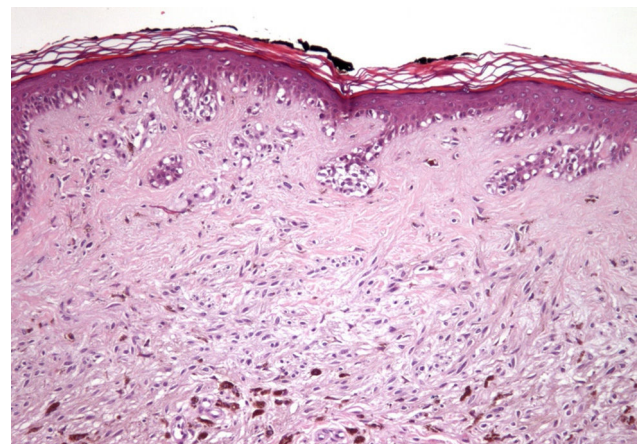


Figure 3 Histopathology revealed a combined lesion, with findings characteristic of a blue nevus (a dermal proliferation of spindle-shaped melanocytes associated with melanophages) and findings corresponding to nevus spilus (a lentiginous proliferation of melanocytes at the dermoepidermal junction and nests of melanocytes with no atypia in the superficial dermis). Hematoxylin and eosin, original magnification x10.

presented a case and defined 3 histologic variants of this entity: type I, a combination of blue nevus and cellular nevus; type II, a combination of blue nevus with nevus spilus; and type III, a combination of blue nevus and fibromatous or myomatous nevoid formation. There is controversy regarding the cause of the association. Some authors consider that this is a random phenomenon,⁵ while others believe that nevus spilus provides a favorable environment for the growth of other nevi.³ The risk of malignant change is low in nevus spilus, although cases of melanoma arising on this pigmented lesion have been reported in the literature.⁶⁻⁸ Our case presents the rare combination of nevus spilus with agminated blue nevi and, despite the clinical and dermoscopic diagnosis, it was necessary to perform several biopsies of the pigmented plaque to exclude a diagnosis of melanoma.

We have presented a case of Kawamura type II blue nevus, highlighting the need to perform periodic clinical control of pigmented lesions and suggesting the possibility of monitoring this type of lesion using digital dermoscopy.

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D. Ayala,^{a,*} M.D. Ramón,^a M. Cabezas,^b E. Jordá^a

^a Servicio de Dermatología, Hospital Clínico Universitario de Valencia, Valencia, Spain

^b Servicio de Anatomía Patológica, Hospital Clínico Universitario de Valencia, Valencia, Spain

* Corresponding author.

E-mail address: dayalca83@hotmail.com (D. Ayala).

Initial Evaluation of Patients with Pigmented Skin Lesions[☆]



Valoración inicial del paciente con lesiones cutáneas pigmentadas

To the Editor:

The incidence of melanoma has increased significantly in Spain in recent decades, and this tumor is now a public health problem.¹ The role of the dermatologist is fundamental to the identification of high-risk patients and to the adoption of appropriate primary and secondary preventive measures for the early detection of skin cancer.¹⁻³

Several well-standardized international clinical guidelines have been drawn up on the management of patients with melanoma,⁴⁻⁹ but no protocols exist on how to take an appropriate medical history and physical examination. The Australian guideline proposes an initial evaluation to determine the future risk of melanoma (grade B recommendation) looking at various factors, including age, sex, past history of melanoma or nonmelanoma skin cancer, family history of melanoma, number of melanocytic and atypical nevi, skin and hair color, skin phototype, and actinic damage.⁴

When a patient attends dermatology outpatients for an initial clinical evaluation of a nevus or suspected melanoma,

an exhaustive medical history must be taken to detect the main risk factors (Table 1) and a complete physical examination performed.¹⁻³ In the literature, we have found no descriptions of a protocol for the initial clinical evaluation of this type of patient. We therefore present our standard approach to the first consultation in the melanoma unit of Hospital Clínic in Barcelona:

- Personal history of drug allergy, drinking and smoking, current and previous occupations, known diseases, surgical history, noncutaneous tumors, and usual medical treatments.
- Past dermatologic history: known dermatoses, history of skin tumors, dysplastic nevus syndrome, treatments performed, previously excised nevi, and risk classification (Table 2).
- Family history of dysplastic nevus syndrome and of skin and other tumors.
- History of sun exposure, UV protection (Table 3), pattern of intermittent or chronic exposure, and time dedicated to outdoor occupational or leisure activities.
- Detailed history of the suspected melanoma lesion^{3,10}: site, time since onset, presence of a precursor lesion, symptom or sign that prompted consultation, pruritus, pain, bleeding, erosion, ulceration, suppuration, changes in color (multiple shades of dark brown or black, or appearance of various colors, including light brown, dark brown, black, red, blue, gray, and white), changes in morphology (appearance of irregular margins), change in size (rapid or continuous growth), elevation of the lesion, changes in the surrounding skin (erythema, edema,

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