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Eruptive Melanocytic Nevi without Any Trigger in a 5-Year-Old Healthy Girl

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Dear Editor:

Eruptive melanocytic nevi (EMN) are rare skin manifestations characterized by the simultaneous and abrupt development of numerous melanocytic nevi on the skin[1]. Although the exact mechanism of EMN development is not well understood, it has been associated with various triggers including light exposure, cutaneous injury such as the Koebner phenomenon, bullous dermatoses, systemic immunosuppression, biologic chemotherapeutics, increased hormone levels, and others including atopic dermatitis in children, postoperative fever, and seizures[2]. However, EMN without any trigger, especially in a healthy girl, are rather rare.

A 5-year-old Korean girl presented with multiple hyperpigmented maculopapules over the whole body. The lesions first appeared on her chest when she was 1 year old, and then hundreds of similar lesions covering her entire skin surface developed continuously during the next 2 years. The girl was of Fitzpatrick skin type IV and had no specific medical and family histories including multiple nevi. On physical examination, there were no systemic abnormalities except for the skin lesions that appeared as multiple small (0.5～3 mm diameter) brown to black pigmented maculopapules with a globular pattern on dermoscopy (Fig. 1). The histopathologic finding was compatible with compound nevus. Findings of routine laboratory examinations including complete blood counts, peripheral blood smear, liver/renal function test, venereal disease research laboratory test, antinuclear antibody, and urine analysis were either negative or within the normal limits. The test for BRAF V600E mutation was negative.

There have been very limited data about the changes in

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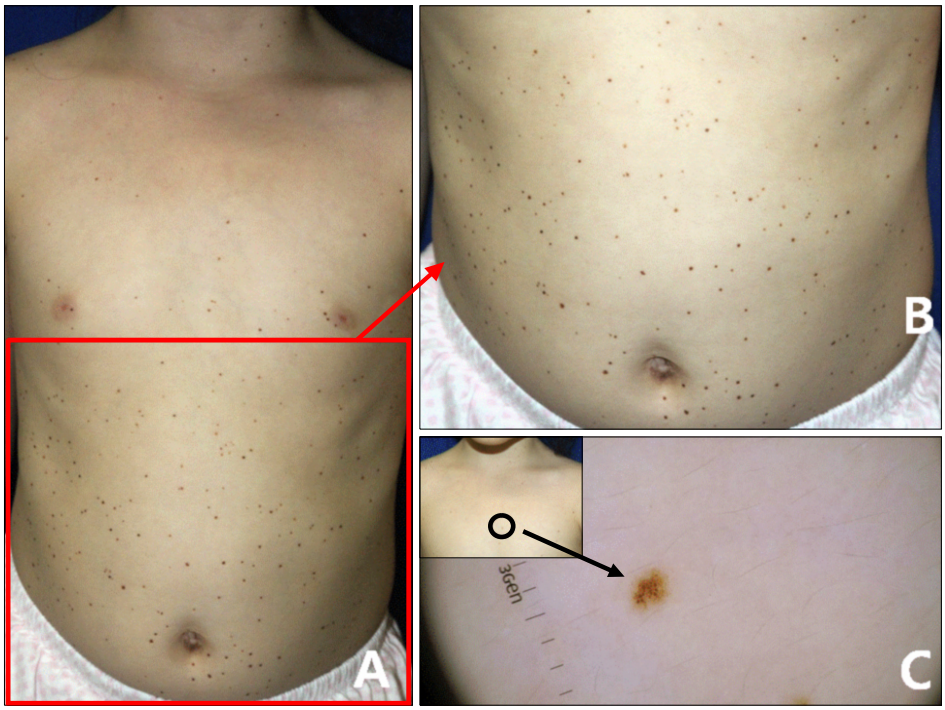

Fig. 1. (A, B) Clinical photographs of eruptive melanocytic nevi in a 5-year-old healthy girl and its magnified image. (C) Dermoscopic finding of brownish macules on the chest (marked by the circle) showing a globular pattern.

Table 1. Eruptive melanocytic nevi in healthy children without any triggering events

	Coskey[5] (1975)	Zalaudek et al.[1] (2013)	Our case (2016)
Sex (patient no.)	M	M (6), F (1)	F
Age (yr)	5	Mean (range): 8.1 (4～12)	5
Fitzpatrick skin type	NM	II～III	IV
Country	USA	Italy	Korea
Onset age (yr)	5	NM	1
Number of nevus	24	Lower compared with previous EMN	>200
Location	Face, trunk, extremities	NM	Face, trunk, extremities
Color	Dark brown	Pink to skin colored	Brown to black
Hispathology	Junctional nevus	Compound nevus	Compound nevus

M: male, F: female, NM: not mentioned, EMN: eruptive melanocytic nevi.

the number of melanocytic nevi with aging. In a Scottish study, there were 2～3 nevi in the first decade, 22～33 nevi in the third decade, and 4～6 nevi in the seventh decade[3]. Considering this age-related change in nevus number, EMN seem to be a rather rare condition.

Recently, studies on molecular nevogenesis have been a hot topic and revealed significant mutations of NRAS in congenital nevi, GNAQ in blue nevi, and BRAF in acquired nevi. Although these mutations were not always detected, they were discovered with various frequencies of positivity. For example, BRAF mutation in acquired nevi was found in 67.2% of intradermal nevi, 57.5% of compound nevi, 37.8% of junctional nevi, and 43.3% of dysplastic nevi[4]. In the present patient, no BRAF mutations were found. This could be due to the mutation heterogeneity of BRAF in the nevi. Furthermore, there is a possibility that the patient may have other mutations.

There were two previous reports on EMN in healthy children without any triggering events (Table 1)[1,5]. Our case differs from these reports in terms of ethnicity and the nevus number. The nevus counts in our child were much higher (>200 nevi) than those of Coskey[5] (one boy with 24 nevi) and Zalaudek et al.[1] (seven children with much lower nevus counts than those of previous EMN cases). To our knowledge, this is a very rare case of EMN in a healthy Asian girl without any triggering factors. This case could highlight the complicated aspects of nevogenesis and provide clues for further understanding of nevogenesis.

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CONFLICTS OF INTEREST

The authors have nothing to disclose.

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Type I Lepra Reaction as the Presenting Sign of Histoid Leprosy

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Dear Editor:

A 47-year-old woman presented with a two-week history of multiple asymptomatic erythematous eruptions over the face, trunk and extremities following a transient fever. She was otherwise healthy. Physical examination revealed disseminated erythematous to violaceous plaques and nodules with tumidity and sharp margination over her face, trunk and extremities. The lesions were neither painful nor tender (Fig. 1A, B). Additionally, one asymptomatic skin-colored nodule over her right arm was noted (Fig. 1C). It lasted for 2 years and was previously misdiagnosed as dermatofibroma. Neither anesthesia nor enlarged peripheral nerves was presented. Laboratory tests revealed slightly increased C-reactive protein (11 mg/L; normal range, 0～10 mg/L), marked increased erythrocyte sedimentation rate (42 mm/h; normal range 0～15 mm/h) and elevated serum IgM (3.52 g/L; normal range, 0.63～2.77 g/L).

Skin biopsies were taken from a plaque on the face as well as the persistent nodule on the arm. Histologically, the plaque lesion showed marked dermal edema with loose lymphocyte and histiocyte infiltration (Fig. 2A, B), and the nodular lesion demonstrated dense infiltration of foamy histiocytes (Fig. 2D, E) with abundant acid-fast bacilli (Fig. 2F) which were confirmed as *Mycobacterium*

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