

Amelanotic blue nevus



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CLINICAL PRESENTATION

A 38-year-old woman presented to clinic with a solitary 6.5- × 4-mm sharply demarcated ivory-white papule on her left temple of unknown duration (Fig 1). The lesion had a smooth surface without scale or ulceration. Small perifollicular dells were also noted. The patient reported no symptoms but believed the lesion recently turned white. She had no other similarly appearing lesions.



Fig 1. Amelanotic blue nevus. Clinical appearance shows a sharply demarcated ivory-white papule with smooth surface and small perifollicular dells on the left temple.

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DERMOSCOPIC APPEARANCE

Dermoscopy found a featureless white area containing a few scattered thin, superficial linear, and arborizing vessels (Fig 2).

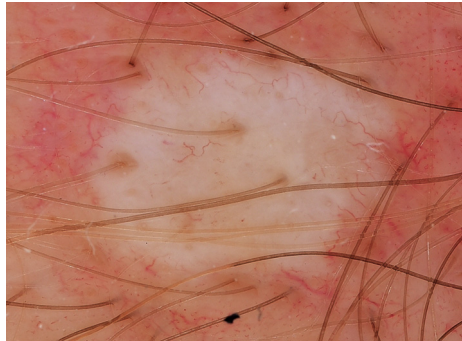


Fig 2. Amelanotic blue nevus. Dermoscopy shows a featureless white area with scattered thin, superficial linear, and arborizing vessels.

HISTOLOGIC DIAGNOSIS

Histologic examination found a proliferation of bland spindle cells in the dermis, with associated sclerosis and little to no associated pigment (Fig 3). There were no features of malignancy. In addition, immunohistochemical stains were positive for S-100 and negative for polykeratin. These findings supported a diagnosis of hypopigmented sclerotic (or desmoplastic) blue nevus.

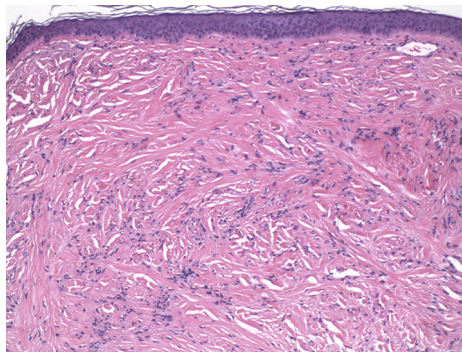


Fig 3. Amelanotic blue nevus. Histopathology shows a proliferation of bland spindle cells within the dermis with associated sclerosis and without associated pigment.

KEY MESSAGE

Blue nevi are classically highly pigmented benign lesions with a bluish coloration, arising from dermal dendritic melanocytes. A hypomelanotic blue nevus, an uncommon variant, generally presents clinically as a depigmented papule with focal residual blue-brown pigment.¹ However, to our knowledge, clinical images of a completely amelanotic blue nevus have not been published in the literature. We present clinical and dermoscopic images of an amelanotic sclerotic blue nevus with complete lack of pigment. Awareness of this variant is important for clinicians, as absence of expected pigmentation may result in diagnostic errors. Diagnosis rests on histopathology demonstrating dermal proliferation of spindle cells, associated desmoplastic stroma, and expression of melanocytic markers (ie, S-100, MART-1, and HMB-45) on immunohistochemistry.²

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