**Dysplastic Pointillist Nevus**

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**Background:** Three cases of pointillist nevus, which is a distinctive clinical type of benign melanocytic nevus with variegated pigment, have been described in the literature to date.

**Observations:** A 24-year-old man presented with an acquired melanocytic lesion composed of multiple tiny pigmented dots. Dermoscopy revealed multiple brown globules on a reddish skin-colored background, and histologic examination demonstrated architectural disorder with cytologic atypia.

**Conclusion:** To the best of our knowledge, we report a case of dysplastic pointillist nevus.

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In 2001, Huynh et al described 3 cases involving a distinctive clinical type of "benign" melanocytic nevus with variegated pigment, which they called the pointillist nevus, a clear reference to the pointillist style of painting. The 3 cases were characterized by a pigmented lesion composed entirely of tiny, dark-brown to black dots on a skin-colored background, which had the appearance of "brown globules" on dermoscopy. However, despite the variegation of color and the irregular borders of the lesions, the authors concluded, on the basis of a banal histologic description, that this clinical presentation involved an unusual pattern of a benign melanocytic lesion. To date, no other cases with this uncommon presentation have been reported, to our knowledge; therefore, little is known about the potential behavior of this lesion.

**REPORT OF A CASE**

A 24-year-old man presented with a 3-year history of a lesion on his upper back area. He had no history of malignant melanoma or dysplastic nevus. He did not mention any local symptoms or trauma. Clinical examination revealed a 3.0-mm-diameter melanocytic lesion composed of multiple tiny brown dots grouped on a reddish skin-colored background. The brown dots were similar in size (0.2-0.5 mm), symmetrical, and uniformly pigmented, with diffuse borders (Figure 1, inset). On dermoscopy, brown pigmented spots with remnants of pigment network, globules, and dots were observed on a remarkable erythematous background. No branched telangiectasias were demonstrated, and normal-appearing skin without dermoscopic structures could be seen between the brown spots (Figure 1). The lesion was completely excised, and histologic analysis was performed. The brown blotches with remnant network that were seen on dermoscopy correlated to areas of lentiginous hyperplasia, bridging of the rete ridges, fibroplasia, and cytologic atypia (Figure 2), all of which were particularly demonstrated in the histologic section from the area of confluence of the pigmented spots. The erythematous background was associated with ectasia of the vessels at the middle and upper dermis. There was no evidence of histologic regression or an inflammatory infiltrate.

In the pointillist nevus, nests of melanocytes or melanophages become clinically apparent as a result of the minimal amount of pigment in the rest of the lesion, giving rise both to the brown globules observed under the dermoscope and to the clinically distinctive appearance. In contrast to the present case, however, no architectural disorder or cytologic atypia was observed in the 3 cases described by Huynh et al, who came to the conclusion that the pointillist nevus is a benign condition.
nevus is a benign form of the melanocytic nevus. Our patient’s nevus showed a reddish hue, which has also been accepted as a clinical criterion for the diagnosis of clinically atypical nevus. This clinical and dermoscopic finding, along with the variegation of color and the irregular borders of the entire lesion, were sufficient to consider the lesion a clinically atypical nevus, a diagnosis that was later histologically confirmed.

To the best of our knowledge, we report a case of dysplastic pointillist nevus. In addition to the 3 cases already published, the present case offers a new approach to the management of this type of nevus. However, more cases are needed to determine the potential of these clinically unusual moles.

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REFERENCES