

## Dermoscopy of nevus comedonicus

**Melek Aslan Kayiran,<sup>1</sup> Filiz Cebeci,<sup>1</sup> Ilkin Zindanci,<sup>2</sup> Mehmet Salih Gurel,<sup>1</sup> Necmettin Akdeniz<sup>1</sup>**

<sup>1</sup>Department of Dermatology, Istanbul Medeniyet University Goztepe Training and Research Hospital, Istanbul, Turkey

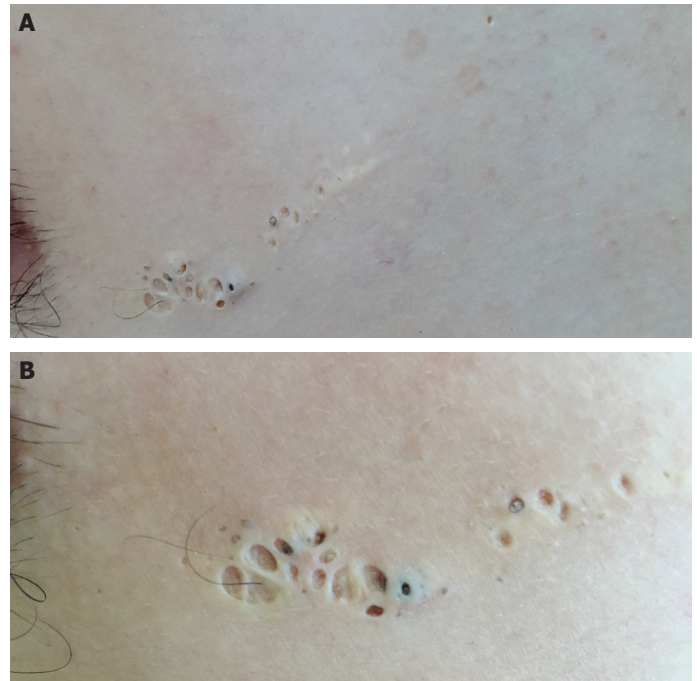
<sup>2</sup>Department of Dermatology, Health Sciences University Umraniye Training and Research Hospital, Istanbul, Turkey

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A 38-year-old male patient admitted to our clinic due to a lesion on the left side of his body. The asymptomatic lesion had been present since childhood. The dilated follicular openings were spreading linearly from the left areola to his back and some of them had black keratotic plugs reminiscent of open comedones. (Fig. 1A, B) No evidence of any additional skin disease was observed. Multiple, circular and oval-shaped, white-light brown colored homogenous areas along with some dark grey-blackish keratin plugs were seen on its dermoscopic examination. (Fig. 2A, B) We used an epiluminescence microscopy (Dermlite DL4W, Leofarma, CA, USA) without an immersion oil. There were no systematic findings. The patient didn't want to have any treatment because it was only a cosmeceutical situation. However, the patient was followed up because it could be accompanied by some systemic anomalies. This case is presented for emphasizing the point that dermoscopy can be supportive for the diagnosis of nevus comedonicus and for contributing to the literature with its dermoscopic findings.

Nevus comedonicus is a rare type of nevus originating from the epithelial part of the center of the pilosebaceous unit. It is characterized by the combination of the dilated follicular openings resembling comedones. It may be seen in any part of the body but especially face and neck. It is usually solitary but sometimes it may be associated with central nervous system (microcephaly, mental deficiency, pathologic electroencephalographic findings, dysgenesis of corpus callosum), skeletal system (syndactyly, clinodactyly,

polydactyly, scoliosis, vertebral defects) and eye (ipsilateral cataract, corneal erosions) anomalies and in that case, it is called nevus comedonicus syndrome. Accompanying skin diseases are ichthyosis, trichilemmal cysts, sebaceous nevi, Becker nevus, leukoderma, white hair, Sturge Weber Syndrome and hemangiomas. The treatment options if



**FIGURE 1.** (A, B) The dilated follicular openings are spreading linearly from the left areola to his back and some of them have black keratotic plugs reminiscent of open comedones.

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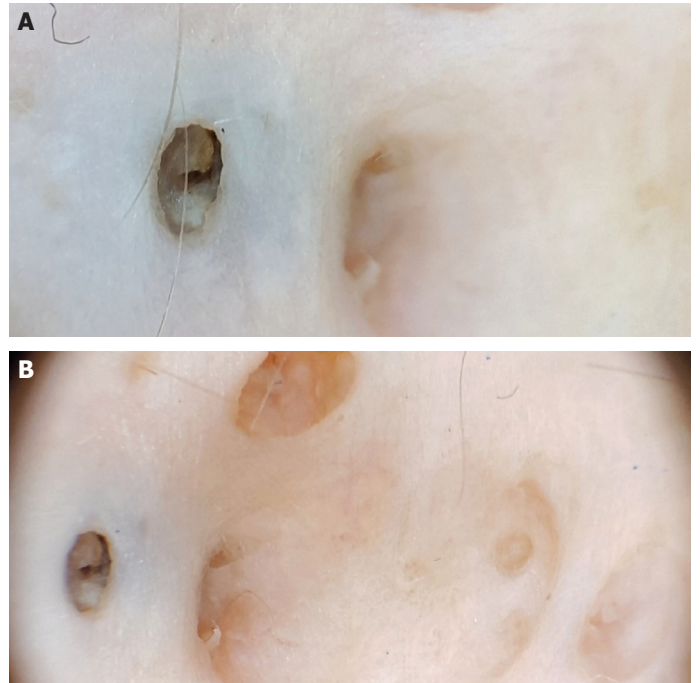
Correspondence: Dr. Melek ASLAN KAYIRAN. Istanbul Medeniyet Universitesi Goztepe Egitim ve Arastirma Hastanesi, Deri ve Zuhrevi Hastaliklar Anabilim Dalı, Istanbul, Turkey.

Tel: +90 532 523 28 73 e-mail: melekaslan@gmail.com

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needed, are topical retinoid applications, and in resistant forms laser therapy or surgical excision. History and clinical examination leads to the diagnosis and there is no need to perform a histopathological examination in most cases. The diagnosis can be supported by dermoscopic findings. We found many circular and oval-shaped, white and light brown colored homogenous areas along with some dark grey-blackish keratin plugs on the dermoscopic examination. The dermoscopy of our case was similar to the findings of the present reports. The dermoscopic findings of the previous cases are multiple, well-defined, structureless brown homogenous areas surrounding the keratin plugs and many circular homogenous areas in light and dark-brown shades with remarkable keratin plugs. Dermoscopy may help to differentiate nevus comedonicus from comedones of acne. There are many homogenous, usually circular, dark brown and black areas and those are located superficially on dermoscopic examination of comedones of acne vulgaris. Nevus sebaceous, a type of epidermal nevus, may be considered for differential diagnosis. Bright and yellow dots which are not associated with hair follicles and sometimes yellow globules with crown vessels are seen on dermoscopy of sebaceous nevus.



**FIGURE 2.** (A, B) Multiple circular and oval-shaped, white-light brown colored homogenous areas along with some dark grey-blackish keratin plugs are seen.