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QUIZ SECTION

”Bathing Trunk” Eruption of Papules and Nodules in a Young Woman: A Quiz

Andrea Saggini[1], Alessandro Di Stefani[2], Rosita Saraceno[1] and Sergio Chimenti[1]
[1]Department of Dermatology, and [2]Institute of Anatomic Pathology, University of Rome Tor Vergata, Rome, Italy. E-mail: andreasaggini@gmail.com

A 36-year-old woman presented with a papulo-nodular eruption of 13 years’ duration over her buttocks and proximal lower limbs. Hundreds of lesions had appeared within months. No associated cutaneous or systemic symptoms were reported; biochemical testing, ultrasonographic examination, and chest computed tomography (CT) scan were non-contributory. New lesions were still erupting, although at a significantly slower pace. Once lesions had appeared, they remained stable in size or underwent mild enlargement. The patient’s family and medical history were unremarkable; she was in excellent health.

Approximately 150 erythematous-to-tan, dome-shaped or verrucous, firm papules and nodules were seen, ranging from 2 to 13 mm in diameter (Fig. 1). The lesions were symmetrically distributed, with a striking predilection for the buttocks.

An excisional biopsy specimen was taken for histological evaluation and immunostaining with S-100, HMB-45, and Melan-A (Fig. 2).

What is your diagnosis? See next page for answer.

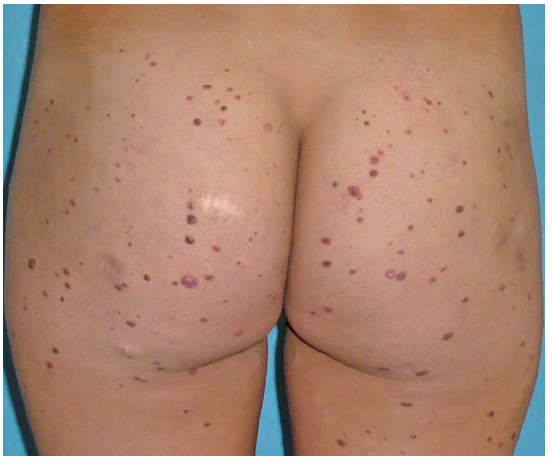

Fig. 1. Dozens of symmetrical, pinkish to tan, firm papules and nodules in a “bathing trunk” distribution. Most of the lesions exhibit a smooth surface, with a minority having a verrucous appearance.

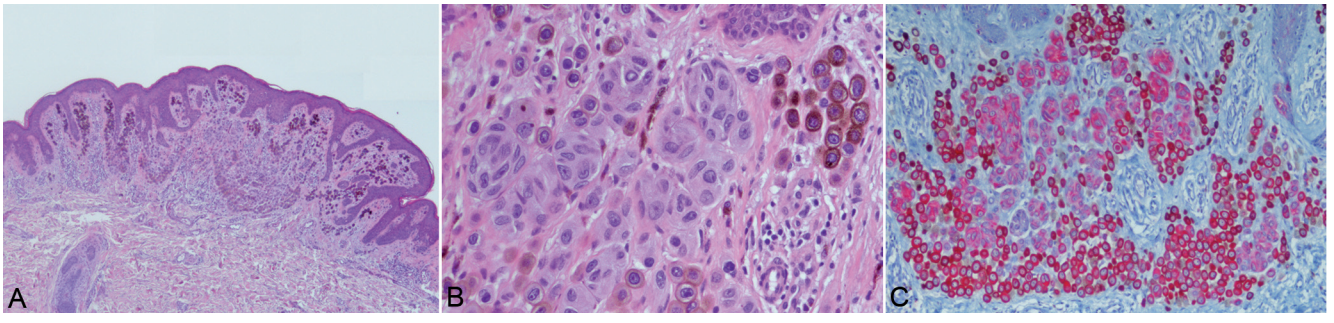

Fig. 2. (A) Dome-shaped, mostly dermal tumour with striking pigmentation (haematoxylin and eosin (H&E) ×20). (B) Epithelioid cells showing large vesicular nuclei, conspicuous nucleoli, and abundant eosinophilic cytoplasm (H&E ×200). (C) Immunoreactivity for Melan-A (×100).

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ANSWERS TO QUIZ

"Bathing trunk" Eruption of Papules and Nodules in a Young Woman: Comment

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Diagnosis: **Eruptive disseminated Spitz naevi**

The histologic findings combined with a strong and diffuse positivity for S-100, HMB-45 and Melan-A were consistent with the diagnosis of pigmented spindle and/or epithelioid cell naevus (pigmented Spitz naevus (SN)). Analogous cytological features were observed in a second excisional biopsy specimen taken from another representative lesion (not shown).

SN are benign melanocytic proliferations characterized by clinico-pathological features that may resemble malignant melanoma (MM) (1). Multiple SN are uncommon, with two variants being currently recognized: grouped/agminated SN and, more rarely, eruptive-disseminated SN (EDSN) (2).

ESDN were first reported in 1974 as "eruptive juvenile melanomata" (3), with only 14 cases described subsequently (2, 4, 5). The third decade is favoured, with no gender predilection (2, 5). Despite reported associations with sun-exposure, pregnancy, intravenous drug abuse, and post-operative stress, the pathogenesis of ESDN is largely unknown (2, 5). More generally, factors that may predispose to eruptive melanocytic naevi include anti-neoplastic and immunosuppressant drugs, blistering diseases, immunodepression, hormonal changes, and systemic infections; naevogenesis would ensue owing to increased levels of growth stimuli, loss of control from the immune system, and/or genetic damage (2, 6).

Typically, an abrupt onset is followed by a smouldering course, resulting in hundreds of papules and nodules. Individual lesions do not differ significantly from solitary SN (2, 5). Scalp, mucosae, and palmoplantar surfaces are usually spared, but eruptive SN in a "bathing trunk" distribution have not been described previously. New SN may continue to erupt up to 26 years later, persisting indefinitely or undergoing spontaneous regression (2, 4, 5). No lymphadenopathy or systemic involvement has been reported; two cases of EDSN were associated with electroencephalogram abnormalities, with one patient experiencing seizures (2).

Clinically, the differential diagnosis includes urticaria pigmentosa, generalized eruptive histiocytosis, xanthoma disseminatum, as well as generalized eruptive variants of angiomas, pyogenic granulomas, dermatofibromas, and xanthogranulomas.

Histopathologically, no unequivocal criteria are available to distinguish between benign and malignant spitzoid lesions (1); ambiguous cases of "atypical Spitz tumours" may share criteria of both SN and MM, with a final diagnosis possible only in retrospect (7); assessment of specific genetic mutations (i.e. *HRAS*) may be of help in the future (8).

Neither dermoscopy (1, 4) nor reflectance confocal microscopy (9) can reliably distinguish between SN and MM. Systematic surgical excision (as suggested for solitary lesions occurring after 12 years age) (1) is not a feasible approach for EDSN; electrodessication, imiquimod, or cryotherapy have all provided unsatisfactory outcomes (2, 4). No malignant transformation of EDSN has been reported; however, an immunosuppressed patient has been described presenting with multiple, eruptive cutaneous metastases of MM, which initially received a clinico-pathological diagnosis of EDSN (10). Thus, careful follow-up aided by clinical and dermoscopic photography is advisable, with surgical excision reserved for suspicious lesions (2, 4).

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