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Commentary II: The Void of Congenital Naevi

In this special issue 2 articles deal with congenital melanocytic naevi (CMN); the paper by Surrenti et al. (p. 605–606) illustrates the worst scenario, while the one by Trocoli Drakensjö et al (p. 607–608) illustrates a favourable course: the rapid involution of 2 CMN in small children. Thinking about how to comment on these reports, it struck us that CMN might be the condition most lacking in evidence in the field of dermatology. There is very little we can say for sure when talking to the parents of a newborn baby with a CMN. There are no evidence-based national guidelines in PubMed, apart from expert opinions on the management of CMN. Even if Ashfaq Marghoob, the leading authority on CMN, had been the author of this commentary, he would not have been able to give us any further evidence. So, what questions do we most need to be answered? The problem starts with diagnosis. The time-frame for making a clinical diagnosis of CMN is not well defined: so-called tardive CMN can become apparent some time after birth; thus CMN are not always congenital in the literal sense. At what age do we stop diagnosing CMN and start diagnosing acquired naevi? The next, and perhaps most basic, problem is the categorization of CMN. Although most investigators have used an arbitrary categorization on the basis of (projected) adult size divided into 3–6 groups (with alternative size categories), naevus surface area and other classifications have also been used, either including or excluding numbers of satellites, thus hampering the comparability of studies. The same applies to anatomical localization and features such as hypertrichosis or pigment heterogeneity: they are simply registered differently or not at all. The reason we want to classify CMN in the first place is because of their risk of melanoma, which seems to be dependent on size: the larger the mole, the higher the risk of melanoma. However, this may be the only certainty about CMN. What is the magnitude of the risk for each size category? Can independent risk factors be recognized? How disturbing is selection bias, given that melanoma cases enter databases much more readily than cases without problems? How do interventions influence the risks, and do we observe lower risks now that many patients with CMN are being treated? Are results from recent meta-analyses on the melanoma risks of CMN better than the worst study included? Do all melanomas occur within the CMN? Do melanomas develop in satellites, as seems to be the case in the report by Surrenti et al. in this issue? What proportion of CMN involutes, as is illustrated by Trocoli Drakensjö? Can we predict the occurrence of involution? We could easily produce another list of questions on the topic of neurocutaneous melanocytosis, but perhaps it would be best to stop here!

Finally, there may be light at the end of the tunnel: on checking PubMed we found an E-pub article by Krengel et al. (1) in which an international group of experts recommend a standard categorization of CMN and have successfully tested the proposed scheme. It is hoped that such standardized reporting will facilitate the creation of an international database and lead to answers to the above questions in the next 10 years. We very much hope that this initiative will pay off, as doctors want to be able to answer their patients' questions based on evidence, and make it easier for parents to make decisions regarding their newborn baby.

REFERENCE

1. Krengel S, Scope A, Dusza SW, Vontheim R, Marghoob AA. New recommendations for the categorization of cutaneous features of congenital melanocytic nevi. J Am Acad Dermatol, 10.1016/j.jaad.2012.05.043.

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