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Original Article

Nevi in children: Epidemiological, clinical, and dermoscopic profiles and epidemiological-clinical-dermoscopic correlations

Oumaima Bouraqqadi[1], Meryem Soughi[1,2], Sokaina Chhiti[1,2], Zakia Douhi[1,2], Sara Elloudi[1,2], Hanane Baybay[1,2], Fatima Zahra Mernissi[1,2]

[1]Dermatology Department, Hassan II University Hospital, Fez, Morocco, [2]Dermatology Department, University Hospital Hassan II, URL CNRST N15, Human Pathology, Biomedicine, And Environment Laboratory. Faculty of Medicine, Pharmacy, And Dental of Fez, Sidi Mohamed ben Abdellah University, Fez, Morocco

Corresponding author: Oumaima Bouraqqadi, MD, E-mail: Bouraqqadi.oumi@gmail.com

ABSTRACT

Background: Melanocytic nevi are frequently encountered benign cutaneous lesions that develop when altered melanocytes cluster together. Their prevalence, morphology, and dermoscopic patterns vary according to age, phototype, and anatomical location. While extensively studied in Caucasian populations, data on nevi in non-Caucasian pediatric populations remains limited. **Objective:** The objective was to determine the epidemiological, clinical, and dermoscopic characteristics of melanocytic nevi in Moroccan children and establish epidemiological–clinical–dermoscopic correlations. **Methods:** This was a retro-prospective, cross-sectional, analytical investigation of 850 melanocytic nevi collected from 264 pediatric patients aged 0–16 years. Epidemiological, clinical, and dermoscopic data was collected. Nevi were classified into congenital and acquired types and further categorized based on histological and dermoscopic patterns. All statistical tests were conducted using SPSS, version 23, with a significance threshold of $p < 0.05$. **Results:** More than half of the patients (56.4%) were between 11 and 16 years, with a predominance of phototype IV skin (61.3%). A family history of nevi was reported in 55.8% of the cases, and sun exposure in 64.7%. Nevi were most frequently located on the head and neck (34%) and trunk (32.8%). Acquired nevi were predominantly junctional (76.78% on the head and neck, 53.4% on the limbs), while dermal and compound nevi were more common on the trunk. Dermoscopic analysis showed a predominance of the reticular pattern in junctional nevi (82.6%) and the globular pattern in dermal nevi (71.1%). Congenital nevi displayed diverse features, including hair (76.1%), perifollicular white spots (67.4%), and a cobblestone pattern (13%). Statistical analyses showed significant associations between nevus type, anatomical location, and dermoscopic patterns ($p < 0.05$). **Conclusion:** Our study provides a comprehensive overview of melanocytic nevi in Moroccan children, highlighting their epidemiological, clinical, and dermoscopic characteristics. The findings emphasize the influence of phototype and anatomical location on nevus presentation and dermoscopic patterns. These findings contribute to our knowledge of nevi in North African populations and may help refine diagnostic approaches and surveillance protocols for pediatric patients.

Key words: Child, Dermoscopy, Nevus, Pigmented, Skin Neoplasms

INTRODUCTION

Nevi, previously known as pigmented or melanocytic nevi, are benign tumors formed by the clustering of altered melanocytes (known as "nevocytes") at the dermo-epidermal junction [1]. Such clusters, known as nests, differentiate nevi from normal melanocytes. Common in children, nevi are a frequent reason for

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dermatological consultations. They may be congenital, appearing at birth, or acquired, developing later in life. Clinically, nevi appear as macules, papules, or pigmented plaques with symmetrical borders and a homogeneous color, ranging from pinkish orange in lighter skin tones to brown or black in darker phototypes [2,3].

Melanocytic nevi are especially common in children, particularly among Caucasians who typically present with 15 to 30 nevi, while individuals of African, Asian, or Native American heritage tend to exhibit fewer, averaging 5 to 10 nevi by the end of their first decade [4] Several epidemiological factors influence the development of nevi [5]. Age plays a key role, as dermoscopic patterns shift over time: Globular patterns dominate in pre-pubertal years, while reticular-homogeneous patterns are more common during puberty and adulthood [6]. Race also impacts prevalence, with nevi being more frequent in Caucasians and rarer in sub-Saharan African and Asian populations [4,5]. Additionally, phototype influences nevus characteristics, with lighter-skinned individuals typically developing lighter brown, hypopigmented nevi, and darker-skinned individuals exhibiting darker, hyperpigmented, reticular patterns [4,7]. Other factors, including sun exposure, immunosuppression, and family history, may affect nevi characteristics, size, and color [6].

The diagnosis of nevi is primarily clinical, although some lesions may closely resemble melanomas. Clinically, nevi are classified as congenital or acquired, and histologically, they are subdivided into junctional, compound, and dermal nevi based on where the melanocytic clusters are in the skin [2,3]. Dermoscopy has revolutionized the assessment of melanocytic proliferations by enabling high-resolution, non-invasive visualization of the skin's surface. It provides detailed insights into the structures, colors, and patterns of nevi, facilitating their dermoscopic classification. This technique aids in the precise differentiation of nevus types by identifying characteristic features, such as the reticular, globular, or homogeneous patterns, as well as specific features of nevi in special sites [8]. Dermoscopy not only confirms the benign nature of many nevi yet also helps to detect suspicious changes early, guiding clinicians in deciding when further evaluation, such as a biopsy, may be necessary [9,10].

OBJECTIVES

This study aimed to determine the epidemiological, clinical, and dermoscopic profiles of nevi in children in our context and to establish an epidemic-clinical-dermoscopic correlation of nevi in children.

MATERIALS AND METHODS

Study Design and Patients

We conducted a retro-prospective, cross-sectional, and analytical study involving 850 nevi from 264 patients diagnosed at our department. Epidemiological, clinical, and dermoscopic data was collected, covering data such as demographics and family history of nevi, nevus evolution, functional symptoms, sun exposure, and skin reactions to sunlight.

The participants included in the study were individuals aged 0–16 years, regardless of the reason for consultation, who presented with at least one lesion of any size identified as a melanocytic nevus. The nevus had to be confirmed both clinically and dermoscopically, regardless of its location or whether it was acquired or congenital.

Patients were excluded if they had lesions deemed suspicious and required a biopsy to exclude a malignancy, as well as special types of nevi such as Spitz nevus, nevus spilus, Sutton nevus, and blue nevus.

Diagnosis

The diagnosis was based on clinical and dermoscopic evaluation, with images captured by a single examiner using a DermLite 4 paired with a smartphone in both non-polarized and polarized light modes, with and without immersion. For the purpose of the study, the participants were categorized into two age groups: 0–10 years and 11–16 years. Two examiners analyzed the images independently, and any discrepancies were resolved by consensus. Dermoscopic patterns were classified into four primary groups: globular (Figs. 1a and 1b), reticular (Fig. 2), homogeneous (Fig. 3), and compound (Figs. 4a and 4b), with the latter comprising combinations of the other patterns, such as globular-reticular, globular-homogeneous, and reticular-homogeneous. Nevi located on the scalp, mucosa, nails, and palmoplantar areas were counted in the overall tally of nevi yet evaluated separately for

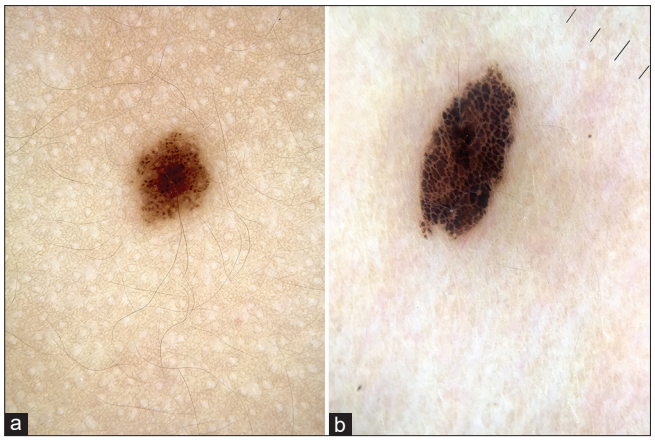

Figure 1: (a) Globular pattern nevi in a 7-year-old child. (b) Cobblestone pattern in an adolescent.

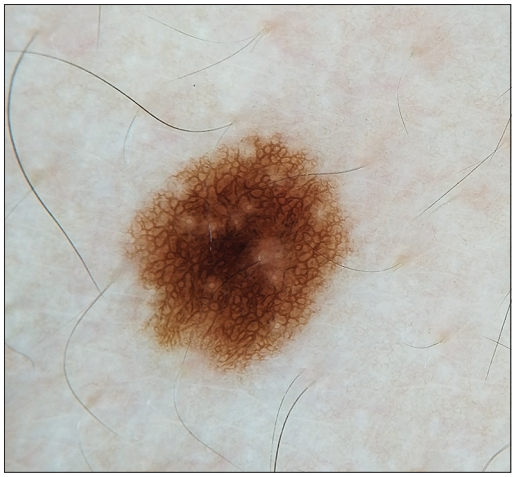

Figure 2: Reticular pattern in a 16-y.o. adolescent.

dermoscopic characteristics when determining the predominant pattern.

Statistical Analysis

Percentage comparison tests served to determine epidemiological, clinical, and dermoscopic characteristics associated with nevi in children. Data was analyzed with SPSS Statistics software, version 23. Correlation analyses between variables—such as age and nevus type, nevus topography and type, and dermoscopic features and nevus type—were conducted using chi-squared and Fisher tests. A p-value below 0.05 was deemed statistically significant, highlighting a meaningful correlation between the variables.

RESULTS

We collected 850 nevi from 264 children, distributed across three age groups: 56.4% were aged 11–16 years,

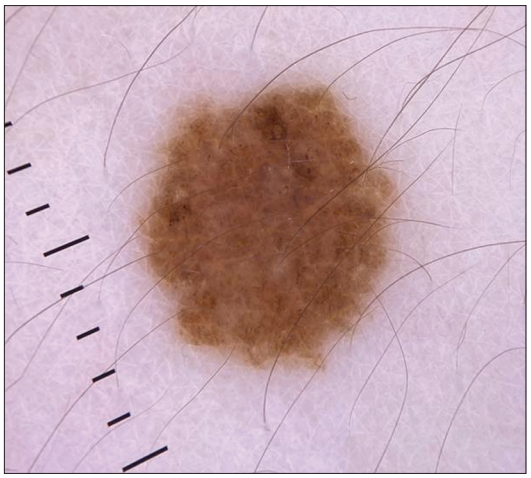

Figure 3: Homogeneous pattern in a 14-y.o. adolescent.

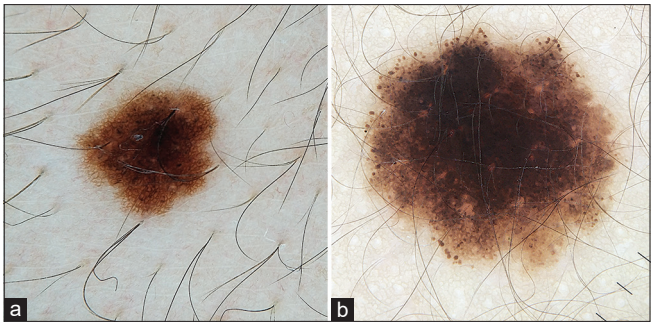

Figure 4: (a) Compound pattern: reticular-globular. (b) Compound pattern: homogeneous center with peripheral globules indicating growth.

28.8% were aged 6–10 years, and 15.2% were aged 0–5 years. A family history of nevi was present in 55.8% of the patients, of which 64% were acquired. Sun exposure was noted in 64.7% of the cases. Recent changes were observed in 31.1% of all nevi, all of which were regular and symmetrical. In terms of lesion distribution, the most frequently affected areas were the head and neck (34%), followed by the trunk (32.8%) and limbs (19.6%). In terms of special site nevi, palmar-plantar nevi were the most frequently observed (45%), followed by scalp nevi (30%), nail nevi (13.5%), and mucosal nevi (11.5%). Most participants had phototype IV skin (61.3%).

The majority of nevi (89%) were smaller than 1.5 cm in diameter, while 9.3% measured between 1.5 cm and 19.5 cm, and 1.5% exceeded 20 cm. Congenital nevi, which constituted 20% of all cases, were primarily located on the trunk (50%), followed by the head and neck (30%) and the limbs (20%). For acquired nevi, the ones located in the head and neck region were predominantly junctional (76.78%), followed by compound nevi (13.67%) and dermal nevi (9.55%).

On the trunk, compound nevi were the most common (45%), with dermal nevi accounting for 33.4% and junctional nevi comprising 21.5%. Acquired nevi on the limbs included 53.4% junctional nevi, 24.4% dermal nevi, and 22.1% compound nevi.

The dermoscopic patterns associated with junctional nevi were predominantly reticular (82.6%), followed by central hyperpigmentation with a peripheral network (16.3%). Among the dermal nevi, 71.1% displayed a globular pattern, 68% a homogeneous pattern, and 21% contained hairs. Mixed or compound nevi commonly exhibited a peripheral reticular network with central globules (62.5%), a multicomponent pattern (27.5%), or a homogeneous pattern combined with a reticular network (5%). Congenital nevi showed various features, with 76.1% presenting hair, 67.4% showing perifollicular white spots, 39.1% having dots, 30.4% exhibiting a globular pattern, 50% displaying a reticular pattern, and 34.8% showing a homogeneous pattern. Additional findings in congenital nevi included a cobblestone pattern in 13%, pseudocysts in 6.5%, and one nevus displaying a blue-white veil.

Palmar-plantar nevi most frequently demonstrated a parallel-furrow pattern (61.1%), followed by a homogeneous pattern (16.4%), a fibrillar pattern (15%), and a lattice-like pattern (10%). Nail nevi consistently exhibited a regular pattern with pseudo-Hutchinson's sign. Four cases involved longitudinal melanonychia covering more than two-thirds of the nail.

Statistical analyses revealed significant age-related and anatomical associations. Junctional nevi were most common in the 11–16 age group, while congenital nevi were more frequent in the 0–10 age group ($p = 0.014$). Junctional nevi were predominantly located on the head and neck (65.1%; $p < 0.0001$). Dermal nevi were primarily found on the trunk (54.1%; $p = 0.032$), as were compound or compound nevi (53.8%; $p = 0.04$) and congenital nevi (52.2%; $p = 0.04$) (Table 1). Dermoscopic correlations for junctional nevi included the reticular pattern (82.6%) and central hyperpigmentation with a peripheral network (14%), both statistically significant. For dermal nevi, significant associations were found with the globular pattern (71.1%), homogeneous pattern (68.4%), and the presence of hair (23.7%) ($p < 0.0001$). Compound nevi significantly correlated with a peripheral reticular network with central globules (62.5%), a multicomponent pattern (27.5%), and a globular peripheral pattern with a central network (5%).

Table 1: Distribution of nevus types by anatomical location.

Nevus Type	Scalp n (%)	Head and neck n (%)	Trunk n (%)	Limbs n (%)	*p* value
Junctional nevi	7 (2.3%)	190 (65.1%)	37 (12.8%)	58 (19.8%)	< 0.0001
Dermal nevi	3 (2,7%)	24 (18.9%)	68 (54.1%)	31 (24.3%)	0.032
Compound nevi	7 (5.3%)	27 (20.4%)	71 (53.8%)	27 (20.4%)	0.04
Congenital nevi	7 (4.3%)	34 (21.7%)	82 (52.2%)	34 (21.7%)	0.04

DISCUSSION

Melanocytic nevi, benign proliferations of melanocytes, are a cornerstone of pediatric dermatology. These lesions are not only highly prevalent yet also hold clinical significance as potential markers of melanoma risk in adulthood [11]. Their occurrence is shaped by a complex interplay of genetic and environmental factors, varying widely across different ages, anatomical locations, and racial backgrounds. Despite their ubiquity, data on their epidemiological and dermoscopic characteristics in non-Caucasian pediatric populations remain limited. Our study bridges this knowledge gap by providing a comprehensive analysis of nevi in a cohort of Moroccan children, offering valuable insights into the interplay between age, phototype, and anatomical location in shaping nevus characteristics.

The age of onset for nevi revealed that 60.8% developed during the first years of life (6 months to 10 years), while 20% developed before 6 months, and 19.2% appeared between the ages of 11 and 16. This finding is consistent with studies showing that nevi counts increase toward the end of the first decade, with a mean count of 15 to 30 in Caucasian children and 5 to 10 in non-Caucasian populations [5,12,13]. Furthermore, 20% of nevi in our cohort appeared before 6 months of age, suggesting that these may be congenital, reinforcing the literature's assertion that early-onset nevi are often congenital in nature [14].

Hereditary factors were significant in our study, with 55.8% of the patients reporting a history of nevi in the family. This supports findings in other studies, which highlight the role of genetics in the development of congenital and acquired nevi [1]. Sun exposure, particularly intense and intermittent exposure, was another commonly reported factor among most of our patients. This may have influenced the number and type of nevi observed, which is in line with studies showing

the impact of sun exposure on nevi development in children [4,15,16]. However, it is worth noting that Yarak et al.'s study of Brazilian schoolchildren did not find a significant correlation between sun exposure and the number of nevi, which may point to environmental or genetic variations across different populations [17].

The clinical presentation of nevi may change dynamically over time, particularly during childhood and adolescence. In our study, 30.1% of nevi were symptomatic, with symmetrical changes, increased palpability, and regression being common features. Studies suggest that such changes in pediatric nevi are part of their natural evolution and do not necessarily indicate a malignancy [4,18,19]. This finding is supported by a Spanish study that reported frequent clinical and dermoscopic changes in melanocytic nevi in children, including the development of new nevi and regression of existing ones over time [20,21].

Regarding phototype, 61.3% of our patients had phototype IV, which reflects Morocco's predominant skin type. Research suggests that children with darker skin, such as those with phototypes III and IV, generally have fewer nevi than those with lighter skin tones [1,22,23]. Additionally, Zalaudek et al. and others have shown that reticular dermoscopic patterns are more frequently observed in individuals with darker skin, whereas globular and homogeneous patterns are more typical in those with lighter skin [21,24,25]. Our results are consistent with these findings, as the majority of nevi in our population exhibited reticular patterns, likely due to increased melanocyte activity and melanin transfer in darker skin types.

Dermoscopic analysis revealed that junctional nevi were the most frequent type of nevi in our sample, accounting for 36.4% of the cases. A significant association was observed between age and nevus type, with junctional nevi more commonly seen in older children (11–16 years) while dermal nevi tended to develop later in life. This pattern was noted in previous studies [24,26]. Additionally, Zalaudek et al. noted that reticular patterns are more frequent in younger children, whereas globular patterns become increasingly prominent with age [25]. Genetic and phenotypic variations may explain these differences in nevus types and patterns across populations, as our study predominantly involved patients with darker skin types.

Topographically, nevi were most frequently observed in the head and neck (34%) and the trunk (32.8%), similarly to findings from studies conducted in Brazil and Spain [21,24]. Junctional nevi were more commonly found on the head and neck, which is consistent with reports from multiple studies [24,27]. In contrast, dermal nevi were predominantly located on the trunk, which is consistent with research indicating that this nevus type is more commonly found in this area [28]. Congenital nevi in our sample were most commonly found on the trunk, further supporting Stefanaki et al.'s findings that the trunk and extremities are the most frequent sites for congenital nevi [29].

Our dermoscopic findings confirmed well-established associations between certain nevus types and dermoscopic patterns. Junctional nevi were primarily linked to the reticular pattern (82.6%), which has been well documented in the literature as a hallmark of junctional melanocytic nevi [6,30]. Dermal nevi were most commonly correlated with the globular pattern (63.4%), a dermoscopic feature reflecting dermal melanocytic activity [24,26]. Compound nevi, characterized by both junctional and dermal components, predominantly exhibited both reticular and globular patterns, reflecting their mixed histopathological structure [6].

In our study, congenital nevi displayed a reticular pattern in 60% of the cases and a globular pattern in 30%, which aligns with previous research identifying these patterns as typical for congenital nevi, especially smaller and medium-sized lesions [25,31]. Additionally, palmoplantar nevi were most often linked to the parallel furrow pattern (68%), a characteristic dermoscopic feature for nevi located on acral areas such as the palms and soles [32].

Our study found a significant correlation between skin phototypes and dermoscopic patterns. Patients with darker phototypes predominantly displayed reticular patterns, aligning with findings from other studies that attribute this to increased melanin activity in darker skin [27]. Symptomatic nevi in our cohort were mostly correlated to the globular pattern, a relationship supported by the literature on symptomatic nevi [29].

This study offers a detailed analysis of melanocytic nevi in a North African pediatric population, offering valuable insights into the epidemiological, clinical, and dermoscopic characteristics of these lesions. Our findings underscore the significant influence of regional and racial factors on nevus characteristics, as evidenced by the high prevalence of phototype IV in our cohort

and its association with darker, hyperpigmented nevi. This observation highlights the need to consider demographic and phenotypic diversity in studies of melanocytic nevi, as such factors influence both the clinical presentation and dermoscopic patterns of these lesions. However, our single-center design suggests that future multicentric studies are warranted to validate these observations and further elucidate the genetic and environmental determinants of nevus characteristics in diverse populations.

CONCLUSION

Our study provides important insights into the epidemiological, clinical, and dermoscopic characteristics of melanocytic nevi in a Moroccan pediatric population. The findings highlight the influence of age, phototype, and sun exposure on nevus development and appearance. The significant correlations between these factors and specific dermoscopic patterns enhance our understanding of nevus management in children. Future research should prioritize longitudinal studies to deepen the understanding of these relationships, particularly for the early detection and treatment of atypical nevi and melanoma in pediatric populations.

Statement of Human and Animal Rights

All the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the 2008 revision of the Declaration of Helsinki of 1975.

Statement of Informed Consent

Informed consent for participation in this study was obtained from all patients.

REFERENCES

1. Levy R, Lara-Corrales I. Melanocytic nevi in children: A review. Pediatr Ann. 2016;45:e293-8.
2. Tan J-M, Tom LN, Soyer HP, Stark MS. Defining the molecular genetics of dermoscopic naevus patterns. Dermatology. 2019;235:19-34.
3. Zalaudek I, Longo C, Ricci C, Albertini G, Argenziano G. Classifying Melanocytic Nevi. Nevogenesis, Berlin, Heidelberg: Springer Berlin Heidelberg; 2012, p. 25-41.
4. Schaffer J V. Update on melanocytic nevi in children. Clin Dermatol. 2015;33:368-86.
5. Zhang Y, Ostrowski SM, Fisher DE. Nevi and melanoma. Hematol Oncol Clin North Am. 2024;38:939-52.
6. Zalaudek I, Manzo M, Savarese I, Docimo G, Ferrara G, Argenziano G. The morphologic universe of melanocytic nevi. Semin Cutan Med Surg. 2009;28:149-56.
7. Zalaudek I, Argenziano G, Mordente I, Moscarella E, Corona R, Sera F, et al. Nevus type in dermoscopy is related to skin type in white persons. Arch Dermatol. 2007;143:351-6.
8. Kaushik A, Natsis N, Gordon SC, Seiverling EV. A practical review of dermoscopy for pediatric dermatology part I: Melanocytic growths. Pediatr Dermatol. 2020;37:789-97.
9. Scope A, Marchetti MA, Marghoob AA, Dusza SW, Geller AC, Satagopan JM, et al. The study of nevi in children: Principles learned and implications for melanoma diagnosis. J Am Acad Dermatol. 2016;75:813-23.
10. Shah SA, Jahnke MN. Nevi: When to refer. Curr Opin Pediatr. 2024;36:411-7.
11. Keskinkaya Z, Kaya Ö, Işık Mermutlu S, Garipcan Karaemir H, Oğuz Kılıç S. Clinical and dermoscopic patterns of acquired melanocytic nevi in children and adolescents: A cross-sectional study from Turkey. An Bras Dermatol. 2025;100:22-30.
12. Crane LA, Mokrohisky ST, Dellavalle RP, Asdigian NL, Aalborg J, Byers TE, et al. Melanocytic nevus development in Colorado children born in 1998. Arch Dermatol. 2009;145:148-56.
13. Buendía-Eisman A, Paláu-Lázaro MC, Arias-Santiago S, Cabrera-León A, Serrano-Ortega S. Prevalence of melanocytic nevi in 8- to 10-year-old children in Southern Spain and analysis of associated factors. J Eur Acad Dermatol Venereol. 2012;26:1558-64.
14. Marghoob AA. Congenital melanocytic nevi. Dermatol Clin. 2002;20:607-16.
15. Oliveria SA. Sun exposure and risk of melanoma. Arch Dis Child. 2005;91:131-8.
16. Lee TK, Rivers JK, Gallagher RP. Site-specific protective effect of broad-spectrum sunscreen on nevus development among white schoolchildren in a randomized trial. J Am Acad Dermatol. 2005;52:786-92.
17. Yarak S, Ogawa MM, Hirata S, De Almeida FA. Prevalence of acquired melanocytic naevi in Brazilian schoolchildren. Clin Exp Dermatol. 2009;35:581-7.
18. Cohen B. To biopsy or not to biopsy changing moles in children and adolescents: Are we removing too many pigmented nevi in this age group? Arch Dermatol. 2011;147:659.
19. Siskind V, Darlington S, Green L, Green A. Evolution of melanocytic nevi on the faces and necks of adolescents: A 4-year longitudinal study. J Invest Dermatol. 2002;118:500-4.
20. Scope A, Dusza SW, Marghoob AA, Satagopan JM, Braga Casagrande Tavoloni J, Psaty EL, et al. Clinical and dermoscopic stability and volatility of melanocytic nevi in a population-based cohort of children in Framingham school system. J Invest Dermatol. 2011;131:1615-21.
21. Sosa-Seda IM, Valentín-Nogueras S, Figueroa LD, Sánchez JL, Mercado R. Clinical and dermoscopic patterns of melanocytic nevi in Hispanic adolescents: A descriptive study. Int J Dermatol. 2014;53:280-7.
22. Dulon M, Weichenthal M, Blettner M, Breitbart M, Hetzer M, Greinert R, et al. Sun exposure and number of nevi in 5- to 6-year-old European children. J Clin Epidemiol. 2002;55:1075-81.
23. Synnerstad I, Nilsson L, Fredrikson M, Rosdahl I. Frequency and distribution pattern of melanocytic naevi in Swedish 8–9-year-old children. Acta Derm Venereol. 2004;84:271-6.
24. Piazza CD, Yamada S, Marcassi AP, Maciel MG, Seize MP, Cestari SCP. Dermoscopic patterns of melanocytic nevi in children and adolescents: A cross-sectional study. An Bras Dermatol. 2017;92:340-4.
25. Zalaudek I, Grinschgl S, Argenziano G, Marghoob AA, Blum A, Richtig E, et al. Age-related prevalence of dermoscopy patterns in acquired melanocytic naevi. Br J Dermatol. 2006;154:299-304.
26. Zalaudek I, Schmid K, Marghoob AA, Scope A, Manzo M, Moscarella E, et al. Frequency of dermoscopic nevus subtypes by age and body site. Arch Dermatol. 2011;147:663.
27. Krengel S. Nevogenesis: New thoughts regarding a classical problem. Am J Dermatopathol. 2005;27:456-65.

28. Hofmann-Wellenhof R, Blum A, Wolf IH, Piccolo D, Kerl H, Garbe C, et al. Dermoscopic classification of atypical melanocytic nevi (Clark nevi). Arch Dermatol. 2001;137:1575-80.
29. Stefanaki C, Soura E, Stergiopoulou A, Kontochristopoulos G, Katsarou A, Potouridou I, et al. Clinical and dermoscopic characteristics of congenital melanocytic naevi. J Eur Acad Dermatol Venereol. 2018;32:1674-80.
30. Scope A, Marghoob AA, Dusza SW, Satagopan JM, Agero ALC, Benvenuto-Andrade C, et al. Dermoscopic patterns of naevi in fifth-grade children of the Framingham school system. Br J Dermatol. 2008;158:1041-9.
31. Martin L. Naevus: physiopathologie et conseils pratiques. Réalités Pédiatriques - Mises au point interactives – Dermatol Pédiatr. 2018;221:16-8.
32. Savas Erdogan S, Falay Gur T, Turgut Erdemir AV, Dogan B. Dermoscopic characteristics of acral melanocytic nevi in children and adolescents. Pediatr Dermatol. 2020;37:597-603.

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