Figure. Girl with large facial infantile hemangioma.

To our knowledge only 1 similar case has been reported.[3] A 2-month-old infant developed severe respiratory distress from diffuse airway hemangiomas and was treated with 3.5 mg/kg per day of prednisone. After 5 weeks of therapy, she was readmitted to the hospital with labored breathing and required mechanical ventilation. A bronchoalveolar lavage revealed PCP. Intravenous trimethoprim sulfamethoxazole was administered, and mechanical ventilation was discontinued after 3 days.[3]

Trimethoprim sulfamethoxazole is effective prophylaxis against the development of PCP. The most accepted regimen is 150 mg of trimethoprim/m^2 per day plus 750 mg of sulfamethoxazole/m^2 per day divided twice daily on 3 consecutive days weekly.[4] Currently, there are no PCP prophylaxis guidelines for infants undergoing oral corticosteroid treatment for hemangiomas. Prophylaxis for PCP should be a consideration in this setting, given the 2 case reports now in the literature.

Mandi L. Maronn, MD
Timothy Corden, MD
Beth A. Drolet, MD

Correspondence: Dr Maronn, Department of Dermatology, Medical College of Wisconsin, 9200 W Wisconsin Ave, Milwaukee, WI 53226 (mmaronn@mcw.edu).
Financial Disclosure: None reported.

1. Haggstrom A, Drolet BA, Chamlin SL, et al. Prospective study of infantile hemangiomas: demographic, prenatal and perinatal characteristics. *J Pediatr*. 2007; 150(3):291-294.
2. Yale SH, Limper AH. *Pneumocystis carinii* pneumonia in patients without acquired immunodeficiency syndrome: associated illnesses and prior corticosteroid therapy. *Mayo Clin Proc*. 1996;71(1):5-13.
3. Aviles R, Boyce TG, Thompson DM. *Pneumocystis carinii* pneumonia in a 3-month-old infant receiving high-dose corticosteroid therapy for airway hemangiomas. *Mayo Clin Proc*. 2004;79(2):243-245.
4. Hughes WT, Rivera GK, Schell MJ, et al. Successful intermittent chemoprophylaxis for *Pneumocystis carinii* pneumonitis. *N Engl J Med*. 1987;316(26): 1627-1632.

Clinical and Dermoscopic Features of Agminated Blue Nevus

Blue nevi are usually solitary but may rarely appear grouped in an agminated pattern. Clinically, they present as a group of multiple blue nevi in a circumscribed skin area smaller than 10 cm in diameter.[1] The skin between the papules may not be discolored and may show a speckled or uniform blue-black or brown pigmentation.[1] We report a case of agminated blue nevus.

Report of a Case. A 59-year-old woman presented with an asymptomatic dermatosis localized on the anterior lower extremity of her left leg characterized by brown-blue macules and papules. It initially developed during her late teens, and although its size had increased slightly over the earlier years, during the last 20 years, its size, color, and texture had not changed. No family history

Figure 1. Clinical image revealing numerous grouped pigmented lesions on the left leg of a 59-year-old woman. A cluster of about 20 blue-brown to slate gray macules and papules of various sizes, some of which were confluent, can be observed (original magnification ×10).

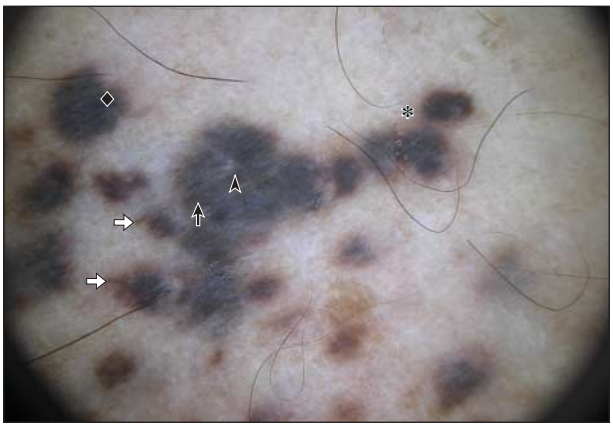

Figure 2. Dermoscopic image of part of the lesion exhibiting a cluster of blue nevi on the anterior lower extremity on the left leg of a 59-year-old woman. Multiple, grouped, homogeneous, confluent, steel blue to brown-blue pigmented areas fading into the surrounding skin can be seen. On the surface of some steel blue areas, linear pigmented structures appear as darker sulci (diamond). In addition, blue areas, some globules and dots (black arrow), a brown veil (black arrowhead), and brown-blue and out-of-focus pseudopods (white arrows) can be recognized. A small rim of tan pigmentation (asterisk) can also be seen around some blue nevi (original magnification ×10).

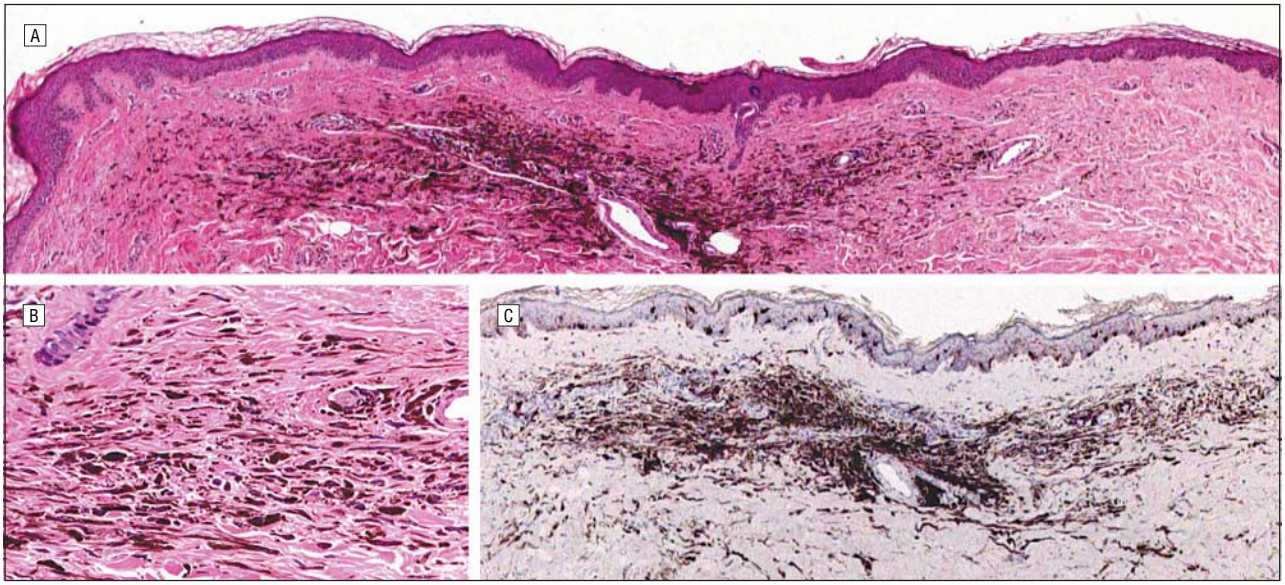

Figure 3. Histopathologic examination revealed a superficial type of blue nevus characterized by a bandlike proliferation of dendritic melanocytes in the superficial dermis. A, Dense, diffuse, bandlike proliferation of dendritic melanocytes in the superficial dermis. Note that there is no junctional involvement at all. An increased melanin pigmentation of the epidermal basal layer can also be seen (hematoxylin-eosin, original magnification ×40). B, Higher magnification reveals morphologic details of numerous dendritic melanocytes and also a few melanophages (hematoxylin-eosin, original magnification ×400). C, Scanning magnification nicely shows that all the dendritic melanocytes are clearly S-100 positive (S-100 staining, original magnification ×40).

of melanoma or similar nevi was reported. Clinical examination revealed a group of approximately 20 blue-brown to slate gray macules and papules of various sizes, some confluent, and within a perimeter of 4 × 2 cm; the skin between the macules and papules had either the color of the surrounding normal skin or a brown-gray pigmentation (**Figure 1**).

In the dermoscopic image (**Figure 2**), a cluster of lesions was recognizable, all with a homogeneous pattern, the morphologic hallmark of blue nevus, characterized by multiple, grouped, homogeneous, confluent, steel blue to brown-blue pigmented areas. On the surface of some of the steel blue areas, typical linear pigmented structures[2] were present (Figure 2). A brown veil, a small rim of tan pigmentation, gray-blue globules and dots, and out-of-focus pseudopods were also seen within the diffuse pigmentation (Figure 2).

Two biopsy specimens were taken with a 5-mm skin punch, one of a steel blue macule, the other of a brown-blue papule. The histopathologic examination revealed a superficial type of blue nevus characterized by a bandlike proliferation of dendritic melanocytes in the superficial dermis (**Figure 3**). Both biopsy specimens showed identical features of a superficial blue nevus, but the second one showed a slightly more pronounced melanin pigmentation of the epidermal basal layer (Figure 3A). Using both the clinical and dermoscopic images, we diagnosed the lesion as a speckled or agminated blue nevus.

Comment. The few cases of agminated nevi described in the literature have been reported as plaque type,[3] eruptive,[4] and patch type,[5] corresponding histopathologically to common or cellular blue nevus.[1] Our case was clinically similar to one described by Hendricks[4] as an eruptive blue nevus.

Dermoscopically, in addition to structureless areas, our case presented the local features associated with blue nevi already reported in the literature.[2]

Agminated blue nevi may present a diagnostic problem in that the differential diagnosis includes agminated blue nevus or agminated intradermal Spitz nevus combined with speckled lentiginous nevus.[5] Since differential diagnosis of these nevi must also include melanoma and malignant blue nevus, a biopsy and histopathologic examination are necessary for the diagnosis.[4] Our case is of special interest because for the first time to our knowledge, the dermoscopic features of this rare entity are described.

Maria A. Pizzichetta, MD
H. Peter Soyer, MD
Cesare Massone, MD
Lorenzo Cerroni, MD

Correspondence: Dr Pizzichetta, Division of Medical Oncology C–Preventive Oncology, Centro di Riferimento Oncologico, Via Pedemontana Occidentale 12, I-33081 Aviano, Italy (pizzichetta@cro.it).
Financial Disclosure: None reported.
Additional Contributions: Anna Maria Colussi, RN, performed editing for this article.

1. Vélez A, del-Rio E, Martin-de-Hijas C, Furio V, Sanchez Yus E. Agminated blue nevi: case report and review of the literature. *Dermatology*. 1993;186(2):144-148.
2. Stolz W, Braun-Falco O, Bilek P, Landthaler M, Burgdorf WC, Cognetta AB. *Color Atlas of Dermoscopy*. 2nd ed. Berlin, Germany: Blackwell Publishing; 2002.
3. Pittman JL, Fisher BK. Plaque-type blue nevus. *Arch Dermatol*. 1976;112(8):1127-1128.
4. Hendricks WM. Eruptive blue nevi. *J Am Acad Dermatol*. 1981;4(1):50-53.
5. Misago N, Narisawa Y, Kohda H. A combination of speckled lentiginous nevus with patch-type blue nevus. *J Dermatol*. 1993;20(10):643-647.