Case report

Coexistence of Giant Congenital Melanocytic Nevus and Neurofibromatosis Type 1 in a Child : A Rare Association

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ABSTRACT

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| **Background:** Giant congenital melanocytic nevi (GCMN) are rare pigmented lesions present at birth, often exceeding 20 cm in size, and may be associated with serious complications such as melanoma and neurocutaneous melanosis. Neurofibromatosis type 1 (NF1) is a common phakomatosis characterized by café-au-lait macules and neurofibromas. The coexistence of GCMN and NF1 is rare and may represent overlapping activation of the RAS/MAPK pathway.**Case report:** We report the case of a 5-year-old boy presenting with a bathing trunk–type GCMN involving the trunk, buttocks, and thighs, along with multiple smaller pigmented nevi. He also exhibited soft, mobile nodules on the lower back and pubic region, consistent with cutaneous and plexiform neurofibromas. Numerous café-au-lait macules were noted, but no axillary freckling. Ophthalmological, neurological, and radiological evaluations were normal. Histopathological examination confirmed congenital melanocytic nevi and neurofibromas. The diagnosis of NF1 was established based on NIH criteria.**Discussion:** This case illustrates a rare co-occurrence of GCMN and NF1. Although both conditions share a RAS pathway dysregulation, their combination is seldom reported. The association may increase the risk of melanoma or neurocutaneous melanosis, requiring long-term clinical and imaging surveillance.**Conclusion:** Recognizing the simultaneous presence of GCMN and NF1 is essential for early diagnosis, multidisciplinary management, and genetic counseling. Lifelong monitoring is advised to detect potential complications. |

*Keywords: Congenital melanocytic nevus, Neurofibromatosis type 1, Plexiform neurofibroma, Pediatric dermatology, Café-au-lait macules, Bathing trunk nevus, RAS/MAPK pathway.*

1. INTRODUCTION

Giant congenital melanocytic nevi (GCMN) are large pigmented lesions present at birth that typically exceed 20 cm in projected adult diameter. They are often associated with complications such as malignant melanoma and neurocutaneous melanosis, and their extensive distribution, especially in a "bathing trunk" pattern, poses additional aesthetic and psychological challenges (Macneal P, et al., 2025), (Ruth J., 2024).

Neurofibromatosis type 1 (NF1), an autosomal dominant genodermatosis caused by mutations in the *NF1* gene, is characterized by café-au-lait macules, neurofibromas, Lisch nodules, and various systemic manifestations (Legius E, et al., 2021). Although both GCMN and NF1 involve dysregulation of the RAS/MAPK signaling pathway, their coexistence in a single patient is rare and may present diagnostic and prognostic implications (Mahajan A, et al., 2022), (Charbel C, et al., 2014).

Herein, we report a unique pediatric case of GCMN in a bathing trunk distribution associated with multiple cutaneous and plexiform neurofibromas fulfilling diagnostic criteria for NF1. This case highlights the importance of thorough systemic evaluation and long-term surveillance in patients presenting with extensive pigmented lesions.

2. PRESENTATION OF CASE

A 5-year-old boy was referred to our dermatology department for extensive pigmented skin lesions noted since birth. At delivery, the patient presented with a large confluent pigmented patch involving the trunk, buttocks, and thighs, covered with long dark hairs, consistent with a giant congenital melanocytic nevus, so-called “bathing trunk nevus” (Figure 1 and 3). In addition, numerous smaller pigmented macules were scattered over the face, scalp, and limbs (Figure 1 and 2). Some of these lesions were congenital, while others appeared during the first year of life.

Clinical examination revealed a homogeneous pigmented plaque with perifollicular hypopigmentation and terminal hairs on dermoscopy, supporting the diagnosis of a congenital melanocytic nevus. Multiple soft, skin-colored to slightly pigmented nodules were noted over the lower back and pubic region. These nodules were non-pulsatile, non-tender, and mobile on palpation, suggestive of cutaneous and plexiform neurofibromas (Figure 2).

Additionally, numerous medium-brown macules (0.5–1 cm) resembling café-au-lait spots were observed over the trunk, limbs, and face. However, axillary or inguinal freckling was absent. Ophthalmologic and neurologic evaluations were unremarkable. Imaging studies, including skeletal X-ray and MRI of the brain and spine, showed no abnormalities. Histopathologic examination of skin biopsies confirmed the presence of congenital melanocytic nevi and neurofibromas.

Based on the presence of café-au-lait macules and multiple neurofibromas, the diagnosis of Neurofibromatosis Type 1 (NF1) was established, according to the NIH diagnostic criteria.

3. discussion

Giant congenital melanocytic nevus (GCMN) is a rare dermatosis (≈ 1 : 20 000 births) that arises from post-zygotic activating mutations, most often in NRAS, and may cover large anatomical surfaces such as the “bathing-trunk” distribution seen in our patient (Legius E, et al., 2021). Neurofibromatosis type 1, by contrast, is an autosomal-dominant phakomatosis caused by pathogenic variants in NF1, with a clinical diagnosis based on the 2021 revised NIH criteria (Macneal P, et al. 2025). Although both conditions involve dysregulation of the RAS/MAPK pathway, their coexistence is decidedly uncommon; fewer than a dozen paediatric cases combining GCMN and NF1 have been documented, including the Indian case of Mahajan *et al.* (2022) and the Egyptian child reported in 2024 (Mahajan A, et al., 2022), (Sadek, A.A., et al. 2024).

Pathogenetically, NRAS mosaicism drives proliferative melanocytic nests in the dermis, whereas NF1 loss leads to constitutive RAS activation in Schwann-cell lineages. Convergence on RAS signalling offers a biologic rationale for their association and may potentiate tumourigenesis through additive pathway activation (Macneal P, et al., 2025), Legius E, et al., 2021).

Malignant melanoma is the gravest complication of GCMN, with meta-analyses estimating a lifetime incidence of 2-4 %, highest during early childhood and in lesions > 20 cm (Scard C, et al., 2023). NF1 individuals independently exhibit a 2- to 4-fold increased melanoma risk and tend to present with thicker tumours and poorer survival (Meyer SN, et al., 2023). In patients harbouring both conditions, cumulative oncologic risk is presumed to be amplified, justifying rigorous, lifelong dermatologic surveillance.

GCMN involving the axial midline also raises concern for neurocutaneous melanosis (NCM), leptomeningeal melanocytic proliferation that can provoke seizures or hydrocephalus. Although our patient’s brain and spinal MRI were normal, periodic neuro-imaging during early childhood is advocated when neurological signs emerge or when extensive posterior midline nevi are present (Ruth J., 2024).

Management of GCMN remains multidisciplinary. Staged surgical excision, curettage, dermabrasion, laser ablation or tissue expansion are selected case-by-case to lower melanoma risk and improve cosmesis; none eliminates risk entirely (Mologousis MA, et al. 2024). Experimental targeted approaches are under investigation : a 2025 *in vivo* study showed that BCL-2 inhibitors induced apoptosis of nevus cells and durable regression of GCMN in murine models, highlighting future therapeutic avenues (Wei B., et al., 2025)

Our case enriches the literature by illustrating, the *bath-ing-trunk* variant of GCMN coexisting with multiple cutaneous and plexiform neurofibromas, the fulfilment of two NIH criteria (café-au-lait macules and ≥ 2 neurofibromas) sufficient for NF1 diagnosis at age five, and the importance of comprehensive systemic evaluation even when neuro-ophthalmologic and radiologic findings are initially unremarkable. Early recognition of this rare association permits tailored surveillance for melanoma, NCM and NF1-related neoplasms, and facilitates genetic counselling for the family.

4. Conclusion

This case illustrates a rare coexistence of two distinct but potentially overlapping neurocutaneous conditions : giant congenital melanocytic nevus and neurofibromatosis type 1. Given the increased risk of melanoma and neurocutaneous melanosis associated with GCMN, especially when involving the axial midline, early recognition and multidisciplinary management are essential. Regular follow-up, patient education, and genetic counseling should be integral components of care to monitor for complications and provide appropriate support to affected families.

Consent

All authors declare that ‘written informed consent was obtained from the patient’s legal guardian for publication of this case report and accompanying images. A copy of the written consent is available for review by the Editorial office/Chief Editor/Editorial Board members of this journal.

Ethical approval

All authors hereby declare that all experiments have been examined and approved by the appropriate ethics committee and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki.

Disclaimer (Artificial intelligence)

Authors hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during the writing or editing of this manuscript.

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Figure 1 : Extensive bathing trunk–type giant congenital melanocytic nevus with numerous satellite nevi. Large, pigmented plaque covering the trunk, buttocks, and upper thighs, consistent with a bathing trunk distribution. The lesion is covered with terminal hairs and is associated with multiple satellite melanocytic nevi of varying sizes scattered over the surrounding skin.



Figure 2 : Satellite congenital melanocytic nevi on the face and scalp. Close-up view showing several pigmented macules and papules located on the forehead, cheeks, and scalp, in keeping with satellite nevi commonly associated with giant congenital melanocytic nevi.



Figure 3 : Multiple cutaneous and plexiform neurofibromas involving the lower back and pubic region. Multiple soft, skin-colored to slightly pigmented nodules and tumefactions are visible over the lower back and pubic area. These lesions are non-tender, mobile, and consistent with cutaneous and plexiform neurofibromas.