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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии

საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНИТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНИТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman** (**Кириллица**), для текста на грузинском языке следует использовать **AcadNusx.** Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - http://www.spinesurgery.ru/files/publish.pdf и http://www.nlm.nih.gov/bsd/uniform_requirements.html
В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or compu-ter-printed on a single side of standard typing paper, with the left margin of **3** centimeters width, and **1.5** spacing between the lines, typeface - **Times New Roman** (**Cyrillic**), print size - **12** (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf
In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.

ავტორთა საყურადღებოდ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე,დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx.** შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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NEVI IN CHILDREN: CLINICO-DERMOSCOPIC CONCEPTS ASSOCIATED WITH LOCATION

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Abstract.

Nevi developed in children are one of the topical issues of pediatric dermatology. The constant change in size and shape often worries parents, and unnecessary removal of the nevi is planned. The development of accompanying scars and sometimes recurring nevi presents a new problem for parents and dermatologists.

Aim: The aim of the study was to study acquired moles in children to reveal the predominant clinical and dermoscopic characteristics, their general and location-related features.

Material and methods: Clinical-dermoscopic manifestations of 107 acquired pigmented nevi of 43 patients were studied. Patients age ranged from 3 to 12 years. Dermoscopic features were assessed using a digital dermoscope. The data were statistically evaluated in the SPSS system using the chi-square test, a significance level of 0.05.

Results: The 24 scalp nevi of 11 patients included the following forms: 14 (58.3%) solid brown, 7 (29.2%) Eclipse nevus, 2 (8.3%) solid pink and one (4.2%) Cockade nevus. Distribution of the dermoscopic characteristics was as follows: globular pattern 12(50%); homogenous-reticular 7(29,1%); globular-homogenous-reticular 1(4,2%); reticular-globular 4(16,7%). 35 nevi of 14 patients detected in the face area included the following forms: 30(85.7%) solid brown, 3(8.6%) solid pink and 2(5.7%) Spitz nevus. Distribution of the dermoscopic characteristics was as follows: globular pattern 33 (94,3%%), homogenous and dotted vascular pattern 2 (5,7%). 48 nevi of 18 patients detected on the body (trunk and limbs) included the following forms: 45 (93.8%) solid brown nevus and 3 (6.2%) Spitz nevus. Distribution of the dermoscopic characteristics was as follows: globular pattern 28 (58,3%) , reticular 11(22,9%), reticular-globular 7(14,6%), homogenous and dotted vascular pattern 2 (4,2%).

Conclusion: The most common type of nevus in children solid brown, was found to be universal for all locations, and presented dermoscopically with the predominant characteristic of globular structures. Clinically different nevi in children were presented with pronounced symmetry and were mostly characterized by two-component dermoscopic features. Spitz nevi presented as single moles on the face and upper extremities, and Eclipse nevi as multiple pigmented nevi on the scalp.

Key words. Nevus, children, dermoscopy.

Introduction.

Moles developed in children are one of the topical issues of pediatric dermatology. The constant change in size and shape often worries parents, and unnecessary removal of nevi is planned. The development of accompanying scars and sometimes recurring nevi presents a new problem for parents and dermatologists. Therefore, timely and accurate assessment of moles in children is very important to determine the correct management. In order to improve the diagnosis of moles in children, the area of use of non-invasive methods is expanding day by day and the availability of digital research is increasing. The development of image characteristics obtained by digital dermoscopic diagnosis provides an opportunity for early and accurate assessment of skin formations and is an important non-invasive diagnostic method for dermatological oncology [1,2]. The importance of the research method is particularly important for monitoring multiple moles. Regular dermoscopic examination and digital monitoring have a special function for patients with atypical mole syndrome, in whom early diagnosis of melanoma is extremely difficult. Digital dermoscopy helps us identify both new moles and changes in existing formations [3].

Clinical and dermoscopic characteristics of moles in children differ significantly from the adult population. Moles in specific locations, such as the scalp, acral, and genital areas, are of particular interest in pediatric dermatology [4,5].

The number of scalp nevi is related to the total number of moles on the body and is more common in males [6,7]. Due to the different clinical manifestations and high rates of dysplasia, scalp nevi in children are a field of constant study [6-10]. The results of the studies already conducted in this direction also provide interesting data. On clinical evaluation, scalp nevi are constantly changing and dynamic in all age groups of children. Changes over time vary and include an increase or decrease in atypical signs. Some degree of atypia is predominantly seen in the evaluation of the excision material, although these changes are not often associated with melanoma [6,7]. Predominant dysplasia of scalp and frontal nevi was also found in a study conducted in children to reveal a significant difference in the relative frequency and degree of atypia of sporadic dysplastic nevi on the scalp, face, and neck compared to nevi on the rest of the body [9]. Two different clinical forms of scalp nevi, such as Eclipse and Cockade nevi, are distinguished by special clinical-dermoscopic characteristics. These moles are often large in size and multi-pigmented, which is associated with a predominantly malignant perception. A careful evaluation reveals a symmetrical shape and an even distribution of pigmented colors. Formations are characterized by benign development and need to be observed only in dynamics. They do not require biopsy confirmation [8]. Increasing awareness of the changes in scalp nevi in children can help to correctly assess their natural progression and reduce unnecessary surgical manipulations [10].

A number of studies have been devoted to Spitz-nevi developed in children, which it remains an actual problem due to atypical detection and development features [11-14]. A Spitz nevus is by narure benign a melanocytic neoplasm of epithelioid cells that usually appears in childhood. There are 3 types of spitzoid neoplasms: typical Spitz nevus, atypical Spitz nevus, and spitzoid melanoma. [11,12]. The results of the study, which

determined the natural evolution of Spitz nevus by comparing the data obtained by monitoring and follow-up images, turned out to be interesting. For the presented group of Spitz nevi, whose diagnosis was confirmed clinically and dermoscopically, spontaneous involution was found to be the most common biological behavior [13]. Due to the lack of criteria, it was not possible to evaluate the biological behavior of atypical Spitz nevi and determine the prognosis [11].

Melanoma rarely develops in children at an early age, and spitzoid formations often imitate it. That is why correct differentiation, constant monitoring and screening of similar formations is very important [12,15-17]. It should also be noted that melanoma in children often does not show typical clinical symptoms, they often manifest such as symmetric, amelanotic, nodular lesions. In such cases, specific dermoscopic features help us to make a correct differential diagnosis. Melanomas usually manifest at least 1 of the 10 melanoma-specific structures: atypical network, negative network, streaks, crystalline structures, atypical dots and globules, irregular blotch, blue-white veil, regression structures, peripheral brown structureless areas, and atypical vessels [14]. Scientists also discuss the course of melanoma of specific localizations in childhood. In children, melanoma develops more often on the scalp than on the limbs or trunk. In addition, melanoma developed on the scalp is characterized by an aggressive course and a worse prognosis [6]. Studies are also ongoing to examine risk factors for pediatric melanoma. Risk factors for melanoma in children with moles include having lightly pigmented skin, excessive ultraviolet light exposure and family history of melanoma. It is also very important to have more than 50 acquired melanocytic nevi and atypical moles. Increasing age and immunosuppression also play a certain role [18,19].

The aim of the study was to study acquired moles in children to reveal the predominant clinical and dermoscopic characteristics, their general and location-related features.

Materials and Methods.

Clinical-dermoscopic manifestations of 107acquired pigmented nevi of 43 patients were studied. Nevi on the scalp, face and body (trunk and limbs) were processed and evaluated to identify specific characteristics. Moles evaluated included 24 scalp nevi in 11 patients, 35 facial nevi in 14 patients, and 48 nevi in 18 patients on the trunk and extremities. Patients referred to the National Center of Dermatology and Venereology. Patients age ranged from 3 to 12 years. The size of the moles ranged from 2-4 mm in diameter. None of the patients or their family members had a dermatological history of melanoma. Dermoscopic features were assessed using a digital dermoscope. The data were statistically evaluated in the SPSS system using the chi-square test, a significance level of 0.05.

Results.

22.4% of the total number of evaluated nevi were scalp nevi, 32.7% were facial nevi, and 44.9% were moles on the body (trunk and limbs). Types of nevus were divided into the following groups: solid brown, solid pink, Spitz naevus, Cockade nevi, Eclipse nevi.

The 24 scalp nevi of 11 patients included the following forms: 14 (58.3%) solid brown, 7 (29.2%) Eclipse nevus, 2 (8.3%) solid pink and one (4.2%) Cockade nevus. 14 solid brown nevi were detected in five patients: 4 of them had 3, and one had 2 scalp moles; 7 Eclipse nevi were detected in 3 patients. Of these, two patients had two and one had three scalp moles. Cockade nevus was detected in only one patient in a single form. A solid pink nevus was also detected in two patients.

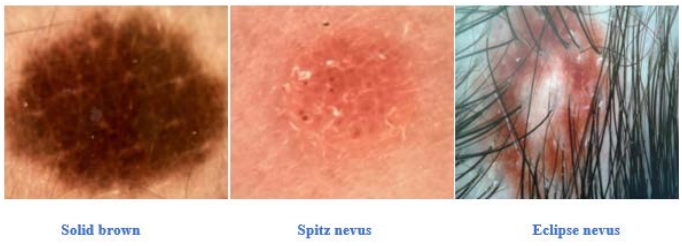

Figure 1. *The results obtained from the total processing of 107 mole data included the following types of moles: solid brown 89(83,2%), Eclipse nevi 7(6,5%), Solid pink 5(4,7%), Spitz naevi 5(4,7%), Cockade nevi 1(0.9%).*

Table 1. *The table presents the types of nevi and the dermoscopic features identified in them, indicating the corresponding numbers.*

Types of nevus (N)	Dermatoscopic characteristics (N)
Solid brown (89)	Globular (67); reticular (11); reticular-globular (11)
Eclipse nevi (7)	homogenous-reticular (7)
Solid pink (5)	Globular (5)
Spitz naevus (5)	homogenous and dotted vascular pattern (4) globular pattern (1)
Cockade nevi (1)	globular- homogenous-reticular (1)

As a result of the statistical processing of the data, the globular pattern in solid brown nevi was found to be significant (P<0.05).

35 nevi of 14 patients detected in the face area included the following forms: 30(85.7%) solid brown, 3(8.6%) solid pink and 2(5.7%) Spitz nevus. 30 solid brown nevi were detected in 10 patients (three patients had two, four patients had three, and three patients had four moles in the facial area); Single solid pink nevus was detected in 3 patients, while two patients had pink single Spitz nevus.

48 nevi of 18 patients detected on the body (trunk and limbs) included the following forms: 45 (93.8%) solid brown nevus and 3 (6.2%) Spitz nevus. The distribution of nevi among patients was as follows: 15 patients had 45 solid brown nevi (including three patients with two, nine patients with three, and three patients with four nevi). Three patients had a single Spitz nevus on the upper extremity (two pink, one with pigment).

Dermoscopic features were evaluated according to moles in specific locations.

During the dermatoscopic assessment of 24 scalp nevus, the distribution of the main characteristics was as follows: globular pattern was detected in 12(50%) cases; homogenous-reticular in 7(29,1%) cases; globular- homogenous-reticular in 1(4,2%) case; reticular-globular in 4(16,7%) cases. 50% of scalp nevi presented with only one dermoscopic feature, 45.8% with two dermoscopic features, and 4,2% with three features. All seven cases of Eclipse nevus presented with the same two-component dermoscopic picture: tan homogenous center and a darker, reticulated peripheral ring. One case of Cockade nevus presented

with a three-component dermoscopic picture: a darker, central globular pattern, lighter homogenous inner ring, and a peripheral darker reticular ring. In both cases of solid pink nevus, the dermoscopic picture was represented by a globular pattern; Solid brown 10(71.4%) cases were presented only with globular pattern, and 4(28.6%) cases with two-component reticular-globular dermoscopic picture. Perifollicular hypopigmentation was manifested in 9 (64.3%) cases.

During the dermatoscopic assessment of 35 facial nevus, the distribution of the main characteristics was as follows: globular pattern was detected in 33 (94,3%%) cases, homogenous and dotted vascular pattern in 2 (5,7%) cases. 94,3% of facial nevi presented with only one dermoscopic feature, 5,7% with two dermoscopic features. In 33 cases, globular pattern was revealed during dermoscopic evaluation of 30 solid brown and 3 solid pink nevi. In both cases of pink Spitz nevus, the dermoscopic picture included homogeneous structures with a dotted vascular pattern.

During the dermoscopic assessment of 48 body (trunk and limbs) nevus, the distribution of the main characteristics was as follows: globular pattern was detected in 28 (58,3%) cases, reticular in 11(22,9%) cases, reticular-globular in 7(14,6%), homogenous and dotted vascular pattern in 2 (4,2%) cases. 81,2% of body nevi presented with only one dermoscopic feature, 18.8% with two dermoscopic features.

By evaluating dermoscopic features of 45 solid brown nevus, globular pattern was detected in 27 (60%) cases, reticular in 11 (24.4%), reticular-globular in 7 (15.6%) cases. In both cases of pink Spitz nevus, the dermatoscopic picture included homogeneous structures with a dotted vascular pattern; In case of pigmented Spitz nevus dermatoscopic picture was presented with globular pattern.

The dermoscopic characteristics detected in them were distributed as follows: globular pattern was detected in 73 (68,2%)cases; reticular in 11(10,3%)cases; homogenous-reticular in 7(6,6%)cases; reticular-globular in 11(10,3%) cases; homogenous and dotted vascular pattern in 4(3,7%) cases; globular- homogenous-reticular in 1(0,9%) cases; One dermatoscopic feature was detected in 84(78,5%) cases, two in 22(20,6%) cases, and three in 1(0,9%)case

Discussion.

Dynamic observation of moles is of particular importance in pediatric dermatology. The reasons for visiting a dermatologist are different and are related to both the change of nevi and the discovery of new formations. Nevi of small size and level with the skin in the hairy area of the head often go unnoticed, pigmented nevi of different shape and color attract the attention of parents. In the presented study, nevi of Eclipse and Cockade belonged to this type of nevi. Eclipse nevi presented with more than one formation and different clinical form. It was the form and the emergence of new elements that caused concern for parents. However, they also noted a steady stabilization of existing formations over the course of months. In the case of Spitz nevi, the main reason for visiting a dermatologist was the sudden appearance of the formation, rapid growth, within 2-4 months, different shape and color. In the presented study, the majority of nevi of this type were detected with formations containing pink, less pigmented and vascular components. In the case of solid brown and solid pink nevi, the reasons for visiting a dermatologist were the new appearance or increase in size without changes in shape and color.

In all such cases, digital dermoscopy was chosen as the best diagnostic tool, considering that this non-invasive method allows to see changes invisible to the naked eye [20]. The prevalence of age-related dermoscopy in acquired melanocytic nevi and their classification based on morphological type and pigment distribution are also important [21].

Since the present study included only children's moles aged 2-12 years, we can evaluate the dermoscopic characteristics of nevi developed at this age. The dermoscopic picture of all moles of the solid brown form of the scalp and face were similar, presenting a globular pattern and an even distribution of pigments. Solid brown moles developed on the body were represented by three different dermoscopic types: globular, reticular, reticular-globular, although all of them showed a symmetrical distribution of pigments. Solid pink moles were localized only on the scalp and face, dermoscopically represented by globular patterns, with an even distribution of pigments. All cases of Eclipse nevi presented with a similar dermoscopic picture, with a pronounced light homogeneous component in the center and a dark reticular network around it. All of them showed symmetry of both structural and pigment distribution. A symmetrical structural and pigment distribution was also revealed in Cockade nevus, which included layered arrangement of globular, homogenous and reticular dermatoscopic features. All pink Spitz nevi on the face and upper extremities were dermoscopically presented with a non-pigmented (slightly pigmented) uniform, homogeneous structure with multiple punctate vascular components. A single pigmented Spitz nevus with dark brown globular structures was revealed. All dermoscopic images of Spitz nevus were characterized by marked symmetry.

Accurate and detailed evaluation of dermoscopic images allowed us to identify specific features and rule out malignancy.

Conclusion.

The most common type of nevus in children solid brown was found to be universal for all locations and presented dermoscopically with the predominant characteristic of globular structures. Clinically different nevi in children were presented with pronounced symmetry and were mostly characterized by two-component dermoscopic features. Spitz nevi presented as single moles on the face and upper extremities, and Eclipse nevi as multiple pigmented nevi on the scalp. The importance of a digital dermoscope for pediatric dermatology is particularly important because it allows us to save and monitor changes in moles.

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