

Case Report/Case Series

Activating *HRAS* Mutation in Agminated Spitz Nevi Arising in a Nevus Spilus

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IMPORTANCE Spitz nevi are benign melanocytic proliferations that can sometimes be clinically and histopathologically difficult to distinguish from melanoma. Agminated Spitz nevi have been reported to arise spontaneously, in association with an underlying nevus spilus, or after radiation or chemotherapy. However, to our knowledge, the genetic mechanism for this eruption has not been described.

OBSERVATIONS We report a case of agminated Spitz nevi arising in a nevus spilus and use exome sequencing to identify a clonal activating point mutation in *HRAS* (GenBank 3265) (c.37G→C) in the Spitz nevi and underlying nevus spilus. We also identify a secondary copy number increase involving *HRAS* on chromosome 11p, which occurs during the development of the Spitz nevi.

CONCLUSIONS AND RELEVANCE Our results reveal an activating *HRAS* mutation in a nevus spilus that predisposes to the formation of Spitz nevi. In addition, we demonstrate a copy number increase in *HRAS* as a "second hit" during the formation of agminated Spitz nevi, which suggests that both multiple Spitz nevi and solitary Spitz nevi may arise through similar molecular pathways. In addition, we describe a unique investigative approach for the discovery of genetic alterations in Spitz nevi.

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Spitz nevi are benign melanocytic neoplasms composed of epithelioid or spindle cell melanocytes. While Spitz nevi have distinct histologic criteria for diagnosis, a subset of Spitz nevi can be clinically and histopathologically difficult to distinguish from malignant melanoma, leading to controversy regarding the nature of these lesions.^{1,2} Some Spitz nevi harbor activating mutations in *HRAS* (GenBank 3265) and *BRAF* (GenBank 673), serine-threonine kinases in the mitogen-activated protein kinase pathway that play a critical role in epidermal development, homeostasis, and tumor progression.³⁻⁵ In addition, approximately 20% of Spitz nevi, predominantly those harboring *HRAS* mutations, have an increased copy number of chromosomal locus 11p, where *HRAS* resides.^{3,6} These *HRAS* mutations can be a favorable prognostic biomarker since *HRAS* is rarely mutated in melanoma.^{6,7}

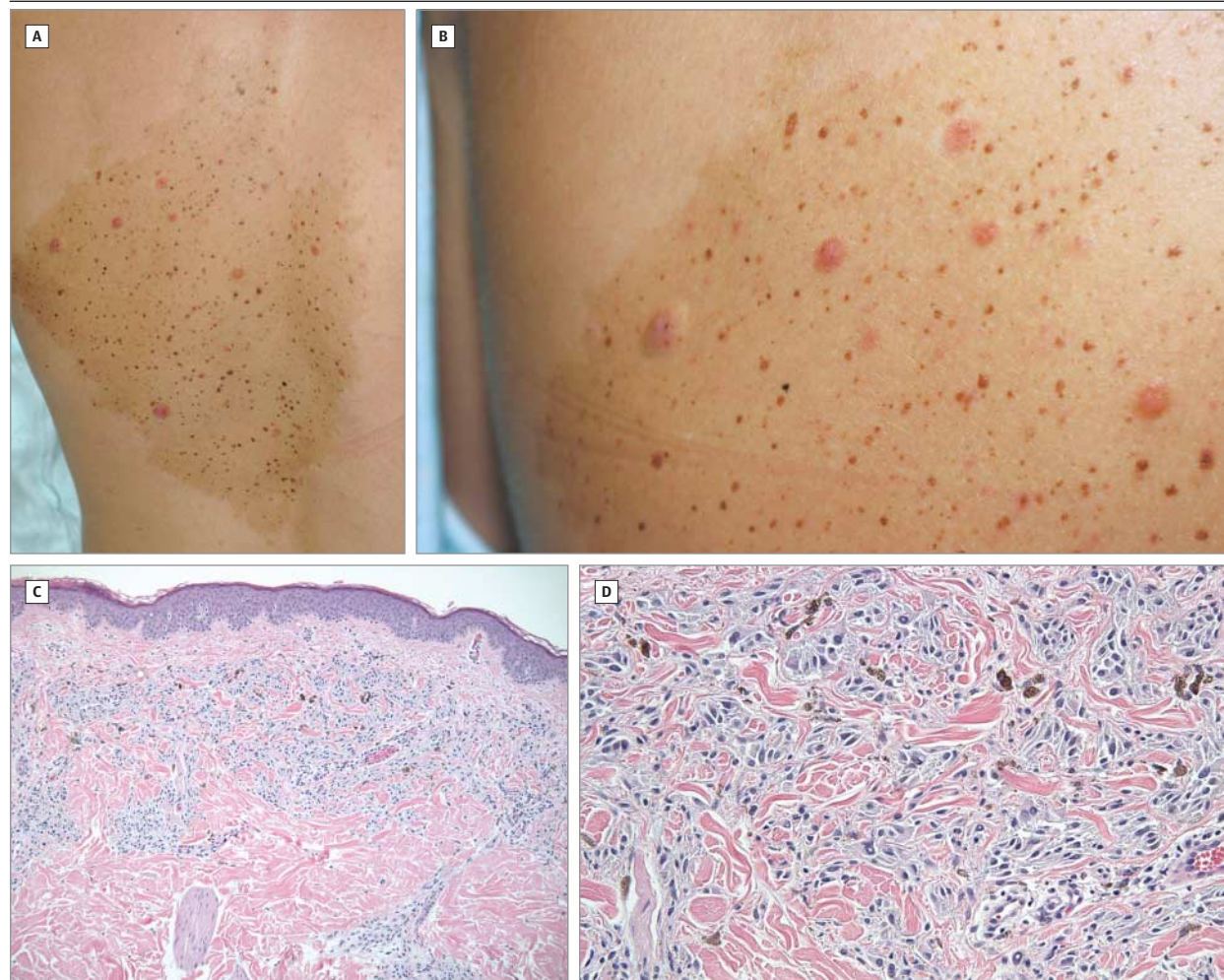
Spitz nevi usually present as solitary skin tumors but can occur in multiple patterns, having agminated, dermatomal, and disseminated forms.⁸⁻¹⁰ Agminated Spitz nevi occur rarely, with fewer than 50 cases reported in the literature. They have been reported to arise spontaneously, in association with an underlying nevus spilus, and after radiation or chemotherapy.¹⁰⁻¹² Despite the clinical and histopathologic resemblance to solitary Spitz nevi, the genetic alterations in these lesions remain unknown. It is unclear if these agminated lesions har-

bor the same mutations as solitary Spitz nevi or arise from an alternate pathway. These lesions represent a compelling approach to studying Spitz nevi since they may potentially arise from an early mutation, producing a clone of melanocytes predisposed to developing into Spitz nevi. Herein, we applied exome sequencing to identify genetic changes in agminated Spitz nevi arising in a nevus spilus and demonstrate a common mosaic mutation among them.

Report of a Case

A 25-year-old man presented to the Stanford Pigmented Lesion and Melanoma Clinic with a 4-year history of pink papules emanating in a large congenital pigmented tan patch on his left lower back. Clinical examination revealed a more than 20-cm tan patch speckled with 1- to 2-mm hyperpigmented macules, characteristic of a nevus spilus, and containing fifteen to twenty 4- to 6-mm pink papules, characteristic of Spitz nevi (Figure 1A and B). The patient was otherwise healthy, with no personal or family history of malignant melanoma. Histopathologic specimens of 2 pink papules revealed symmetric, well-demarcated melanocytic proliferations consisting of spindle cell melanocytes with large vesicular nuclei splayed

Figure 1. Clinical and Histopathologic Features of the Agminated Spitz Nevi Arising in a Nevus Spilus



A and B, Photograph of a large tan patch on the left lower back with 1- to 2-mm hyperpigmented macules and 4- to 6-mm pink papules. C, Pink papule showing plump melanocytes splayed through desmoplastic collagen, consistent with

Spitz nevi (hematoxylin-eosin, original magnification $\times 10$). D, Melanocytes with amphophilic cytoplasm in the dermis (hematoxylin-eosin, original magnification $\times 20$).

through the dermis, consistent with intradermal Spitz nevi (Figure 1C and D). To identify underlying genetic alterations, we obtained specimens from 2 additional pink papules, with histopathologic features also confirming the diagnosis of Spitz nevi. Our study complied with the Declaration of Helsinki and was approved by the institutional review board at Stanford University School of Medicine. Genomic DNA was isolated from these 2 lesional samples along with the adjacent normal skin, 1 cm outside the boundaries of the nevus spilus, and subjected to exome sequencing (eMethods and eTable in the Supplement).

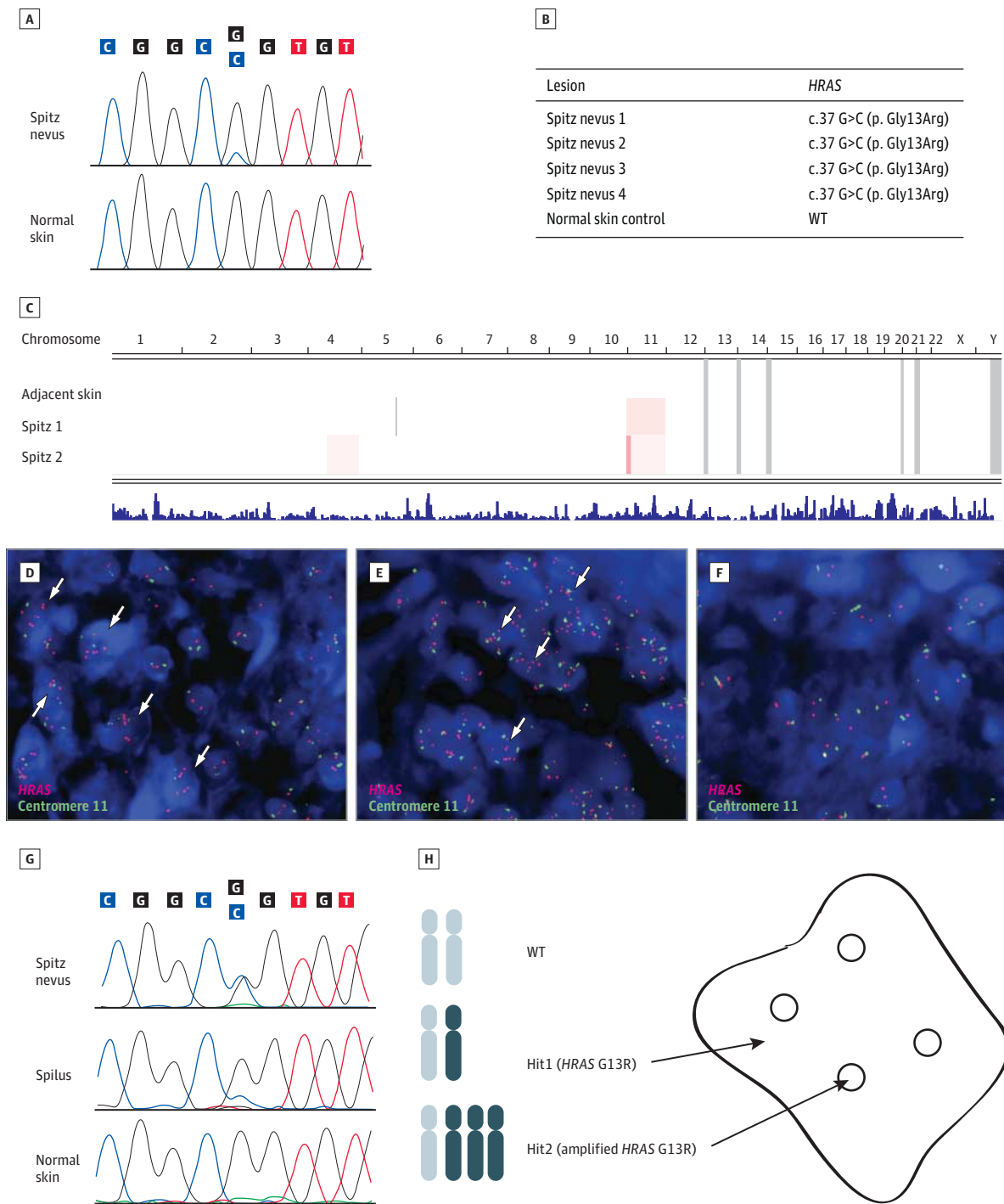
Results

Comparison of recurrent variants from the exome sequencing identified an *HRAS* point mutation (c.37G→C, p.Gly13Arg) in both Spitz nevi that was absent in the adjacent normal skin (Figure 2A). No other recurrent somatic mutations were de-

tected (eMethods in the Supplement). Sanger sequencing confirmed the presence of the *HRAS* mutation in both Spitz lesions. We performed Sanger sequencing on DNA derived from 2 additional formalin-fixed, paraffin-embedded Spitz nevi obtained from the same patient that also demonstrated the *HRAS* point mutation (Figure 2B). Therefore, all 4 Spitz nevi obtained from our patient harbored the same single-nucleotide variation.

To evaluate for copy number changes, we used SeqGeneCNV on the exome sequencing data.¹³ This algorithm detects regions with abnormal copy number changes using circular binary segmentation. This revealed a copy number increase in chromosome 11p in both Spitz nevi compared with the normal skin control (Figure 2C). We then performed fluorescent in situ hybridization using an *HRAS* probe that confirmed amplification of *HRAS* in the melanocytes from 2 Spitz nevi (Figure 2D) and polysomy in the melanocytes from a third Spitz nevus (Figure 2E). No *HRAS* amplification was detected in adjacent fibroblasts or epidermal keratinocytes (Figure 2F).

Figure 2. Activating *HRAS* Mutations and Amplification of Chromosome 11p in Agminated Spitz Nevi



A, Sanger sequencing of a representative Spitz nevus and adjacent unaffected skin demonstrates a c.37G→C, p.Gly13Arg mutation specific to the lesional tissue. B, Table of *HRAS* mutations showing the *HRAS* mutation is present in all 4 Spitz nevi but undetectable in the adjacent normal skin. C, Chromosomal amplifications predicted by SeqGene CNV and displayed with an Integrative Genomics Viewer (<http://www.broadinstitute.org/igv/>). Both Spitz nevi have a predicted amplification (red bars) over chromosome 11p. D, Dual-color fluorescent in situ hybridization (FISH) with *HRAS* probe (red signals) and a reference centromeric probe for chromosome 11 (green signals) showing a focus of melanocytes with increased red signal significantly above reference green

signals, indicating *HRAS* amplification (arrows). E, Dual-colored FISH showing a focus of melanocytes with polysomy demonstrated by increased *HRAS* (red) and centromeric (green) signals in the nucleus (arrows). F, Dual-color FISH showing epidermal keratinocytes and papillary dermal fibroblasts with equivalent red and green signals. G, Sanger sequencing of *Acil1*-digested DNA from a Spitz nevus, nevus spilus, and the adjacent normal skin demonstrating the *HRAS* mutation in the nevus spilus and Spitz nevus but not in the normal skin. H, Diagram of 2-hit model of a nevus spilus, with the first hit leading to the nevus spilus and the second hit leading to the formation of Spitz nevi. WT indicates wild type.

Spitz nevi are heterogeneous melanocytic tumors, with less than 20% of these lesions harboring *HRAS* activating mutations and even fewer containing the *HRAS* point mutation.³ Thus, it would be highly improbable for all Spitz nevi obtained from our patient to develop identical mutations if they represented independent lesions. We hypothesized that these Spitz nevi arose in an agminated fashion from a common postzygotic clone of melanocytes, likely demarcated by the nevus spilus. To improve our sensitivity to detect this mutation in the nevus spilus, we performed polymerase chain reaction amplification of the genomic DNA followed by enzymatic digestion with *AciI*, which digests the wild-type sequence but not the mutant sequence (eMethods and eFigures 1 and 2 in the Supplement). Subsequent Sanger sequencing reproducibly detected the *HRAS* point mutation in the nevus spilus and Spitz nevi but not in the adjacent normal skin (Figure 2G). This implicates the *HRAS* point mutation as the initiating mutation predisposing melanocytes to develop into Spitz nevi. In this model, a “second hit” may be required for the formation of Spitz nevi (Figure 2H). Our data support *HRAS* amplification as a secondary change because its mechanism was not identical in all Spitz nevi, with 1 nevus demonstrating polysomy of chromosome 11.

Discussion

Multiple Spitz nevi can occur rarely in agminated and disseminated forms, but the genetic alterations that lead to these occurrences are unknown. To our knowledge, this is the first report demonstrating mosaicism in agminated Spitz nevi and identifying an activating *HRAS* mutation in agminated Spitz

nevi. Mosaic *HRAS* mutations were recently recognized in the nevi sebacei and nevi spili in patients with phacomatosis pigmentokeratocytica.¹⁴ This report extends this finding by demonstrating an *HRAS* mutation in a sporadic nevus spilus. Interestingly, the *HRAS* point mutation, in particular, has been detected in a variety of benign skin neoplasms, including epidermal and sebaceous nevi, Spitz nevi, and nevi spili, providing a unique example of genetic pleiotropy within the ectodermal lineage.¹⁵

Our data indicate that multiple Spitz nevi may have a similar pathogenesis to that of solitary Spitz nevi since a subset of solitary Spitz nevi also harbors activating mutations in *HRAS* and copy number increases in chromosome 11p.³ However, similar to solitary Spitz nevi, other genetic alterations also may play a role in the pathogenesis of multiple Spitz nevi. Gantner et al⁹ recently demonstrated the absence of *HRAS*-activating mutations in a patient with eruptive Spitz nevi, suggesting that alternate genetic alterations may be responsible for the lesions in this patient. It is tempting to speculate that many cases of multiple Spitz nevi may result from an early clonal mutation, as demonstrated in our patient.

Recently, significant progress has been made in understanding the genetic alterations in cutaneous tumors, in part due to the advances in sequencing technology. Many of these technologies rely on a large number of samples to determine recurrent mutations. This approach may be difficult in solitary Spitz nevi since the lesions are uncommon and possess heterogeneous mutations. Identifying clonal mutations in patients with multiple Spitz nevi presents a promising approach to distinguish genetic alterations in all Spitz nevi. Insight into these genetic changes is critical to improve our ability to diagnose and manage these controversial lesions.

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Analysis and interpretation of data: Sarin, Sun, Bangs, Cherry, Kim, Khavari.

Drafting of the manuscript: Sarin, Bangs, Swetter, Kim.

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Administrative, technical, and material support: Sun, Bangs, Cherry, Kim, Khavari.

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NOTABLE NOTES

***Euphorbia peplus*: 18th-Century Insights on a 21st-Century Therapy**

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In 2012, the US Food and Drug Administration approved a new therapeutic agent, ingenol mebutate, for the topical treatment of actinic keratoses. Ingenol mebutate is a diterpene ester with the chemical formula $C_{25}H_{34}O_6$ and is extracted from the sap of the plant species *Euphorbia peplus*, also known as the petty spurge. *Euphorbia peplus* extract has been used for centuries as a topical agent for the treatment of a variety of skin conditions in traditional medicine systems from around the world.

Euphorbia peplus was first taxonomically categorized in the Western scientific community by Carl Linnaeus in the 1750s and presented in a thesis defended by his student Johannes Wiman at Uppsala University in Sweden.¹ Linnaeus described a variety of medicinal uses for the genus of *Euphorbia* plants as topical treatments and systemic agents for gastrointestinal tract purging. Members of this genus were known to cause skin irritation on contact with the plant's sap. The genus was named after the ancient Greek physician Euphorbus, who in the first century AD documented the laxative properties of the spurge.

A monograph published in London, England, circa 1770 highlights specific insights into several plants, including *E peplus*.² The manuscript (Figure), published in both Latin and English, likely represents one of the earliest documentations of the dermatologic applications after Linnaean classification. The monograph authors describe "the milky fluid which it abounds with, is by some applied to Warts, which it is said to destroy."² The other members of the *Euphorbia* genus, particularly *Euphorbia helioscopia*, or sun spurge, were also recognized to have sap with similar properties in the monograph.

A later selection from the same monograph discusses the sun spurge or "wart-wort" species in greater detail, including its toxicity. "My friend Mr William Wavell lately informed me of a case which fell under his notice in the Isle of Wight, where from the application of the juice of this Spurge [*E helioscopia*] to some Warts near the eye of a little girl, the whole face became inflamed to a very great degree," noted the author of the monograph.²

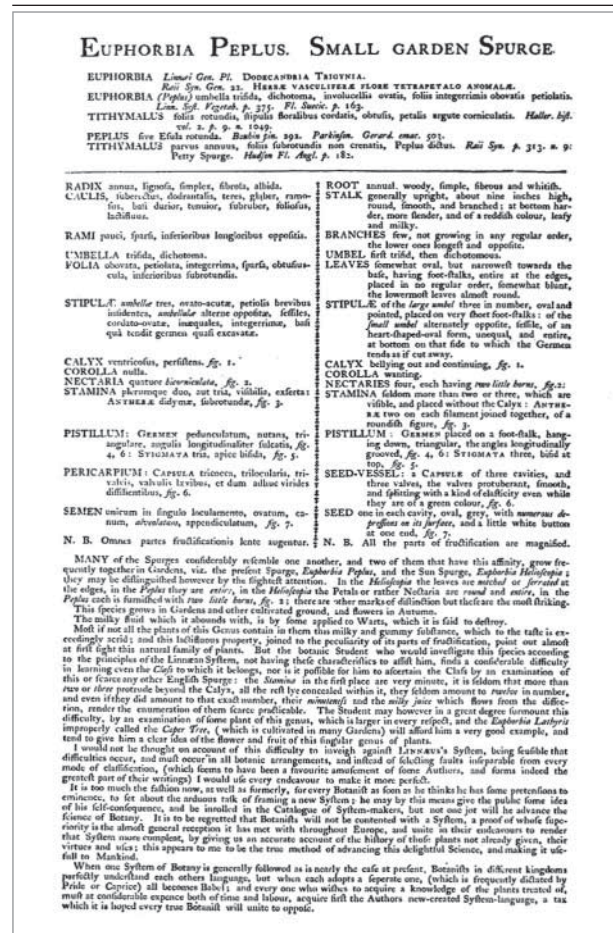
Consistent with these case reports from more than 2 centuries earlier, most patients enrolled in clinical trials demonstrating the efficacy of ingenol mebutate for actinic keratoses developed clinically significant erythema at the site of application.³ It is also notable that a lower concentration of the drug is approved for treatment of the face and that the most common adverse effects of ingenol mebutate in the aforementioned clinical trials were pruritus, irritation, and pain—echoing the cautionary case described in the monograph. As future work unfolds examining additional applications for topical ingenol mebutate, looking back into the past may help uncover other natural remedies awaiting our rediscovery.

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Additional Contributions: We thank the JJ Horticulture Folder, The Bodleian Libraries, The University of Oxford, for image permissions.

Figure. Eighteenth-Century Monograph Describing the Dermatologic Use of *Euphorbia peplus*, the Plant From Which Ingenol Mebutate Is Derived



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