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# "Sprucing The Beauty Spot To Aesthetically Beautify Face: A Case Series"

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***Abstract***
*Melanocytic nevi are the common benign proliferation of melanocytes. These can be congenital or acquired. Acquired melanocytic nevi, also known as moles, appear from childhood to usually midlife, are present in all races, and are more in number in the white population. Moles can be classified based on the depth at which the melanocytic nevus cells or nevomelanocytes are present. Single nevus cells in the basal layer with nests of nevus cells are present in the tips of rete ridges or between them, in the case of junctional nevus. In addition to the junctional component, compound nevus has nevomelanocytes in the dermis, arranged as nests, cords, or single units. Intradermal nevus has only the dermal component of the compound nevus. As melanocytes move*

*from the epidermis to the dermis, they gradually lose their ability to produce pigment. Junctional nevus presents as a flat, pigmented brown macule while a compound nevus is a slightly raised, brown papule with the color of the brown ranging from light to dark according to the individual's skin color. Intradermal nevi present as skin-colored, dome-shaped papule or nodule with hair projecting from the surface at times.*

***Keywords:*** *melanotic nevus, nasolabial fold, surgical excision, maxillofacial surgery, esthetic reconstruction*

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## I. Introduction

Melanotic nevi are common cutaneous lesions resulting from congenital or acquired proliferation of melanocytes. They typically appear during childhood or adolescence and may darken with age. While usually benign, their location in facial esthetic zones often warrants removal due to cosmetic disfigurement, functional impairment, or suspicion of dysplastic transformation. The nasolabial fold, being a prominent facial feature, demands careful surgical planning to achieve an optimal balance between complete excision and esthetic reconstruction [1, 2]. Here, we present a case of melanotic nevus excision in the nasolabial region treated by surgical excision and primary closure. Melanocytic nevi are common facial lesions excised primarily for cosmesis or diagnostic certainty. Contemporary reviews emphasize tailoring management to lesion size, location, and patient priorities: while observation is reasonable for uncomplicated lesions, excision remains the most definitive option because it provides tissue for histopathology and lowers true recurrence compared with destructive methods [3]. Laser, cryotherapy, and electrosurgery can lighten pigment but often fail to eradicate deeper nevus cells, with higher recurrence and textural scarring reported versus scalpel excision. For small facial nevi (≤1 cm) in esthetic subunits such as the nasolabial fold, elliptical (fusiform) excision along relaxed skin tension lines (RSTL) with primary layered closure remains the workhorse technique, balancing clearance and scar quality. Evidence and expert guidance highlight that incision orientation parallel to RSTL or natural creases minimizes scar spread and visibility critical in the mobile midface [4]. Comparative outcome data show that shave excision can yield good cosmetic satisfaction but carries higher positive-margin and clinical recurrence rates than elliptical excision—hence, when diagnosis is uncertain or long-term clearance is desired (as on the face), full-thickness elliptical excision is favored. In congenital or larger lesions, recent systematic updates underscore that treatment goals have shifted from melanoma-prevention toward cosmetic and functional optimization, with excision still safe and effective in many medium lesions, while larger/complex defects may require staged or flap-based reconstruction [4, 5].

## II. Case Report:

A 36 years female patient reported to the Department of Oral and Maxillofacial Surgery with a chief complaint of a darkly pigmented lesion in the **left nasolabial fold** since birth. The lesion was asymptomatic but cosmetically unacceptable to the patient.

Extraoral findings**:** A solitary, well-circumscribed, pigmented lesion measuring approximately 2.5*0.5 cm located in the left nasolabial fold. Surface was Smooth, non-ulcerated. Margins were well defined (figure 1). No associated lymphadenopathy. Provisional diagnosis was Melanotic nevus.

Surgical Management: The procedure was performed under local anesthesia (2% lignocaine with adrenaline 1:80,000). A fusiform/elliptical incision was designed along the relaxed skin tension lines (RSTL) of the nasolabial fold (figure 1). The lesion was excised en bloc with 1–2 mm margins to ensure complete removal. Meticulous layered closure was performed using 5-0 non-absorbable interrupted sutures to minimize scarring (Figure 1.1). Excised tissue was sent for histopathological examination, which confirmed the diagnosis of melanotic nevus.

Postoperative Outcome: Healing was uneventful with satisfactory esthetic results. Sutures were removed after 10 days. No recurrence or scar hypertrophy was noted during follow-up at 6 months (Figure 1.2).

## III. Discussion:

Melanotic nevi in the nasolabial fold pose unique challenges due to their visibility in facial expressions and proximity to vital structures. Complete excision is essential to prevent recurrence and eliminate malignant potential. Various treatment modalities include shave excision, cryotherapy, electrocautery, laser ablation, and surgical excision [5]. Among these, surgical excision with primary closure remains the gold standard as it provides tissue for histopathological evaluation and minimizes recurrence [4]. Designing the incision along the RSTL and natural skin creases ensures minimal scar visibility and optimal cosmetic results. Long-term follow-up is essential to monitor recurrence or malignant transformation [1,3].

## IV. Conclusion:

Surgical excision of melanotic nevi in the nasolabial fold is a reliable, safe, and effective procedure with excellent cosmetic outcomes when meticulous planning and technique are employed. Early intervention is recommended to address both esthetic concerns and potential malignant risk.

## References:

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[3]. Macneal P, Et Al. Congenital Melanocytic Nevi. Statpearls, 2023 Update.
[4]. Shave Excision Versus Elliptical Excision Of Intradermal Melanocytic Nevi: Recurrence And Cosmetic Outcomes. 2021.
[5]. Lemperle G, Et Al. Prevention Of Hyper- And Hypotrophic Scars Through Understanding Skin Tension Lines. 2020.

## Legends

1. **Figure 1: Front Profile with Skin marking for surgical excision.**
2. **Figure 1.1: Suturing with 5-0 Prolene Suture.**
3. **Figure 1.2: 6 months follow up.**
4. **Figure 2: Front Profile**
5. **Figure 2.1: 6 months follow up.**
6. **Figure 3: Front Profile**
7. **Figure 3.1: 6 months follow up.**

**<u>Images</u>: Patients and their attenders have given written consent and permission for publishing and sharing the images.**

**Figure 1: Front Profile with Skin marking for surgical excision.**

**Figure 1.1: Suturing with 5-0 Prolene Suture.**

**Figure 1.2: 6 months follow up.**

**Figure 2: Front Profile**

**Figure 2.1: 6 months follow up.**

**Figure 3: Front Profile**

**Figure 3.1: 6 months follow up.**