

A CRITICAL REVIEW OF NEVUS SEBACEOUS OF JADASSOHN THROUGH THE LENS OF *SHALYA TANTRA* WITH CORRELATION TO *CHARMAKEELA*

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ABSTRACT

In *Ayurveda*, *Kṣhudra roga* refers to a group of comparatively minor, localized disorders described in classical texts such as the *Susruta samhita*. Among them, *charmakeela* is explained as a nail-like elevated lesion arising over the skin due to vitiation of *doshas*, predominantly *kapha*, involving *twak* and *mamsa dhatu*. Clinically, *charmakeela* is characterized by localized thickening, elevation, roughness, stability and minimal symptoms, though variations may occur according to *dosha* predominance. Nevus Sebaceous of Jadassohn is a congenital benign cutaneous hamartoma involving epidermal and adnexal structures, especially sebaceous glands. It usually presents as a well-defined yellowish, hairless plaque over the scalp or face and may become verrucous after puberty because of hormonal influence and sebaceous hyperplasia. Modern dermatology considers it a developmental anomaly with potential for secondary neoplastic changes in some cases. Although no exact disease entity corresponding to Nevus Sebaceous is directly

mentioned in Ayurvedic classics, a conceptual and morphological similarity may be observed with *charmakeela*. Both conditions demonstrate localized elevated lesions with *kapha*-dominant proliferative characteristics and involvement of skin and underlying tissues. The necessity for comparison between *charmakeela* and nevus sebaceous arises from the

increasing need for integrative understanding between classical Ayurvedic dermatology and contemporary dermatological entities. Establishing such probable correlations may help in academic interpretation, Ayurvedic diagnosis, and development of interdisciplinary approaches for skin disorders. Therefore, the present review attempts to explore the probable Ayurvedic correlation of Nevus Sebaceous of Jadassohn with *charmakeela* on the basis of classical descriptions, dosha-dushya involvement, morphology and clinical presentation.

KEYWORDS: *Kshudra roga*, *Charmakeela*, Nevus Sebaceous of Jadassohn.

INTRODUCTION

Skin disorders constitute a significant portion of day-to-day clinical practice because of their chronicity, cosmetic impact, psychological burden and increasing prevalence in modern lifestyle conditions. *Ayurveda* describes a wide spectrum of dermatological disorders under *Kuṣṭha* and *Kṣhudra roga*. The term *kṣhudra roga*, explained in the *Susruta samhita* and other classical texts, includes comparatively minor yet clinically important localized diseases affecting the skin and superficial tissues.^[1] Though considered “minor” in severity, these disorders possess considerable relevance in present clinical practice due to their recurrent nature, cosmetic disfigurement and effect on quality of life. Hence, proper understanding of *kṣhudra roga* is essential for accurate diagnosis, differential assessment and integrative dermatological management in *Ayurveda*. Among the *kṣhudra roga*, *charmakeela* is described as a localized elevated lesion produced by vitiated *doshas* involving *twak* and *mamsa dhatu*.^[2] Classical descriptions mention nail-like projections, thickening, roughness, localized growth and variations according to *dosha* predominance, particularly *kapha*. In current clinical practice, lesions resembling *charmakeela* such as warts, skin tags, papillomatous growths and benign verrucous proliferative lesions are frequently encountered in dermatology and Ayurvedic clinical practice. The increasing incidence of benign cutaneous proliferative conditions may be associated with altered lifestyle patterns, environmental exposure, hormonal changes, metabolic disturbances, stress, dietary irregularities and increased cosmetic awareness leading to greater healthcare consultation. Nevus Sebaceous of Jadassohn is a congenital benign hamartomatous lesion involving epidermal, follicular, sebaceous and apocrine structures.^[3] It commonly appears as a yellowish, hairless plaque over the scalp or facial region and tends to become thicker and verrucous after puberty due to hormonal stimulation of sebaceous glands. Modern medicine attributes its development mainly to

postzygotic genetic mutations, particularly involving the RAS pathway, leading to abnormal adnexal proliferation.^[4] Although it is primarily congenital, present-day lifestyle-associated hormonal influences, endocrine disturbances, environmental factors, chronic chemical exposure and altered cutaneous physiology may influence the progression and morphological prominence of the lesion during later stages of life. No exact disease entity corresponding to Nevus Sebaceous of Jadassohn is directly available in Ayurvedic classics. However, a probable conceptual correlation with *charmakeela* can be considered on the basis of clinical morphology, localized elevated growth, kapha-dominant proliferative features, twak-mamsa involvement and benign slow progression.^[5] Additionally, the sebaceous and glandular overgrowth seen in Nevus Sebaceous may be interpreted through *meda* involvement, while its congenital presentation supports the concept of *sahaja vyadhi* described in *Ayurveda*. The comparison between *Charmakeela* and Nevus Sebaceous of Jadassohn is therefore scientifically and conceptually relevant because both conditions demonstrate localized proliferative cutaneous lesions with comparable gross clinical appearance. The congenital nature and sebaceous overgrowth of Nevus Sebaceous additionally suggest *sahaja* and *meda* involvement from an Ayurvedic perspective. Such comparative interpretation may contribute to better interdisciplinary understanding between Ayurvedic dermatology and contemporary dermatological science. Furthermore, available literature specifically correlating *charmakeela* with Nevus Sebaceous of Jadassohn is extremely limited, indicating the need for further scholarly exploration. Hence, the present article attempts to analyze the probable Ayurvedic correlation of Nevus Sebaceous of Jadassohn with *Charmakeela* through classical references, dosha-dushya involvement, clinical morphology and contemporary dermatological understanding.

MATERIALS AND METHODS

Review of literature from *samhitas* with commentaries that appraises concept of *Kshudra roga*, *Charmakeela* corroborating with contemporary analysis upon Nevus Sebaceous of Jadassohn through scientific articles.

DISCUSSION

Nevus Sebaceous of Jadassohn is an uncommon congenital cutaneous malformation classified as a non-hereditary hamartoma involving the adnexal components of the skin.^[6] The exact etiopathogenesis remains incompletely understood and however, current evidence suggests that the lesion is associated with postzygotic somatic mutations affecting genes of

the RAS signaling pathway, particularly HRAS, KRAS, and NRAS.^[7] It is also referred to as organoid nevus, Jadassohn nevus, or pilosebaceous-apocrine hamartoma, nevus sebaceous is characterized by abnormal proliferation and hyperplasia of epidermal, follicular, sebaceous, and apocrine structures. Clinically, the lesion typically presents as a well-demarcated plaque associated with partial or complete alopecia, most commonly involving the scalp or facial region. The plaques are usually linear or oval in configuration and may vary in color from skin-colored to yellowish-orange or brownish-black. Their surface morphology evolves with age and lesion maturation, ranging from smooth and velvety in childhood to papillomatous, verrucous, or nodular during adolescence and adulthood. Schimmelpenning Syndrome, also referred to as Schimmelpenning–Feuerstein–Mims syndrome, is characterized by the presence of extensive or disseminated Nevus Sebaceous of Jadassohn in association with extracutaneous abnormalities involving the central nervous, skeletal, and ocular systems.^[8] Neurological manifestations may include seizures, intellectual disability, and structural brain anomalies, while skeletal and ophthalmologic abnormalities are variably observed. A rare variant within the spectrum of epidermal nevus syndromes is Phakomatosis Pigmentokeratotica, characterized by the coexistence of nevus sebaceous and at least one speckled lentiginous nevus. This condition is considered a mosaic disorder arising from postzygotic genetic alterations affecting pluripotent ectodermal cells.^[9] Recent studies have demonstrated that the majority of secondary neoplasms arising within nevus sebaceous are benign in nature. Historically, many lesions were diagnosed as basal cell carcinoma because of overlapping histopathological features; however, contemporary evidence suggests that several of these tumors were more accurately classified as trichoblastomas, which closely resemble basal cell carcinoma microscopically. Consequently, the true incidence of basal cell carcinoma arising in nevus sebaceous is now considered to be less than 1%. Among secondary tumors, trichoblastoma represents the most frequently encountered neoplasm, followed by syringocystadenoma papilliferum. Other benign adnexal tumors reported in association with nevus sebaceous include trichilemmoma, sebaceous adenoma, desmoplastic trichilemmoma, apocrine adenoma, and poroma. Rare malignant transformations have also been documented and include basal cell carcinoma, sebaceous carcinoma, squamous cell carcinoma, microcystic adnexal carcinoma, and melanoma. The risk of malignant transformation is considered extremely low during childhood and remains uncommon overall. The differential diagnosis of nevus sebaceous varies according to the stage of lesion development. In infancy, conditions such as aplasia cutis congenita and mastocytoma should be considered. During later stages, the lesion may mimic congenital melanocytic nevus,

epidermal nevus, seborrheic keratosis, verruca vulgaris, or juvenile xanthogranuloma. Accurate diagnosis is based on clinical morphology, dermoscopic findings, and histopathological evaluation when necessary. The lesion of Nevus Sebaceous of Jadassohn undergoes distinct clinical and histopathological changes throughout life, which are generally categorized into three developmental stages.^[10] The first, or infantile stage, is characterized histologically by mild acanthosis of the epidermis, which may occasionally exhibit hyperpigmentation. Hair follicles are usually immature, underdeveloped, and frequently represented by primitive cords of undifferentiated basaloid cells. Sebaceous glands are inconspicuous or poorly developed during this period. Clinically, the lesion remains relatively flat and smooth in appearance. The second stage typically occurs during adolescence, coinciding with hormonal stimulation of sebaceous structures. During this phase, the lesion becomes thicker and more prominent, often developing nodular, papillomatous, or verrucous surface changes. Histopathological examination demonstrates marked verrucous epidermal hyperplasia, a feature that may resemble epidermal nevus. However, nevus sebaceous can be distinguished by the presence of characteristic dermal adnexal abnormalities, particularly sebaceous gland hyperplasia and abnormal positioning of sebaceous structures within the dermis. Hair follicles continue to remain small, rudimentary, and incompletely differentiated. At this stage, sebaceous glands become numerous and hyperplastic, while ectopic or dilated apocrine glands and eccrine hyperplasia may also be observed. These findings reflect the shared embryologic origin of the pilosebaceous-apocrine unit and account for the variable adnexal differentiation encountered in nevus sebaceous. Recognition of these divergent histologic patterns is important to avoid diagnostic confusion. One of the most characteristic histopathological features of nevus sebaceous is the absence of mature terminal hair follicles within the lesion, despite their presence in the adjacent uninvolved skin. This finding is considered diagnostically significant and may serve as an important clue during low-power microscopic examination, particularly in determining whether a biopsy specimen is representative of the lesion. The third stage occurs during adulthood and is characterized by further epidermal hyperplasia, prominent sebaceous gland enlargement, and the persistence of ectopic apocrine structures. Primitive hair follicles continue to predominate.^[11] This stage is clinically significant because of the potential development of secondary adnexal neoplasms. Although the majority of these tumors are benign, malignant transformation may rarely occur. Benign neoplasms are reported more frequently and include trichoblastoma and syringocystadenoma papilliferum, which are considered the most common secondary tumors associated with nevus sebaceous. Malignant neoplasms are uncommon and most often include

basal cell carcinoma, followed less frequently by squamous cell carcinoma. Nevus Sebaceous of Jadassohn typically presents at birth or during early childhood as a solitary, well-demarcated, hairless plaque most commonly involving the scalp, face, or neck. Clinically, the lesion appears smooth, velvety, and slightly elevated in infancy, with coloration varying from skin-colored to yellowish-orange or light brown. Alopecia over the affected area is a characteristic finding, particularly in scalp lesions, due to the absence or incomplete development of terminal hair follicles. During puberty, hormonal stimulation leads to progressive enlargement and thickening of the lesion, resulting in a verrucous, papillomatous, nodular, or cerebriform surface texture. The plaque may become greasy or more prominently hyperkeratotic because of sebaceous gland hyperplasia. Although the lesion is generally asymptomatic, some patients may experience mild pruritus, irritation, crusting, or secondary infection, especially in traumatized lesions. In adulthood, secondary adnexal neoplasms may arise within the lesion, clinically manifesting as rapid growth, ulceration, bleeding, pain, color change, or development of discrete nodules. Rarely, extensive lesions may be associated with extracutaneous abnormalities involving the neurological, ocular, or skeletal systems as part of Schimmelpenning Syndrome. With respect to the risk factors, the primary “risk factor” is intrinsic and developmental rather than external, related to random genetic events occurring during embryogenesis. There is no proven association with parental age, infection, trauma, radiation exposure, or nutritional factors during pregnancy. However, lesions that are extensive or segmental may be associated with a higher likelihood of syndromic involvement, forming part of Schimmelpenning Syndrome, which includes neurological, ocular, and skeletal abnormalities. Additionally, although not a true risk factor for development, pubertal hormonal influence plays an important role in lesion progression, as androgen-mediated stimulation leads to sebaceous gland hyperplasia and clinical thickening during adolescence. Importantly, the risk of secondary neoplasms—most of which are benign—is related more to lesion duration and age rather than external risk exposures, with malignant transformation remaining rare overall.

References to *Charmakeela* are not found in Vedic or Pre-Vedic literature. Among the *Brihatrayi* texts, descriptions of *charmakeela* are available in the *Susruta samhita* and *Ashtanga Hridaya*.^[12,13] The earliest reference to *charmakeela* is found in the *Susruta samhita*. *Acharya Susruta* explained in detail its causes (*samprapti*), symptoms (*lakshana*) and treatment (*chikitsa*).^[14] Among the *Laghutrayi* texts, it is mentioned in *Madhava Nidana* and *Sharangadhara Samhita*. *Charmakeela* is a commonly seen clinical condition in general

practice. Its occurrence differs from person to person. It has been prevalent since ancient times and is mainly treated for cosmetic reasons. *Ayurveda* describes specific treatments for *charmakeela* and also aims to prevent recurrence. *Acharya Susruta* classified *charmakeela* under *kshudra roga* (minor diseases). Among skin disorders, warts are often considered harmless by the general public, yet they are known to resist many forms of treatment. According to *Acharya Susruta*, aggravated *vyana vata* along with *kapha* produces nail-like, immovable growths on the skin known as *Charmakeela* or *Charmaarsha*.^[15] These growths may cause pricking pain due to the influence of *vata*. *Kapha* causes the lesions to become knotty and similar in colour to the surrounding skin. When *pitta* and *rakta* are involved, the lesions may become dry, hard, black, or sometimes white and smooth to touch.^[16] It presents as a skin (*charma*) lesion that causes pricking pain like a nail (*keela*).^[17,18] The lesion may appear moist (*snigdhata*), similar in colour to the surrounding skin (*savarnata*), hard or nodular (*grathita*) and in advanced stages may develop into an ulcer with bloody discharge (*sarakta vrana*).^[19]

CONCLUSION

The congenital nature of Nevus Sebaceous further supports its understanding through the Ayurvedic concept of *Sahaja vyadhi*. Such comparative analysis helps bridge the gap between classical Ayurvedic dermatology and contemporary dermatological science, thereby improving conceptual clarity in integrative clinical practice. Study of *Kshudra roga* is highly important in present-day clinical practice because many benign and localized skin lesions encountered in modern dermatology may show similarities with classical Ayurvedic descriptions. Developing probable modern correlations for various *kshudra rogas* can aid in accurate diagnosis, better clinical interpretation and selection of appropriate Ayurvedic management principles. Furthermore, conceptual and scientific understanding of these conditions may open future scope for evaluating Ayurvedic treatment modalities in selected modern dermatological disorders, particularly in conditions involving chronicity, cosmetic concern and limited definitive management options. Hence, systematic exploration of classical concepts with modern clinical entities is essential for strengthening evidence-based Ayurvedic dermatology and promoting effective interdisciplinary healthcare approaches.

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