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Cutaneous pseudolymphoma, skin lymphoma or lymphoid papulosis

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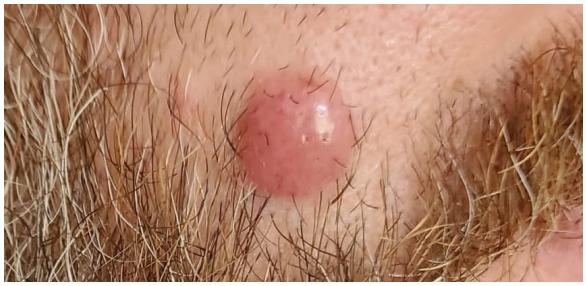

Figure 1. The skin lesion on the right cheek before excision

The terminology and classification of lymphoproliferative skin lesions is complex. It includes multivarious reactive conditions with diversified etiology and clinical picture. The cutaneous pseudolymphoma (PSL) term relates to a group of benign, reactive T- or B-cell lymphocyte-rich infiltrat. It is required to compare clinical presentation with histological findings to reach a correct diagnosis [1]. A wide range of causative agents (e.g. Borrelia, injections, tattoo, scars, arthropod-bite reaction) has been described, but most of the lesions are idiopathic [2]. Lymphomatoid papulosis is a benign, chronic T-cell lymphoma characterized by recurrent, spontaneously regressive papulonodular with tendency to necrotic lesions, often disseminated with histologic features suggestive of a CD30-positive lymphoma [3].

A 34-year-old male with a 12 mm firm lump on the right cheek without any specific signs or symptoms was referred by dermatologist with suspicion of cutaneous lymphoma, sarcoidosis or facial granuloma (fig.1). An incisional skin biopsy was nondiagnostic. The subsequent excisional biopsy indicated an ambiguous picture composed of a mixed population of lymphocytes with a predominance of small cells and the presence of histiocytes. Immunochemistry revealed a mixed population of T (CD3+) and B (CD20+) lymphocytes and a few small CD30+ lymphocytes (activated B and T lymphocytes with some atypic cells). Ki-67 proliferation index was 20–30%. The final pathology report revealed polimorphic lymphoid infiltration of T and B cell lines with the presence of atypical forms with immunoblast and centroblast morphology as well as single cells with multilamellar nuclei. Due to the lack of a granulocytic components, facial granuloma was excluded. A wide local excision of the residual lesion with the surrounding skin was undertaken. Preliminary pathology was suggestive of cutaneous pseudolymphoma, but the profound final pathology report was inconclusive, with a suggestion of either lymphoma or lymphomatoid papulosis, and a recommendation of further immunochemical analyses and incorporation of data from history and clinical picture.

The presented case illustrates the complexity of lymphoproliferative skin lesion diagnostics and the frequent lack of possibility in setting a final diagnosis despite all the available methods used.

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