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CUTANEOUS B-CELL LYMPHOMA

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Primary cutaneous B-cell lymphoma is associated with poor prognosis. But with low grade pathology it may have a good prognosis. A 32-year-old man presented with hyperpigmented patches over chest which on biopsy showed perivascular infiltrate and was treated as vasculitis. After 8 months he came again with multiple nodules and plaques with ulceration. Biopsy of the plaque showed evidence of B-cell lymphoma. With chemotherapy the patient died after 6 months. Retrospective study of the earliest biopsy showed atypical lymphoid cells. This emphasizes the importance of the dermatopathological interpretation at the earliest stage.

Key Words : B-cell lymphoma, Lymphoma

Introduction

Cutaneous lymphoma is a type of extranodal lymphoma in which the skin is mainly involved.[1] Nowadays the frequency of the primary cutaneous B-cell lymphoma seems to have increased, because of the usage of monoclonal antibodies.[2] Cutaneous involvement by B-cell lymphoma has been considered a sign of progression and dissemination of lymph node disease and thus associated with a poor prognosis.[3]

Case Report

A 32-year-old man reported in March 1992 with history of erythematous and slightly hyperpigmented patches over the chest and back of 10 days duration. On examination the condition was provisionally diagnosed as urticaria pigmentosa or as post-inflammatory pigmentation. A biopsy was taken from one of the chest lesions and under H & E the specimen showed a mononuclear perivascular infiltrate in the upper dermis. A diagnosis of lymphocytic vasculitis was suggested. The patient was given prednisolone 15 mg/day with dapsone 100 mg/day and chlorpheniramine maleate 25 mg b d. The patient was asked to come for follow up after a fortnight. On recurrence of the lesions patient consulted a private dermatologist and was prescribed inj. dexamethasone and antihistamine. Since he did not find any improvement, he sought help with alternative medicine for 40 days. His skin lesions got further aggrevated and he came to our hospital again 8 months after the first episode.

On examination patient had oedema of the face, upper and lower limbs. Axillary and horizontal group of inguinal lymph nodes were enlarged. They were discrete and tender. Blood pressure was 160/120 mm of Hg.

Dermatological examination revealed multiple erythematous hyperpigmented plaques distributed over the forehead, butterfly area of the face, neck, chest, back, abdomen, upper and lower limbs.

The plaques over face, cheek and chest were studded with papules and nodules (Fig 1). The plaque over the back was infiltrated. In one area it showed on oval depression with a peripheral induration. Biopsy was taken from one of the plaques over the face. The biopsy

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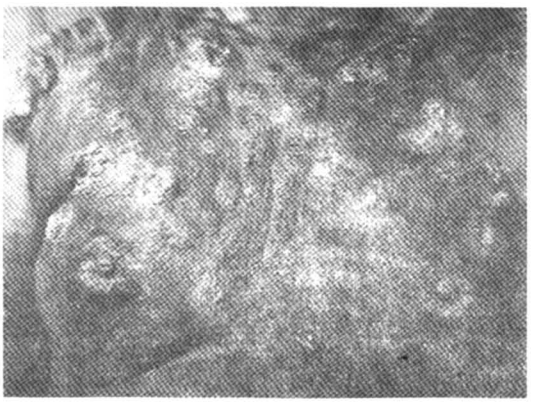

Fig . 1. Multiple infiltrated palques studded with papules and nodules over the chest.

showed a monomorphous infiltrate of large lymphoid cells throughout the dermis and subcutis with a clear zone. A retrospective study of the first biopsy slide showed atypical cells among the infiltrate (Fig 2).

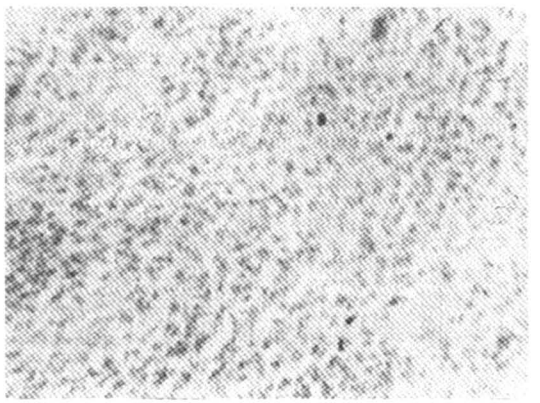

Fig . 2. High power view showing large lymphoid cells with mitotic figures and hyperchromasia (H&E).

Monoclonal antibodies for B-cells and T-cells were used. The majority of the infiltrate showed B-cell lineage. Chemotherapy was given with cyclophosphosphamide, methotrexate, vinctristine and betamethasone for 5 cycles. There was no improvement and finally patient died after the 6 months of hospitalisation.

Discussion

Involvement of the skin as a primary extranodal tumour site is one of the risk factors for shortened survival.[4] It was shown that poor performance status, advanced age, high grade pathology, a primary extranodal tumour site other than upper GI tract, or prior therapy (either surgery or irradiation) was significantly associated with shortened survial in a study of 82 cases of advanced B-cell lymphoma.[4]

Our case was characterised by monomorphic lymphoid cell infiltration throughout the entire dermis and subcutis; the infiltrate was composed of large lymphoid cells with a definite clear zone. The B-cell lineage was confirmed by monoclonal antibody technique.

Primary cutaneous B-cell lymphoma was sometimes recognized as a unique type of low grade lymphoma[5] and confused with pseudolymphoma. Multilobated T-cell lymphoma is a morphologic variant of peripheral T-cell lymphoma with a favourable prognosis. B-cell lymphoma also shows multilobated cells and is associated with a favourable prognosis.[6]

Our patient had three risk factors i.e., primary cutaneous lymphoma, high grade pathology and advanced stage. But if we had identified the abnormal atypical lymphoid cells with a clear zone around it in the earliest biopsy which was interpreted as vascultis, chemotherapy might have been instituted at the early stage.

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