H.K. Dermatol. Venereol. Bull. (2003) **11**, 222-223

Dermato-venereological Quiz

WS Lam 林渭新

This 36-year-old Chinese man presented with recurrent crops of slightly itchy spots over limbs for one year. Individual lesion resolved with crusting and subsequent post-inflammatory pigmentation. He was otherwise healthy and was not on any long term medication. Physical examination showed lesions mainly on limbs in various stages of evolution: discrete erythematous papules, pustules, crusting, desquamation, and post-inflammatory pigmentation (Figure 1). There was no lymphadenopathy or hepatosplenomegaly.

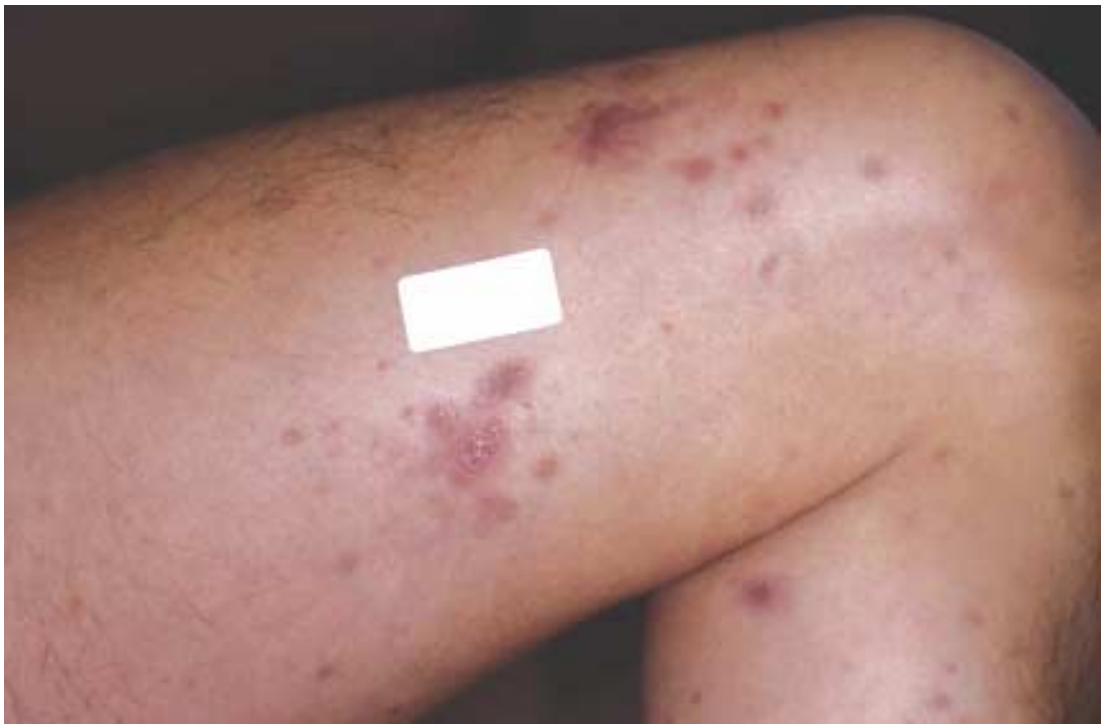

Figure 1.

Social Hygiene Service, Department of Health, Hong Kong

WS Lam, FHKCP, FHKAM(Medicine)

Correspondence to: Dr. WS Lam

Social Hygiene Service Headquarters, 3/F West Kowloon Health Centre, 303 Cheung Sha Wan Road, Kowloon, Hong Kong

Questions

1. What is the clinical differential diagnosis?
2. A skin biopsy was performed (Figures 2 & 3). What is your diagnosis?
3. What is the management?
4. What is the prognosis?

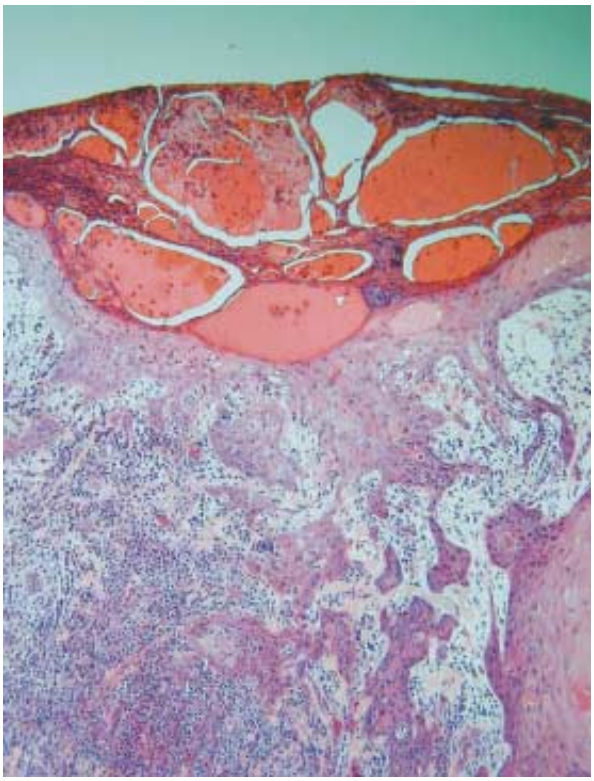

Figure 2. H & E, x 25.

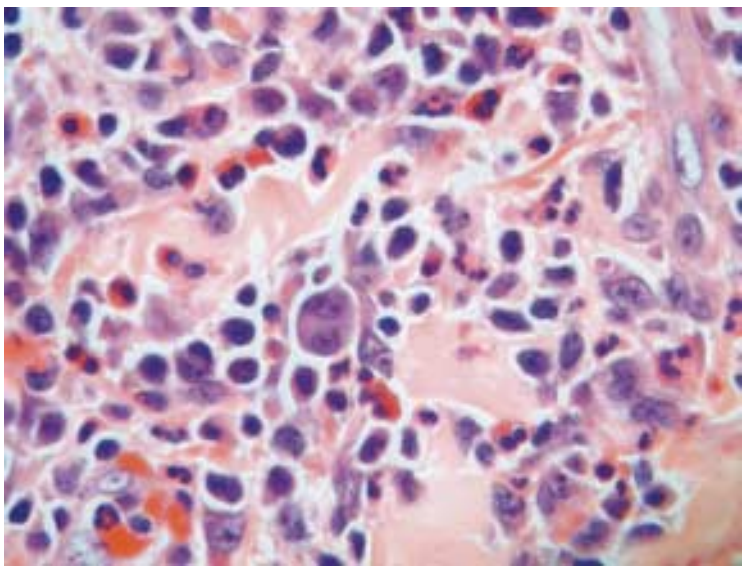

Figure 3. H & E, x 200.

(Answers on page 231)

Answers to Dermato-venereological Quiz on pages 222-223

1. The clinical differential diagnosis includes pityriasis lichenoides et varioliforms acuta, lymphomatoid papulosis, papulonecrotic tuberculids, cutaneous vasculitis, lymphoma cutis, and eczema.

2. The skin biopsy shows hyperplasia of the epidermis, with elongation of rete ridges. Encrustation and parakeratosis is seen on the surface. In the dermis, there are superficial and deep mixed cellular infiltrates, with epidermotropism. Some large cells with atypical nuclei and copious cytoplasm are seen. These atypical cells are confined to the dermis and are subsequently found to be CD30-positive. The histological diagnosis is lymphomatoid papulosis with pseudoepitheliomatous hyperplasia of epidermis. Thus, the patient has lymphomatoid papulosis which is also consistent with the clinical picture.

3. No treatment has been proven to be consistently effective and there is no evidence that treatment of lymphomatoid papulosis prevents the development of lymphoma. Most patients do not require specific treatment, apart from education and long-term regular follow-up. Treatment if given is symptomatic or suppressive. Topical corticosteroids are often prescribed. Systemic antibiotics like tetracycline or erythromycin or phototherapy may be effective in some patients. Low-dose oral methotrexate may be considered for severe or resistant cases.

4. The course of lymphomatoid papulosis is highly variable. It may remit in a few months or persist for decades. Moreover, it was estimated to be preceded by, coexistent with, or followed by lymphoma in 10-20% of cases. This malignant evolution cannot be predicted by clinical features, histologic findings, or clonality. The most common types are mycosis fungoides, Hodgkin's disease, and CD30-positive large cell lymphoma. Fortunately, the prognosis remains favourable if they are limited to the skin.