Case 10a

A 22 years old Thai female from Pijit

Chief complaint::

Expanding nodule on right ear and right periauricular area for 4 years

Present illness:

Four years ago, she had inflammation on her right ear after it was pierced. She was treated with seven-days of oral antibiotics and improved. She developed asymtomatic skin-colored expanding nodule on her right ear and periauricular area. She was treated with several injections of intralesional steriods and two times of excision with some degree of improvement but no complete remission so she was refered to Ramathibodi hospital.

Past illness:

No underlying disease. No history of taking oral pills.

Physical examination:

VS : T 37 C BP 120/80 mmHg, P 80/min

GA : A young Thai woman, not pale, no jaundice

HEENT: Right periauricular area and right ear – ill defined firmy lobular surface, slightly erythematous plaque on right pinna extending to postauricular area.

Two rubbery subcutaneous nodules with 0.8 cm on submandibular area.

Resipatory: Clear

CVS: Normal S1 S2, no murmur

Abdomen: Soft, no hepatosplenomegly

Histopathology: Dense diffuse, nodular infiltration of the cells composed of lymphocytes and eosinophils. Most of the cells tend to form lymphoid follicles.

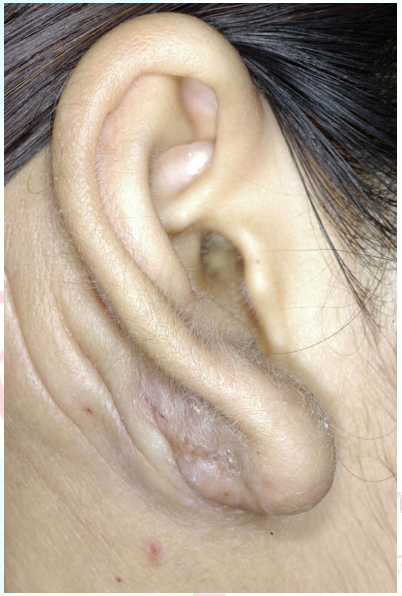

Fig 10a.1

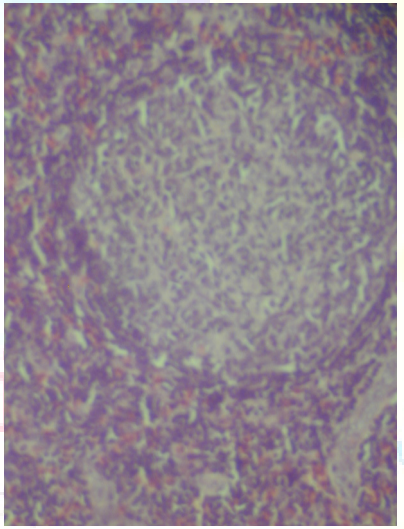

Fig 10a.2

Diagnosis : Pseudolymphoma

Presenter: Suthinee Kunkonkarn

Consultant: Siripen Puavilai

Somnuk Kamtavee

Case 10b

A 74 years old Thai man from Singha-buri

Chief complaint: Swelling of both earlobes for 15 years.

Present history: 15 years ago, the patient developed slightly pruritic papules at both earlobes.

The lesions became inflammed off and on without obviously precipitating factor and gradually enlarged over

many years. The symptoms were partially relieved by using clobetasol cream.

Past history:

The patient has underlying hypertension, ischemic heart disease s/p Coronary artery bypass graft.

Current medications: ASA, betalol, apressoline, omeprazole.

Family history: nil

Physical examination:

A Thai old man, looked healthy, not pale, not icteric.

lymph node not enlarged.

liver and spleen –not palpable

Skin examination:

Right and Left earlobes: ill-defined border, skin-colored infiltrative nodules.

Left temporal area: solitary, well-circumscribed, erythematous plaque with minimal induration with size about 2 cm. in diameter.

Histopathology: Dense diffuse lymphocytic infiltration with eosinophils forming germinal centers in dermis.

Investigations: CBC, BUN, Cr - normal values.
Anti-HIV – non-reactive.

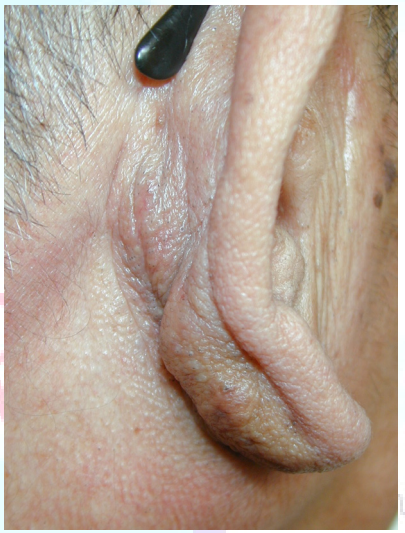

Fig 10b.1

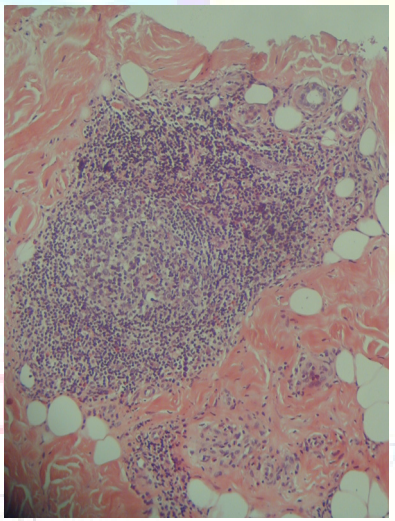

Fig 10b.2

Diagnosis: Cutaneous pseudolymphoma.

Presenter: Panunee Sudthikanung
Consultant: Siripen Puavilai

Discussion:

Pseudolymphoma is uncommon, but not rare, non-specific, B-cell predominated. Inflammatory response to stimuli is usually observed. It can occur at any ages, more common in female, about 2 times than male. In most cases, pseudolymphoma is idiopathic, but there are many reports showing association with exposure to antigens from arthropods, infections(HZV, *Borrelia burgdorferi*), tattoos, acupunctures, trauma, ear piercing, gold jewelry, nickel, vaccinations, hyposensitization injection. Some medications are also

reported; e.g. phenytoin, carbamazepine, phenobarbital, beta blockers, calcium channel blockers, ACEIs, allopurinol, penicillin, antihistamines, tricyclic antidepressant, etc.

The clinical manifestations typically present solitary nodule, various in size, firm in consistency, red-brown to violaceous in color, usually asymptomatic. About 1/4 of cases represent groups of nodules, plaques and papules in single defined region. Disseminated lesions are rare. The sites of predilection are face (~70%), upper parts of body, and genitalia.

To gain proper diagnosis, and to exclude lymphoma, biopsy and histopathological study are essential. The main affected site is a reticular dermis, showing dense nodular or diffuse lymphoid infiltrate, that tends to top-heavy and taper out in lower dermis.

Most infiltrative cells are small mature B cells, usually form to be follicles. Other admixed cells can be found, such as large lymphoid cells, tangible-body macrophages, histiocytes, dermal dendritic cells, Langerhans cells, plasma cells, eosinophils, mast cells, neutrophils.

Additional, capillary hyperplasia and endothelial swelling are also present.

Immunohistochemistry analysis shows B-cell predominant or mixed B-cells and T-cells.

Immunophenotypic feature is polytypic that is a mixture of kappa and lambda positive cells.

No bcl-2 oncoprotein is found.

Lymphoma, to differentiate from pseudolymphoma, is more bottom heavy, with adnexal infiltration, monomorphous, follicles are lack of cellular heterogeneity and macrophages. Immunophenotypic feature is monotypic or negative Ig.

Almost all of pseudolymphomas are benign. Idiopathic type is usually chronic and indolent, recurrence or spontaneous regression can occur in several months to years.

The evolution to lymphoma is also reported, may be subtle lymphoma from the onset is possible.

Treatments include removal of known causes (if exist), or eradicate infections.

For idiopathic, treatment is not mandatory, cures may be affected via surgical removal, cryosurgery, local irradiation, topical and injected glucocorticoids.

References:

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3. Zilinski I, Pseudolymphoma of the earlobes due to ear piercing. J Dermatol Surg Oncol 1989 ;15(6):666-8.
4. Gary S. Wood, Inflammatory diseases that simulate lymphomas:cutaneous pseudolymphomas, in Fitzpatrick's Dermatology in General Medicine, 6th ed, edited by Irwin M. Freedberg, et al. McGraw-Hill, 2003, p1567-1580