

## Generalized Reddish Skin Nodules

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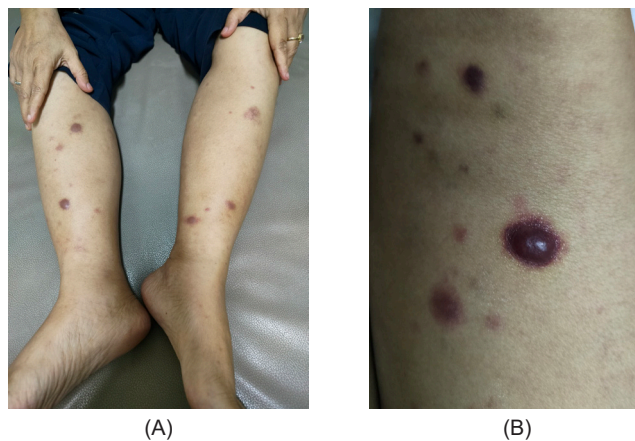
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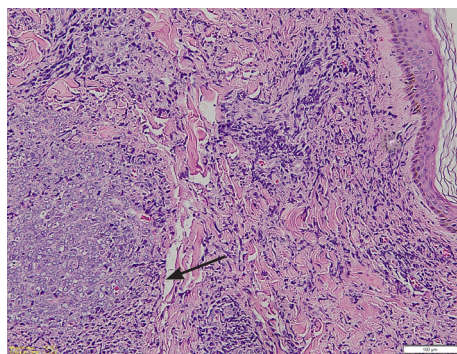
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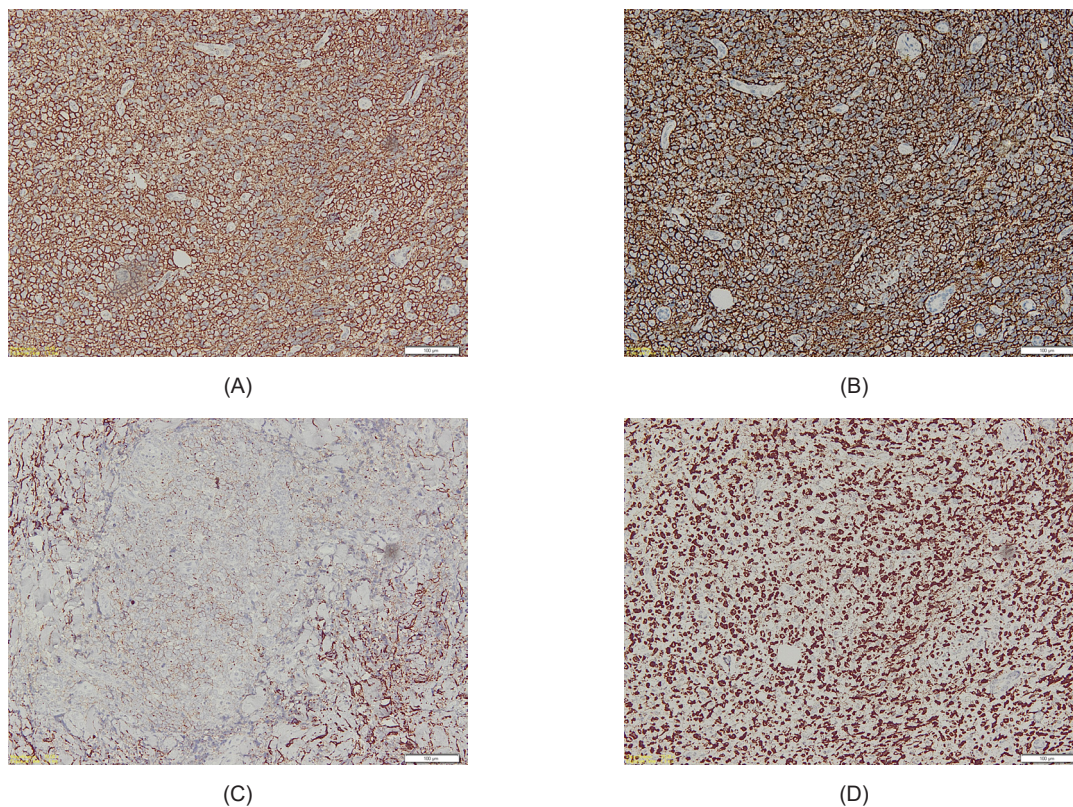
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**Figure 1.** Skin nodules on both legs (A), the reddish nodule (B).



**Figure 2.** Histopathology H&E stain of the skin biopsy (1:100).



**Figure 3.** The IHC stain (1:100) of CD45 (A), CD20 (B), CD10 (C) and Ki67 (D).

Diagnosis of nodular skin red lesions is challenging. The differential diagnosis includes dermal nevus, angioma, pyogenic granuloma, amelanotic melanoma, eccrine poroma, Kaposi's sarcoma, skin malignancy or metastasis.<sup>1</sup> Fully work up should be done to find the right diagnosis.

A 60 years old female admitted to our hospital due to generalized reddish skin nodules since one month. She had continuously high grade fever of 39 Celsius accompanied by arthralgia and fatigue since two months prior to admission and she lost 6 kg of weight in 2 months. She had visited a physician, diagnosed as erythema nodosum and was given low dose corticosteroid. On admission, physical examination revealed slight fever, pale conjunctiva, mild hepatosplenomegaly, non-tender reddish skin nodules from 0.3 to 2.0 cm with firm edge on her cheek, abdominal area and both lower extremities (**Figure 1**). No lymph nodes enlargement was noticed. Her laboratory test showed haemoglobin 9.1 g/dl, WBC 3,040/ $\mu$ L, PLT 149,000/ $\mu$ L, SGOT 48 U/L, SGPT 43

U/L, urea 12.5 mg/dL, creatinine 0.67 mg/dL. She was found to be non-reactive for HBsAg, HCV, and HIV antigens. Urine routine and microscopic examination was unremarkable.

Her histopathology of left foot nodule biopsy showed cutaneous lymphoma (**Figure 2 and 3**). It lined by stratified squamous epithelium, nuclei are within normal limit. Subepithelial consists of edematous fibrocollagenous connective tissue with dilatation of large blood vessel and bleeding. Round, oval, medium size tumor cells (arrow) are seen diffusely within stroma and nuclei with coarse chromatin; mitotic figures are noted.

The immunohistochemical (IHC) stain of CD45, CD20, and CD10 were positive, and Ki67 were also positive with >70% tumor cells, while CD3, CD56, CD30, and Granzyme were negative. Her final diagnosed was Cutaneous Diffuse large B cell lymphoma.

Primary cutaneous B-cell lymphoma (PCBCL) is a rare malignancy of primary B-cell lymphocytes in the skin with varied

clinicopathological, immunophenotypic and prognostic features. They may appear on the skin as a reddish rash, lump or nodular lesions.<sup>2</sup> Primary cutaneous lymphomas of B-cells occur less frequently than primary cutaneous T-cells lymphomas.<sup>3</sup> Primary extra-nodal diffuse large B-Cell lymphoma (DLBCL) can be seen in up to 40% of cases. However skin involvement is less common and in a large cohort of DLBCL cases, skin involvement at presentation was seen only in 3.3% of cases.<sup>4</sup> It characterized by few lesions, in general showing nodules or infiltrations of relatively fast growth and have no itching. The diagnosis is made by the immunohistochemical findings, clinicopathological correlation, and molecular pathology.<sup>5</sup> Cutaneous lymphomas have different clinical behaviours despite being identical in morphological appearance. Many types of cutaneous lymphoma start as flat red patches on the skin, which can sometimes be itchy. With darker skin, the patches may appear lighter or darker than the surrounding skin. In the early stages, the skin patches can look like other common conditions such as eczema or psoriasis. PCBCL tend to have lumps on their skin in 1 or 2 areas, rather than affecting all of the body. Local recurrence in PCBCL is up to 68% of the cases and with rare extra-cutaneous dissemination, with an average rate of 5-year survival varying from 89 to 96%.<sup>6</sup> Cutaneous B-cell lymphoma could become one of considered diagnosed of generalized skin reddish nodules even it is rare.

## REFERENCES

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