INTRODUCTION

Lymphocytoma cutis refers to a group of skin disorders that are characterized by lymphoproliferation, primarily T and B cell populations. These lesions are also referred to as pseudolymphoma to distinguish these benign lesions from malignant cutaneous lymphomas. The differentiation between pseudolymphoma and lymphomas requires careful histopathological evaluation and may even necessitate immunohistochemistry studies. The presentation of cutaneous B-cell pseudolymphoma (CBPL) includes a solitary red nodule or plaque in about 90% of patients, however about 10% of patients will present with multifocal diseases. Pruritis, edema and inflammation of the involved area are also common. The skin of the head and neck seems to be affected more than other parts of the body. The mainstay of treatment of CBPL is topical corticosteroids, intralasional injections may also be considered for lesions that do not completely resolve with topical injections.

CASE PRESENTATION

Ms. P is a 67-year-old female referred to our clinic for a 4.5 x 1.5-cm firm nodule located in the right temporal region. She complained of pruritis and bleeding, she denied any known history of trauma. The lesion was pink with areas of hyperpigmentation. It also appeared edematous and inflamed on the surface. Punch biopsy was taken that returned as lymphocytoma cutis. The lesion contained a dense cellular infiltrate of lymphocytes, eosinophils, a few plasma cells, and histiocytes in the dermis that spared the epidermis. There was no increase in mitotic activity noted, and tingible body macrophages were present.

TREATMENT

The patient was started on twice daily topical clobetasol for 5 weeks. On follow up, the lesion was 1 x 1.5 cm, but not completely resolved. The lesion was then injected with triamcinolone (10 mg per ml) for a total of 0.5 ml used at 4 separate injections around the periphery of the lesion. She was seen approximately 5 weeks after her intralesional injection and had complete resolution of the lesion.

CONCLUSIONS

Benign lymphoproliferative lesions should be kept in the differential for cutaneous lesions presenting in the head and neck. Once identified by careful histopathological exam, these lesions can be addressed with topical steroid creams. Lesions refractory to topical treatment can be managed with intralasional steroids.