

images and diagnoses

Skin involvement in a Hodgkin lymphoma

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Accepted for publication 3 June 2013

Hematol Oncol Stem Cell Ther 2013; 6(2): 68–70

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DOI: <http://dx.doi.org/10.1016/j.hemonc.2013.06.001>

Unlike non-Hodgkin's lymphomas in which skin involvement is well recognized, skin infiltration of Hodgkin's lymphoma (HL) is extremely rare and is associated with poor prognosis. We report a case of skin involvement in a case of HL. The skin lesions were completely healed after conventional chemotherapy.

In April 2008, a 22-year-old male farmer was referred to our department for further evaluation of cutaneous nodules spread on the chest. Family history revealed a sister treated for HL who was in complete remission at the time.

At the first consultation, the patient complained of a dry cough, chest pain, fever, drenching night sweats and pruritus evolving over a period of two months. The clinical examination showed a pale and tired patient who was breathless at rest. Multiple lymphadenopathies were found in the cervical, supraclavicular and axillae regions measuring 1–4 cm.

The inspection of the chest showed cutaneous lesions spread all over the thorax made of erythematous and infiltrated plaques; these were later found to be an agglomeration of nodules. These lesions were firm and painful at palpation (Figure 1). There was no hepatosplenomegaly.

The fine needle aspiration of the lymph nodes showed many lymphocytes and Reed-Stenberg cells (Figure 2). The lymph node and skin biopsies confirmed a diagnosis of classical Nodular Sclerosis of HL.¹

Computerized tomography and chest and abdominal scans showed a conglomerate of lymph nodes in the mediastinum measuring 77 × 31 mm, an osteolytic lesion of the sternum with thickening of the soft

tissues predominating in the pre-sternum region and porta hepatis node measuring 16 mm in diameter.

The complete blood count revealed a normocytic, normochromic anemia (Hb = 9.6 g/dl), WBC = 12,100 mm³, Neutrophils = 9200/mm³, Lymphocytes = 2200/mm³. The ESR was 100 mm in the 1st hour (Westergren method). Biochemical tests revealed a hyper- α 2-globulin and a hyper γ -globulin.

According to the Cotswold staging system, the patient was classified as "stage IV B with skin and bone involvement".¹ He was treated with eight cycles of conventional chemotherapy: ABVD regimen (Adriamycine, Bléomycine, Vinblastine and Dacarbazine).¹

At the end of the treatment, the cutaneous lesions healed completely (Figures 3 and 4), as well as in the adénopathies, the bone lesions and the B symptoms. The patient remains in complete remission and in good general health since the last follow-up.

The frequency of skin involvement is estimated between 0.5% and 7.5% in HL.^{2–4} Medina et al reviewed 150 cases of HL with extra nodal sites of invasion. Twelve (8%) of them had skin or subcutaneous tissue invasion during the course of their illness.⁵ Six out of the 12 skin lesions were located on the thorax.⁵ This location seems to be the most frequent as other sporadic cases on the chest have also been reported.

Skin lesions of cutaneous involvement of HL are classified as follows: (1) papules, (2) infiltrations or plaques, (3) nodules or tumors, (4) ulcerative lesions, (5) various combinations of these lesions, and (6) erythroderma.^{2–4} The most common clinical presentation is of single or multiple dermal or subcutaneous nodules, many of which grow progressively and some of which become ulcerated.^{3,4}

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Figure 1. At diagnosis (April 23, 2008).



Figure 3. After 4 cycles of ABVD (July 12, 2008).

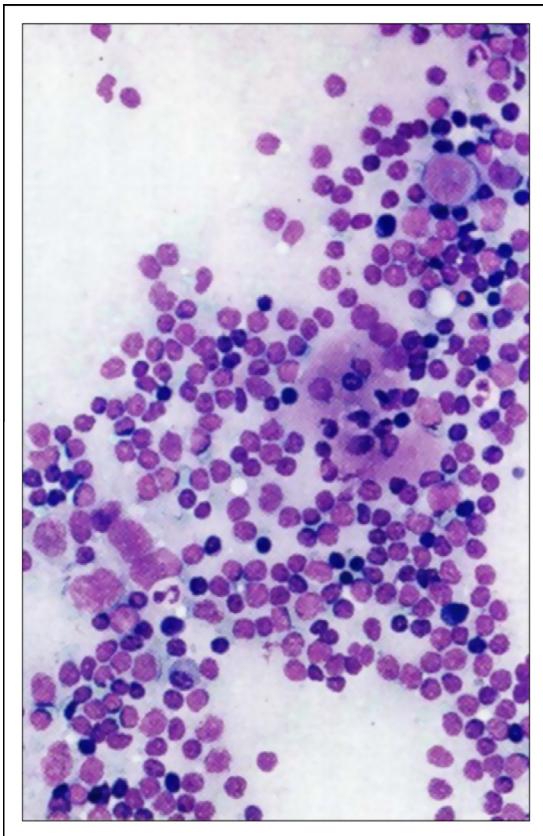


Figure 2. Fine needle aspiration smear of a lymph node showing many lymphocytes and Reed-Sternberg cells.



Figure 4. After 8 cycles of ABVD (February 7, 2009).

Skin invasion by HL has a poor prognosis in almost all documented cases.²⁻⁵ In the series of Medina et al., seven out of the 12 patients survived less than one year after the appearance of skin invasion.⁵ In other reported sole cases, the follow-up ranged from seven to 12 months after skin involvement.²⁻⁴ In our patient, cutaneous HL was confirmed in April 2008 and as of [Feb 2009] the patient was in complete remission.

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