Pseudolymphomatous folliculitis

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Abstract

Pseudolymphomatous folliculitis is a benign entity that is included within pseudolymphomas. Because of its rapid clinical growth and suspicious histology it has to be differentiated from malignant entities. Given its low frequency, the dermatoscopic characteristics of this entity are not well-characterized and have been described only once previously. We present a middle-aged woman with a facial erythematous plaque of 6 months' evolution, with dermatoscopy in which follicular plugs on an erythematous base were appreciated. The histology showed a dense lymphocytic infiltrate with folliculotropism and follicular alteration, with numerous peripheral histiocytes positive for S100 and CD1a. The lesion partially disappeared after the biopsy, and completely after topical treatment.

Keywords: pseudolymphoma, cutaneous lymphoid hyperplasia, lymphoma

Introduction

Pseudolymphomatous folliculitis is an infrequent variant of unknown etiology. It is a form of pseudolymphoma/ cutaneous lymphoid hyperplasia that must be distinguished from malignant entities. Given its low frequency, the dermatoscopic characteristics of this entity have not been established [1].

Case Synopsis

A 42-year-old woman presented with a 6-month history of an occasionally pruritic facial lesion. The patient reported progressive growth and fluctuating course, with episodes of inflammation. Physical examination revealed a well-delimitated, erythematous, infiltrated plaque of one centimeter in size on the left temple (**Figure 1**). On dermatoscopy follicular plugs over an erythematous base were observed (**Figure 2**).

A punch biopsy showed a normal epidermis and a dense dermal inflammatory infiltrate with perifollicular invasion, folliculotropism, and follicular distortion. The infiltrate was predominantly formed by T and B lymphocytes without atypia and with numerous histiocytes and perifollicular dendritic cells (CD1a+, S100+, and CD30-), (**Figure 3**). The immunoglobulin heavy chain gene rearrangement evaluation was negative. Based on the histologic findings the patient was diagnosed with pseudolymphomatous folliculitis. The lesion

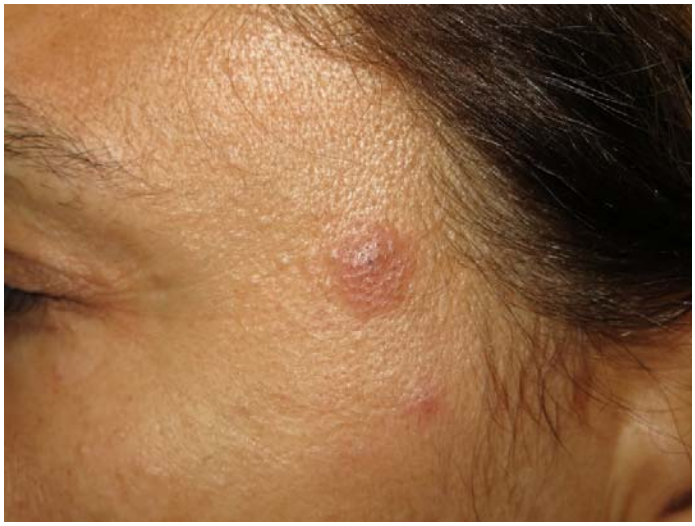

Figure 1. *Well-demarcated erythematous plaque of the left temple.*

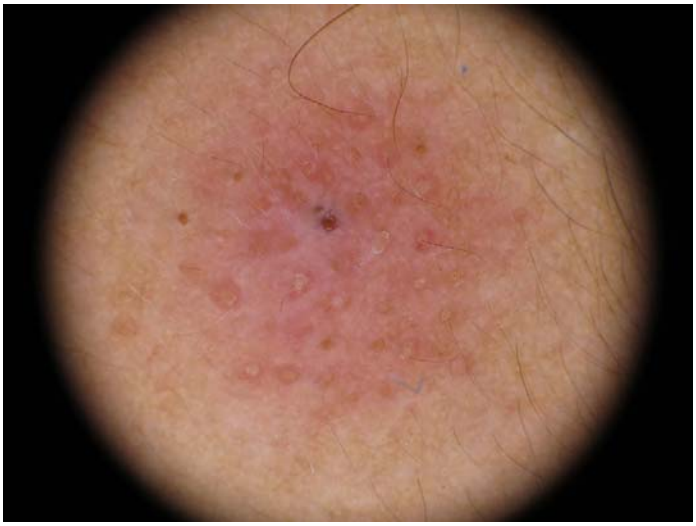

Figure 2. *Dermatoscopy with follicular plugs over an erythematous base.*

disappeared partially after biopsy and completely after topical corticosteroids and clindamycin for one month. There was no recurrence.

Case Discussion

Pseudolymphomatous folliculitis was first described by McNutt in 1986 as a variant of pseudo-lymphoma/cutaneous lymphoid hyperplasia. Since then, 90 cases have been described. It affects similarly both sexes and is more common in lower middle-aged patients (30-40 years). It has been postulated to be a delayed response to a follicular antigen, a lymphoid reaction to a follicle alteration, or even a form of atypical rosacea [2].

The typical presentation is as a rapidly growing centrofacial nodule less than two centimeters in size and asymptomatic, although there have been painful or pruritic cases. Only 9 cases (10%) manifested atypically as papules or plaques and 5 cases (5.6%) presented with multiple lesions. Only one article described dermatoscopy with prominent arborizing vessels, follicular red dots, and follicular and perifollicular yellow spots [1]. The clinical differential diagnosis generally includes other forms of cutaneous lymphoid hyperplasia and lymphoma.

Histology shows a mixed infiltrate with perifollicular distribution invading and altering the follicle. The infiltrate is predominantly composed of well-differentiated B and T lymphocytes mixed with

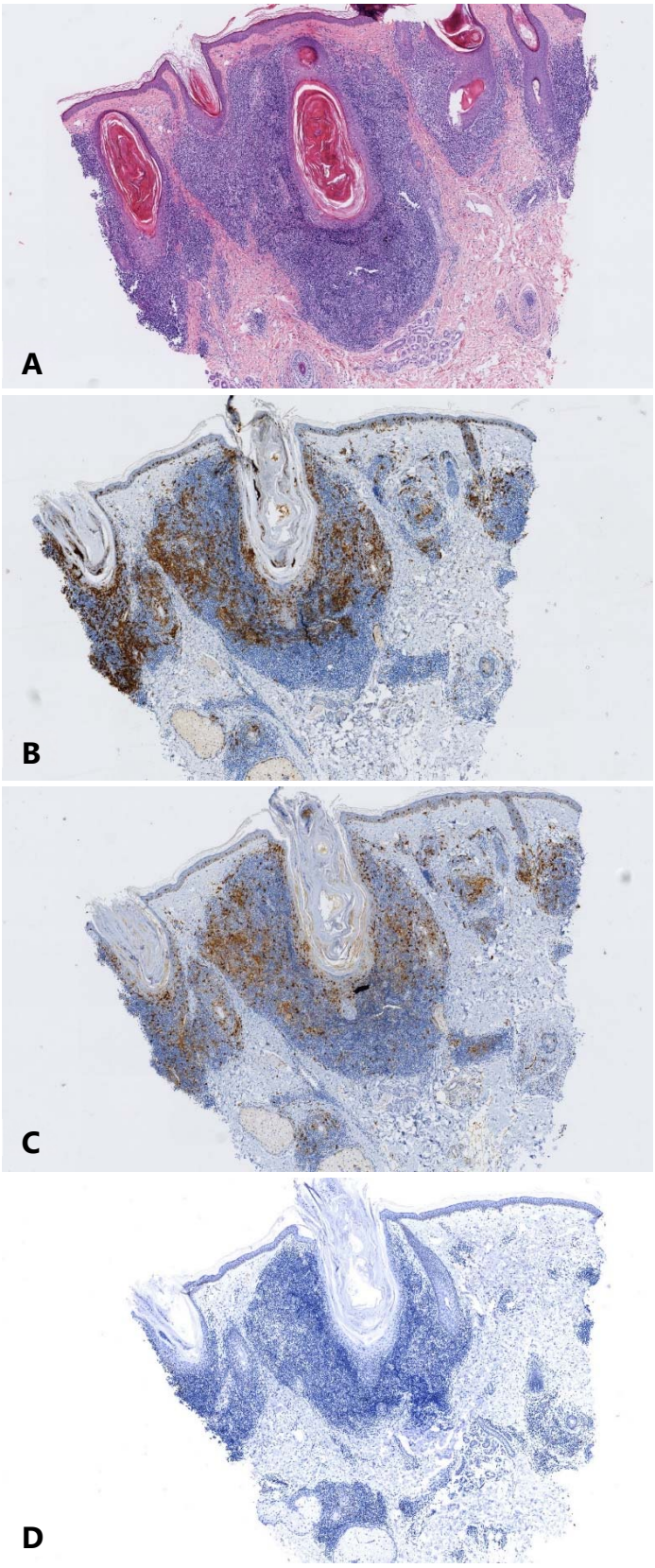

Figure 3. ***A)*** *Dense inflammatory infiltrate in the dermis with perifollicular invasion, folliculotropism, and follicular distortion. Immunodetection. H&E, 4×.* ***B)*** *S100 positive, 4×.* ***C)*** *CD1a positive, 4×.* ***D)*** *CD30 negative, 4×.*

histiocytes and dendritic cells. Hypertrophia, distortion, and destruction of the follicle can be seen, occasionally with reactive hyperplasia of the sebaceous glands. There have been cases with atypia, epidermotropism, and invasion of the subcutaneous fat or muscle. Diagnostic criteria include a dense nodular lymphoid infiltrate in the dermis and subcutaneous tissue and an increase in perifollicular histiocytes (S100+ and CD1+), [3].

The histopathological differential diagnosis should include lymphoma, which exhibits epidermotropism, light chain restriction, and lymphoid atypia. Although atypia can be seen in pseudolymphomatous folliculitis, this will be mild. Moreover, the infiltrate is composed of reactive macrophages, Langerhans cells, and dendritic dermal cells, all of them unusual in lymphomas. Another possible entity in the differential diagnosis would be follicular lymphomatoid papulosis, which is ruled out in our case by the non-recurrence of the lesion and by the negative CD30 immunostaining.

The majority of described cases in the literature have been treated with surgery and only three cases have exhibited recurrence [4, 5]. Given that pseudolymphomatous folliculitis is a benign, self-limited entity observation is generally adequate. Although clear spontaneous remission has not been described, many disappear after the biopsy. No cases of evolution to lymphoma have been described.

Conclusion

Pseudolymphomatous folliculitis is an infrequent entity that must be considered in the differential diagnosis with lymphoma and other lymphocytic infiltrates in facial nodules with rapid growth.

Potential conflicts of interest

The authors declare no conflicts of interests

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