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Cutaneous T-Cell Lymphoma in a Patient With Psoriasis

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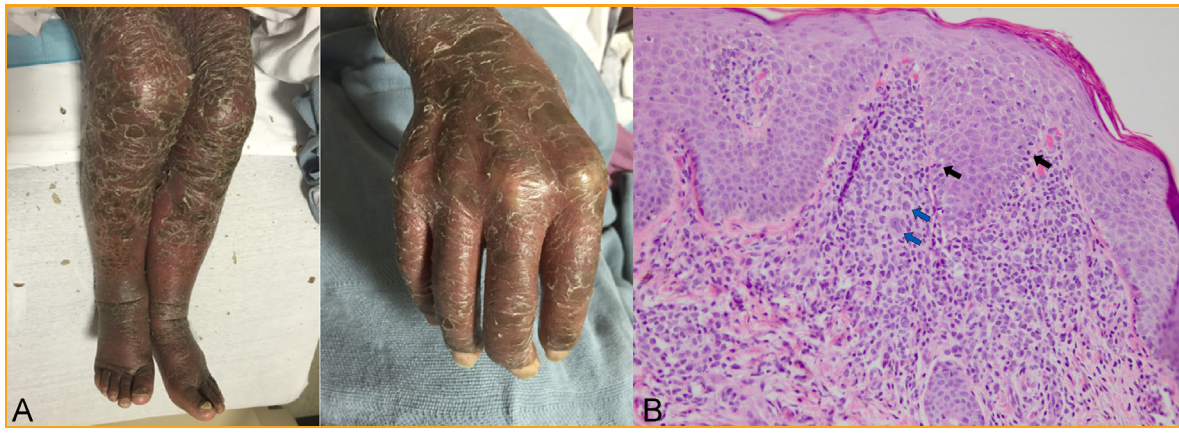

FIGURE.

CASE PRESENTATION

An 85-year-old male presented to the West Los Angeles Veterans Affairs Emergency Department with 3 weeks of diffuse, erythematous, scaly skin plaques covering greater than 90% of his body (Figure A). He was previously diagnosed with plaque psoriasis and polyarthralgia. Recent rheumatologic workup for this was suggestive of calcium pyrophosphate deposition disease and osteoarthritis, and he was started on colchicine and a prednisone taper 3 weeks prior. Within a week of completion of the taper, he developed a burning sensation of his skin, pruritus, diffuse scaling and peeling.

At the time of admission, his skin exfoliations involved greater than 90% of his body surface area. The dermatology service performed a punch biopsy. He was prescribed fluocinonide ointment for his body rash and hydrocortisone cream for his face. The rheumatology service evaluated him and deferred any systemic therapy until final biopsy results. His erythroderma and scaling improved, and he was discharged home on Hospital Day 4 with dermatology and rheumatology follow-up.

On pathological examination of the skin biopsy using hematoxylin and eosin stain sections the overall histologic and immunologic impression was highly suspicious for cutaneous T-cell lymphoma. There was perivascular and lichenoid lymphocyte predominant inflammatory infiltrate with scattered intermediate-sized atypical lymphoid cells within the superficial papillary dermis (Figure B, blue arrows). Scattered intermediate-sized atypical hyperchromatic lymphoid cells were seen haphazardly dispersed throughout the epidermis and focally "lining up" along the dermoepidermal junction (Figure B, black arrows). Further workup, including a second biopsy and gene rearrangement studies, were then sent to confirm the primary diagnosis.

Most frequently, generalized erythroderma is caused by exacerbation of a preexisting dermatitis or psoriasis.[1] Exacerbations can be triggered by systemic illnesses, emotional stress, ultraviolet exposures and the abrupt withdrawal of steroids.[2,3] Cutaneous T-cell lymphoma accounts for generalized erythroderma in only 3% of cases.[1]

This patient had a long-standing history of psoriasis and had recently completed a prednisone taper, a medication known to trigger erythroderma.[2,3] However, upon obtaining the biopsy results and following up with immunohistochemical tests, we concluded that cutaneous T-cell lymphoma was indeed responsible for his new symptoms. Since treatment of erythroderma hinges upon identifying and eliminating the causative factor, which necessitates an accurate diagnosis of the cause, the authors of this study recommend that etiology of erythroderma always be confirmed histologically, especially in patients with multiple potential causes.

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