A case of non-Hodgkin's lymphoma presenting as adult onset recalcitrant eczema

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Generalized pruritus is recognized as a dermatological manifestation of underlying malignancy, especially in the leukemia, lymphoma group. However recalcitrant eczema is not commonly known to be associated with malignancy. Patients with adult onset recalcitrant eczema without a history of contact allergy, drug ingestion, or childhood atopic dermatitis should not be labeled as having "idiopathic chronic dermatitis" but should repeatedly be examined for possible underlying causes.

The differential diagnosis of eczematous dermatitis includes contact dermatitis, drug reactions, infections and infestations, as well as atopic dermatitis. An appropriate evaluation will exclude those cases caused by irrtant dermatitis and allergic contact dermatitis. A review of medication and discontinuation of those frequently implicated is appropriate in drug-induced dermatitis. Atopic dermatitis begins during the first 5 years of life in 90% of patients and the majority of cases clear during adult life. Atopic dermatitis may reappear in adulthood, but the initial onset after 50 years of age is rare. After careful evaluation, the residual subsets of patients have been routinely termed as having "idiopathic chronic dermatitis". We describe a patient with "idopathic chronic dermatitis" who, after a thorough and repeated evaluation was found to have an underlying lymphoma.

Case report

A 53-year-old man presented with a 4-year history of eczema. He had been treated with oral and topical corticosteroids, oral antihistamines, and oral antibiotics without relief. The patient had no family or personal history of atopy. Examination revealed generalized erythema, scaling and excoriations. Repeated skin biopsy specimens revealed psoriasiform dermatitis.

Two years later he was treated for tuberculosis of the spine. Five months later painless reddish nodules appeared over his abdomen associated with loss of appetite and weakness. He had generalized lymphadenopathy with hepatomegaly.

Full blood count, ESR and biochemical tests were normal. Ultrasound scanning of the abdomen confirmed hepatomegaly with normal echopattern. Skin biopsy from a nodule showed hyperplastic stratified squamous epithelium and lymphoplasmacytic infiltration in the dermis. Lymph node biopsy revealed a non-Hodgkin's lymphoma. Bone marrow was infiltrated with lymphoma cells. He received chemotherapy. Follow up revealed that his eczema cleared following chemotherapy.

Discussion

Eczema antedated noncutaneous lymphoma by as long as 4 years and was refractory to topical and systemic corticosteroids. In our patient, peripheral lymphadenopathy and skin nodules suggested the diagnosis. Lymph node biopsy and bone marrow biopsy confirmed it. Our patient received systemic chemotherapy and eczema subsided.

Eczema other than erythroderma is not commonly linked to internal malignancy[1-3]. Generalized eczema craquele has been reported associated with lymphoma in two cases, and as the presenting symptom of adenocarcinoma in one case[2]. Nonspecific cutaneous manifestations of lymphoma leukaemia group include pruritus, purpura, exfoliative erythroderma, erythema multiforme and non-specific generalized morbilliform rash[3].

Our case illustrates the importance of through follow up of any patient with adult onset recalcitrant eczema in whom the cause is not clear. In the majority of cases the type of eczema such as asteatotic eczema, drug allergy, contact dermatitis and atopic dermatitis can be identified. However in a minority of patients with idiopathic chronic dermatitis regular follow up is suggested.

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We suggest that all patients with adult onset recalcitrant eczematous dermatitis, without a clear history of contact with allergens, drug ingestion, atopic dermatitis or other obvious etiology should not be labelled as "idopathic chronic eczematous dermatitis". A careful examination including palpation of the lymph nodes, liver and spleen is recommended. A complete laboratory evaluation including complete blood count with peripheral smear, chest x-ray, multiple skin biopsies, and biopsy of enlarged lymph nodes is suggested. Frequent follow up with repetition of this workup every 3-6 months may be necessary for the early definitive diagnosis of an underlying malignancy.

References

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