Three Sequential Lymphomatous Tumors in a Patient - Reader's Question

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Sir,

In their interesting case report, Choi et al.[1] described a series of lymphomas, namely, Hodgkin's lymphoma, mycosis fungoides, and marginal zone B‑cell lymphoma/chronic lymphomatous leukemia in a Singaporean patient. In view of the rarity of sequential tumors to develop in a patient, I presume that the authors ought to take into consideration defective immune status in the studied patient. Among defective immune states, infection with human immunodeficiency virus (HIV) is the leading. My presumption is based on the following point. It is obvious that immunocompromised patients are more susceptible to various types of tumors compared to healthy controls. The increased susceptibility has been attributed to different factors, namely impaired immunity, co‑infection with oncogenic viruses, and life extension due to the use of antiretroviral treatment.[2]

In Singapore, HIV infection is an important health hazard. The recently published data pointed out to 0.2% adult HIV prevalence rate.[3] Regrettably, the HIV status of the studied patient was not determined. Hence, arranging for HIV testing through the diagnostic set of CD4 lymphocyte count and viral load estimations were solicited. If these tests were to disclose HIV reactivity, the case in question could be truly considered a novel case report in Singapore. This is because sequential tumors in a HIV‑positive patient has been rarely reported in the world literature.[4]

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Conflicts of interest
There are no conflicts of interest.

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Three Sequential Lymphomatous Tumours in a Patient - Authors' reply

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Sir,

We thank the readers for their letter and comment. Indeed, defective immunity in an HIV‑infected individual predisposes one to the development of multiple tumors, especially hematological malignancies.[1] In this patient, an HIV antigen–antibody test (4th generation test for the p24 antigen and HIV antibody)[2] performed in 2016 after the diagnosis of small B cell lymphoma was found to be negative. We trust this clarifies.

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Sir,

Rosacea and seborrheic dermatitis are chronic inflammatory skin disorders that cause redness, scales, and itching in the face or scalp. The diagnosis of both the diseases is made mainly on the basis of clinical features. However, due to several similar clinical features of both the diseases, their differentiation is diagnostically challenging in some cases.

In this study, we clarified the clinical differentiation between rosacea and seborrheic dermatitis on the face based on dermoscopic findings. A retrospective chart review and photographic review of patients who visited the Department of Dermatology at Kyung Hee Medical Center, from January 1, 2015 to March 31, 2017 were performed. A Dermlite DL3 with polarized light (3Gen, Inc., San Juan Capistrano, CA, USA) (10-fold magnification) mounted on a Canon EOS 350D camera (Canon Corp., Tokyo, Japan) was used. Statistical analyses were performed using Fisher's exact test and by linear association test.

The study included 49 patients with rosacea and 30 patients with seborrheic dermatitis. Dermoscopic features of patients are summarized in Table 1 and illustrated in Figure 1. Background color, vascular morphology, and arrangement showed significant differences. The most frequently observed background colors were dark red (73.5%) in the rosacea group and pinkish (63.3%) in the seborrheic dermatitis group. Arborizing vessels (49.0%) in network-like pattern (59.2%) were the most common in patients with rosacea, and dotted vessels (36.7%) and curved vessels (33.3%) in patchy pattern (63.3%) were common in patients with seborrheic dermatitis. Scales were commonly observed in both the groups. No significant difference in the frequency of appearance of scales was observed. However, white scales with scattered distribution were common in rosacea and yellow scales with a patchy distribution were common in seborrheic dermatitis. Follicular plug, demodex tails, and demodex follicular opening were more common in the rosacea group.

Dermoscopy is a noninvasive in vivo imaging technique and can be used not only for pigmented lesions but also for inflammatory skin disorders.

Lallas et al. described dotted vessels and yellow scales in seborrheic dermatitis and vascular polygons in rosacea as useful dermoscopic criteria. Errichetti et al. suggested the dermoscopic hallmark of rosacea was linear vessels in a polygonal network. These results are partially consistent with our study in which arborizing vessels with network-like distribution were the most common in rosacea group, and dotted or curved vessels with patchy distribution were the most common in

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