A Rare Follicular Lymphoma Case: Relapsed with Skin Involvement

Mehmet Can Ugur¹, Alp Ozguzer², Dudu Kahraman Solakoglu², Gulden Diniz² and Cengiz Ceylan³

¹Izmir Tepecik Education and Training Hospital, Department of Internal Medicine, Turkey
²Izmir Tepecik Education and Training Hospital, Department of Pathology, Turkey
³Izmir Tepecik Education and Training Hospital, Hematology, Turkey

*Corresponding author: Mehmet Can Ugur, Department of Internal Medicine, Izmir Tepecik Education and Training Hospital, Turkey, Tel:+90 5058861126; E-mail: med.can@hotmail.com

Citation: Ugur MC, Ozguzer A, Solakoglu DK, Diniz G, Ceylan C (2016) A Rare Follicular Lymphoma Case: Relapsed with Skin Involvement. Gavin J Case Rep 2016: G117. DOI: 10.29011/2574-7754/100017

Received Date: 03 October, 2016; Accepted Date: 25 October, 2016; Published Date: 31 October, 2016

Abstract

Isolated cutaneous follicular lymphoma as are common; cases with isolated skin involvement are rare in the literature. We presented a relapsed follicular lymphoma case, initially diagnosed in cervical lymphnode, with skin involvement following the treatment.

A 70 year woman presented with cervical lymphadenopathy and she was diagnosed Follicular Lymphoma. A diagnosis of Follicular Lymphoma was made and the patient underwent 6 cycles of CHOP chemotherapy. The patient was admitted with abdominal lesions occurred in the preceding month. There were 2 lesions on the abdomen skin. Biopsy specimens obtained from skin lesions showed the similar results with the previous biopsy specimens obtained from lymph nodes. All these results pointed out the skin involvement of follicular lymphoma. The patient underwent 6 cycles of CHOP chemotherapy for the second course. Complete remission was obtained and the lesions disappeared. She has gone into complete remission for 5 months.

Relapsing FL involves usually lymphnodes and bone marrow while skin involvement is very rare. Our case is quite different from other cases in the literature by means of site of involvement and lack of CD20 expression. Although R-CHOP is recommended for the therapy, we gave 6 cycles of CHOP chemotherapy due to financial reasons and lack of CD20 expression. Lesions completely disappeared and this was a favorable prognosis.

Introduction

Follicular lymphoma (FL), classified under the headline of B-cell neoplasm by World Health Organization, is thesecondmost frequent neoplasm among Non-Hodgkin Lymphomas (NHL) in America and West European countries. It accounts for 20-25% of NHL and 70% of indolent Lymphomas. It is also the most common form of extra-nodal B-cell Lymphomas with a rate of 60% [1,2]. Although isolated cutaneous follicular lymphomas are common, cases with isolated skin involvement are rare in the literature. We presented a relapsed follicular lymphoma case, initially diagnosed in cervical lymphnode, with skin involvement following the treatment.

Case

A 70 year old woman admitted to our clinic with cervical lymphadenopathy in 2012. In Lymph node biopsy, neoplastic cells were negative for CD3, CD20, CD30, CD45 and Row here as neoplastic cells were strongly positive for CD79a and Bcl2 (Figure 1A and 1B). A diagnosis of Follicular Lymphoma was made and the patient underwent 6 cycles of chemotherapy of cyclophosphamide, vincristin, adria blastin and methyl prednisolone (CHOP). Bone marrow biopsy did not reveal any involvement.

Figures 1A and 1B: Microscopic image of lymphnode with H&E and lymphoid cell infiltration with immuno-histochemistry and Bcl-2 positivity. DAB.x200.
The patient was admitted to our clinic with abdominal lesions occurred in the preceding month. On examination, the vital findings of the patient were normal. In the physical examination, there were 2 pale red colored slightly elevated lesions with a diameter of 1-2 cm on the surface of the abdomen skin (Figure 2). Her complete blood cell count (CBC) showed leucocyte: 3500/uL, hemoglobin: 12.1 g/dL platelet: 194000/uL. In biochemical assessment, all the tests were within normal limits except for lactate dehydrogenase (LDH) with a level of 361 U/L.

![Figure 2: Pale red colored slightly elevated lesion with a diameter of 1-2 cm and the incision scar of the biopsy procedure.](image)

Abdominal, thoracic and cervical computerized tomography with contrast revealed multiple, solid, subcutaneous, ovoid and round shaped nodular lesions with the largest one of 26mm in diameter. These images are in concordance with soft-tissue involvement in a patient with lymphoma.

Biopsy specimens obtained from skin lesions showed the similar results with the previous biopsy specimens obtained from lymphnodes; neoplastic cells were negative for CD3,CD20,CD30,CD45 and Row here as neoplastic cells were

![Figure 3: Microscopic image: Patchynodular lymphoid infiltrates in dermis. H&E,x40.](image)

![Figure 4: Centrositcneoplast lymphoid cells together with small numbers of centroblastic neoplastic lymphoidcells.H&E,x200.](image)

Discussion

Follicular lymphomas, account for the majority of indolent lymphomas, is slightly more likely to be diagnosed in women than men [3]. FL might be presented as primary skin lesions but to our knowledge, only one case of relapsed follicular lymphoma with skin involvement was reported in the literature. Palacios Abufón A et al. reported subcutaneous lesions located on the face, chest and back in a patient with a previously diagnosed FL following splenectomy. In the biopsy specimen detection of CD20, Bcl2 and Bcl6 positivity was accepted as relapse [4]. It is similar with our case except for CD20 negativity.

Generally, 20% of patients with FL suffer from B symptoms at the time of diagnosis. Although it is characterized by nodal disorder, bone marrow involvement is present in 70% of patients at diagnosis and the other sites of involvements are not common [5,6]. In our case, being female gender and lack of extra nodal involvement except for skin are in accordance with the literature. In follicular lymphomas there are not any characteristic laboratory findings but elevated LDH levels and cytopenia are common as in our case [7].

Follicular Lymphoma International Prognostic Index (FLIPI) was developed by international cooperative studies in 1985 and 1992 to collect data on initial characteristics of a large number of patients with FL and to propose the long term survival of the patient. In this scoring system, the prognostic factors are age, stage, number of lymph node areas involved, serum hemoglobin and LDH levels [8]. The FLIPI score placed our patient into the high risk group.

As for the other lymphomas, diagnosis of FL is done by excisional biopsy. Bone marrow biopsy does not have diagnostic priority although it is an important part of the staging procedure [9]. While these tumor tissues express characteristically CD20 (or CD19), CD10 and BCL-6, they are negative for CD5 and CD23. The (14;18) translocation that inhibits apoptosis and bcl-2 gene over expression as seen in our case, are both pathognomonic for FL and can be detected in 89% of the cases [10,11]. The differential diagnosis has to be performed with cutaneous follicle center lym-
References

1. (1997) A clinical evaluation of the International Lymphoma Study Group classification of non-Hodgkin’s lymphoma. The Non-Hodgkin’s Lymphoma Classification Project. Blood 89: 3909-3918.

2. Senff NJ, Hoeffnagel JJ, Jansen PM, et al. (2007) Reclassification of 300 primary cutaneous B-Cell lymphomas according to the new WHO-EORTC classification for cutaneous lymphomas: comparison with previous classifications and identification of prognostic markers. J Clin Oncol 25:1581.

3. Armitage JO and Weisenburger DD (1998) New approach to classifying non-Hodgkin’s lymphomas: Clinical features of the major histologic sub types. Non-Hodgkin’s Lymphoma Classification Project. J Clin Oncol 16: 2780-2795.

4. Palacios Abufón A, Acebo Mariñas E, Gardeazabal García J, García-Ruiz J C (2012) Systemic Follicular Lymphoma with Cutaneous Manifestations and Exclusively Cutaneous Recurrence. Acta Dermosifiliogr 103: 253-255.

5. Fernándezde Larrea C, Martínez-Pozo A, Mercadal S, Gutierrez-Garcia G, Valera A, Ghi ta G, etal. (2011) Initial features and out come of cutaneous and non cutaneous primary extranodal follicular lymphoma. Br J Haematol 153: 334-340.

6. Federico M, Vitol uo L, Zinzani PL, Chisiesi T, Cló V, Bellesi G, et al.(2000) Prognosis of follicular lymphoma: a predictive model base don retrospective analysis of 987 cases. Intergruppo Italiano Linfomi Blood 95: 783-789.

7. Martin AR, Weisenburger DD, Chan WC, Ruby EL, Anderson JR, et al. (1995) Prognostic value of cellular proliferation and histologic grade in follicular lymphoma. Blood 83: 3671.

8. Solal-Céli gny P, Roy P, Colombat P, Josephine White, Jim O, et al. (2004) Follicular lymphoma international prognostic index. Blood 104:1258.

9. (1997) A clinical evaluation of the International Lymphoma Study Group classification of non-Hodgkin’s lymphoma. The Non-Hodgkin’s Lymphoma Classification Project. Blood 89: 3909.

10. Knut sen T (1997) Cyto genetic mechanisms in the pathogenesis and progression offolicular lymphoma. Cancer Surv 30: 163-192.

11. Morin RD, Mendez-Lago M, Mangall AJ, Rodrigo Goy a l, Karen L. Mangall, et al. (2011) Frequent mutation of histone-modifying genes in non-Hodgkin lymphoma. Or la H etal. responded well to dexamethasone, cytarabine, cisplatin (DHAP) combination [15]. Orla H, O’Mahony Annette Riley CD20-negative follicular lymphoma. Diagnostic Histopathology Volume 18, Issue 10, October 2012, Pages 457–460. Nature 476: 298.

12. Kalkanz G, Takçı Z, Akbay G, Giingör E, Uner A (2013) Primary cutaneous follicle center lymphoma Journal of Clinical and Experimental Investigations 4: 521-524.

13. Alvaro-Naranjo T, Jaen-Martinez J, Guma-Padro J, Bosch-Princep R, Salva- do-Usach MT (2003) CD20-negativeDLBCLtransformationafterrituximab treatment in follicularlymphoma: a new case report and review of the literature. Ann Hematol 82: 585e8.

14. Chu PG, Loera S, Huang Q, Weiss LM (2006) Lineage determination of CD20-B-cellneoplasms: animmuno-histochemical study. Am J Clin Pathol 126: 534e44.

15. Orla H and O’Mahony Annette Riley (2012) CD20-negative follicular lymphoma. Diagnostic Histopathology 10: 457-460.

16. Anderson T, Chabner BA, Young RC, Berard CW, Garvin AJ,etal.(1982) Malignant lymphoma. The histology and staging of 473 patients at National Cancer Institute. Cancer 50: 2699-2707.

17. Cetin M and Kabukcu Hacioglu S (2007) Follicular lymphomas. Turkiye Klinikleri. J Int Med Sci 3: 69-72.

18. Johnson NA, Boyle M, Bashashati A, Leach S, Brooks-Wilson A, et al.(2009) Diffuse large B-cell lymphoma: reduced CD20 expression is associated with an inferior survival. Blood 113: 3773e80.