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CLINICAL IMAGE

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Leukocytoclastic vasculitis in T-cell lymphoma

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Abstract

This case highlights the importance of looking for an occult malignancy when LCV is diagnosed clinically without any other signs suggestive of an infectious or autoimmune cause.

KEYWORDS

lymphoma, malignancy, vasculitis

A 61-year-old man presented to the emergency room with a 2-week history of a nonpruritic rash. The rash first appeared on his legs, spreading to his abdomen and bilateral arms. He reported night sweats, weight loss of 10 lbs, and anorexia over the past 2 months. He reported no new medications in the past 3 months. On examination, erythematous thin papules and plaques were noted on the dorsal feet and legs (Figure 1A), arms, and lower abdomen (Figure 1B). Skin biopsy revealed marked extravasation of erythrocytes in the superficial dermis (Figure 2), accompanied by a neutrophil-rich infiltrate with nuclear dust—findings consistent with leukocytoclastic vasculitis (LCV). Computed tomography (CT) of the chest, abdomen, and pelvis demonstrated ascites, splenomegaly, and nonbulky retroperitoneal lymphadenopathy. Lymph node biopsy revealed the diagnosis of angioimmunoblastic T-cell lymphoma (AITL).

The most common etiologies for LCV are infections (herpes, viral hepatitis, Streptococcus, or mycoplasma infections), autoimmune disorders (rheumatoid arthritis or systemic lupus erythematosus), and medications.[1] In 5% of cases, it can present as a paraneoplastic syndrome associated with lymphoid malignancies.[2-4] It is recommended that workup for the etiology of LCV should depend on the patient history.[1] As our patient had no other concerning history, he underwent workup to look for an occult malignancy. Although the pathogenesis of LCV-associated lymphoid malignancy remains unknown, the prognosis of paraneoplastic vasculitis depends on treating the underlying malignancy. As the patient is currently undergoing treatment with chemotherapy, it remains unclear if there will be complete regression of the vasculitis. This case highlights the importance of looking for an occult malignancy when LCV is diagnosed clinically without any other signs suggestive of an infectious or autoimmune cause.

CONFLICT-OF-INTEREST

No conflict of interest to declare.

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The author thanks Laura Pruitt for taking the photograph.

AUTHOR CONTRIBUTION

MYL: was involved in the diagnosis of the patient and wrote the manuscript.

ETHICAL APPROVAL

Patient consent was obtained for the photographs.

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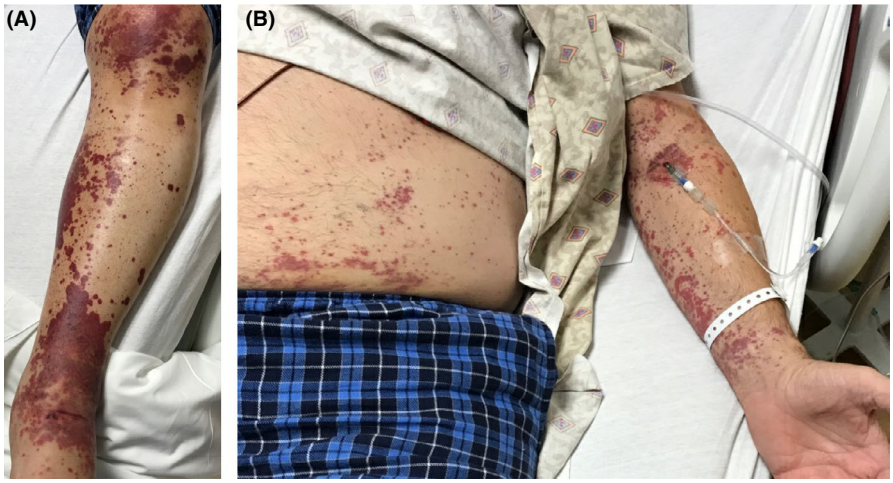

FIGURE 1 A, Erythematous thin papules and plaques on the dorsal feet and legs. B, Erythematous thin papules and plaques on the arms and lower abdomen

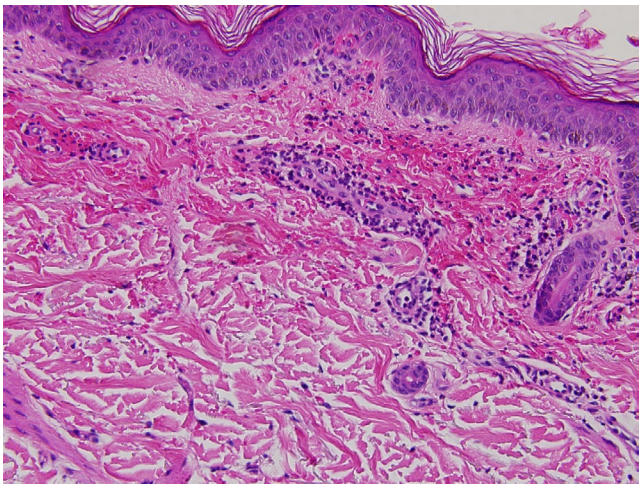

FIGURE 2 Marked extravasation of erythrocytes in the superficial dermis

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