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Case Report—Indurated Plaques and Recurrent Fevers in a 37-Year-Old Man: Challenge

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A 36-year-old previously healthy man presented to the ED with recurring fevers of unknown origin concurrent with a skin rash for 2 months.

The patient had no prior medical problems, and he did not take any home medications. He initially noted a violaceous, nontender, and nonpruritic plaque present on his lower back that spread to his flank, groin, and posterior neck. He also reported constitutional symptoms of fatigue, night sweats, loss of appetite, and an unintentional weight loss of about 7 kg in 2 months. The patient was previously seen by

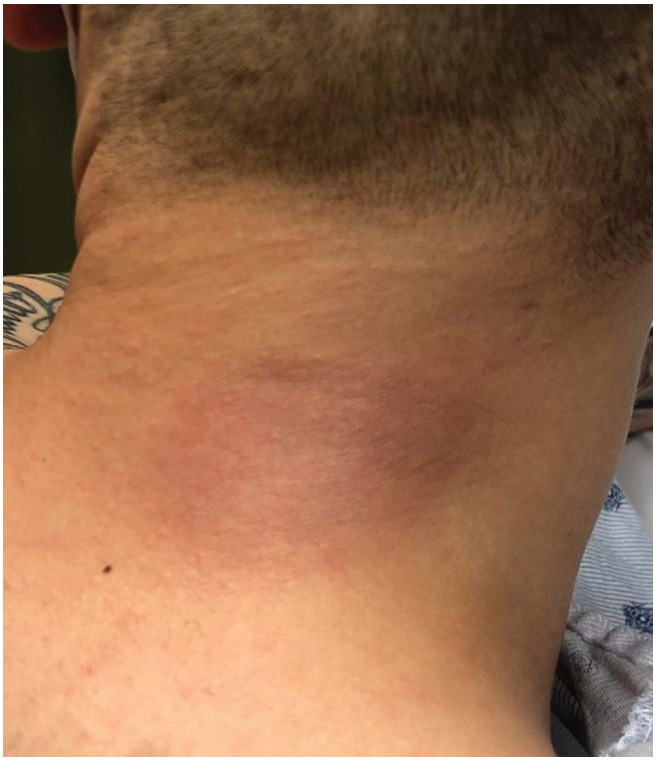

FIGURE. 1. Clinical image. Indurated, erythematous plaque on patient's neck.

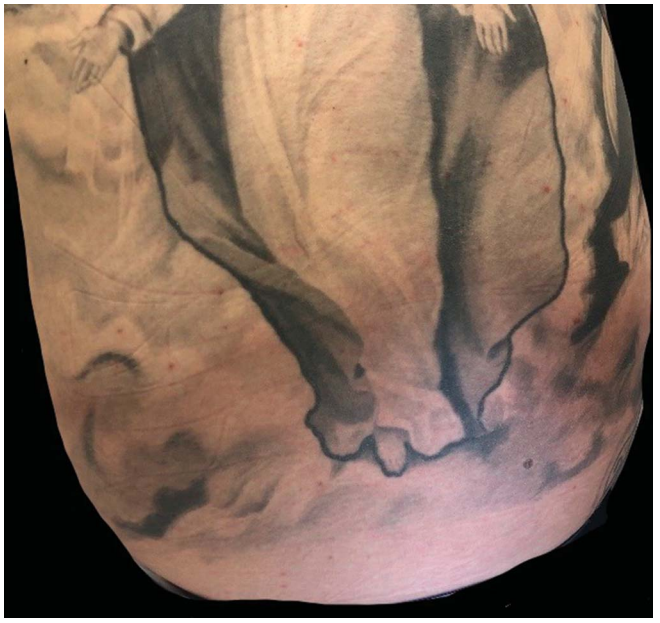

FIGURE. 2. Clinical image. Plaque on patient's lower back.

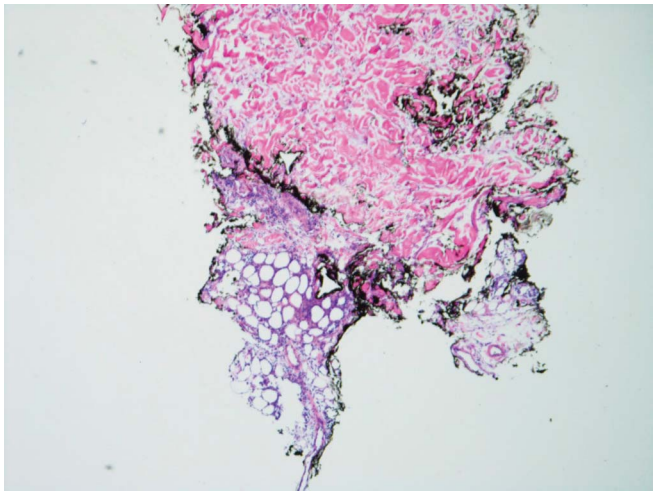

FIGURE. 3. Lymphocytic lobular panniculitis (hematoxylin & eosin; ×40).

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The authors declare no conflicts of interest.

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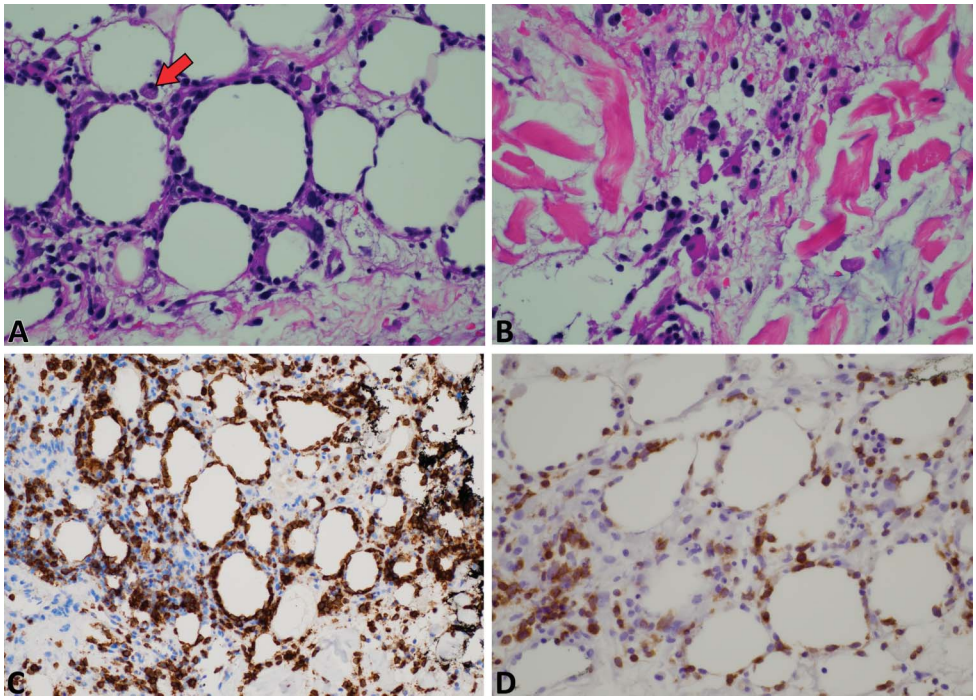

FIGURE. 4. Histopathology and immunohistochemistry. High-power images (×400), from left to right: (A) Rimming of adipocytes by hyperchromatic lymphocytes. Red arrow indicates hemophagocytosis (hematoxylin & eosin); (B) Hemophagocytosis (hematoxylin & eosin); (C) CD8, positive; (D) Beta-F1, positive.

his primary care physician and completed courses of ceftriaxone, trimethoprim–sulfamethoxazole, and clindamycin without resolution of fevers or skin changes. The clinical history was negative for autoimmune disease.

Physical examination revealed several erythematous, nonblanching, indurated plaques present on his lower back and hips, groin, upper abdomen, and the extensor surface of his neck (Figs. 1 and 2). All skin lesions were asymptomatic with no associated pruritus, pain, or purulence. No lymphadenopathy or organomegaly was noted on examination.

Histopathologic examination of a punch biopsy showed rimming of adipocytes by atypical lymphoid cells with hyperchromatic nuclei (Fig. 3). Prominent erythrophagocytosis was also noted (Fig. 4). Immunohistochemistry revealed positive staining for CD3, CD5, and CD8. Staining for the beta-F-1 chain of the alpha/beta T-cell receptor was positive. CD4, CD20, CD56, CD30, and S100 were negative. PCR for the delta chain of the T-cell receptor was negative.

Of note, laboratory data were significant for an extremely high ferritin level. Further testing revealed elevated transaminases, soluble IL-2R, LDH, and fasting serum triglycerides.

WHAT IS YOUR DIAGNOSIS?

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