



Lymphoma Erysipeloides[☆]

Fusun Zeynep Akcam^{a,*}, Onur Unal^a, Onur Kaya^a, Gamze Erkilic^b, Gul Ruhsar Yilmaz^a, Sirin Baspinar^b

^aSuleyman Demirel University Medical School Department of Infectious Diseases and Clinical Microbiology, Turkey

^bSuleyman Demirel University Medical School Department of Pathology, Turkey



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The human skin, being the largest organ of the body, is a barrier protecting us from the outer environment. Destruction of the integrity of the skin causes the start of skin and soft tissue infections facilitating the penetration of microorganisms. Just as remaining superficial and localized at the site of entry, microorganisms can also lead to focal and systemic infections spreading through blood and lymph ducts. Among the superficial and soft tissue infections, cellulitis and erysipelas progress with systemic infection findings with severe prognosis [1].

Apart from its barrier feature, the skin also supports our defense system with defensive cells [2]. The lymphatic tissue generated by the defensive cells contained within its structure can carry a tendency to canceration as in other lymphoid tissues in the body.

A 37-year-old male patient presented with erythema and pain in the right axillary region. The patient applied to a hospital when the first lesion, which started as a pimple five days prior to his application to our hospital, had spread and become painful within two days (Fig. 1). The patient was recommended fucidic acid + metronidazole treatment with a diagnosis of folliculitis, cellulitis. Upon experiencing spread in lesions under treatment and increase in pain, the patient was referred to our infectious diseases clinic. In line with our physical examination and laboratory findings, the patient was started on parenteral ampicillin sulbactam treatment



Fig. 1. Picture of the patient at the first inspection.

[☆] Attention to skin lesions that do not respond to antimicrobials
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* Corresponding author.

E-mail addresses: fusunzeynepakcam@gmail.com (F.Z. Akcam), onurunal_84@hotmail.com (O. Unal), dronurkaya@hotmail.com (O. Kaya), gamzecerak@gmail.com (G. Erkilic), ruhsar6@yahoo.com (G.R. Yilmaz), sirinbaspinar@gmail.com (S. Baspinar).



Fig. 2. The lesion was like cellulitis-erysipelas.



Fig. 3. The picture of progressing lesion despite treatment.

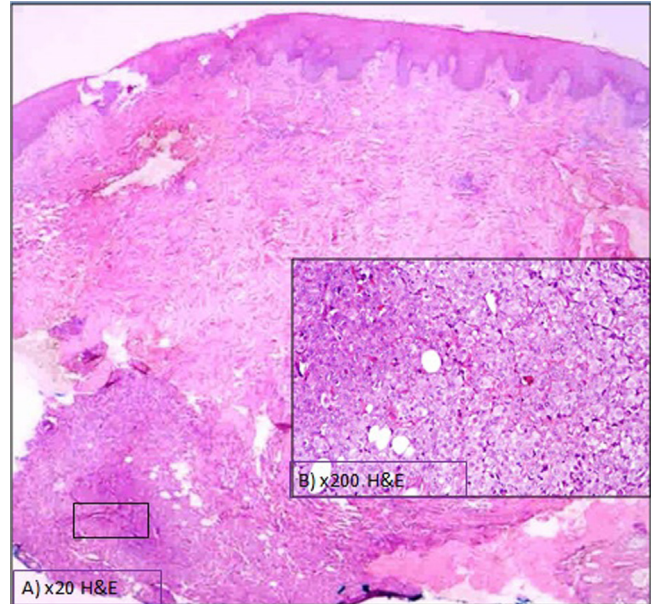


Fig. 4. The picture of pathological examination.

with a preliminary diagnosis of cellulitis-erysipelas (Fig. 2). Superficial tissue USG revealed solid lesions, largest with a 3-cm diameter, considered to be compatible with LAP showing multiplexed conglomeration on the right axillary region and subclavicular region, thickening of the cutaneous and subcutaneous tissue of the right chest wall, and edematous density changes in the fatty tissue. Clindamycin was added to the treatment regimen since edema and erythema tended to spread to the forearm and neck on the second day of treatment with sulbactam-ampicillin. Biopsy was planned for having not received any response to this treatment on its second day (Fig. 3), and the treatment was revised as meropenem + linezolid. Dermal biopsies were performed and samples were sent to microbiology and pathology with a preliminary diagnosis of granulomatous panniculitis, vasculitis, and carcinoma erysipeloid. The patient whose pathologic diagnosis was concluded as anaplastic large cell lymphoma (Fig. 4) was referred to the hematology clinic.

Skin lesions not responding to appropriate antimicrobial treatment should be investigated thoroughly.

References

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