

Lymphomatoid Allergic Contact Dermatitis Mimicking Cutaneous T cell Lymphoma

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Précis

We present a patient with an unusual groin eruption to highlight the importance of considering patch testing for patients who have atypical lymphomatoid reactions.

Discussion

A 68-year-old female was referred to us with a 10-month history of a pruritic pink patch that began on the left anterior thigh and spread to involve the buttocks, lateral thighs, and genitals. The patient noted the rash to be associated with her wearing of panty hose. The eruption responded partially to treatment with betamethasone dipropionate 0.05% ointment. A biopsy specimen revealed a superficial and deep perivascular lymphoid infiltrate with a palisading granulomatous response. This nondiagnostic histology originally raised concern about a cutaneous T-cell lymphoma (CTCL); however, subsequent flow cytometry results were negative. Given the relationship of the rash to clothing, allergic contact dermatitis was considered. The patient was patch-tested with the Tufts standard, preservative, fragrance, rubber, and textile series. Readings were performed at 48 hours and 72 hours. At 72 hours, her clinically relevant reactions included + reactions to Reactive Black 5, Reactive Blue 238, Reactive Red 238, carba mix, and diphenylguanidine.

The combination of positive reactions to textile dyes, rubber additives, diphenylguanidine, and carba mix with the location of her rash suggested that dyes and rubber additives in the patient's underwear and panty hose were contributing to her symptoms. The patient was counseled to wear white elastic-free underwear and to avoid garments, such as girdles and pantyhose, that could contain her rubber aller-

gens. After she adhered to these instructions, her rash resolved.

The superficial and deep lymphoid infiltrates originally raised the possibility of CTCL in our patient. Lymphomatoid contact dermatitis (LCD) can mimic cutaneous lymphoma both clinically and histopathologically. The histologic pattern was originally described by Orbaneja and colleagues in a report on four patients who had allergy to the striker surface of a matchbox.¹ Since then, LCD has been reported with ethylenediamine, phosphorus sesquisulfide, mercaptobenzothiazole, N-isopropyl-N-phenyl-phenylenediamine (IPPD), and azo dyes, among other allergens.²⁻⁴ It has been suggested that the diagnostic determination of LCD should include a localized eruption indicative of contact dermatitis clinically, CTCL-like histologic findings, positive patch-test results, and clearance of the lesions with corticosteroids and avoidance of the allergen.¹ Our patient's case met all four criteria. To our knowledge, this is the first report of LCD resulting from hypersensitivity to diphenylguanidine, a component of carba mix.

Pearl

This case highlights the importance of recognizing non-eczematous forms of allergic contact dermatitis, which can easily be determined by patch testing, thereby avoiding unnecessary work-ups for systemic disease and limiting costs and anxiety for the patient.

References

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