We writing to make some comments on the diagnostic and clinical evolution of the case described in the correspondence entitled “Papuloerythroderma of Ofuji associated with chronic lymphatic leukaemia”, recently published in your journal [1].

A patient was studied for his skin lesions by the dermatology department. A papuloerythoderma of Ofuji (PEO) was considered in the differential diagnosis by the dermatology department. Tuberculosis was diagnosed by the infectious disease department. Treatment with rifampicin, isoniazid, pirazinam was started. Rifampicin was soon withdrawn due to toxicoderma. The patient finally completed 12-months of second line treatment against M. tuberculosis.

In the meantime, the patient was evaluated in the internal medicine ward for fever and pruritus. A bone marrow biopsy was indicated during this first hospitalization with us. The revised pathology reported a nodular, not diffuse, infiltration by B lymphocytes. The cytometric study revealed the immunophenotype: CD19+, CD20+, CD5+, CD21−, CD22+, CD23+/−. It was not blood expression. The hemogram just revealed hemoglobin of 9.4 g/dL and the Coombs test was negative. The patient was followed without any specific treatment and 15-months. Later on the patient was again admitted to our ward with fever and itchy skin. This time huge cervical lymph nodes and bilateral hilium lymph nodes were viewed on the thorax CT. The hematological study showed similar parameters. A lymph node biopsy showed a large B-cell non-Hodgkin lymphoma (NHL). Specific chemotherapy was started with good clinical tolerance.

The precise etiology of PEO is still unknown. It could be considered as a clinical syndrome caused by multiple underlying conditions, including paraneoplasia in lymphoma [2, 3]. A recent work of Sugita et al. [4] highlighted T lymphocyte transformations associated to a drug induced papuloerythroderma. Both tuberculosis and NHL are well documented conditions with T-cell immune dysfunctions. The association of PEO preceding pulmonary tuberculosis has not yet been described. PEO preceding NHL has been described even more rarely [5].

In conclusion, PEO could be a paraneoplasia manifestation of an underlying tumoral condition or a systemic infection associated to T-cell alterations.


References