Rapidly evolving ulcer in the groin

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CASE REPORT

A 77-year-old woman was referred for evaluation of a left groin wound (*Fig. 1*) that began as an abscess two weeks ago. She already had a normal blood test. An ultrasound of the groin showed several swollen glands on the left side. Antibiotic treatment did not improve the condition. A week ago the lesion had ruptured spontaneously. She reported no general symptoms.
Clinically, a 5-centimeter necrotized ulceration was observed in the left groin.

Fig. 1 Wound in the left groin

Histological examination showed an infiltrate consisting of CD20+ cells, this implies B-lymphocytes, and numerous EBV positive cells on Epstein-Barr Encoding Region (EBER) staining (*Fig. 2*). These findings were consistent with an EBV-driven lymphoproliferative disorder with a preference for an Epstein Barr virus-positive (EBV+) diffuse large B-cell lymphoma (DLBCL). PET-CT and bone marrow examination were done to distinguish from aggressive lymphoma. Rituximab monotherapy was initiated after PET-CT revealed a hypermetabolic mass in the left inguinal region. CD10+ cells were found in the bone marrow. Staging classified the patient as stage IV. Due to no response to rituximab, CHOP therapy was started. Radiotherapy may follow R-CHOP if the wound responds well and therapy is tolerated.

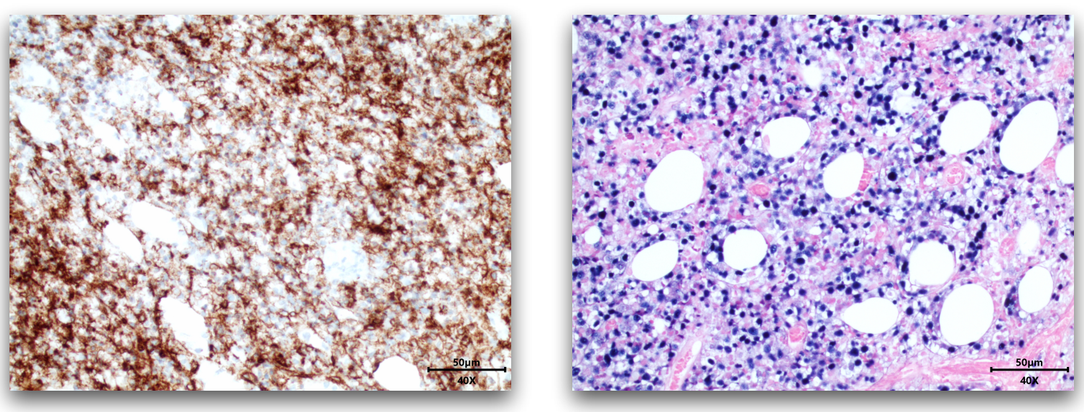

Fig. 2 CD20 staining (left), EBER staining (right)

BACKGROUND

EBV+ diffuse large B-cell lymphoma (DLBCL) is rare and mainly affects individuals over 50 without immunosuppression[1]. It typically represents a more difficult to treat type of aggressive lymphoma than its EBV negative counterpart. Initial treatment options may involve rituximab alone or combined with anthracycline-based chemotherapy such as CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)[2].

HOW TO DISTINGUISH FROM AN EBV+ MUCO-CUTANEOUS ULCER?

EBV+ mucocutaneous ulcer (EBV+ MCU) was less likely due to the extensive nature of the lesion, aggressive course, large underlying glands, and absence of clear immunodeficiency. The patient's circulating CD10+ monoclonal B-cell lymphocytosis suggests limited bone marrow involvement. EBV-MCU typically has a good prognosis, with 25% experiencing spontaneous regression of ulcerations[2].

HOW TO DISTINGUISH FROM A CD30+ LYMPHO-PROLIFERATIVE DISORDER?

CD30+ cells are also present histologically in both EBV+ MCU and EBV+ DLBCL. It is important to know that CD30 is expressed on activated B and T cells. In addition, there is also an increase in CD30 expression in inflammatory skin conditions. The key to making the distinction in many cases is the clinical presentation (aspect, localization, evolution, aggressiveness).

Within the spectrum of CD30+ cutaneous lymphomas, a distinction must still be made between lymphomatoid papulosis, a large cell anaplastic lymphoma or a tumoral phase of a mycosis fungoides.

Lymphomatoid papulosis is characterized by a recurrent and self-limiting course of (often grouped) papules. For comparison with our case, you can see a case of ulcerated lymphomatoid papulosis in *Fig. 3.* Cutaneous or systemic anaplastic lymphoma involves larger lesions (>3 cm) that are usually located on the head or extremities. A tumoral MF can usually be identified by the evolution of the lesions (first patch/plaque stage)[3].

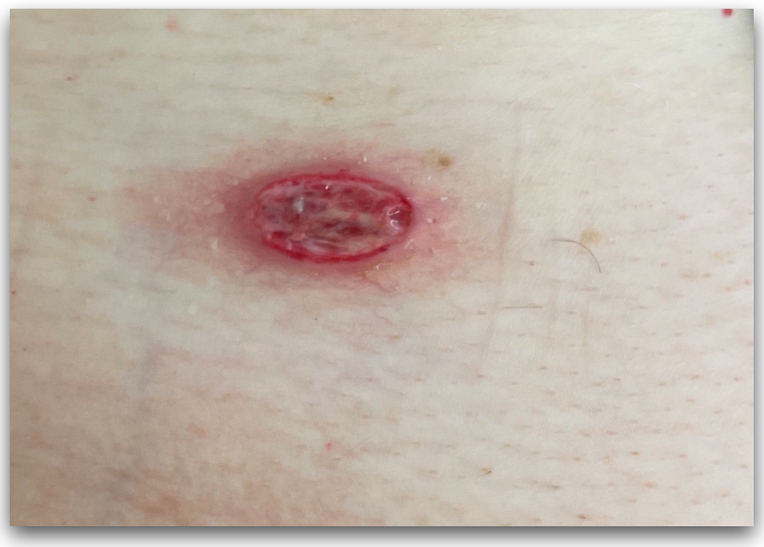

Fig. 3 Ulcerated lymphomatoid papulosis in the groin

KEY MESSAGES

→ Think about the possibility of a (ulcerating) lymphoma in a rapidly evolving wound.
→ When histologically an EBV+ DLBCL is seen, an EBV+ mucocutaneous ulcer should always be considered.

REFERENCES

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