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Letter to Editor

Internal Medicine Section

Hodgkin's Disease Presenting with Chronic Pruritis and Cutaneous Involvement

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Sir,

Hodgkin's disease (HD) involving the skin is very unusual and most often it is secondary to retrograde lymphatic spread from involved lymph nodes. Skin involvement in the absence of systemic evidence of HD is extremely rare [1]. When it occurs, retrograde lymphatic spread, direct extension from the underlying lymph nodes, and hematogenous dissemination is the mechanism usually implicated [2]. In contrast to non-Hodgkin lymphoma subtypes, skin involvement of HD is extremely rare. Furthermore, the prognosis, when cutaneous involvement is present, is felt to be extremely poor in HD [3]. Herein, we present a case of HD who presented with chronic pruritis and cutaneous involvement in the absence of its systemic symptoms and also with normal hematological parameters. The diagnosis was made by clinical suspicion and carefully examination of peripheral lymph nodes.

A 29-year-old woman was admitted to our hospital with generalized pruritis and ulcerated lesions of the skin, especially on her neck, upper extremities, shoulders and facial areas. She was referred to dermatology and psychiatry clinics because of these complaints many times. Her complaints were not responded to antihistamine and antidepressant treatments. Fatigue and constant drowsiness were added to the existing complaints for six months. At the time of admission, physical examination of the patient's vital functions were: 110/70 mmHg tension arterial pressure and 86/min pulse. (She was pale and had cervical lymphodenopathy the largest one being 2 cm. The laboratory findings of the patient were as follows: hemoglobin 9.2 g/dl, hematocrit 32.6 %, MCV 61, leukocyte 14300/l (neutrophil 62%, lymphocyte 27%), platelets 391000/l. Hepatitis and viral serologic markers such as EBV and CMV were normal. The other laboratory and physical examination findings were unremarkable. Chest radiograph revealed multiple nodular lesions both in lungs. five hypodens central echogenic solid lesion the largest one being 14 mm diameter were seen on by abdominal ultrasonography. On neck ultrasonography, multiple lymph nodes were seen and the largest lymph node on the right cervical area was 17x8 mm and 19x7 mm on the left cervical region. Fine needle aspiration biopsy of cervical lymph nodes was performed twice later but the diagnosis was not established and excisional biopsy was performed. Biopsy result was consistent with mix cellular type Hodgkin's lymphoma. Malignant cells were found to be infiltrated in bone marrow biopsy. Skin biopsy of the ulcerated lesions in neck also revealed Hodgkin's lymphoma. We found Reed–Sternberg's cells and Hodgkin's cells with CD15+, CD30+ and CD20-, CD45- cell phenotype in both lymph nodes and the skin lesions. The patient was diagnosed as HD with cutaneous involvement. She was treated with ABVD chemotherapy regimen. After the first course of treatment her pruritis and cutaneous lesions regressed. The patient was discharged and eight-cure chemotherapy was scheduled.

Cutaneous HD is a rare condition that usually occurs late in the course of HD. This rare condition is thought to have decreased in incidence in recent decades, likely owing to improved treatment of patients with HD, who are receiving improved chemotherapy and radiation therapy, and with the advent of peripheral blood stem cell transplantation [4,5]. In conclusion, cutaneous symptoms of HD are not uncommon and non-specific but involvement of the skin is an uncommon, which represents advanced disease. Interestingly, the classic symptoms of HD in our case were not available, only symptom of our patient was generalized pruritis, which was resistant to conventional treatments and also with normal hematological parameters. Therefore, HD should be kept in mind, for patients with generalized pruritis and examination of peripheral lymph nodes and lymphatic organ should be done carefully even if the patient has normal hematological parameters.

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