

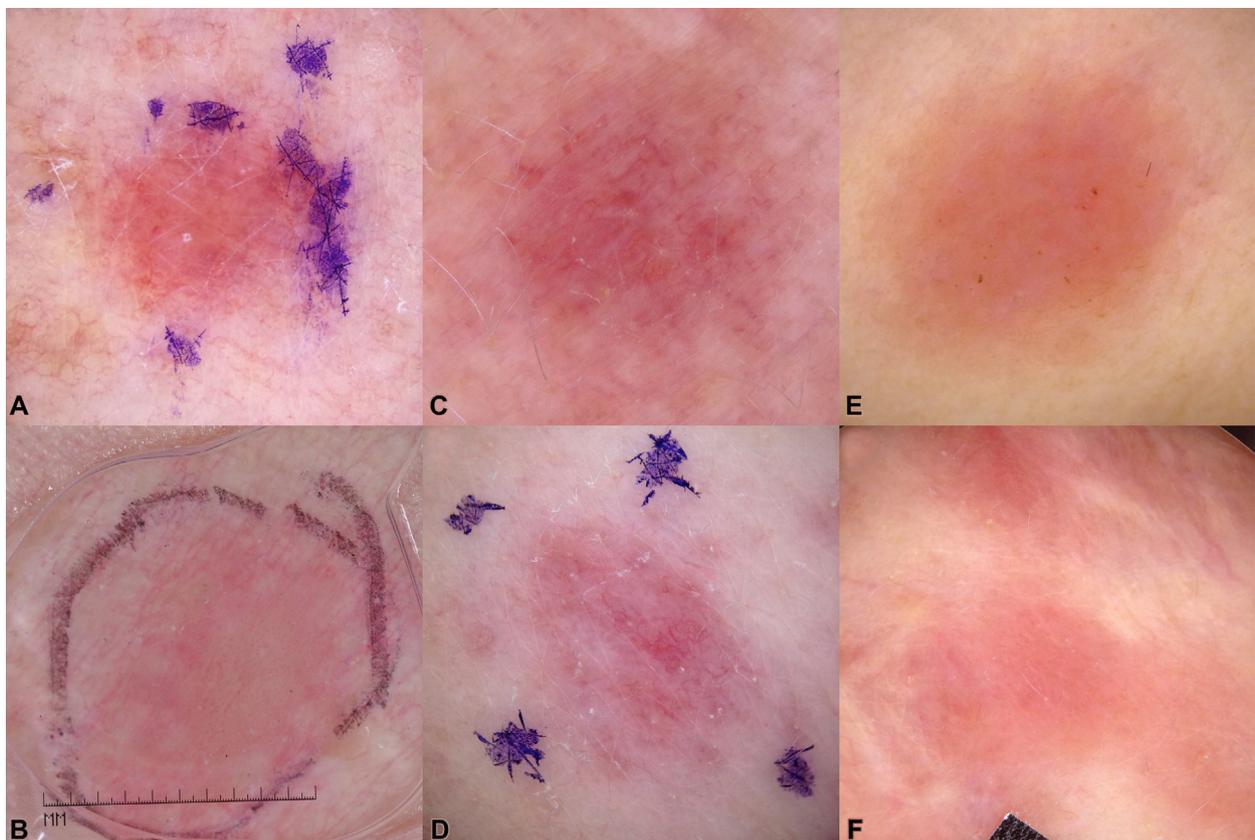
## Dermoscopy in lymphoproliferative disorders—experience from a cutaneous lymphoma clinic in a tertiary cancer center



*To the Editor:* We read with interest the review by Micali et al<sup>1</sup> providing a comprehensive update on the use of dermoscopy beyond pigmented lesions. Data on the role of dermoscopy in the diagnosis of lymphoproliferative disorders (LPDs) have grown significantly in the past 5 years with the publication of case reports, case series, and large studies reporting on the dermoscopic features of specific cutaneous lymphoma subtypes.<sup>1,2</sup> Several publications concluded that LPDs demonstrate characteristic dermoscopic patterns reflective of the specific lymphoma type and that their features differ from those seen in inflammatory skin conditions.<sup>3</sup> Our

experience from a cutaneous lymphoma clinic in a referral cancer center does not support such definite conclusions; rather, it suggests a limited role for dermoscopy in the routine clinical setting of LPD diagnosis.

We have previously studied dermoscopic features in cutaneous B-cell lymphomas and identified orange or salmon color and serpentine vessels in the majority of cases, with no differences between the specific lymphoma subtypes. We concluded that these dermoscopic features are not specific and must be considered within the larger context of the clinical and pathologic findings.<sup>4</sup> Our experience using dermoscopy in many patients with lesions within the wide spectrum of LPDs highlights the lack of specificity of dermoscopic features in LPD lesions. Cutaneous B- and T-cell lymphomas, as well as pseudolymphomas, can look alike under dermoscopy, and a biopsy for histology, immunophenotyping, and molecular



**Fig 1.** Dermoscopic images of lymphoproliferative disorders. **A**, Lymphomatoid papulosis showing an orange background and fine linear vessels. **B**, Anaplastic large cell lymphoma showing a yellowish color and faint vessels. **C**, CD4<sup>+</sup> small medium pleomorphic T-cell lymphoproliferative disorder displaying salmon color and unspecific linear vessels. **D**, Primary cutaneous follicle center lymphoma with an unspecific salmon background and some serpentine vessels. **E**, Primary cutaneous marginal zone lymphoma showing orange color and follicular plugs. **F**, Pseudolymphoma with mixed infiltrate of T and B lymphocytes showing pink-orange color. (**A** and **C** to **F**, Polarized dermoscopy; **B**, nonpolarized dermoscopy; original magnifications: **A** to **F**:  $\times 10$ .)

studies is needed to reach the specific diagnosis of the LPD subtype. The dermoscopic images of 6 LPD lesions of different subtypes are shown in Fig 1; they share an orange or salmon-colored background. This dermoscopic feature has been described previously in both B- and T-cell LPDs by us and by others<sup>1-4</sup> and probably correlates with the dense lymphocytic infiltrate in the epidermis and/or papillary dermis.

Dermoscopy can be used to narrow down the differential diagnosis in some LPD cases, mainly by ruling out skin cancers such as basal cell carcinomas and squamous cell carcinomas when they are a concern clinically. In our clinic, we also use dermoscopy when evaluating recurrent lesions in patients with a known LPD. However, dermoscopy should be used cautiously, as it cannot distinguish between LPD subtypes and it is not uncommon for patients with 1 type of cutaneous lymphoma to develop a second LPD (eg, lymphomatoid papulosis with mycosis fungoides).

In conclusion, as reported by Micali et al,<sup>1</sup> the use of dermoscopy in cutaneous lymphoma is limited and confirmatory biopsies are required for diagnosis. The characteristic dermoscopic findings in LPD may suggest this diagnosis; however, they are not specific and cannot differentiate between LPD subtypes.

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