Infiltrative Dermatoses

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12.1 Mastocytosis

12.1.1 Introduction

The term mastocytosis includes a group of conditions characterized by mast cell proliferation and accumulation in one or more organs, with the skin being the most frequently involved site [1–3]. Three main clinical subtypes do exist, i.e., maculopapular cutaneous mastocytosis (including urticaria pigmentosa [UP] and telangiectasia macularis eruptiva perstans [TMEP]), diffuse cutaneous mastocytosis, and mastocytoma [1–3]. All these conditions are pretty uncommon in very dark phototypes, especially TMEP [1–3].

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12.1.2 Clinical Presentation

UP manifests as either red-brown (fair skin) or brown (especially dark skin) maculae, papules, nodules, and/or plaques that are commonly larger and more infiltrated in pediatric population than adults (Figs. 12.1a, 12.2 and 12.3a); if lesions are rubbed, they may become erythematous/edematous (Darier's sign) [1–3]. TMEP is characterized by erythematous (fair skin) or brown-reddish (dark skin) macules often showing irregular margins and a diameter <5 mm that mainly affect the chest and limbs (Figs. 12.4a and 12.5a). Diffuse cutaneous mastocytosis presents as a diffuse skin thickening with a leathery and "*peau d'orange*" appearance; nodular and blisters may sometimes be seen [1–3]. Finally, mastocytoma is typified by one or a few (up to five) brown (darker in skin of color) nodules/plaques often localized on extremities (Figs. 12.6a and 12.7a) [1–3].

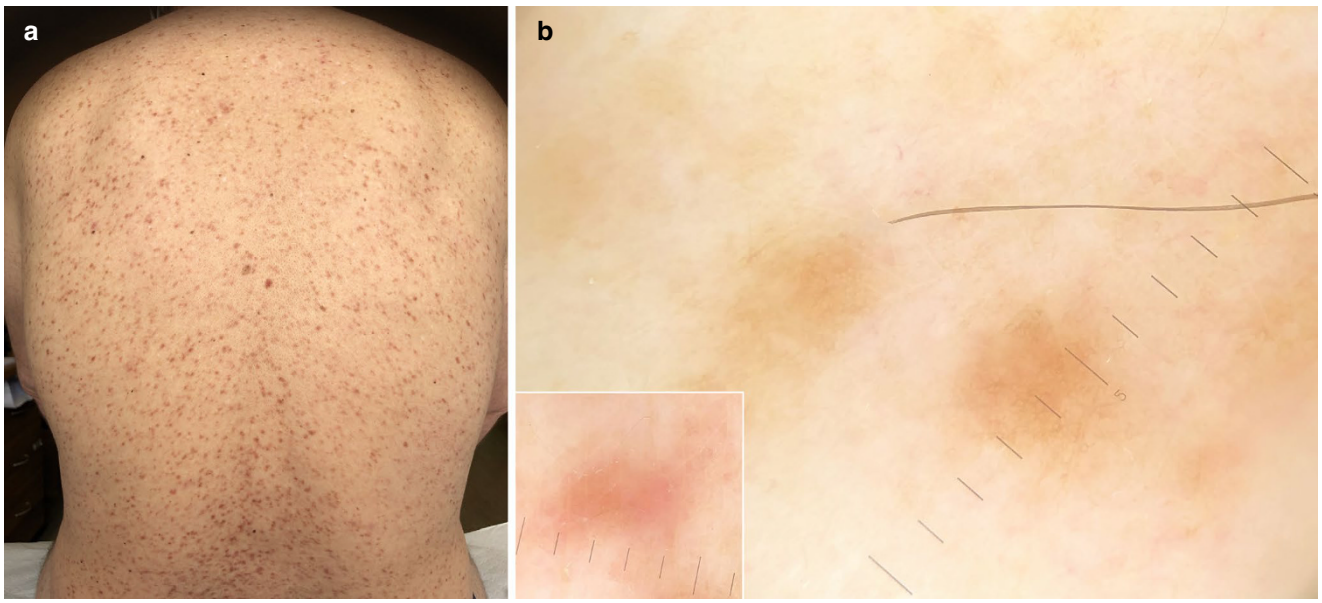

Fig. 12.1 Urticaria pigmentosa in a Caucasian man (**a**). Dermoscopic examination shows a coarse reticular pigmentation; erythema covers the pigmentation after rubbing (dermoscopic Darier's sign) (**b**)

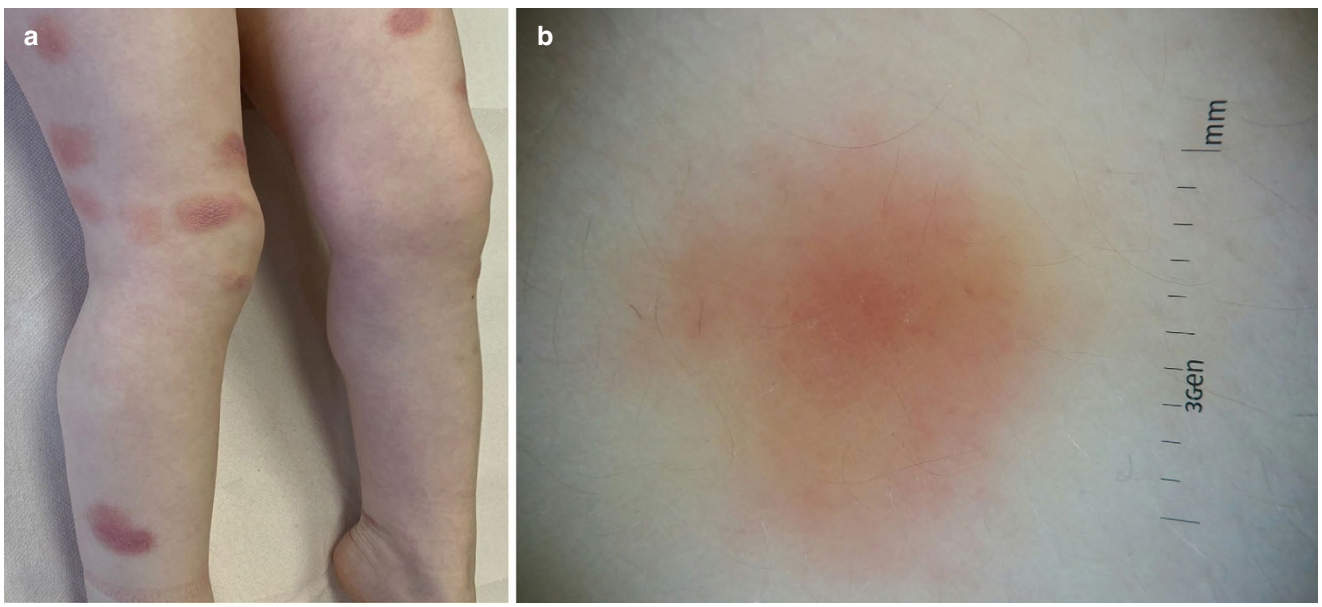

Fig. 12.2 Urticaria pigmentosa in a Caucasian child (**a**). Dermoscopy reveals a diffuse brownish pigmentation with some areas of erythema (**b**)

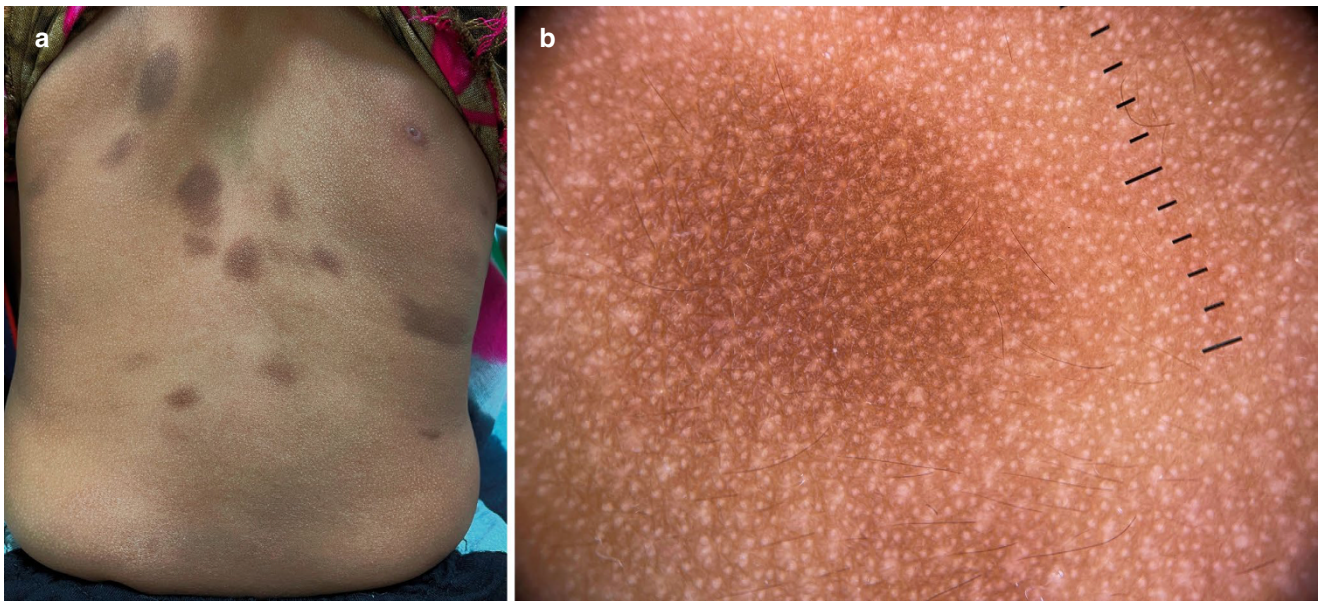

Fig. 12.3 Urticaria pigmentosa in an Indian child (**a**). A diffuse dark brown pigmentation with eccrine glands ostia sparing is evident on dermoscopic assessment (**b**)

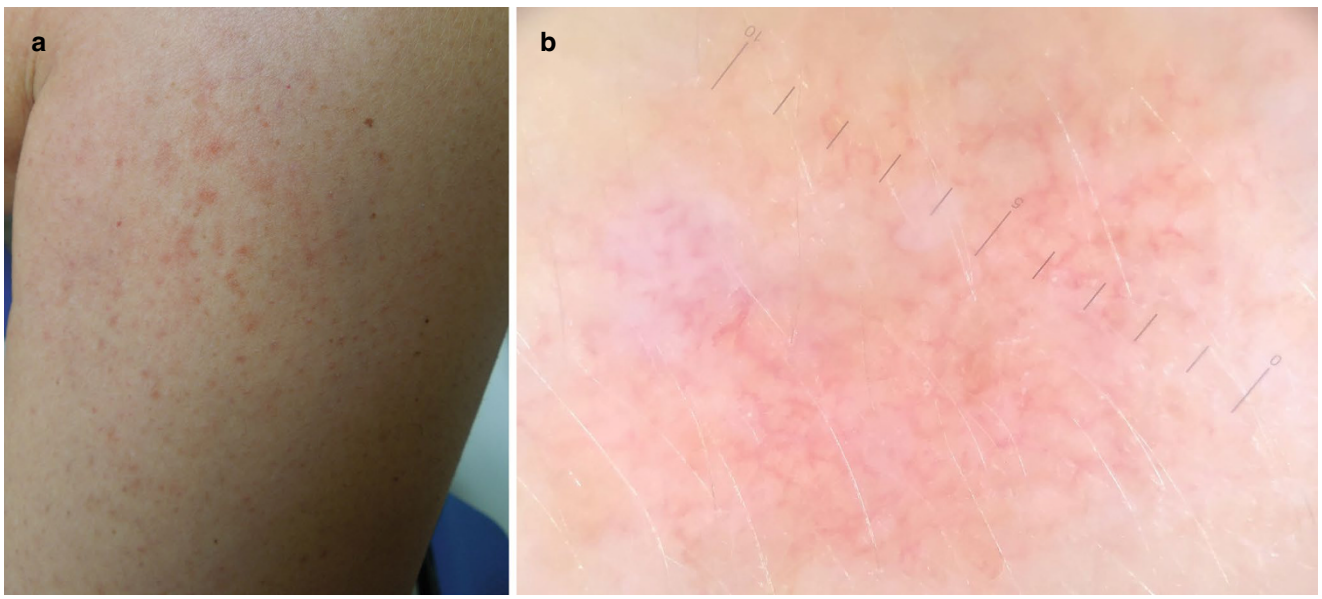

Fig. 12.4 Telangiectasia macularis eruptiva perstans in a Caucasian woman (**a**). Dermoscopy shows blurred reticular vessels on a reddish-brownish background (**b**)

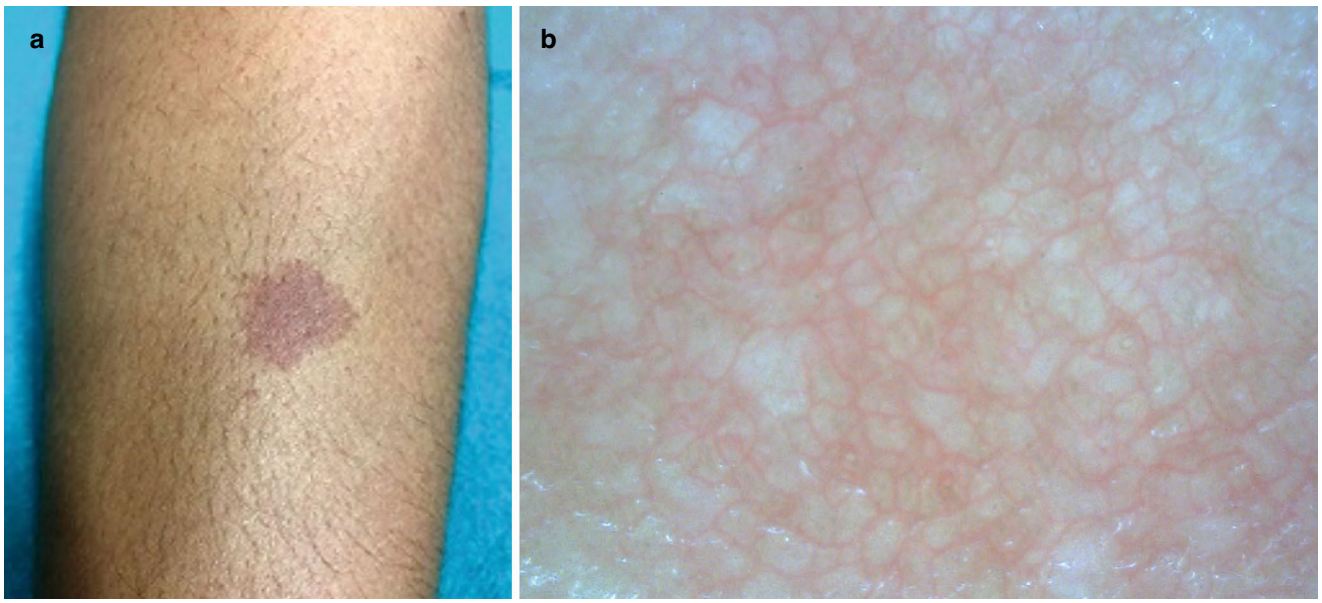

Fig. 12.5 Telangiectasia macularis eruptiva perstans in an Indian man (**a**). Unfocused reticular vessels over a brownish background is visible on dermoscopy (**b**). (*Reused with permission: Kumar S, Jakhar D, Misri R. Dermoscopy of Telangiectasia Macularis Eruptiva Perstans. Indian Dermatol Online J. 2019; 11:131–2*)

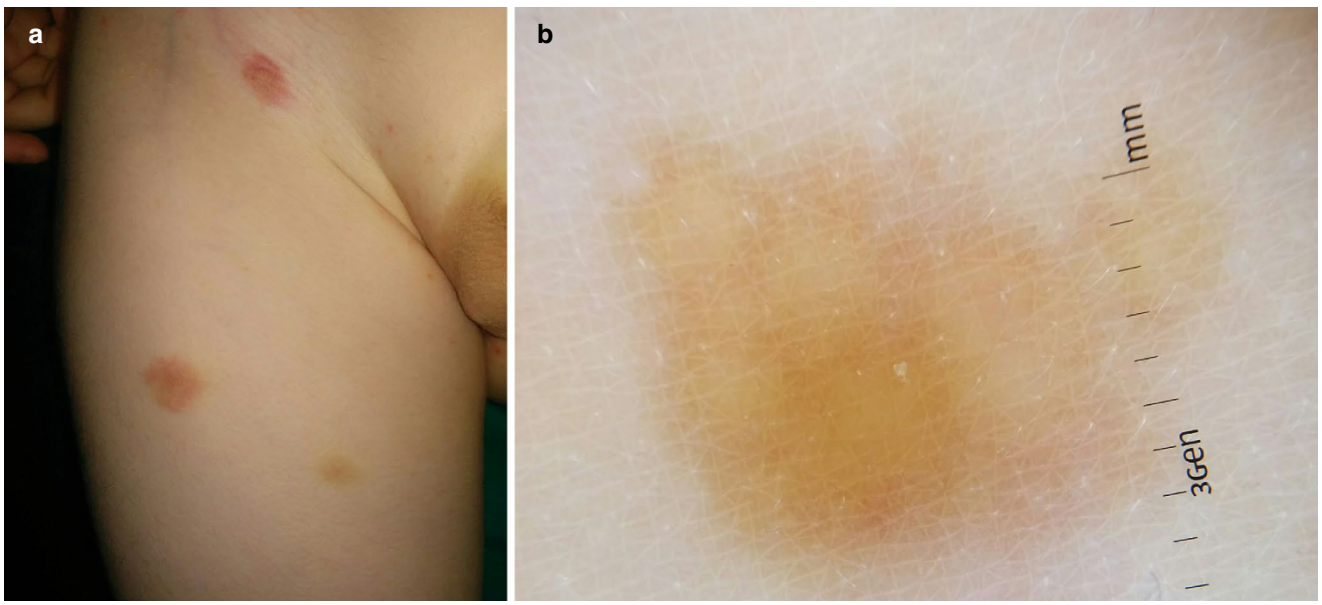

Fig. 12.6 Multiple mastocytomas in a Caucasian child (**a**). Dermoscopy displays multifocal yellow areas (**b**)

12.1.3 Dermoscopy

In both fair and dark skin, UP displays either homogeneous brown structureless areas or coarse pigment network (which are darker in skin of color) (Figs. 12.1b, 12.2 and 12.3b), while TMEP features reticular vessels on an erythematous/brown or brown (especially in darker phototypes) background (with or without brown network), though vessels may be difficult to see in very dark-skinned patients (Figs. 12.4b and 12.5b) [2–5]. Moving to mastocytoma, dermoscopy may show two main patterns, including diffuse/multifocal yellow-orange areas (more infiltrated lesions) or brown background/reticular areas (more common in skin of color) (Figs. 12.6b and 12.7b) [2–5]. Of note, when UP lesions or mastocytoma are rubbed, pigmentary structures may be covered by erythema (light phototypes) (Fig. 12.2b) or become less visible (dark phototypes) on dermoscopy (dermoscopic Darier's sign) [2–5].

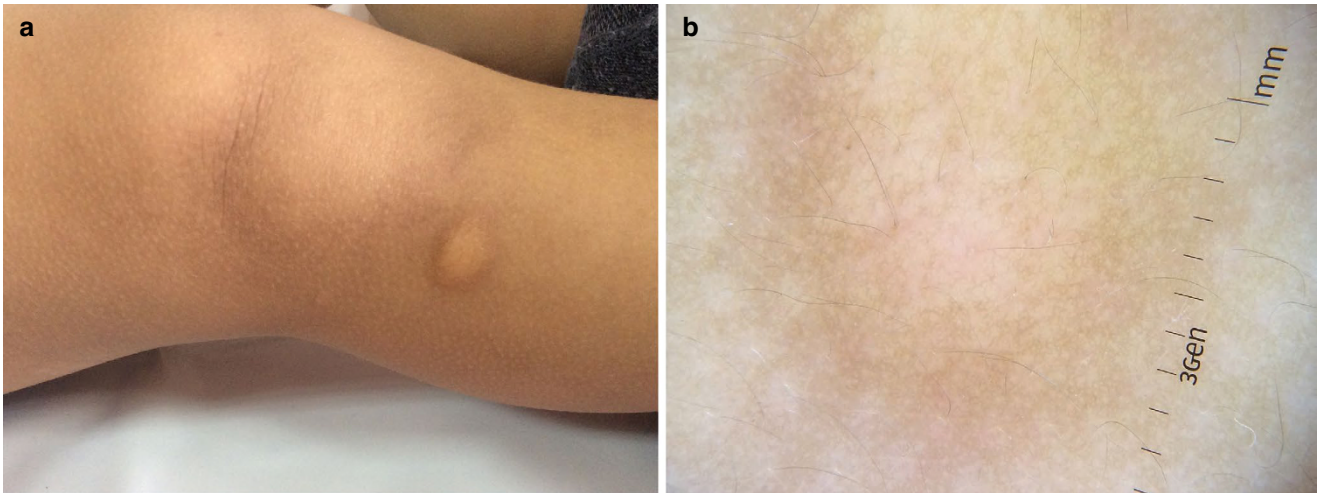

Fig. 12.7 Mastocytoma in an Asiatic child (**a**). Dermoscopic examination shows a yellowish background along with reticular brown pigmentation (**b**). (*Courtesy of Bengü Nisa Akay, MD – Ankara, Turkey*)

12.2 Cutaneous Xanthomas

12.2.1 Introduction

Cutaneous xanthomas are lesions typified by dermal and/or subcutaneous lipid deposits that may be appreciated in several lipoprotein diseases [3, 6]. From a histological point of view, all types of xanthoma feature macrophages loaded with lipids (foam cells) [3, 6].

12.2.2 Clinical Presentation

Various clinical subtypes of xanthomas do exist, including tendon xanthoma (subcutaneous skin-colored nodules most commonly affecting Achilles tendon and knuckles—associated with familial and secondary hypercholesterolemia), tuberous xanthoma (firm yellow-reddish [fair skin], or yellow-brown [dark skin] nodules mainly located on the extensor surface of elbows and knees, buttocks, and heels—associated with type III hyperlipoproteinemia), eruptive xanthoma (yellow-red [fair skin] or yellow-brown [dark skin] papules most often involving extensor surfaces of the limbs—associated with any cause of hypertriglyceridemia), and plane xanthomas (i.e., xanthelasma, plane xanthoma, and palmar xanthoma—associated with familial hypercholesterolemia, type III hyperlipoproteinemia, and chronic cholestasis) [3, 6]. Examples are shown in Figs. 12.8a, 12.9, 12.10, 12.11, 12.12, 12.13 and 12.14a.

12.2.3 Dermoscopy

Dermoscopy of all types of cutaneous xanthomas in both light and dark phototypes reveals bright yellow (fair skin) or yellow-brown (dark skin) structureless areas, lines, or globules, histologically related to macrophages loaded with lipids (foam cells) in the dermis or subcutaneous tissues (Figs. 12.8b, 12.9, 12.11, 12.12, 12.13 and 12.14b) [3, 6]. Of note, the shade of yellow commonly varies in the same lesion due to the presence of lipids deposits at different depths [3, 6]. Importantly, distorted pigment network is also seen in skin of color (Figs. 12.9b, 12.11b, 12.13b), whereas vessels (linear-curved or linear-branched) may sometimes be appreciated in light-skinned patients, particularly in plane (Fig. 12.12b) and eruptive xanthomas [3, 6].

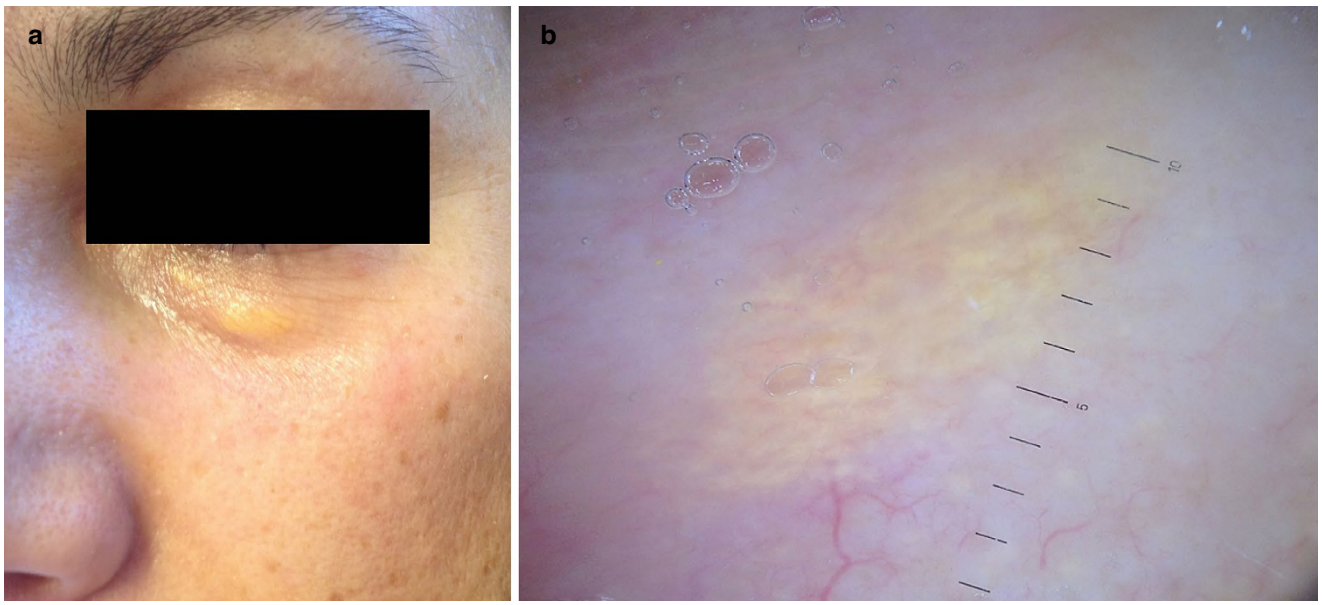

Fig. 12.8 Palpebral xanthelasma in a Caucasian woman (**a**). Multifocal bright yellow areas as well as fine linear vessels with branches are evident on dermoscopy (**b**)

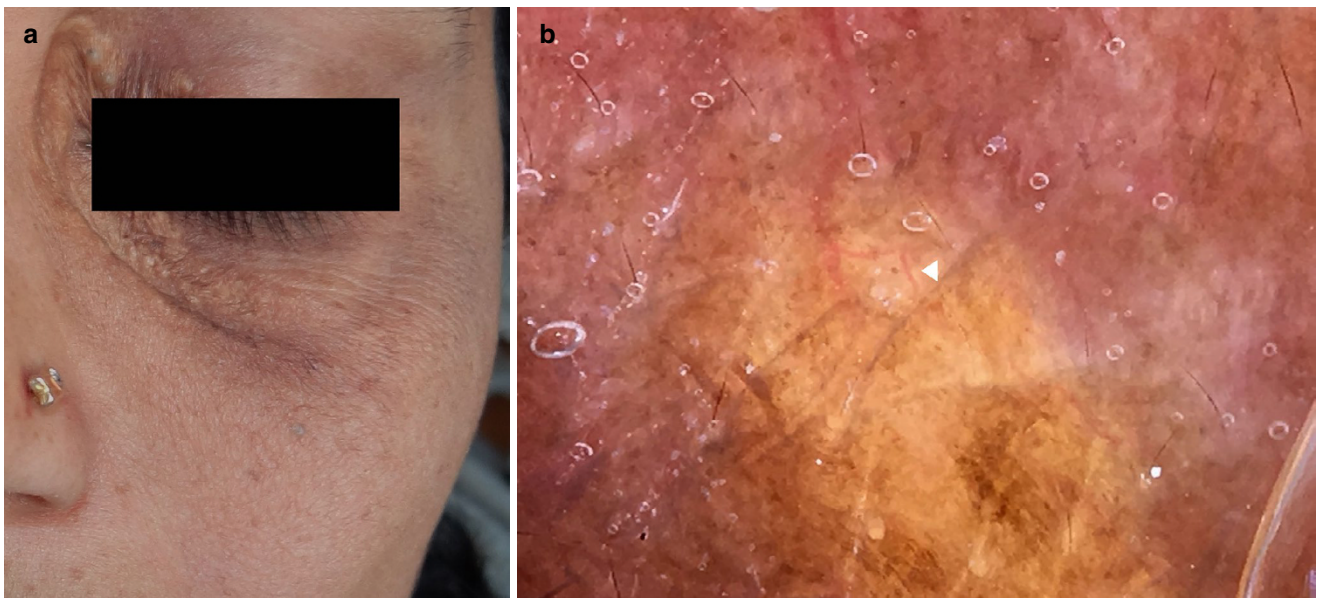

Fig. 12.9 Palpebral xanthelasma in an Indian woman (**a**). Dermoscopic assessment reveals a brown-yellow background with several brown areas/dots and few blurred linear vessels (arrowhead) (**b**)

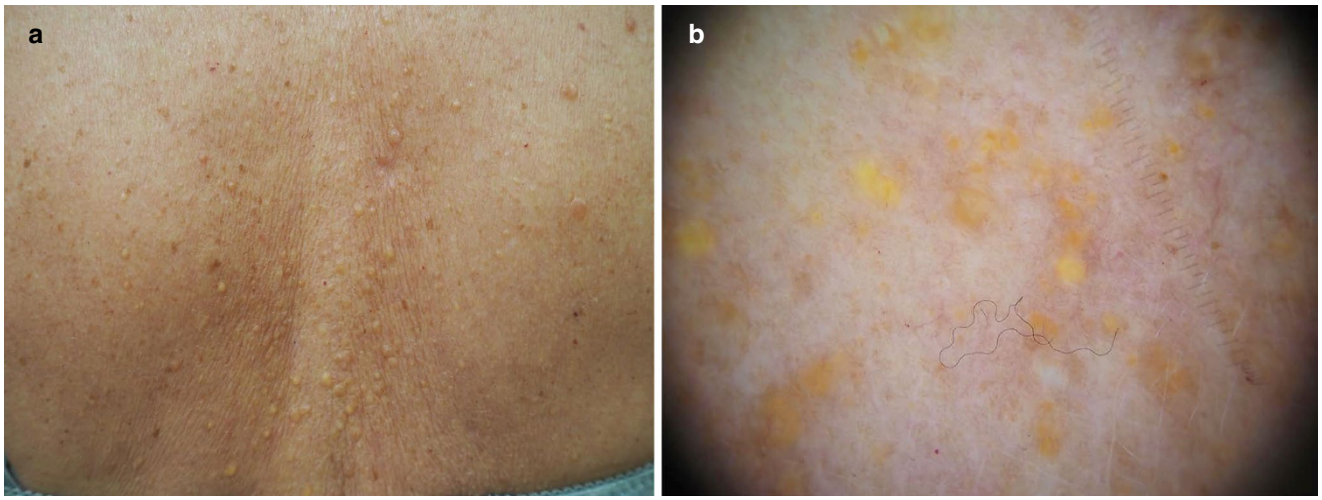

Fig. 12.10 Eruptive xanthomas in a Caucasian woman (**a**). Dermoscopy shows round bright yellow areas along with some linear vessels (**b**). (*Courtesy of Iris Zalaudek, MD – Trieste, Italy*)

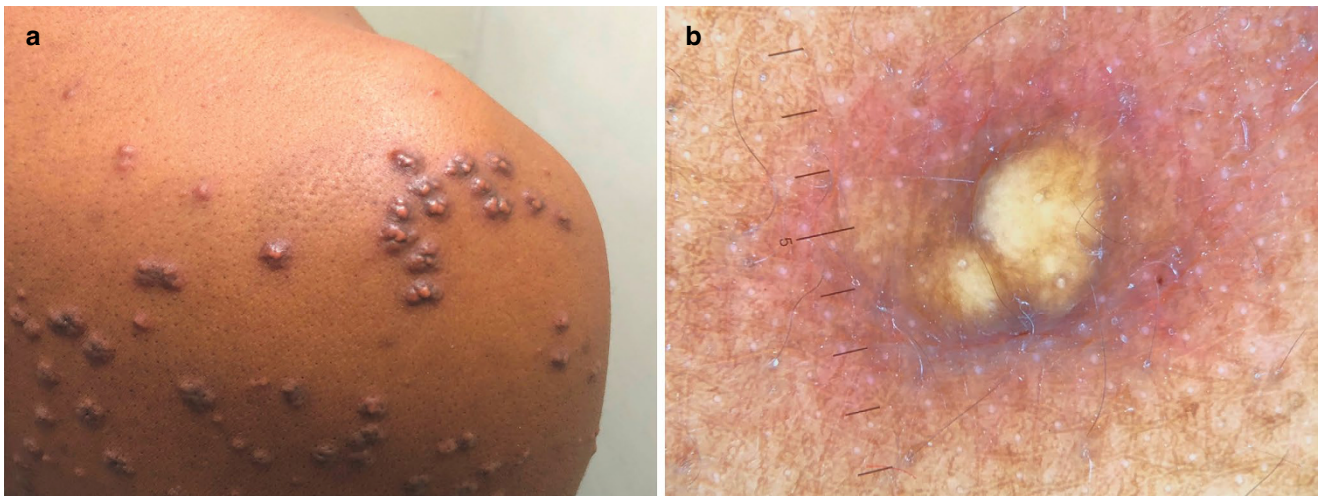

Fig. 12.11 Eruptive xanthomas in an Indian man (**a**). Dermoscopic examination displays brown-yellow areas as well as intralesional brown pigmentation and a brown halo (**b**)

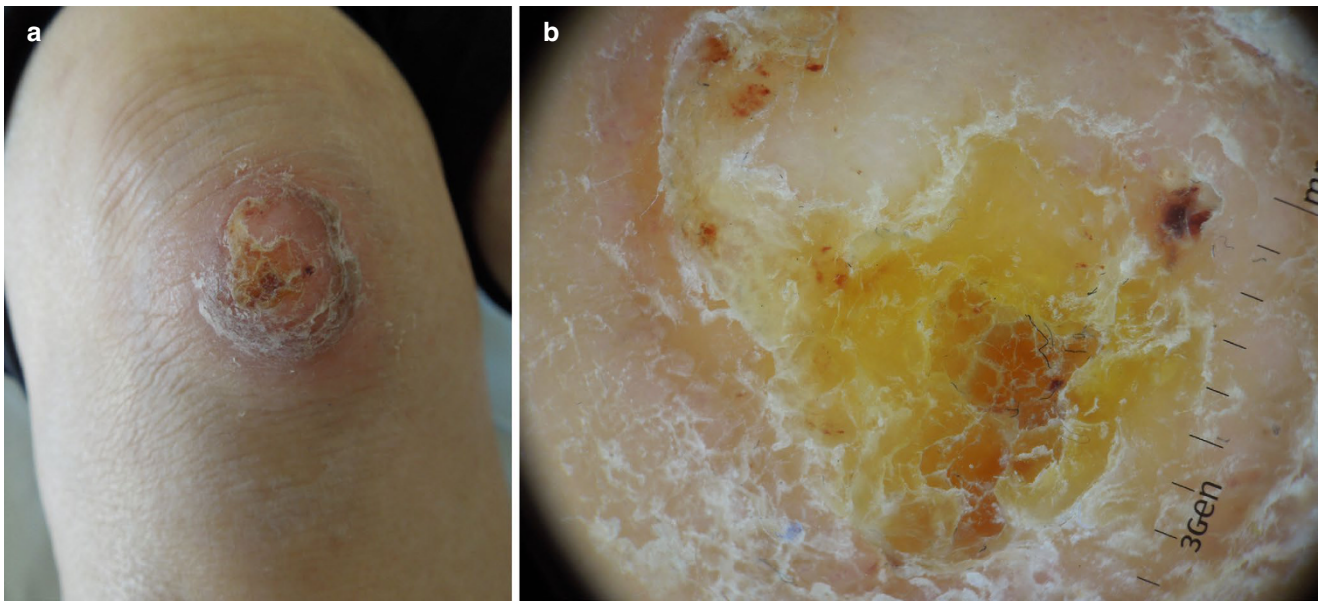

Fig. 12.12 Tuberous xanthoma in a Caucasian woman (**a**). Multifocal bright yellow areas along with hemorrhagic areas and hyperkeratosis are visible on dermoscopy (**b**)

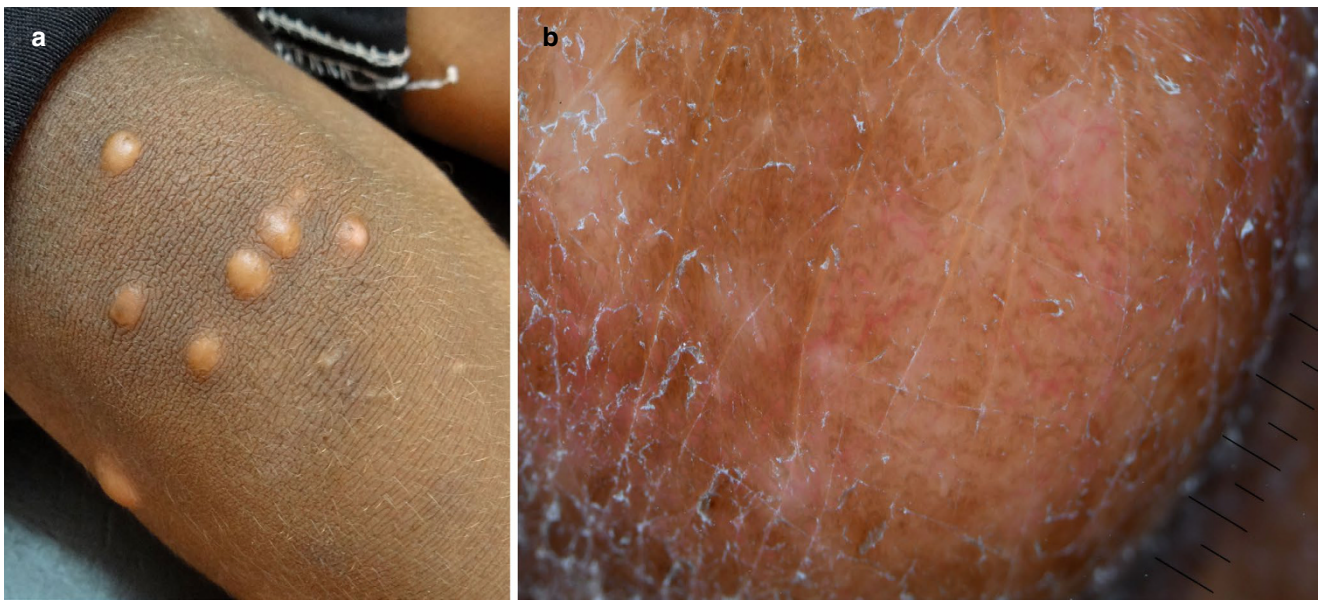

Fig. 12.13 Tuberous xanthoma in an Indian boy (**a**). Dermoscopy reveals an accentuation of reticular brown pigmentation as well as multifocal white areas and few blurred vessels (**b**)

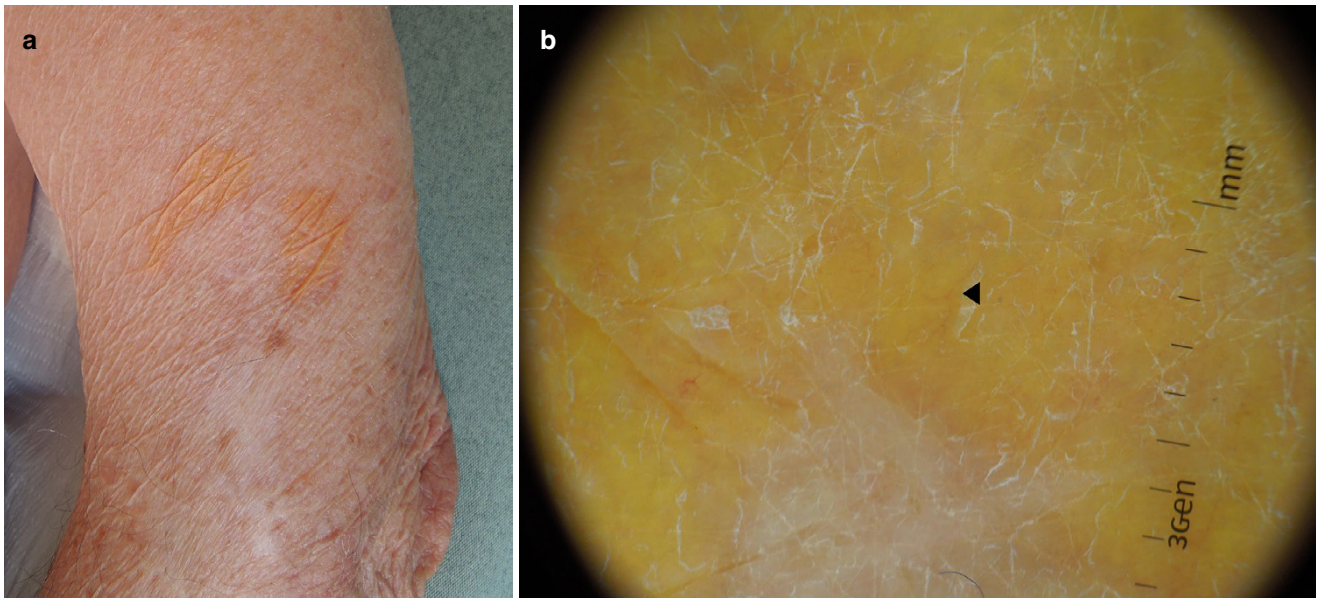

Fig. 12.14 Normolipidemic plane xanthoma in a Caucasian man (**a**). Dermoscopy shows a bright yellow background whose shade varies in the context of the lesion; a few subtle vessels are also seen (arrowhead) (**b**)

12.3 Xanthogranuloma

12.3.1 Introduction

Xanthogranuloma is a form of non-Langerhans cell histiocytosis usually occurring during childhood, yet adults may also be affected [2, 3]. Such a condition typically resolves spontaneously over a time spam of 3–6 years, albeit a chronic course is possible, particularly in adult age [2, 3].

12.3.2 Clinical Presentation

Clinical appearance of xanthogranuloma varies according to the lesion stage and skin type. In detail, it manifests with one or more asymptomatic, discrete, reddish (fair skin), skin-colored or brown (dark skin) papules and/or nodules progressively turning to yellowish as the lesions mature (Figs. 12.15a, 12.16, 12.17 and 12.18a); upper part of the body and arms are the most commonly involved areas [2, 3]. A hyperkeratotic surface may also be seen, particularly in skin of color [3]. Involvement of extracutaneous sites is rare but possible, with the eye being the most frequent one [2, 3].

12.3.3 Dermoscopy

Dermoscopic examination of xanthogranuloma typically shows diffuse or focally distributed (often in a multiglobular pattern) orange (early/inflammatory stages) or yellow (more advanced phases) areas, which histologically correspond to the dense cellular infiltration by histiocytes ("mass effect"—orange shade) and foamy lipid-laden cells (yellow shade) in the dermis (Figs. 12.15b and 12.16b) [2, 3]. Importantly, orange color is less commonly seen in very dark phototypes, while pigmentary findings (e.g., structureless or reticular brown areas) and white fibrotic structures are often present along with yellow areas in these patients (Figs. 12.17b and 12.18b) [2, 3]. Finally, an erythematous halo at the periphery (giving rise to the so-called "setting sun" pattern when it is associated with a central orangish-yellowish area) (Fig. 12.15b) and sharp branching vessels in the center (Fig. 12.16b) may also be appreciated, though they are less common in skin of color [2, 3].

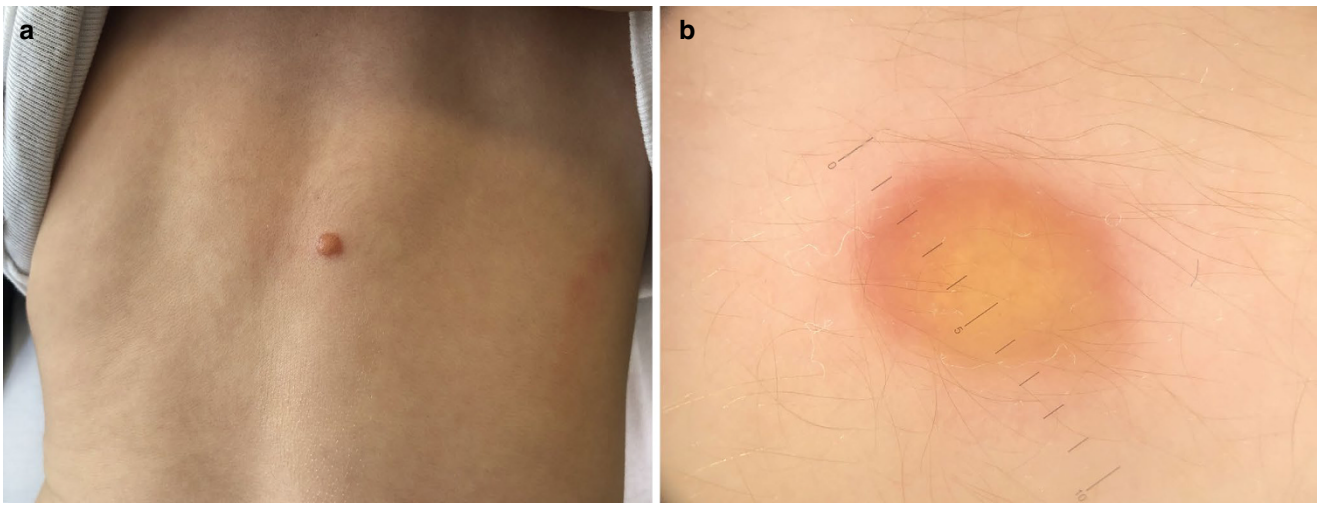

Fig. 12.15 Xanthogranuloma in a Caucasian child (**a**). Dermoscopic assessment displays a central orange area with a peripheral erythematous halo ("setting sun" pattern) (**b**)

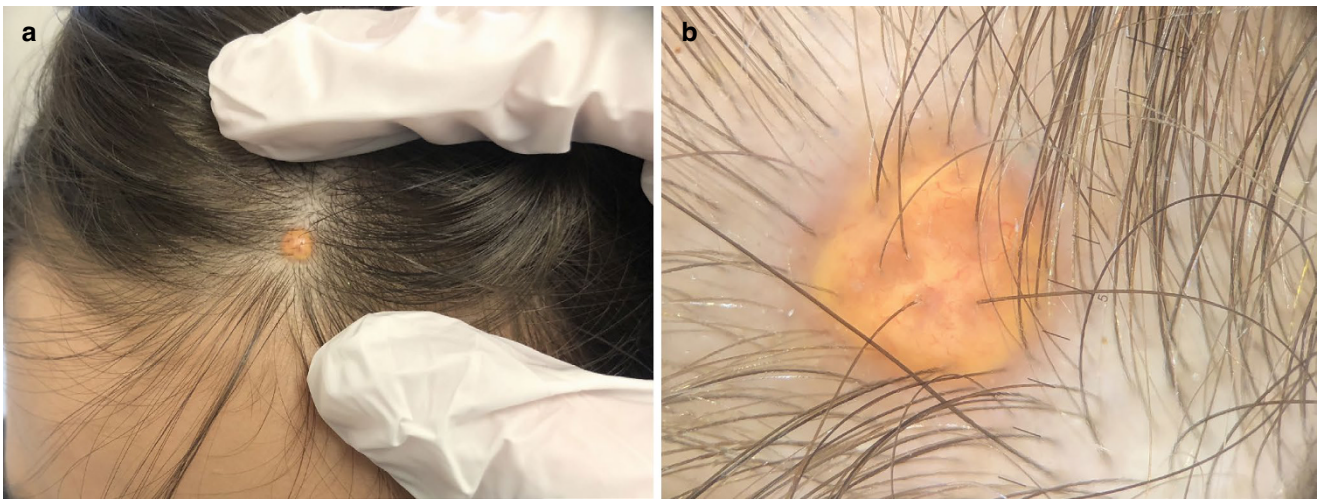

Fig. 12.16 Xanthogranuloma in a Caucasian child (**a**). Multifocal yellow and orange areas along with some sharp linear branching vessels are evident on dermoscopy (**b**)

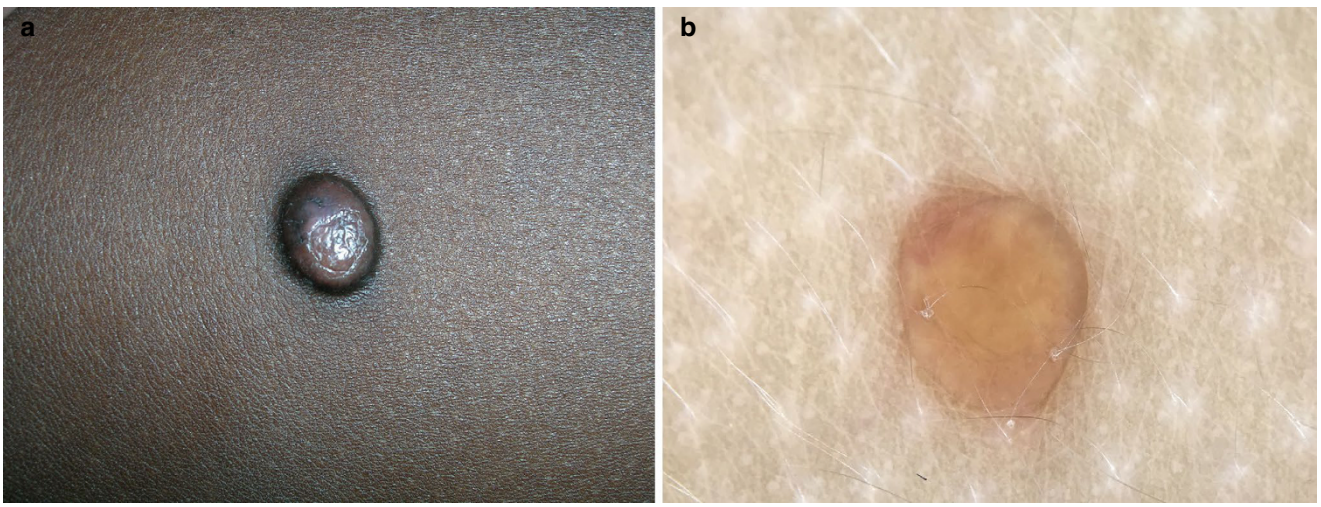

Fig. 12.17 Xanthogranuloma in an African American child (**a**). Dermoscopy reveals a yellow background as well as peripheral brown pigmentation (**b**). (*Courtesy of Richard P. Usatine, MD – San Antonio, USA*)

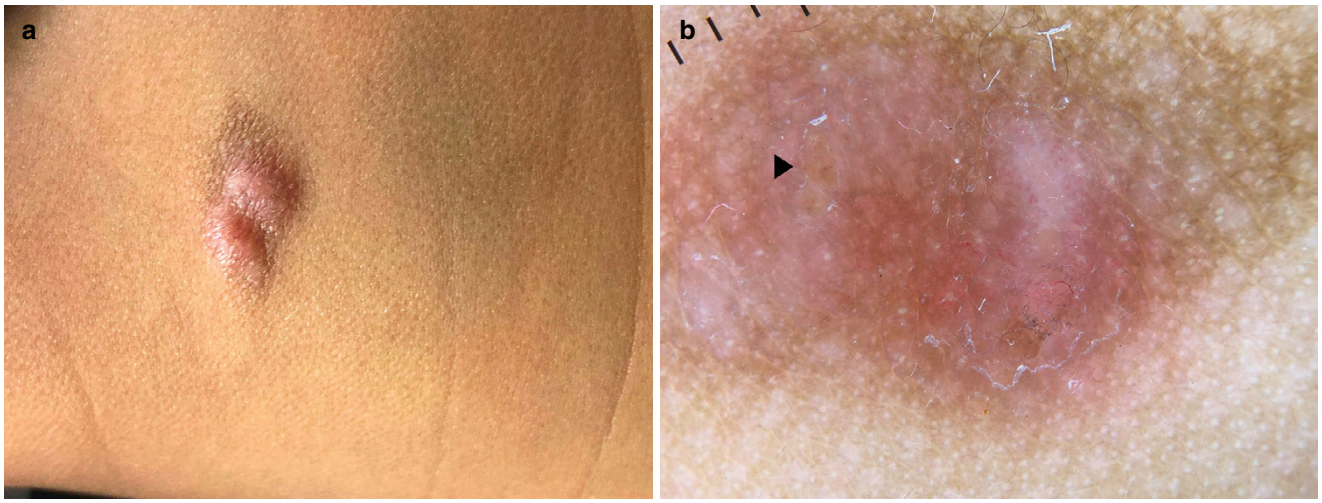

Fig. 12.18 Xanthogranuloma in an Indian child (**a**). Dermoscopic examination displays a brown background along with multifocal bright white areas, some blurred vessels, and subtle yellow areas (arrowhead) (**b**)

12.4 Primary Cutaneous Lymphomas

12.4.1 Introduction

Primary cutaneous lymphomas (PCLs) encompass a heterogeneous group of T- and B-cell lymphomas localized on the skin, with no evidence of extracutaneous involvement at the time of diagnosis [7, 8]. The most common PCL is mycosis fungoides (MF), a T-cell skin lymphoma that has been speculated to be linked to persistent antigenic stimulation and viral agents [7, 8].

Non-MF PCLs are less frequent and include both T-cell and B-cell forms; lymphomatoid papulosis, CD30 anaplastic large cell lymphoma, and CD4 small/medium lymphoproliferative disorder are the most common subtypes belonging to the former group, while marginal zone lymphoma and follicle-center cell lymphoma represent the most frequent variants of B-cell PCLs [7, 8]. Although the etiopathogenesis of non-MF PCLs is yet to be completely clear, it is postulated that an accumulation of genetic alterations leads to clonal proliferation and malignant transformation of skin-homing T cells in CTCLs, whereas chronic antigenic stimulation and immune dysregulation have been speculated to play a role in CBCLs [7, 8].

Whereas the incidence of MF has been reported to be higher in African Americans compared with lighter phototypes, non-MF PCLs tend to be quite rare in skin of color [7, 8]. Notably, MF in dark-skinned patients is usually typified by an earlier onset and increased mortality [7, 8].

12.4.2 Clinical Presentation

From a clinical point of view, MF is typified by three progressive phases, i.e., patch, plaque, and tumoral stages [7, 8]. In lighter phototypes, patches and plaques, respectively, manifest as flat and raised erythematous, scaly or crusted (plaques), well-demarcated lesions, whereas tumors present as nodular/vegetative lesions with crusted/ulcerated surface (Figs. 12.19a, 12.20 and 12.21a) [7, 8]. On the other hand, classic features of MF in skin of color include arcuate, annular patches, plaques, and nodules associated with polymorphic pigmentation that display a variety of secondary changes as they become more infiltrated, such as a lichenified, crusting, and/or a leathery or verrucous appearance (Figs. 12.22a, 12.23 and 12.24a) [7, 8]. Several less frequent clinical variants of MF do exist, including poikilodermatous, erythrodermic, folliculotropic, papular, purpuric, hypopigmented, and hyperpigmented, with the latter two forms being more common in dark-skinned patients [7, 8]. Indeed, hypopigmented MF is often seen in younger patients of African, Arab, and South-East Asian descent and commonly presents as strikingly diffuse hypopigmented patches on sun-exposed sites [7, 8].

Non-MF PCLs have a quite polymorphic presentation [7, 8]. In detail, lymphomatoid papulosis (Figs. 12.25a, 12.26, 12.27 and 12.28a) usually manifests as self-resolving/recurrent crops of red or red-brown (dark skin) papules/nodules progressing into hyperpigmented scars, which are more marked in darker phototypes; hyperkeratotic lesions may also be observed, especially in skin of color (Fig. 12.29a). On the other hand,

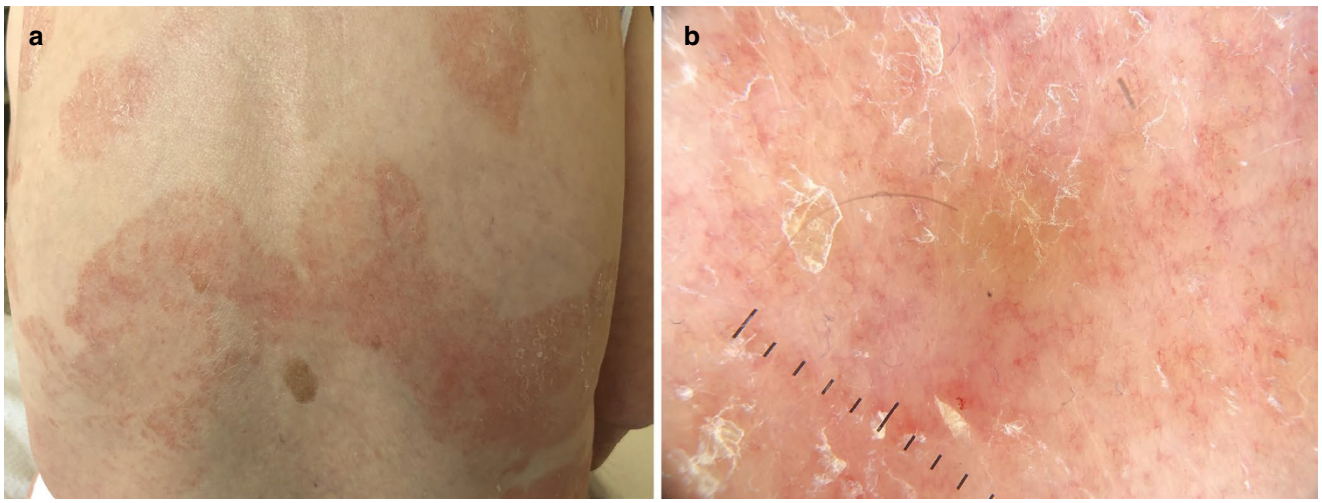

Fig. 12.19 Mycosis fungoides (patch stage) in a Caucasian woman (**a**). Dermoscopy shows white scaling and orange areas along with linear and linear-curved vessels; sparse dotted vessels are also present (**b**)

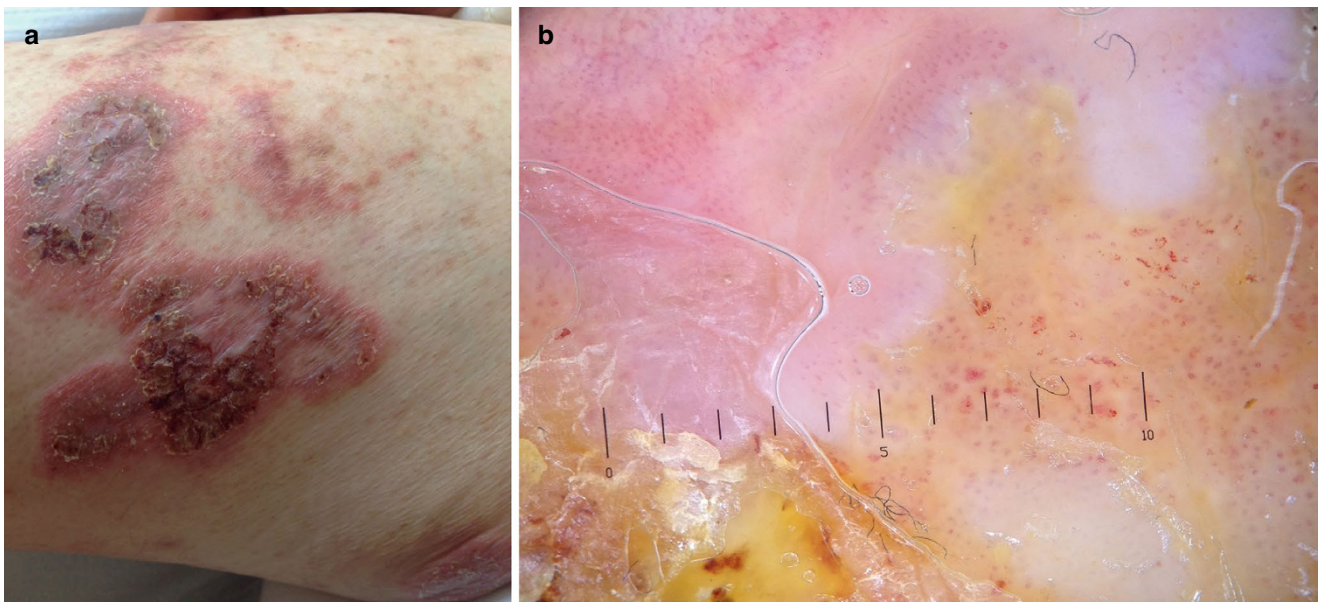

Fig. 12.20 Mycosis fungoides (plaque stage) in a Caucasian man (**a**). Dermoscopic assessment reveals white scaling, yellow crusting, vessels of mixed morphology (linear-curved, linear, and dotted), and bright white areas (**b**)

other non-MF PCLs generally present as either solitary/multiple, ulcerative nodules (primary cutaneous anaplastic large cell lymphoma) or solitary/grouped papules or nodules on the head and neck area (B-cell PCLs) (Figs. 12.30a and 12.31a) [7, 8]. Typically, the shade of the lesions is violaceous in fair skin (Fig. 12.30a) and brownish (Fig. 12.31a) in dark skin [7, 8].

12.4.3 Dermoscopy

Dermoscopic pattern of MF typically varies according to the disease stage [7, 8]. In particular, the main dermoscopic features of patches in light-skinned patients include unspecifically arranged linear and linear-curved vessels (dilated papillary dermal vessels) along with focal orange areas (hemosiderin deposits in the dermis) and white scaling (hyperkeratosis) arranged in a patchy pattern or in the skin furrows (Fig. 12.19b) [7, 9–11]. With disease progression from patches (Fig. 12.20b) to tumoral (Fig. 12.21b) lesions, there is a change in vascular pattern, with linear vessels with branches predominating at the tumoral stage [11]. In addition, bright white structureless areas are mainly seen in more advanced phases (plaques and tumoral lesions) (Figs. 12.20b and 12.21b), and tumors are also characterized by the presence of ulceration (Fig. 12.21B) and red globules separated by white lines, with the latter pattern being seen especially in flat tumoral lesions [11].

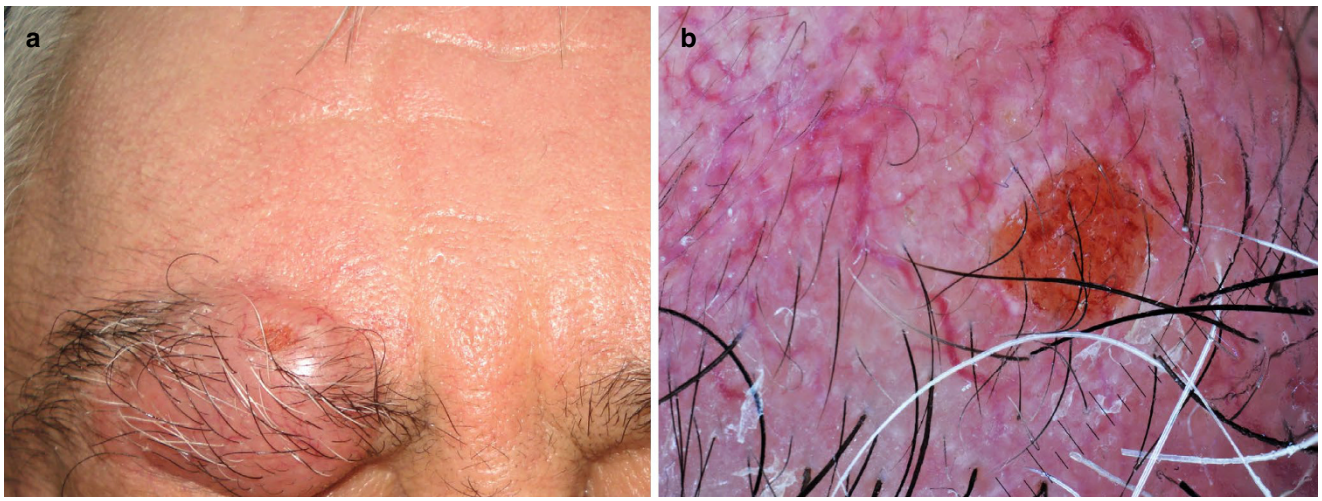

Fig. 12.21 Mycosis fungoides (tumoral stage) in a Caucasian man (**a**). Dermoscopic examination displays central ulceration, white peripheral white areas, and linear branching vessels (**b**). (*Courtesy of Bengü Nisa Akay, MD – Ankara, Turkey*)

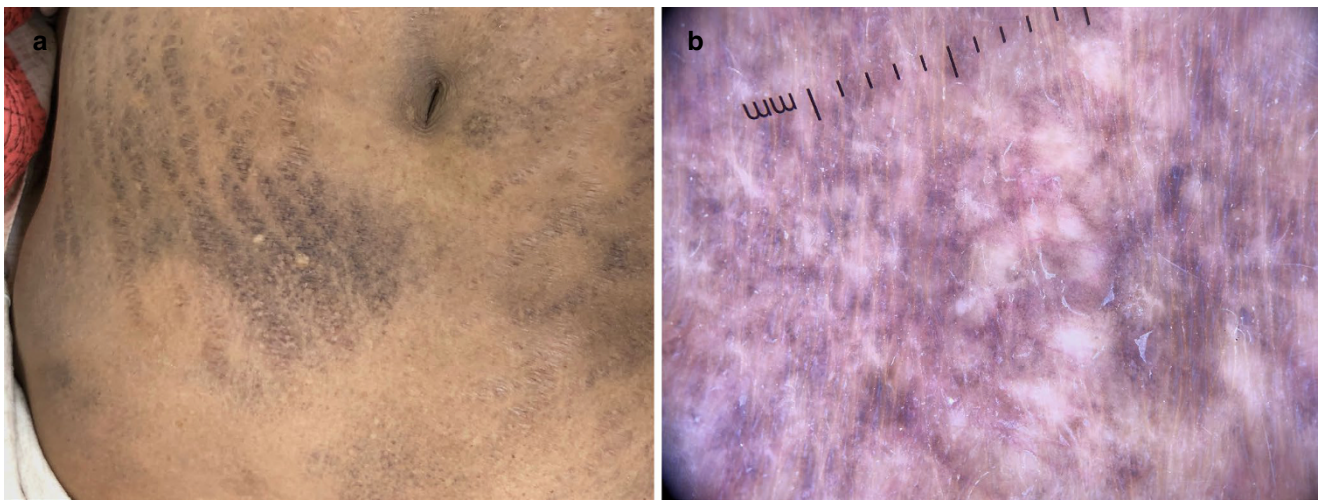

Fig. 12.22 Mycosis fungoides (patch stage) in an Indian man (**a**). Dermoscopy shows pigmentary structures arranged in a network-like pattern as well as multifocal white areas (**b**)

On the other hand, MF in skin of color (especially phototypes V and VI) is generally typified by striking pigmentary changes histologically corresponding to basal layer hyperpigmentation and dermal pigment incontinence [8, 12]. In particular, dark-brown to black thick lines forming pseudonetworks, dots, globules, and structureless areas interrupted by prominent eccrine duct openings are often seen in both patches and plaques (Figs. 12.22b and 12.23b) [8, 12]. Furthermore, geometric white lines (histologically corresponding to acanthosis/dermal fibrosis), patchy pink-red areas (due to vessels dilation), white rosettes, and follicular plugs surrounded by hyperpigmented to violaceous halos may also be evident in plaque-stage/tumoral stage [8, 12]. Importantly, the presence of the last two findings may be indicative of folliculotropism but are also found in classic MF as a result of follicular hyperkeratosis, which is quite common in darker phototypes [8, 12]. Nodular lesions tend also to show ulceration with vessels of variable morphology and white areas due to fibrosis (Fig. 12.24b) [8].

Yellow-gray amorphous structures with ridges may be observed in verrucous MF in skin of color, while hypopigmented MF shows ill-defined white areas (whose shade varies in the same lesion) in both fair and dark skin, yet a distorted or loss of the natural pigment network is seen in darker phototypes [8, 12]. Finally, in erythrodermic MF and Sezary syndrome, serpiginous vessels have been reported to help differentiate such conditions from other common causes of erythroderma in Caucasians, though vessels morphology is difficult to discern in skin of color, and dermoscopic recognition relies on the abovementioned pigmentary changes

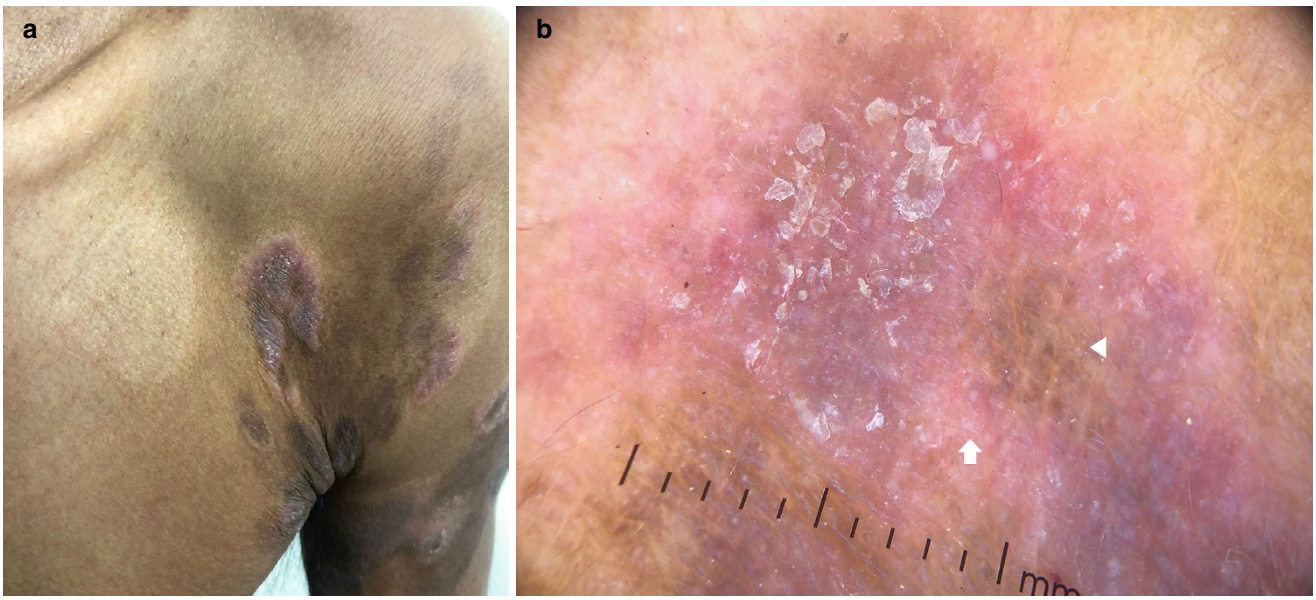

Fig. 12.23 Mycosis fungoides (plaque stage) in an Indian man (**a**). Dermoscopic examination displays white scaling, brown areas with sparing of eccrine openings (arrowhead), patchy pink-red areas, and white lines (arrow) (**b**)

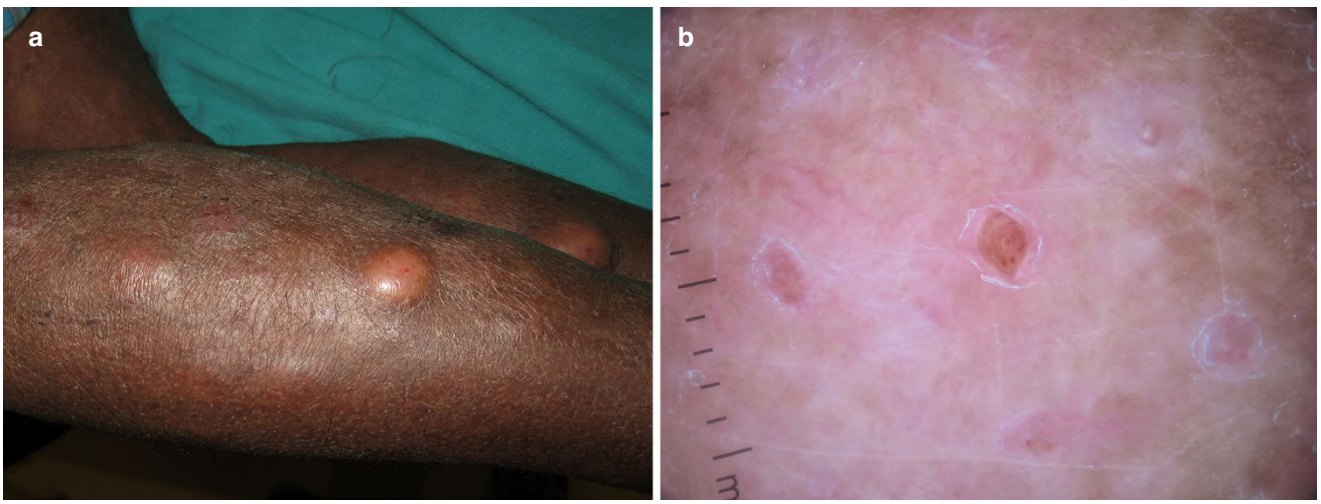

Fig. 12.24 Mycosis fungoides (tumoral stage) in an Indian man (**a**). Dermoscopy reveals multiple ulcerations, white structureless areas, and subtle linear vessels with branches (**b**)

[8]; hypopigmented areas with reduction/lack of the physiological brown network and hemorrhagic dots/globules may also be found [8].

Moving to lymphomatoid papulosis, dermoscopic features classically vary based on the disease stage and phototype [7, 8]. In particular, early lesions in lighter skin often show dotted or tortuous/irregular vessels (corresponding to dermal vessels dilation) (Fig. 12.25b), while they are more difficult to see in very dark phototypes, yet the presence of a paler background due to acanthosis may make vascular structures evident (Fig. 12.26b) [7]. Differently, mature lesions feature a central yellow/white area or brown crust, respectively, resulting from hyperkeratosis/acanthosis or necrosis, and a peripheral white collarette scaling regardless skin type (Figs. 12.27b and 12.28b) [7]. Moreover, a central erosion displaying vessels of mixed morphologies may also be evident in well-developed papules, especially in fair-skinned patients but also in darker phototypes (Figs. 12.27b and 12.28b), whereas brown-gray structureless areas are often observed as a consequence of post-inflammatory pigmentation, particularly in skin of color [8]. Additionally, a more prominent brown halo as well as lesions covered by white hyperkeratosis may also be seen in early/mature lesions in dark phototypes (Figs. 12.28b and 12.29b) [8].

Finally, the most characteristic and frequent dermoscopic findings of non-MF PCLs other than lymphomatoid

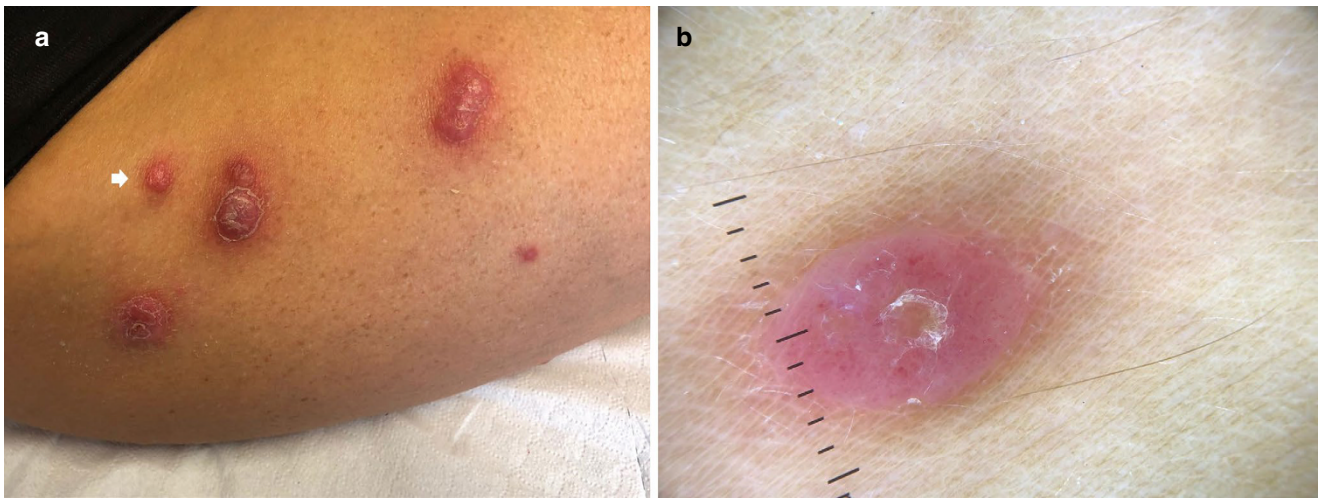

Fig. 12.25 Lymphomatoid papulosis in a Caucasian woman, with multiple red papules/nodules (**a**). Dermoscopy of an early lesion (arrow in clinical image) displays multiple dotted vessels over a reddish background with a subtle brownish halo (**b**)

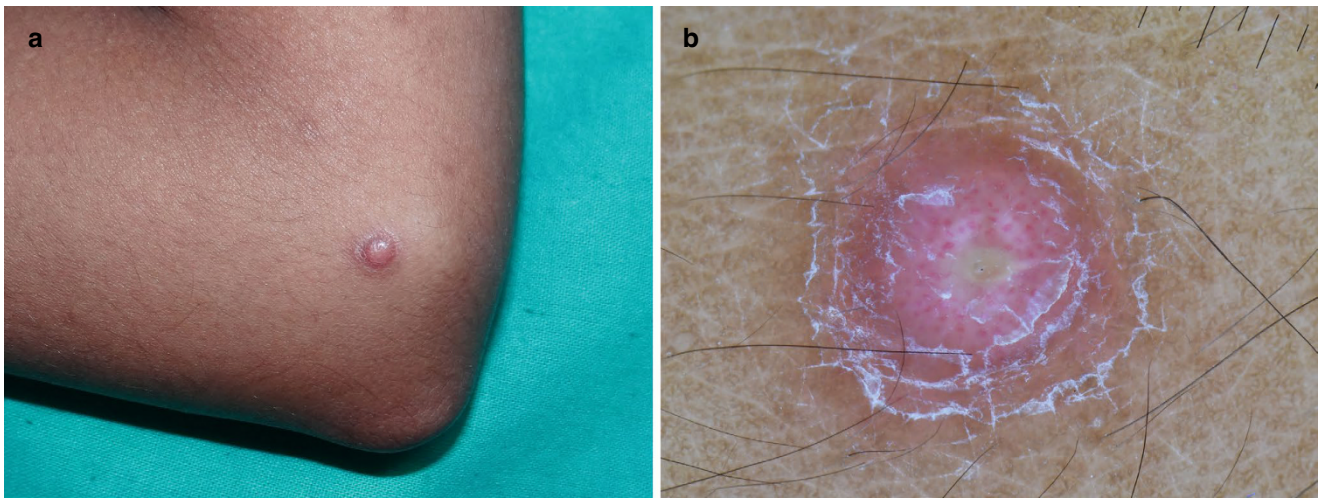

Fig. 12.26 Lymphomatoid papulosis in an Indian man; early lesion appearing as a dome-shaped red-brown papule (**a**) Dermoscopic assessment reveals multiple dotted vessels over a white background along with peripheral white annular scaling and a brown halo (**b**)

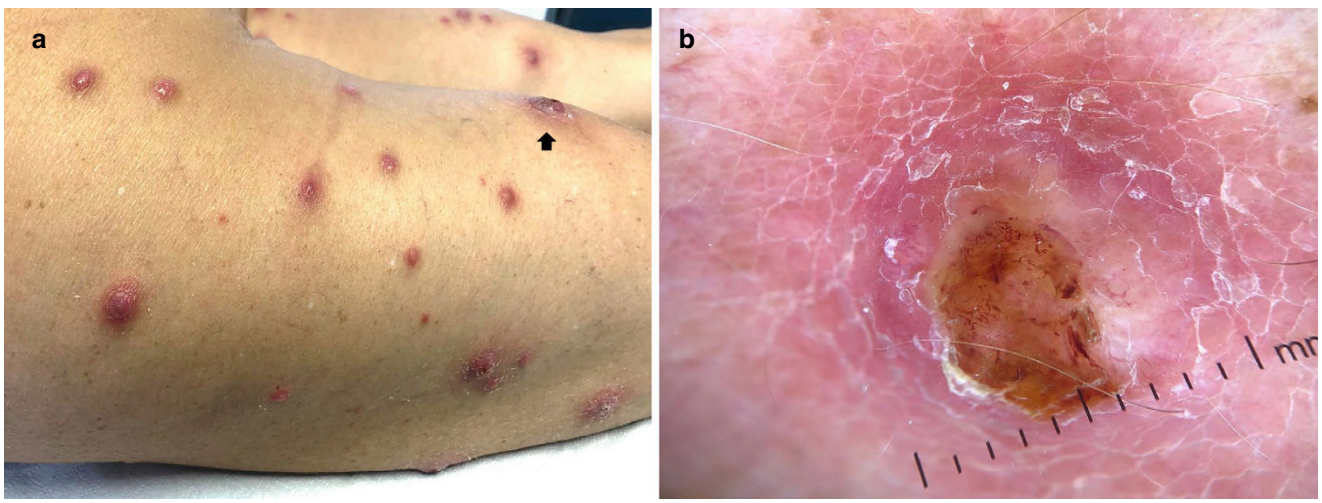

Fig. 12.27 Lymphomatoid papulosis in a Caucasian woman, with polymorphous popular/nodular lesions showing a red hue (**a**). Dermoscopy of a mature lesion (arrow in clinical image) shows a central erosion displaying vessels of mixed morphologies and peripheral white scaling collarette (**b**)

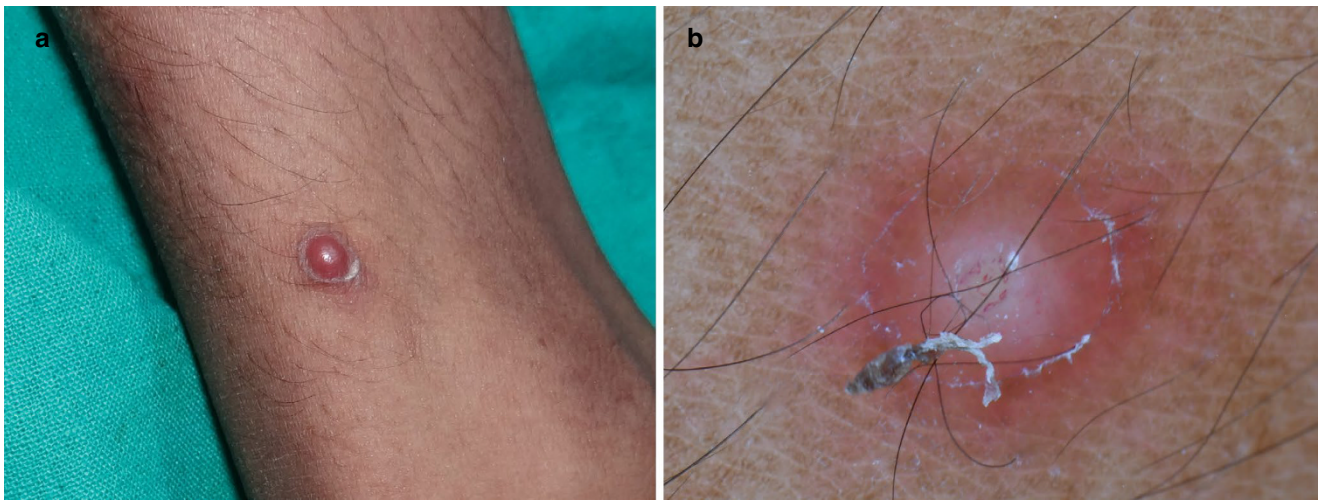

Fig. 12.28 Lymphomatoid papulosis in an Indian man; mature lesion appearing as a dome-shaped red-brown papule with a peripheral scaling collarette (**a**) Dermoscopic assessment reveals a white background surrounded by a scaling collarette located over a brown halo as well as central erosion with vessels of mixed morphologies (**b**)

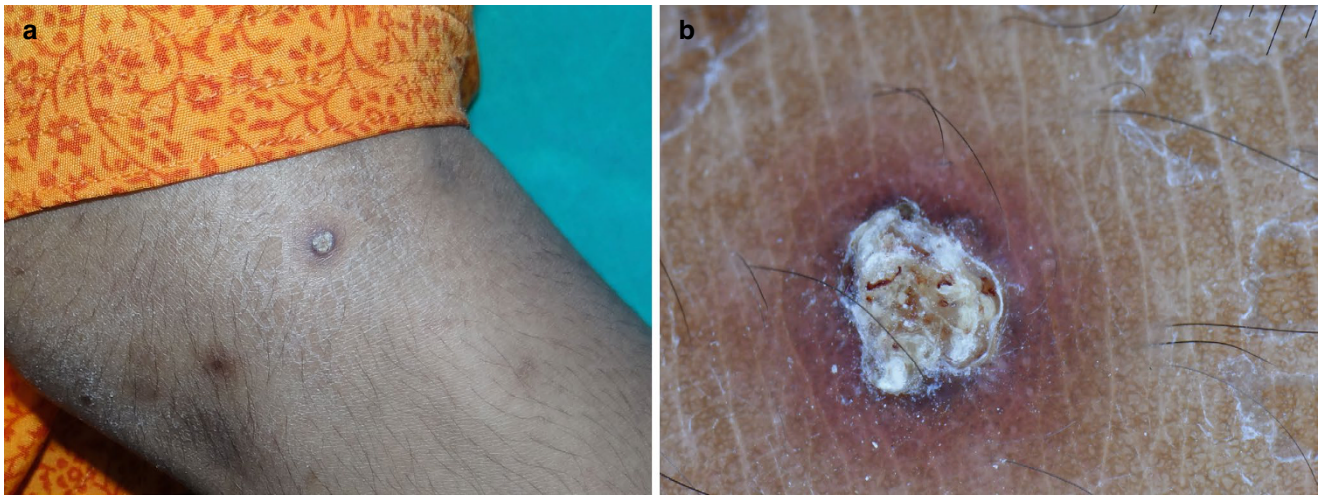

Fig. 12.29 Lymphomatoid papulosis in an Indian woman; hyperkeratotic lesion (**a**) Dermoscopy shows a white hyperkeratotic surface with some hemorrhagic spots and a brown peripheral halo (**b**)

papulosis that clinically present as nodules or plaques in fair-skinned patients include orange and white focal structureless areas (Figs. 12.30b) that are supposed to histologically correlate with the dense dermal cellular infiltrate ("mass effect") and either dermal reactive fibrosis or focally reduced "grenz zone" due to patchy, nodular, more superficial infiltrate in the papillary dermis, respectively [7, 13]. Additionally, unfocused linear vessels with branches are the most frequent vascular pattern of these types of PCLs, followed by linear-curved and dotted vessels; of note, these last vessels' shape is more common in T-cell than B-cell PCLs [7, 13]. On the other hand, nodular/plaque-type PCLs in skin of color are mainly typified by white and brown structureless areas as both vessels and orange areas are usually more difficult to see due the pigmented background (Fig. 12.31b) [8].

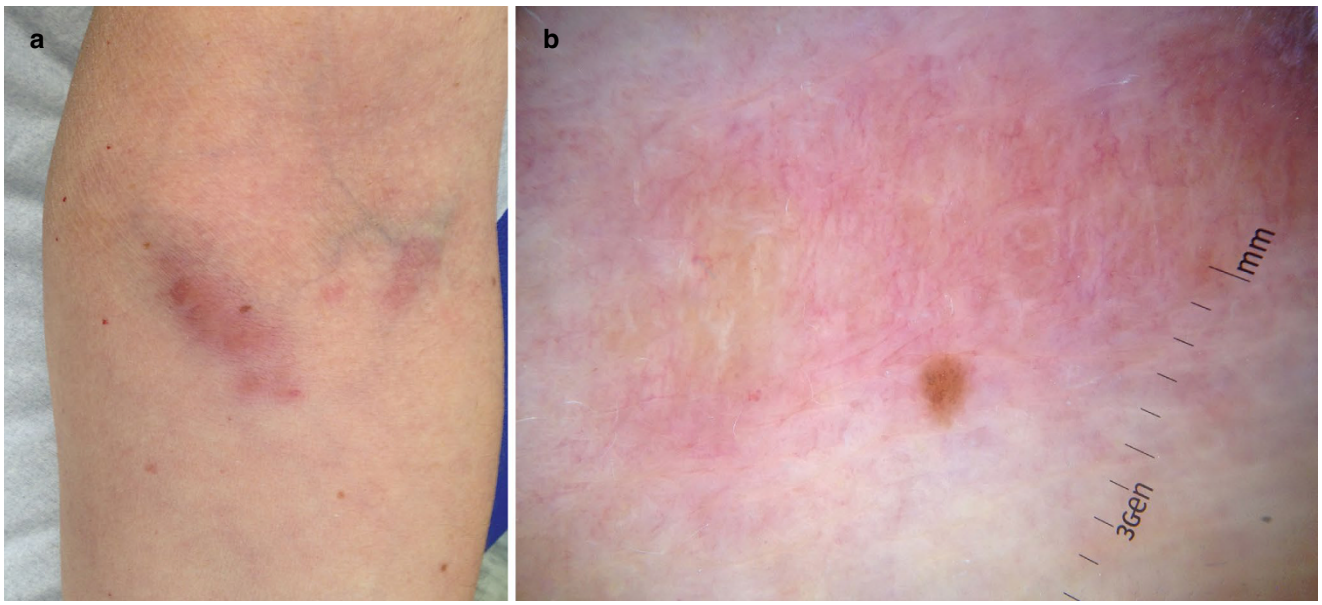

Fig. 12.30 Nodular skin lymphoma (primary cutaneous follicle center lymphoma) in a Caucasian woman (**a**). Dermoscopic assessment displays multifocal orange areas, white areas and lines, and linear/linear-curved vessels (**b**)

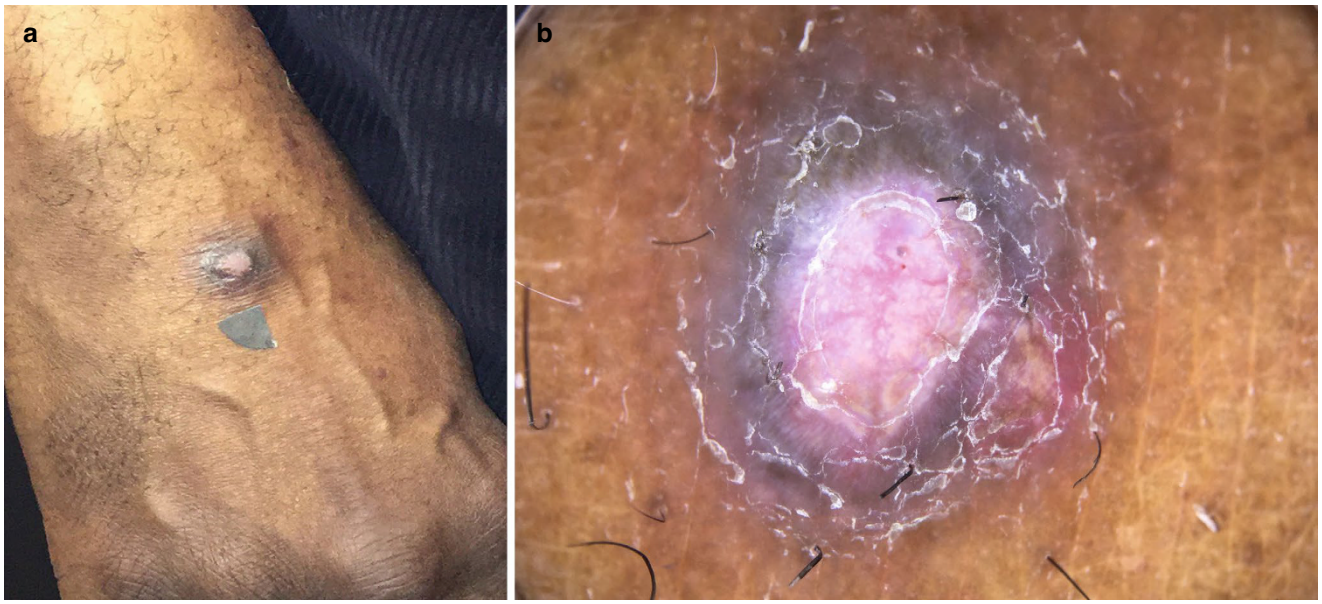

Fig. 12.31 Nodular skin lymphoma (primary cutaneous follicle center lymphoma) in an African American man (**a**). Dermoscopy shows bright white areas with linear vessels and peripheral brown halo (**b**). (*Courtesy of Shamir Geller, MD and Patricia Myskowski, MD – New York, USA*)

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