A case of mistaken identity: primary cutaneous lymphoma presenting as venous ulceration

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CASE REPORT

A 88-year-old woman was referred to the surgical outpatient department with a recurrent, long-standing leg ulcer. On examination she was found to have signs of chronic venous hypertension (varicose veins, varicose eczema and lipodermatosclerosis), and a 10 mm ulcer which was thought to be a benign venous ulcer. Four-layer bandaging was instituted, but the ulcer failed to heal. A punch biopsy was therefore performed which supported the clinical diagnosis of a stasis ulcer. Three months later healing had not taken place, and the ulcer had grown in size and taken on a sinister appearance (*Figure 1*). A presumptive diagnosis of Marjolin's ulcer was made, and she subsequently underwent wide local excision and skin grafting. Histology revealed a high grade cutaneous B cell lymphoma. Excision was complete, with no evidence of regional or distant disease, and no further treatment was undertaken. She unfortunately died soon afterwards from an unrelated problem.

INTRODUCTION

Cutaneous lymphoma is an uncommon entity, but the development of malignancy in a chronic venous ulcer (Marjolin's) is well documented. The following case highlights the importance of biopsy in ulcers which fail to heal (this can be performed under local anaesthesia). Furthermore, it demonstrates the need for maintained clinical suspicion in atypical or non-healing ulcers, even when initial biopsy has failed to demonstrate malignancy.

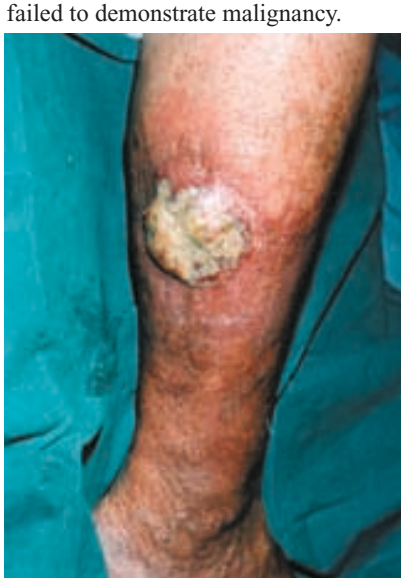

Figure 1. Malignant ulcer arising from postero-lateral aspect of calf.

DISCUSSION

Primary B cell cutaneous lymphoma is a rare tumour, comprising 20% of all cutaneous lymphomas, which has been described in increasing detail over the last 15 years (Domman et al, 1995). It is now recognized that these tumours carry a favourable prognosis, with a tendency to remain localized to a limited area of skin (Santucci et al, 1991). Thus they have a good response to local surgical excision and adjuvant treatment (Watsky et al, 1992).

Patients with multiple lesions, however, comprise a category of patients with aggressive disease, and accordingly a poor prognosis (Nagatani et al, 1993). The less aggressive category of cutaneous lymphoma has now been described in the context of skin-associated lymphoid tissue (SALT), and chronic infective agents such as *Borrelia* have been cited as possible causative agents (Cerroni et al, 1997; Kutting et al, 1997). This view is supported by the observation that some lesions have responded to simple antibiotic therapy, analogous to the response seen in mucosa-associated lymphoid tissue (MALT) tumours following *Helicobacter pylori* eradication.

The occurrence of malignancy within a chronic ulcer is well recognized. Malignancy masquerading as a chronic ulcer is of equal importance. Despite the findings from her initial biopsy, we feel it unlikely that this case represents malignant lymphomatous change in a venous ulcer, a condition not previously reported. Instead, this is a case of malignancy masquerading as benign ulceration, with diagnosis delayed by coincidental disease.

This case highlights a simple principle — an ulcer with atypical features, that fails to respond to recognized treatment, should raise suspicions of malignancy. All suspicious lesions should be biopsied, and biopsy should be repeated if indicated. The possibility of sampling error should be considered, and formal excision may be needed if punch biopsy provides inadequate tissue for analysis. HM

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