Case report

Cutaneous plasmacytosis: Report of a Moroccan case!!

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Received 25 September 2013; accepted 26 November 2013
Available online 18 December 2013

Abstract

Cutaneous plasmacytosis is a rare entity that has been reported almost exclusively in Asian countries and is usually seen in adult males. Primary cutaneous plasmacytosis clinically is characterized by multiple red-brown plaques and nodules typically located on the trunk. We report a case of a Moroccan 65-year-old man presented multiple infiltrated red plaques on the extremities and the trunk, the diagnosis of cutaneous plasmacytosis was retained without systemic involvement. To our knowledge, this is the first case of this type reported in a Moroccan adult man.

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Keywords: Cutaneous plasmacytosis; Systemic plasmacytosis; Lymphoplasmacytic disorder; Moroccan

1. Introduction

Cutaneous plasmacytosis is a rare skin disorder of unknown etiology. This condition has been recognized principally in Asian patients, with a few cases in whites (Xia et al., 2013). Patients presented clinically with multiple, red-brown infiltrated plaques and flat tumors, mainly located on the trunk. The condition can be systemic if polyclonal hypergammaglobulinemia, lymphadenopathy, cutaneous lesions, and systemic symptoms such as fever, weight loss, and fatigue are present (Cheng et al., 2012).

We report a case of 65-year-old man born and grew up in Rabat, presented a primary cutaneous plasmacytosis. To our knowledge, this is the first case of this type reported in a Moroccan adult man.

2. Case report

A 65-year-old male presented with a 2-year history of skin lesions that initially appeared on his lower limbs, then gradually thereafter on his trunk and upper limbs. The lesions were not pruritic. The patient was otherwise healthy and denied any systemic symptoms. His family history was unremarkable for skin disorders or lymphoproliferative disease. On physical examination, the patient had multiple 1 to 6 cm red-brownish macules and infiltrated plaques disseminated symmetrically on the trunk, abdomen, back, upper and lower extremities, sparing the face, scalp and palmoplantar regions (Figs. 1–4) with edema of the lower limbs. There was no enlargement of lymph nodes, liver or spleen.

A skin biopsy taken from his lower limbs showed the presence of a dermal nodular and perivascular mixed cell infiltrate with predominance of plasma cells without atyp-
ical features. The epidermis was not involved (Fig. 5). Immunohistochemical study revealed polyclonality of plasma cells with expression of kappa and lambda light chain (Figs. 6 and 7 and 8).

Laboratory test results revealed no abnormalities in the hemogram. Tests for syphilis and HIV infection were negative. Serologic tests for hepatitis virus types B and C were negative. Serum protein electrophoresis detected polyclonal hypergammaglobulinemia with Ig G 35 g/l (normal, 7–16 g/l), Ig A 6.5 g/l (normal 0.7–4 g/l) and Ig M 3.78 g/l (normal 0.4–2.3). The urine electrophoresis study did not show Bence-Jones protein. A chest radiography and computed tomography scan revealed no apparent extracutaneous involvement.

Following the diagnosis of primary cutaneous plasmacytosis, oral corticosteroids were given with prednisone 40 mg/day which seemed to stabilize the lesions.

3. Discussion

Cutaneous and systemic plasmacytosis is a rare reactive lymphoplasmacytic disorder. It was first described in the
Available treatments for cutaneous plasmacytosis include topical and systemic corticosteroids, topical tacrolimus, systemic chemotherapy, topical photodynamic therapy, PUVA and radiotherapy with poor clinical responses (Miura et al., 2003; Tzung et al., 2005). In our patient, cutaneous lesions were stable after treatment with oral corticosteroids.

4. Conclusion

The dermatologist and dermatopathologist must be aware of this entity and its associations. It is essential to evaluate the patient for systemic disease and the development of a more aggressive disorder.

Description of new cases of cutaneous and systemic plasmacytosis in our country should prompt a search for infectious or environmental cause of the disease.

Conflict of interest

We have no conflict of interest to declare.

References


