microabscesses). Tumor stage reveals a diffuse dermal infiltrate. Cells may lose epidermotropism and show marked size and shape variability cells. Histologic transformation may occur in such cases (>25% large lymphoid cells in the dermal infiltrate). Most cases are CD4 positive. CD30 expression is focal and in less than 50% of cells [1,2,6].

Primary cutaneous aggressive epidermotropic CD8+ cytotoxic T-cell lymphoma is a high-grade, aggressive lymphoma characterized by multiple plaques and tumors which can present with ulceration and necrosis. Histologically, it presents in a lichenoid pattern with characteristic pagetoid epidermotropism by small, medium or large tumor cells with pleomorphic or blastic nuclei. Deep nodular infiltrates are seen. Invasion and destruction of adnexal structures and angioinvasion are commonly observed. A naïve CD45 RA and cytotoxic phenotype is quite characteristic. CD30 is usually negative [2,7].

Primary cutaneous CD8+ T-cell lymphoma, unspecified, characteristically presents as a diffuse nodular infiltrate of atypical lymphoid cells which show loss of T-cell markers and rarely express CD30 in the majority of neoplastic cells. Lack of epidermotropism and perivascular pattern of infiltration are characteristic findings. In our case, systemic lymphoma was ruled out as the patient had no generalized lymphadenopathy, systemic involvement, B symptoms, and was negative for EMA and ALK. There was no history of recurrent eruptions or 3 stages of clinical presentation. CD30 in more than 75% cells and CD8 positivity with lack of epidermotropism, clinched the diagnosis. It is pivotal to highlight that systemic ALCL can present as isolated cutaneous disease. Although negativity for ALK and EMA can successfully differentiate most cases of PC-ALCL, few cases are positive for ALK and in all such cases, a close follow up for atleast 6 months is mandatory [2,3].

PROGNOSIS

PC-ALCL has an extremely favorable prognosis with the 5-year survival rate of 90%[1]. Few cases (upto 25%) show spontaneous regression of the skin lesions. CD8+ expression alone is not an indicator of poor prognosis, but when combined with a high Ki-67 index, has shown to have a more aggressive and prolonged clinical course. Relapses and systemic dissemination are more common in such cases and in multifocal lesions[2].