pruritus were slowly improving, although they had not completely disappeared.

Discussion | In 1995, Benchikhi et al4 reported the first case of cutaneous B-cell lymphoma associated with follicular mucinosis in a patient with bone-marrow and peripheral blood infiltration.4 We report the first case of primary cutaneous follicle center lymphoma with follicular mucinosis.

Cutaneous lymphomas can usually be distinguished by architectural features, where all atypical lymphocytic infiltrates implicate cutaneous T-cell lymphoma, especially when the areas of epidermotropism are present; cutaneous B-cell lymphomas often appear with a nodular to diffuse lymphoid infiltrate and relative sparing of the epidermis. However, B-cell lymphomas can sometimes show atypical lymphoid infiltrates mainly limited to the papillary dermis, epidermotropism, interstitial involvement, and absence of grenz zone, mimicking mycosis fungoides.5,6 To date, at least 3 cases have been reported of epidermotropic marginal zone B-cell lymphoma.6 Immunohistochemical studies demonstrating B-cell phenotype (CD20, and CD79a positivity) with marginal zone differentiation (BCL2 positivity, and BCL6, CD10 and CD5 negativity) for the epidermotropic cells, as well as the majority of the dermal cells, confirmed the diagnosis in these cases. In our case, the tumor cells tested diffusely positive for BCL-6, which rather suggested a follicular center differentiation.

In summary, our case represents the first case to our knowledge of primary cutaneous follicle center lymphoma with follicular mucinosis and a very unusual milia clinical presentation. Morphologic findings, often used to distinguish among different types of cutaneous lymphomas, can sometimes be misleading, and molecular characterization is important to support the diagnosis.

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Periorbital Subcutaneous Emphysema Mistaken for Unilateral Angioedema During Dental Crown Preparation

Subcutaneous emphysema, defined as the abnormal introduction of air into subcutaneous tissues, is a rare complication of dental treatment. More common causes of this entity include trauma, head and neck surgery, and general anesthesia. We present a case of periorbital subcutaneous emphysema that clinically appeared as unilateral angioedema during a dental treatment.

Figure 2. Histologic Specimens From Primary Cutaneous Follicle Center Lymphoma With Follicular Mucinosis

A, High-magnification image showing follicular mucinosis and follicular tropism of the atypical lymphocytes (hematoxylin-eosin, original magnification ×100). B, Dense CD20+ lymphoid proliferation around and within the pilosebaceous unit (CD20 staining, original magnification ×100).
A 72-year-old woman with a medical history of hypertension and hypothyroidism presented to her dentist for a crown preparation of the left maxillary second molar. She denied any recent medication changes and had no history of urticarial drug reactions. She had a history of chronic periodontal disease, which left her with 4 mm of exposed root and a lack of attached gingiva.

During the dental procedure, 1 carpule of 4% articaine hydrochloride with 1:100 000 epinephrine was injected using a 30-gauge needle at the height of the mucobuccal fold of the left maxillary second molar (local infiltration). Nitrous oxide gas was also administered for 35 minutes at the patient’s request. Knitted retraction cord size No. 0 impregnated with aluminum chloride hexahydrate was placed in the gingival sulcus to retract the buccal mucosa and obtain hemostasis. No air-driven tools were used for shaping the tooth.

In preparation for the final impression, the site was then thoroughly rinsed with a combination of air and water, under equal pressure, using an air-water syringe. Within minutes, the patient developed significant soft-tissue swelling of the left lower eyelid and malar cheek. Vital signs were stable. She did not report any pain, visual problems, or difficulty breathing. The procedure was suspended. Twenty-five milligrams of diphenhydramine was administered for a suspected angioedema, and she was escorted to the emergency department (ED) for further evaluation.

Physical examination in the ED revealed prominent soft-tissue swelling of the left lower eyelid and malar cheek (Figure), and crepitus was noted on palpation. Subcutaneous emphysema was diagnosed. Her symptoms resolved over 5 days without any further complications. The patient’s dental treatment was accomplished several weeks later without incident.

Discussion | Subcutaneous emphysema is a rare complication of dental treatment that has been reported in the dental literature.1–5 Dermatologists, emergency care providers, and primary care physicians should be aware of this complication which could be misinterpreted as angioedema as part of an anaphylactic reaction. Tooth extraction, especially the mandibular third molar, is the most commonly reported portal of entry of subcutaneous emphysema. The widespread use of air-driven handpieces has led to an increased risk of iatrogenic subcutaneous emphysema. In this case, no air-driven tools were being used immediately prior to the observation of the reaction. We suspect that the lack of attached gingiva would have allowed air to penetrate under the unattached gingiva during the placement of the retraction cord or during use of the air-water syringe used to maintain dryness and visibility.

Once air enters under the dermal layer, it may remain locally at the surgical site or continue to dissect along the fascial planes. The clinical results are local swelling, tenting of the skin, and crepitation on palpation. In extreme cases, air introduced under high pressure could pass through the masticatory space into the parapharyngeal and retropharyngeal areas, penetrating into the mediastinum. As a result, air embolism is a very rare but serious potential complication.3–4 Patients with subcutaneous emphysema usually recover spontaneously without use of any specific treatment, as was the case with our patient.1

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Recurrent Abscesses of the Neck: Scrofuloderma

Tuberculosis of the skin has become a rare disease in industrialized countries. Polymerase chain reaction (PCR) is a powerful diagnostic tool for mycobacterial infections of the skin, but it can fail, as demonstrated in this case.

Report of a Case | A woman in her 80s was referred for surgical treatment of a cervical abscess. Similar abscesses erupted in the cervical region over the course of 2 years (Figure 1A). A needle aspiration biopsy was performed on a node at the left side of the neck, which measured 2 cm. The histopathologic report described a minor nonspecific inflammatory reaction, not suggestive of infection. Findings of the *Mycobacterium tuberculosis* PCR were negative. A culture was not performed. Two months later, the whole nodule was excised, including the adjacent inflamed skin. The resulting defect, with a diameter of 7 cm, was closed with a rotary-transposition flap. During this intervention, the thoracic nerve was injured resulting in an elevation palsy of the left arm. The histopathologic report of the excised tissue again showed a nonspecific inflammatory reaction; no microbiological analysis was conducted.

At presentation, the patient had puckered scars scattered over the neck in addition to an unusual “cold abscess” (Figure 1B). The clinical appearance was suggestive of scrofuloderma. Results of the Mendel-Mantoux test were positive (diameter, 20 mm), as were those from the interferon-γ release assay. However, PCR findings from the skin biopsy specimen and abscess material were negative for *M tuberculosis*. Histologically, no acid-fast bacilli could be detected by Ziehl-Neelsen staining.

Cervical sonography and magnetic resonance tomography revealed multiple abscesses in the lateral muscle lobe. Chest radiography excluded pulmonary tuberculosis. Laboratory work showed an elevated level of C-reactive protein (115 mg/L; normal, <5 mg/L) but no other pathological findings. (To convert C-reactive protein to nanomoles per liter, multiply by 9.524.)

After 19 days, *M tuberculosis* was cultivated from the skin specimen (Figure 2). The strain was sensitive to isoniazid, rifampicin, pyrazinamide, ethambutol, and streptomycin.

Classic quadruple treatment with isoniazid, 300 mg/d; pyrazinamide, 1500 mg/d; ethambutol, 1200 mg/d; and rifampicin, 600 mg/d, was initiated. After 2 months, the regimen was reduced to isoniazid and rifampicin. After 4 months of the reduced regimen, all skin lesions had healed completely, leaving scars, and sonography revealed no remaining abscesses. Treatment was well tolerated, and at 24-month follow-up, no new nodules had evolved.

Discussion | From 1% to 2% of tuberculosis cases are cutaneous tuberculosis (CTB). Tuberculosis cutis colliquativa, also known as scrofuloderma, is the most common CTB subtype in Europe. Scrofuloderma is a subcutaneous form of CTB manifesting with cold abscesses most commonly on the neck that spreads from underlying lymph nodes. Infection can also involve joints, bones, and epididymis. The same quadruple antibiotic therapy is used as in pulmonary tuberculosis. Before treatment is begun, possible multidrug resistance should be excluded.