pearing in healthy patients. Over time, CA-MRSA incorporated new virulence patterns, acquiring large-scale antibiotic resistance, while maintaining a unique genetic profile compared with nosocomial isolates. Better appreciated through a retrospective lens, this CA form rivals its hospital-based counterpart and can aptly be considered an epidemic.5

*A baumannii* has the potential to evolve in a pattern similar to that of MRSA and should be monitored for growing resistance and virulence. Epidemiologic history has demonstrated how quickly an organism can evolve from benign commensal to resistant pathogen and highlights the need for intense vigilance with regard to infection control and treatment development.2 With continued accrual of pathogenicity and antibiotic resistance, *A baumannii* is offering new diagnostic and therapeutic challenges. Enhanced awareness is paramount to control this growing threat as the practice gap continues to widen.

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Primary Cutaneous Follicle Center Lymphoma With Follicular Mucinosis

*Follicular mucinosis* (FM) is defined as the accumulation of a mucinous material within the hair follicle. Since its first description by Pinkus5 in 1957 in the setting of alopecia mucinosa, 2 main forms have been classically recognized: a benign idiopathic form, primary follicular mucinosis (PFM), which usually appears in young adults and regresses spontaneously; and a secondary form, lymphoma-associated follicular mucinosis (LAFM),2 which mostly occurs in elderly patients. Most cases of LAFM are related to cutaneous T-cell lymphomas (especially mycosis fungoides), although some cases of Hodgkin disease3 and chronic lymphocytic leukemia4 have also been reported.

Report of a Case | A man in his 60s initially presented with a history of an intermittently pruritic eruption on the chest and proximal limbs. Two skin biopsies were performed on the neck and the back. The lesions were reported as primary, cutaneous, low-grade, B-cell lymphoma favoring marginal B-cell lymphoma. The peripheral blood sample test results and the bone marrow core biopsy findings were normal. Computed tomographic scans did not reveal any abnormality. The patient was never treated and did not come back because the lesions disappeared spontaneously. Eight years later, he presented with multiple, millimetric, pruritic, skin-colored papules with a follicular pattern on the chest, back, and upper extremities (Figure 1). He did not have any constitutional symptoms.

Two biopsies performed on the chest and the abdomen revealed dense lymphocytic infiltrate in the reticular dermis, centered around and within hair follicles, which showed cavities filled with abundant mucinous material (Figure 2A). Small and irregular lymphocytes were admixed with large lymphocytes, plasma cells, and eosinophils. Atypical cells expressed CD20, CD43, CD79α and BCL6. Some intraepithelial lymphocytes tested positive for CD3 and CD4, but most of them expressed CD20 (Figure 2B). Polymerase chain reaction revealed a monoclonal rearrangement of the heavy chain immunoglobulin IgH gene with a peak at 160 base pairs. A reactive lymphoid T cell (CD3, CD43 and CD4 positive) infiltrate was found surrounding the neoplastic cells.

The patient was finally diagnosed as having primary cutaneous follicle center lymphoma associated with follicular mucinosis. At last follow-up 4 months later, the lesions and the

Figure 1. A Case of Primary Cutaneous Follicle Center Lymphoma With a Very Unusual Miliary Clinical Presentation

Multiple, diffuse, pruritic, skin-colored papules show a follicular pattern on the chest.
pruritus were slowly improving, although they had not completely disappeared.

**Discussion** | In 1995, Benchikhi et al^4^ 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 most atypical lichenoid infiltrates implicate cutaneous T-cell lymphoma, especially when 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. To date, at least 3 cases have been reported of epidermotropic marginal zone B-cell lymphoma. 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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