Lymphomatoid Papulosis in Children: Report of 9 Cases and Review of the Literature

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KEYWORDS
Cutaneous T-cell lymphoma;
Lymphomatoid papulosis;
Childhood

Abstract
Background: Lymphomatoid papulosis is a rare CD30+ T-cell lymphoproliferative disease with an excellent prognosis. It is usually seen in adults and is rare in children. The clinical and pathologic manifestations and the risk of progression to other types of lymphoma are thus not clearly defined in the pediatric age group.
Objective: To describe the characteristics of lymphomatoid papulosis in a group of children and perform a review of the literature.
Patients and methods: A retrospective study was performed of 9 patients under 18 years of age diagnosed with lymphomatoid papulosis and treated in our department between 1995 and 2009.
Results: The study included 7 boys and 2 girls aged between 2 and 17 years. Lesions compatible with pityriasis lichenoides acuta appeared before the lymphomatoid papulosis in 2 cases and afterwards in 1 case. The lymphomatoid papulosis lesions resolved spontaneously, leaving postinflammatory hyperpigmentation (77%) or hypopigmentation (23%). Scarring occurred in 77% of cases. Histologically, all cases showed features compatible with lymphomatoid papulosis type A. Molecular studies showed monoclonality in all 3 cases in which this technique was performed.
Conclusions: Lymphomatoid papulosis is a rare disease in childhood and the manifestations are similar to the adult form. This lymphoproliferative disease, occasionally associated with pityriasis lichenoides acuta, has histological features compatible with a type A or histiocytoid pattern. Progression to other lymphoproliferative disorders during follow-
**Introduction**

Lymphomatoid papulosis was described by Macaulay\(^1,2\) in 1968 as a benign clinical condition with the histological characteristics of a malignant lymphoma. Once considered an inflammatory process, it is currently defined as an indolent cutaneous lymphoma that principally affects adults. The etiology of the disease is unknown. In 20% of cases, malignant lymphoproliferative disease occurs concomitantly or during long-term follow-up.

Lymphomatoid papulosis is exceptional in childhood, and neither its clinicopathologic characteristics nor the risk of developing malignant lymphoproliferative disease has been well established. We report 9 cases of lymphomatoid papulosis in patients aged between 2 and 17 years and we analyze the main characteristics of this process in children by reviewing previously published cases and compare it with the characteristics observed in adult patients.

**Material and Methods**

**Patients**

We performed a retrospective study using the clinical history of all patients aged 1 to 18 years diagnosed with lymphomatoid papulosis at the Niño Jesús Children’s Hospital in Madrid, Spain. The patients were treated between January 1, 1995 and September 30, 2009.

We analyzed the following parameters: age, sex, presenting lesion and distribution pattern, maximum number of lesions in an outbreak (1-5, 6-10, 11-20, >20), up is less common in the childhood form than in adults. The frequent association of pityriasis lichenoides acuta and lymphomatoid papulosis observed in our study, and the difficulty distinguishing between these 2 conditions in some cases, suggest that these diseases could be part of a single clinical-pathological spectrum.

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**PALABRAS CLAVE**

Linfoma cutáneo de células T; Papulosis linfomatoide; Infancia
presence of associated symptoms, residual lesions, number of outbreaks per year, and long-term follow-up (5 years of periodic checkups).

**Histopathology**

Conventional microscopy was performed using 4% formalin-fixed paraffin-embedded biopsy specimens stained with hematoxylin-eosin. Immunohistochemistry was performed with an automatic immunostainer (Dako Autostainer Link 48, Dako, Denmark) using the EnVision FLEX detection system (Dako). We used antibodies against epithelial membrane antigen, CD2, CD3, CD4, CD8, CD20, CD79a, CD15, CD30, and CD68. Molecular analysis of T-cell receptor rearrangement was carried out in 3 cases.

Analysis of cases was based on morphology following a recent classification differentiating 3 well-defined types of lymphomatoid papulosis: a) type A, or histiocytic type, which is characterized by a mixed infiltrate composed mainly of small lymphocytes and numerous large atypical lymphocytes, accompanied by varying numbers of neutrophils and macrophages, with occasional isolated eosinophils; b) type B, or mycosis fungoides-type, which is characterized by a monomorphous infiltrate of small to medium-sized lymphocytes with cerebriform nuclei; and c) type C, or large cell-type, which is defined as a dense infiltrate composed mainly of large atypical lymphocytes.3

**Results**

Patient data are shown in Table 1.

**Typical Case Report (Patient 5, Table 1)**

A 6-year-old child with no personal or family history of interest attended our dermatology department due to a 2-year history of repeated outbreaks (2 episodes per year) of multiple red-violaceous papules (11-20 lesions) less than 1 cm in diameter that were distributed symmetrically on his legs (Figure 1A). The lesions were asymptomatic, infiltrated, and indurated to the touch; some showed central ulceration with slough. The outbreaks tended to resolve spontaneously after 6-8 weeks of follow-up, leaving areas of residual hypopigmentation and discreet varioliform scars. No other clinical abnormalities were observed and the physical examination was normal.

Analysis of a biopsy specimen revealed a dense, predominately perivascular dermal infiltrate in the papillary and reticular dermis and along the basement membrane. Marked epidermotropism and secondary ulceration of the epidermis were also observed (Figure 1B and C). The inflammatory infiltrate was composed mainly of small lymphocytes and other, larger lymphoid cells with a vesicular nucleus and prominent nucleoli that were reminiscent of Reed-Sternberg cells (Figure 1D). Histiocytes, neutrophils, and isolated eosinophils were also present (Figure 1C and D). Immunohistochemistry revealed all the lymphoid cells to be positive for CD3 and CD8, whereas CD30 immunostaining was only observed in small groups of large cells. This infiltrate was negative for epithelial membrane antigen, CD15, CD20, and CD79a. The cells of the lesion were CD68-negative but accompanying histiocytes were CD68-positive. Polymerase chain reaction performed to analyze T-cell receptor rearrangement revealed a monoclonal population of T lymphocytes.

As type A lymphomatoid papulosis was diagnosed, no treatment was administered.

**Analysis of the Results**

The study sample included 7 boys (77%) and 2 girls (23%) aged between 2 and 17 years (median, 8 years). Two patients developed lymphomatoid papulosis lesions in the context of acute pityriasis lichenoides that was histologically confirmed and had started some years before.

In all 9 cases (100%), the lesions presented as mild to moderately infiltrated red-brownish and/or erythematous-violaceous papules. The maximum number of lesions per outbreak varied between 11 and 20 in 7 cases (77%); fewer than 10 were observed in the other 2 cases. The lesions were pruriginous in 33% of cases and were distributed, in descending order of frequency, on the lower limbs (9 cases, 100%), upper limbs (8 cases, 88%), trunk (4 cases, 44%), and face (1 case, 10%). Of note, the greatest concentration was on the limbs in all cases, whereas in those cases in which the face and trunk were involved, the lesions were isolated (Table 1). The lesions resolved spontaneously in all cases, leaving hyperpigmentation (7 cases, 77%) or postinflammatory hypopigmentation (2 cases, 23%). Residual varioliform scars were observed in 7 patients (77%).

The number of outbreaks per year varied between 2 and 3 in 8 patients (90%). One patient showed a single outbreak that was not subsequently accompanied by new cutaneous symptoms during follow-up. In 6 cases (66%), the disease remained active after 5 years of follow-up. Two patients (22%) were in remission after 3 years of follow-up. One case (12%) only showed activity during the first year of follow-up.

None of the 9 cases presented relevant complications during the 5 years of follow-up. Nevertheless, 1 patient developed lesions that were clinically and histologically compatible with chronic pityriasis lichenoides.

In all 9 cases, histopathology was compatible with lymphomatoid papulosis type A. The molecular study of T-cell receptor rearrangement revealed monoclonality in the 3 cases in which it was performed.

**Discussion**

Lymphomatoid papulosis is a disease of unknown etiology. According to the European Organization for Research and Treatment of Cancer, it is classified as an indolent cutaneous CD30-positive large T-cell lymphoma.

It generally affects adults aged between 40 and 60 years, irrespective of race or sex. It takes the form of multiple outbreaks of papulonodular lesions and, less commonly, vesiculopustular lesions located mainly on the trunk and limbs. The lesions tend to resolve spontaneously, occasionally leaving a residual scar. The outbreaks last from weeks to months, and the disease-free interval varies
<table>
<thead>
<tr>
<th>No./Sex/Age</th>
<th>History of Interest</th>
<th>Presenting Lesion</th>
<th>Distribution Pattern and Severity*</th>
<th>Associated Symptoms</th>
<th>Maximum Number of Lesions in an Outbreak</th>
<th>Residual Lesions</th>
<th>Histopathologic Pattern</th>
<th>Molecular Rearrangement</th>
<th>No. of Outbreaks Per Year</th>
<th>Duration of Disease (5 y)</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/girl/5 y</td>
<td>No</td>
<td>Brownish nonconfluent papules with ulceration</td>
<td>Upper limbs (++), lower limbs (+), and trunk (+)</td>
<td>No</td>
<td>6-10</td>
<td>Areas of residual hyperpigmentation and varioliform scars</td>
<td>Type A&lt;sup&gt;i&lt;/sup&gt;</td>
<td>Not done</td>
<td>1 single outbreak</td>
<td>1 y</td>
<td>No complications</td>
</tr>
<tr>
<td>2/boy/2 y</td>
<td>No</td>
<td>Nonconfluent infiltrated reddish-violaceous nodules and papules, some with central necrosis</td>
<td>Upper limbs (+++), lower limbs (++), and trunk (+)</td>
<td>No</td>
<td>11-20</td>
<td>Areas of residual hyperpigmentation and varioliform scars</td>
<td>Type A&lt;sup&gt;i&lt;/sup&gt;</td>
<td>Not done</td>
<td>3 Persistence after 5 y of follow-up</td>
<td>No complications</td>
<td></td>
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<tr>
<td>3/boy/8 y</td>
<td>No</td>
<td>Brownish nonconfluent papules with ulceration</td>
<td>Upper limbs (+++), Pruritus, lower limbs (++), and trunk (+)</td>
<td>No</td>
<td>11-20</td>
<td>Areas of residual hyperpigmentation</td>
<td>Type A&lt;sup&gt;i&lt;/sup&gt;</td>
<td>Not done</td>
<td>3 Persistence after 5 y of follow-up</td>
<td>No complications</td>
<td></td>
</tr>
<tr>
<td>4/boy/5 y</td>
<td>No</td>
<td>Brownish nonconfluent papules with ulceration</td>
<td>Upper limbs (++), and lower limbs (+)</td>
<td>No</td>
<td>6-10</td>
<td>Areas of residual hyperpigmentation and varioliform scars</td>
<td>Type A&lt;sup&gt;i&lt;/sup&gt;</td>
<td>Not done</td>
<td>2 Persistence after 5 y of follow-up</td>
<td>No complications</td>
<td></td>
</tr>
<tr>
<td>5/boy/6 y  (Figure 1)</td>
<td>No</td>
<td>Brownish nonconfluent papules with ulceration</td>
<td>Lower limbs (+++)</td>
<td>No</td>
<td>11-20</td>
<td>Areas of residual hyperpigmentation and varioliform scars</td>
<td>Type A&lt;sup&gt;i&lt;/sup&gt;</td>
<td>Monoclonality</td>
<td>2 Persistence after 5 y of follow-up</td>
<td>No complications</td>
<td></td>
</tr>
<tr>
<td>Case</td>
<td>Age/Sex</td>
<td>Clinical Features</td>
<td>Histologic Features</td>
<td>Monoclonality</td>
<td>Persistence</td>
<td>Development</td>
<td></td>
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<tr>
<td>6/girl/10 y</td>
<td>Erythematous-violaceous papules with a central necrotic crust</td>
<td>Upper limbs (+++) and lower limbs (+++)</td>
<td>Areas of residual hyperpigmentation and varioliform scars</td>
<td>Type A&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Monoclonality 2</td>
<td>Persistence after 5 y of follow-up</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7/boy/8 y</td>
<td>Firm desquamative erythematous-brownish papules associated with other ulcerated violaceous papular lesions</td>
<td>Upper limbs (+++), pruritus, lower limbs (+++), and trunk (+)</td>
<td>Areas of residual hyperpigmentation and varioliform scars</td>
<td>Type A&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Not done 3</td>
<td>Persistence after 5 y of follow-up</td>
<td></td>
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<tr>
<td>8/boy/17 y</td>
<td>Infiltrated and indurated erythematous-violaceous papules, some with central ulceration</td>
<td>Upper limbs (+++), no lower limbs (+++), and face</td>
<td>Areas of residual hyperpigmentation</td>
<td>Type A&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Monoclonality 3</td>
<td>3 y, No complications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9/boy/9 y</td>
<td>Indurated nodules and papules, some with central ulceration</td>
<td>Upper limbs (++), pruritus, and lower limbs (+++)</td>
<td>Areas of residual hyperpigmentation and varioliform scars</td>
<td>Type A&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Not done 2</td>
<td>Persistence after 5 y of follow-up</td>
<td></td>
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</table>

Abbreviation: AVPL, acute varioliform pityriasis lichenoides.

<sup>a</sup>Grading of concentration of lesions: +, fewer than 5; ++, between 5 and 10; ++++, more than 10.

<sup>b</sup>Type A lymphomatoid papulosis is a deep and superficial perivascular dermal polymorphous infiltrate composed predominately of large atypical CD3 lymphocytes and CD3<sup>+</sup>, CD20<sup>-</sup>, CD15, and epithelial membrane antigen, together with CD3<sup>-</sup>CD20<sup>+</sup> cells and, to a lesser extent, neutrophils, histiocytes, plasma cells, and occasional eosinophils.
from weeks to years. In a large number of patients, this disease-free interval generally increases progressively until the outbreaks stop. Prognosis is excellent, with an overall survival of 100% at 5 years.3

The 3 histological patterns of lymphomatoid papulosis show no correlation with long-term prognosis. The most common form, affecting 75% of cases, is type A (histiocytic), which is characterized by a mixed infiltrate composed mainly of small lymphocytes and multiple large atypical lymphocytes or histiocytic cells. Up to 4% of cases are type B (mycosis fungoides-type), which is characterized by a monomorphic infiltrate of small and medium-sized lymphocytes with a cerebriform nucleus. Lastly, type C (large cell-type), which is characterized by a dense infiltrate composed mainly of large atypical lymphocytes, affects 13% of cases.3

The main complication of this condition during long-term follow-up is the occurrence of lymphoproliferative disease in 5%-20% of patients3; this mainly corresponds to mycosis fungoides, but Hodgkin lymphoma or cutaneous and systemic CD30-positive anaplastic large-cell lymphoma may also occur.4

Exceptionally, the process manifests for the first time in childhood (defined as all patients aged under 18 years). To date, approximately 70 cases of lymphomatoid papulosis have been described in children.5-10 Most cases were reported in 3 large series of 35, 14, and 10 patients by Van Neer et al,5 Nijsten et al,6 and De Souza et al,7 respectively.

Lymphomatoid papulosis in childhood, which accounts for 2%-9% of all cases,3 is slightly more common in boys aged between 1 and 17 years (median, 8 years).5-10 These epidemiologic data are consistent with the results of our series, in which 77% of patients were male, with a mean age of 7.6 years. Initial presentation tends to be earlier in boys (median, 5.5 y) than girls (median, 12 years).5-10

It is striking that in 2 patients in our series the disease first manifested some years before as lesions that were clinically and histologically compatible with pityriasis lichenoides before progressing to CD30-positive lymphoproliferative lesions (Figure 2A and B).

The clinical characteristics of lymphomatoid papulosis in childhood do not seem to differ substantially from the adult form. The latter is characterized by recurrent outbreaks of papules and/or nodules that are symmetrically distributed on the limbs (88% of cases),
where they are more intense and common than on
the trunk (44% of cases) or the face (10% of cases).2–10
The localized and follicular variants of lymphomatoid
papulosis, which are exceptional forms of this condition,
have been reported more commonly in lymphomatoid
papulosis in childhood.2,8 In contrast, involvement of
the oral mucosa has been reported in adults but not in
children.11 The lesions are often asymptomatic; however,
in our series, 33% presented associated pruritus, which has
been reported in up to 40% of cases in the literature.3–10
Recurrent episodes of lymphomatoid papulosis typically
last from 2 to 8 weeks before resolving spontaneously.
Residual scarring is relatively frequent, appearing in
77% of cases in our study. This finding is consistent with
those published elsewhere.3–5 Duration was variable,
although it remained active more commonly after 5 years
of follow-up.

Histologically, lymphomatoid papulosis in childhood
can present any of the 3 patterns described above.
However, previous series show that the most common
pattern is type A (histiocytic).5–10 All of our patients
presented this pattern; therefore, we conclude that,
with few exceptions, type A is the histopathologic pattern
that occurs in pediatric patients. Immunohistochemically
atypical cells are positive for CD2, CD3, and CD30. Isolated
large atypical cells and those that form small groups are
positive for CD30. Nevertheless, unlike the adult form,
in which the predominant lymphocytes in the infiltrate
are CD4+CD8–,3 the infiltrate in the pediatric variant more
commonly contains a predominance of cytotoxic CD8–
T lymphocytes.5,6,12 The results of cell clonality testing
are variable and lack prognostic value.3,5–10 However,
the monoclonal character of the 3 patients we analyzed
did enable us to confirm the diagnosis of lymphomatoid
papulosis.

A joint analysis of the 6 large series of lymphomatoid
papulosis in childhood revealed the existence of only 3
patients who developed a new lymphoproliferative process
in their long-term follow-up. The 3 patients, who belonged
to the series reported by Nijsten et al,6 developed Hodgkin
lymphoma between 1 month and 17 years after the first
manifestations of lymphomatoid papulosis. In our study,
no patients presented complications during the 5 years of
follow-up.

Pediatric lymphomatoid papulosis should mainly be
differentiated from insect stings and pityriasis lichenoides.
Insect stings are self-limiting and have a shorter course.
Histopathology reveals a mixed inflammatory infiltrate
in the shape of an inverted pyramid with its base
parallel to the epidermis and in which eosinophils
predominate. In general, pityriasis lichenoides differs
clinically and histopathologically from lymphomatoid
papulosis. It presents as rapid outbreaks of nonindurated
and noninfiltrated multiple papules and erythematos
desquamative plaques. In histological terms, pityriasis
lichenoides is characterized by epidermal parakeratosis
with vacuolar degeneration of the basement membrane
associated with multiple necrotic keratinocytes and a
lichenoid inflammatory infiltrate composed mainly of
mature T lymphocytes that are CD30-negative or mildly
positive and disperse. However, it is sometimes difficult
to distinguish clearly between acute pityriasis lichenoides
and lymphomatoid papulosis, since there are cases in
which both entities overlap clinically and histologically.
In these cases, the symptoms and progress of the condition
make it possible to establish a definitive diagnosis
(Table 2). Furthermore, the difficulties in differentiating
between these entities, together with the high frequency
of concomitant pityriasis lichenoides and lymphomatoid
papulosis in our series, suggest that they could form part
of a common clinical spectrum.

In many cases, treatment of pediatric lymphomatoid
papulosis is not necessary, since longer active disease is
not associated with a poorer prognosis. With currently
available treatments, remission is not complete, only
partial and temporary. Therefore, treatment is only
indicated in the presence of associated symptoms (eg,
pruritus) or for cosmetic reasons in cases of outbreaks
with several lesions. In lymphomatoid papulosis in childhood,
the main problem lies in the parental anxiety these
lesions cause. Treatment includes topical or systemic
corticosteroids, oral antibiotics (mainly macrolides),13,14
psoralen-UV-A, and UV-B.11

We report this series of pediatric lymphomatoid papulosis
because the disease is uncommon, and, therefore, poorly
characterized in children. Our clinical and pathology
findings agree with those published elsewhere. It is
important to remember that patients with lymphomatoid
papulosis may also experience a process compatible with
pityriasis lichenoides before or afterwards, as occurred
in our series. The increased frequency of the association
between both entities we report suggests that these
diseases represent opposite poles of a common clinical
and pathologic spectrum. Our results suggest that type
A is the most characteristic histopathological pattern
in children. Moreover, we observed that the lesions of
lymphomatoid papulosis in children resolve leaving a
transitory alteration of skin color in all cases, mainly
in the form of hyperpigmentation accompanied by
permanent scarring in more than half. Lastly, we would
like to stress that, according to published series and our
experience, development of other lymphoproliferative
diseases is less common in childhood lymphomatoid
papulosis than in the adult variant and that, according
to the literature, they manifest mainly in the form of
non-Hodgkin lymphoma.

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**Table 2  Lymphomatoid Papulosis and Pityriasis Lichenoides: Differential Characteristics**

<table>
<thead>
<tr>
<th>Lymphomatoid Papulosis</th>
<th>Pityriasis Lichenoides</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of lesions in each outbreak</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Characteristics of the lesion</strong></td>
<td>Papules and nodules that are sometimes associated with central necrotic slough</td>
</tr>
<tr>
<td></td>
<td>Lesions that are indurated to the touch and deeply infiltrated</td>
</tr>
<tr>
<td><strong>Distribution pattern</strong></td>
<td>Predominately on the upper and lower limbs</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Resolution in 3-4 wk</td>
</tr>
<tr>
<td>Duration of individual lesions</td>
<td></td>
</tr>
<tr>
<td>Residual abnormality after resolution of the lesions</td>
<td>Residual varioliform scars</td>
</tr>
<tr>
<td><strong>Duration of outbreaks</strong></td>
<td>Years</td>
</tr>
<tr>
<td><strong>Histopathologic findings</strong></td>
<td>Type A, presence of atypical lymphocytic cells with bizarre nuclei accompanied by a neutrophilic infiltrate and minimum involvement of the epidermis.</td>
</tr>
<tr>
<td></td>
<td>Type B, cerebriform hyperchromatic mononuclear cells arranged in bands in the basement membrane with some hydropic degeneration.</td>
</tr>
<tr>
<td></td>
<td>Type C, large cell-type, which is characterized by a dense infiltrate composed mainly of large atypical lymphocytes.</td>
</tr>
<tr>
<td><strong>Positivity for CD30</strong></td>
<td>Present (absent in 5% of cases)</td>
</tr>
<tr>
<td><strong>Study of molecular rearrangement</strong></td>
<td>Monoclonal (^a) (polyclonal in 30%-40% of cases)</td>
</tr>
<tr>
<td><strong>Potential for malignancy</strong></td>
<td>Occasional</td>
</tr>
</tbody>
</table>

Abbreviations: AVPL, acute varioliform pityriasis lichenoides; CPL, chronic pityriasis lichenoides.

\(^{a}\)The uncommon febrile ulcerative-necrotic variant of Mucha-Habermann disease is characterized by localized ulcerated plaques mainly on the trunk and associated with fever.

\(^{b}\)In some cases, CD30 was positive and the molecular study showed a monoclonal character. In these cases, the definitive diagnosis depends essentially on symptoms and clinical course.

\(^{c}\)The existence of monoclonal rearrangement of T lymphocytes supports the neoplastic character of a process and lacks prognostic value. Nevertheless, the clinical symptoms and course of the disease are more relevant when establishing a definitive diagnosis.