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PHOTOLETTER TO THE EDITOR

# Generalized eruptive histiocytoma

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## Abstract

Generalized eruptive histiocytoma is a rare form of non Langerhan's cell histiocytosis. The disease occurs mainly in adults and its etiology is still unknown. We describe a case of 48-year-old female with multiple, firm, hemispherical, redish brown papules. Lesions were distributed on the face, upper limbs and trunk. Patient's general examination and routine laboratory investigations were normal. Excisional biopsy was taken from one representative lesion. Histopathological examination revealed diffuse dermal histiocytic infiltration that was suggestive of generalized eruptive histiocytoma. Confirmatory immunohistochemical staining for CD68 antibody was done and revealed positive results. Based on clinical and histopathological criteria the diagnosis of generalized eruptive histiocytoma was established.

In conclusion, we present a rare case of generalized eruptive histiocytoma which is an uncommon form of non Langerhan's cell histiocytosis. The disease does not require treatment since it is a self-healing disease. (*J Dermatol Case Rep*. 2011; 5(3): 53-55)

### Key words:

eruptive, histiocytosis, histiocytoma

Generalized eruptive histiocytoma (GEH) is an uncommon benign disorders of non Langerhan's cell histiocytoses (LCH).[1] It is a papular non lipidic self healing and affects mainly adults.[2]

Clinically, asymptomatic, brown coloured, pale erythematous papules and/or nodules are seen over the entire body.[3] The involvement of mucosa can also occur.[4] The lesions disappear spontaneously without a trace or heal leaving brown pigmentation.[5]

48-year-old female presented with multiple firm asymptomatic hemispherical non confluent reddish brown papules. Some of them are umblicated resembling molluscum contagiosum. They were of incidous onset and progressive course during a 8 month duration. Lesions were bilaterally and asymmetrically distributed over the face, upper limbs, front and back of the trunk (Fig. 1A,B). Mucous membranes were not involved. The patient noticed that some lesions resolve spontanously with residual hyperpigmentation. The patient was generally well, liver and spleen were of average size, with no palpaple lymph nodes. There was no history of drug intake. Family history and system review were irrelevant. Routine blood tests, urine analysis, liver and renal function tests were within normal limits. Excisional biopsy was taken from one lesion. Histopathological examination of Hx&E stained sections revealed atrophic epidermis. The dermis is occupied by histiocytic cellular infiltrate reaching the deep dermis. Histiocytes have large vesicular nuclei and pale scanty cytoplasm. There was scanty lymphocytic infiltrate (Fig. 2A). Confirmatory immunohistochemical staining for S100 protein was done and revealed negative results (Fig. 2B) excluding Langerhan's cell origin. Imunohistochemical staining for CD68 antibody revealed positive results confirming histiocytic origin (Fig. 2C). These findings together with the clinical lesions were suggestive of generalized eruptive histiocytoma.

Generalized eruptive histiocytoma is an extremely rare form of non-LCH that was first described by Winkellman and Muller.[5] They listed the following diagnostic features: 1) widespread essentially symmetric multiple lesions particularly involving the trunk and proximal limbs and rarely,

the mucous membranes; 2) distinct red brown to red blue papular lesions evenly distributed without a tendency to grouping; 3) spontaneous resolution of lesions to brown macules or disappearance without trace; progressive development of new crops of lesions for years or even decades and permanent remission usually occurr; 4) a benign histological picture of mononuclear histiocytic cells. Our case has a typical clinical presentation and behaviour.

Molluscum contagiosum like lesions as in our case had been reported.[6]

Although the etiopathogenesis of GEH is unknown, there are published reports of GEH associated with rheumatic fever[3] and with exanthema subitum.[4] Both of these reports suggested that infections might trigger GEH. However, our patient denied any infectious event preceeding the eruption.

Differential diagnoses include LCH and other forms of non LCH (xanthomata, benign cephalic histiocytosis, reticulohistiocytosis, juvenile xanthogranuloma and xanthoma disseminatum).[7]

LCH has a different immunohistochemical profile from GEH, staining positively with S100 and CD1a.[8]

The absence of multinucleated, Touton giant and foamy cells histopathologically excludes GEH from the non-LCH disorders.[1]

Histopathologically, GEH closely mimcs benign cephalic histiocytosis. However, the localization of the latter eruption to the head and neck and the appearance of the disease only in children seem to be distinctive features of benign cephalic histiocytosis.[9]

Multicentric reticulohistiocytosis is ruled out because of the absence of arthritis and the lack of giant cells with ground-glass cytoplasm.[7]

It has been suggested by various authors[8,10] that GEH may represent an early indeterminate stage of more mature non LCH. The very rare cases of GEH evolving into one of the other non-LCH may serve to confirm such a concept.[1] GEH does not require treatment since it is a self-healing disease.[5]

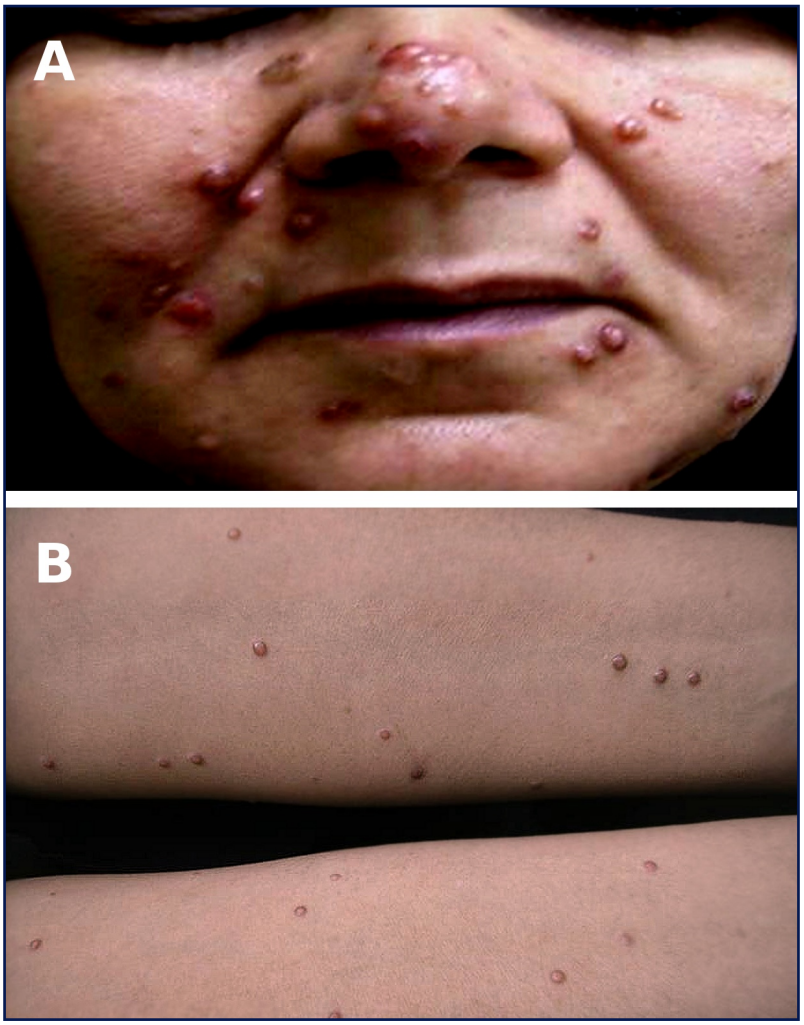


**Figure 1**

*Generalized eruptive histiocytoma presented by reddish brown hemispherical papules affecting A) The face. B) Flexor surfaces of both upper limbs.*

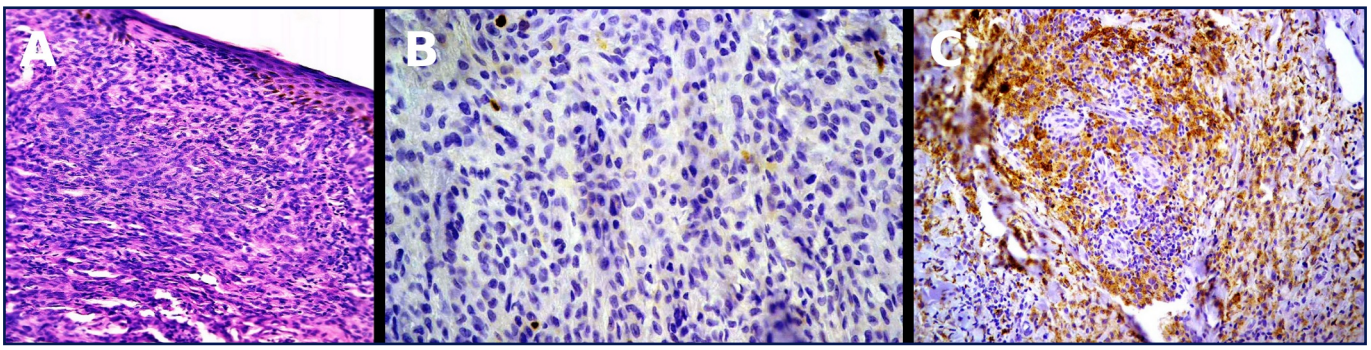


**Figure 2**

*A) Atrophic epidermis. The dermis is occupied by heavy histiocytic infiltrate with vesicular nuclei and scanty cytoplasm. Histiocytes are admixed with lymphocytes (hematoxylin and eosin X200). B) Negative immunohistochemical staining for S100 protein (immunoperoxidase X200). C) Positive immunohistochemical staining for CD68 antibody (immunoperoxidase X200).*

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