



Paediatric Cutaneous Lymphomas

Professor and Chairman of Dermatology and Venereology

President Istituto Superiore di Medicina, Italy

Rector Magnificus

PRISCA SAPIENTIA INSTITUT UNIVERSITY, ZURICH (CH)

Academician of the Italian Republic

www.torellolotti.com

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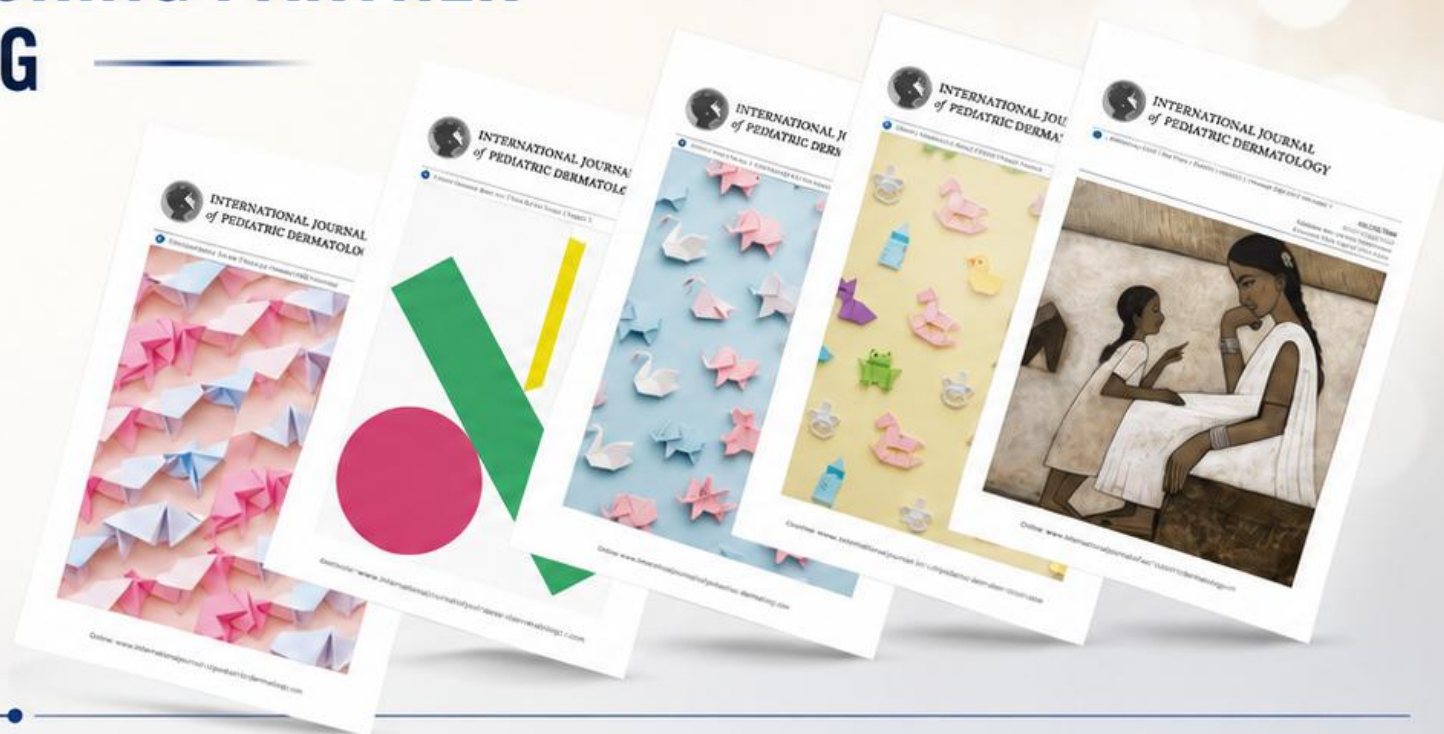
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Gent.ma Prof.ssa
Stefania Conti
Direttrice
Dipartimento di Medicina e Chirurgia
SEDE

Prot. n. 4625
Tit. III Cl. 14

Oggetto: accordo quadro di collaborazione con l'Università degli Studi "Guglielmo Marconi" -
Referente scientifico: Prof. Claudio Feliciani.

In relazione alla richiesta assunta a protocollo UniPR n. 248855 in data 17 dicembre 2018, si comunica che con REP DRD n. 43 /2019 PROT. n. 4623 del 10 GEN. 2019 è stata approvata la stipula dell'accordo in oggetto.

Si restituiscono, pertanto, n. 2 originali dell'accordo debitamente sottoscritti e si invita la S.V. a provvedere al successivo inoltro all'Università degli Studi "Guglielmo Marconi" per la firma di competenza.

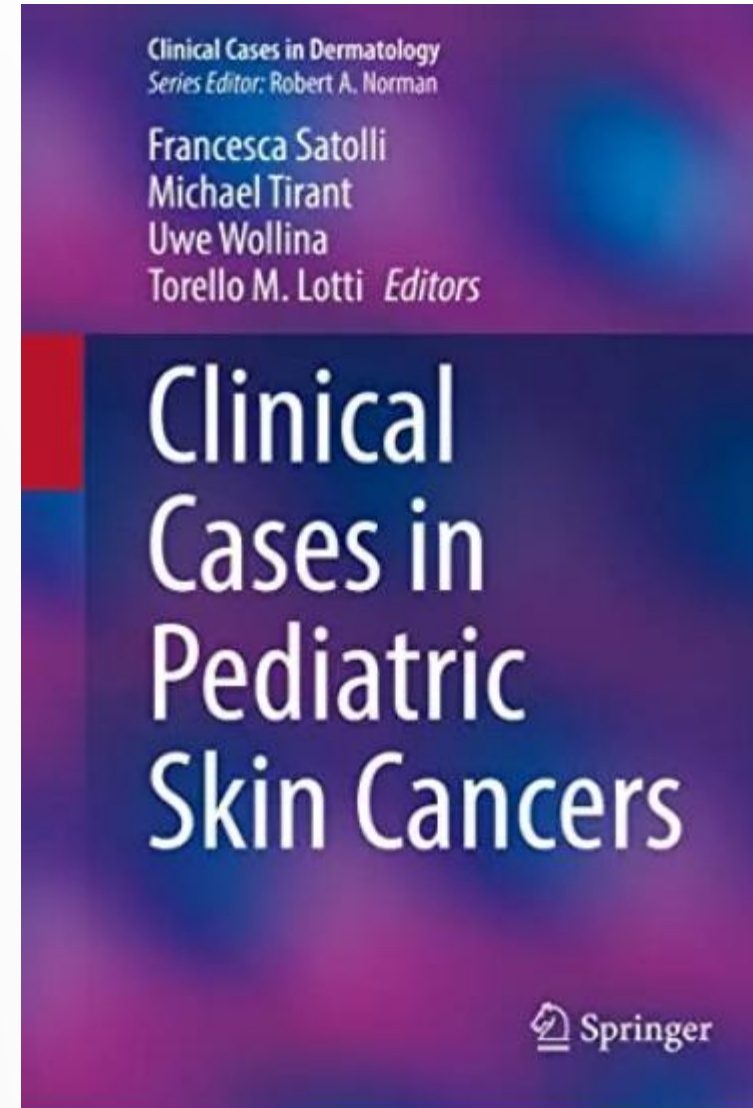
Si rimane in attesa di un esemplare dell'accordo sottoscritto dalle Parti da conservare agli atti dell'ufficio.

Cordiali saluti.

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Paediatric Cutaneous Lymphomas

- Difficult diagnosis
- Difficult follow-up
- Non difficult treatment

Why the VR Foundation is involved



What causes cutaneous lymphoma in younger people?

- No lifestyle factors have been definitely linked to childhood cutaneous lymphoma. **Excluded tatoos which induced local and systemic pseudo-lymphomas and lymphomas**
- Neither parents nor children have control over factors that may cause the disease **beyond tatoos**
- Children, who have had Hodgkin lymphoma, may carry a slightly higher risk of developing cutaneous lymphoma



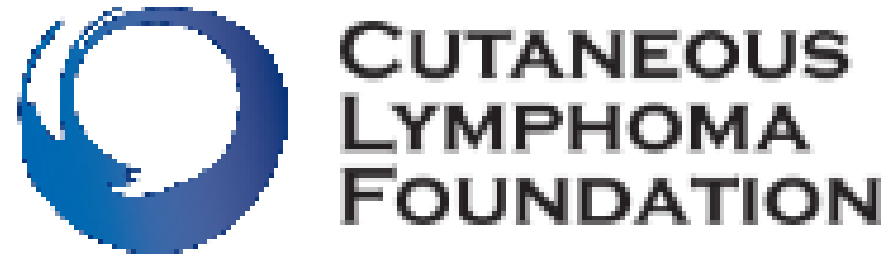
How is cutaneous lymphoma diagnosed in younger people?

- Among children, the distinguishing features of this disease can be **misleading**, making it ever more difficult to diagnose cutaneous lymphoma in **children**;
- **Mycosis fungoides (MF) is the most frequently diagnosed primary cutaneous lymphoma in childhood other than lymphomatoid papulosis**;
- It has only been in the last several years that investigators have truly begun to understand the characteristics of pediatric presentations of cutaneous lymphoma.



Are treatment options different for younger patients?

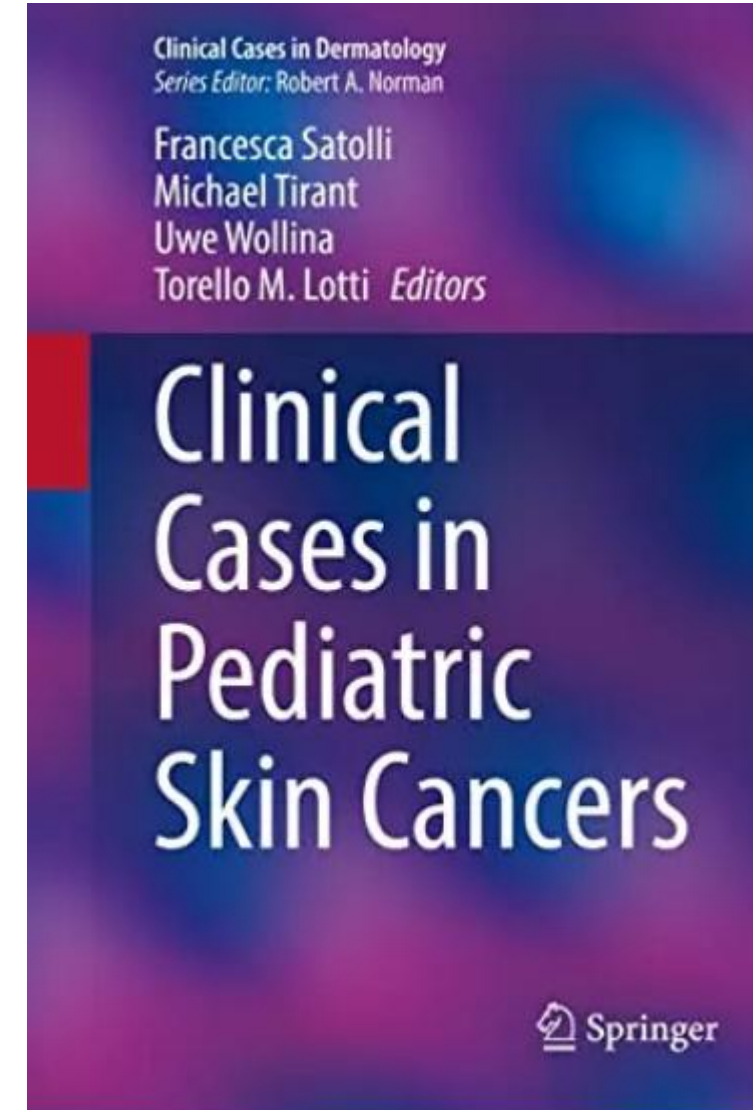
- No specific guidelines
- Rarely, in severe cases systemic therapies are needed.



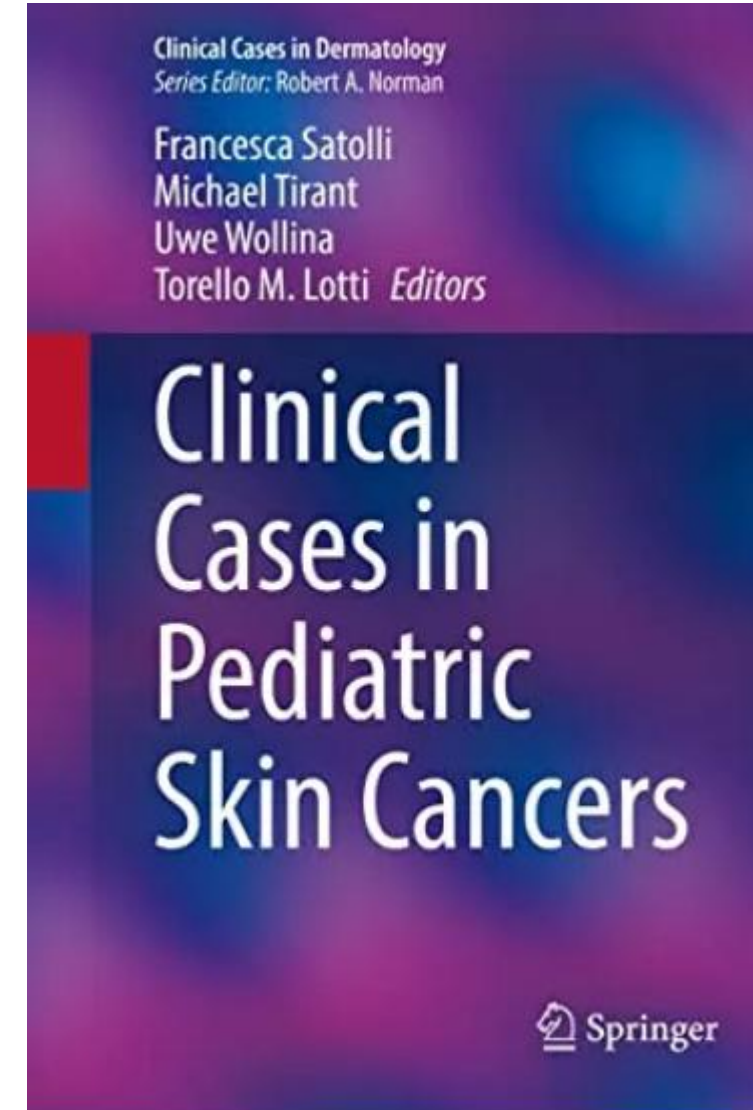
Paediatric cutaneous lymphomas including rare subtypes: A 40-year experience at a tertiary referral centre JEADV, 2024

Silvia Alberti-Violetti et al. & Emilio Berti

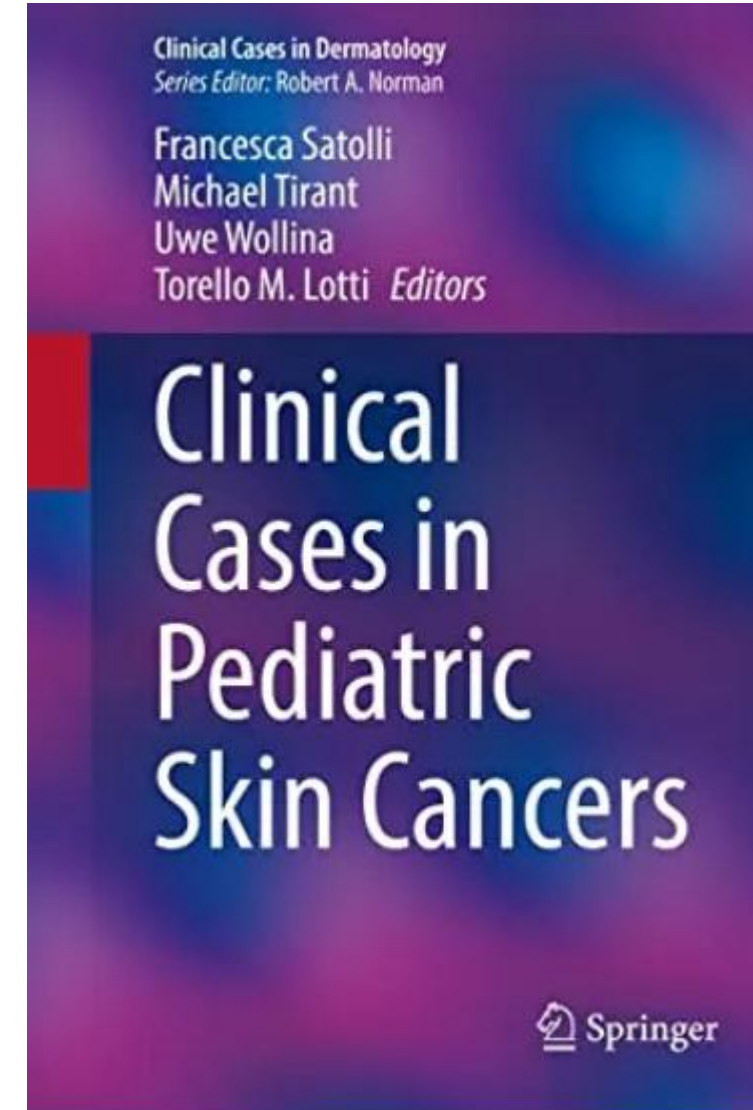
- Primary cutaneous lymphomas are neoplasms of the immune system, characterized by a **proliferation of T, natural killer (NK) or B lymphocytes**, with a distinct tropism for the skin and an absence of extracutaneous manifestations at the time of diagnosis;
- The estimated **annual incidence is 0.1 to 0.3 per million person-years for individuals aged 0–19 years**;
- As observed in adults, the most prevalent cutaneous lymphomas in the paediatric population are **T-cell neoplasms**.



- **Mycosis Fungoides** (MF) and **Lymphomatoid Papulosis** (LyP) are the **most common subtypes**, exhibiting an incidence rate of 0.96 per 100,000 person-years;
- Primary cutaneous **B-cell lymphomas are less frequent**;
- Diagnosis in children and adolescents remain scarce: **this is the problem!**



- Histology and immunohistochemistry:
- **Haematoxylin and eosin-stained sections.**
- Immunohistochemical analyses: CD1a, CD2, CD3, CD4, CD5, CD7, CD8, CD10, CD19, CD20, CD22, CD23, CD25, CD30, CD33, CD34, CD45RA, CD45RO, CD56, CD68, CD79a, CD123, ALK-1, BDCA2, Tc1-1, TIA1, Granzyme B, LFA-1, PD-1, TdT, Mib-1, Bcl2, Bcl6, Pax5, MPO, Kappa light chain, Lambda light chain, and T-cell receptors (TCR) β F1 and TCR δ 1.



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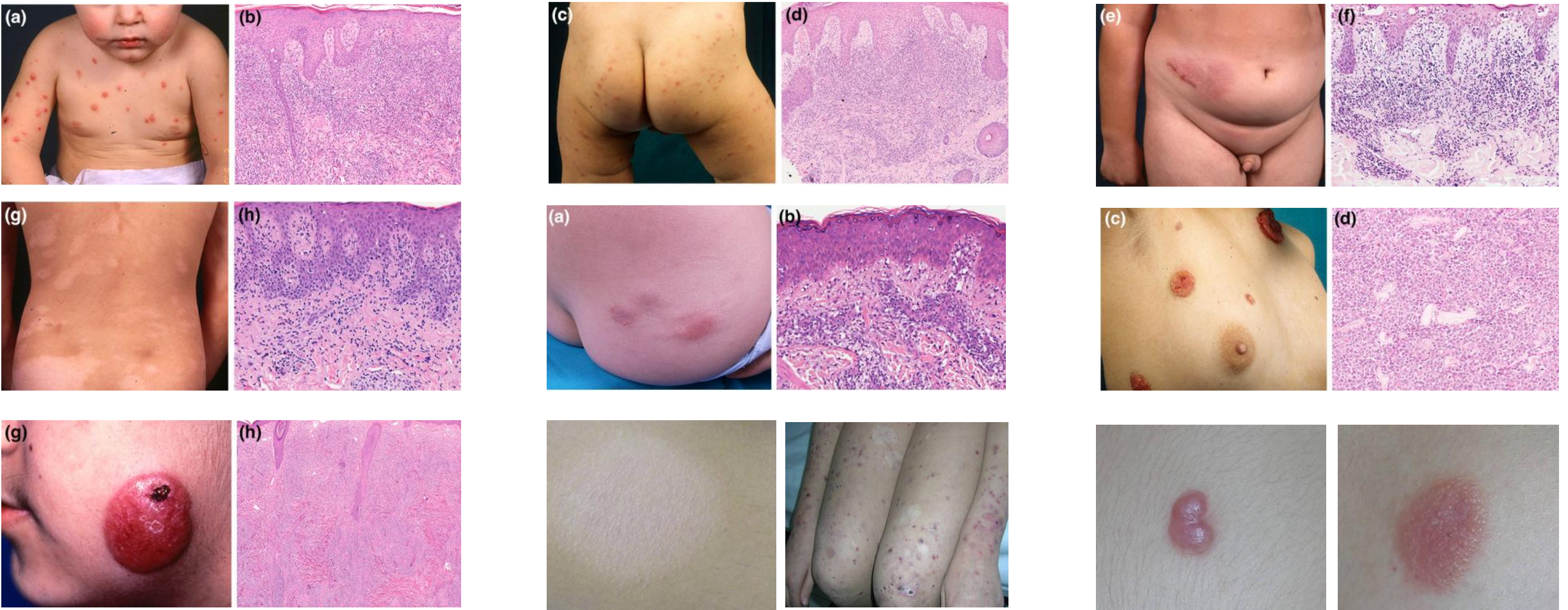
Silvia Alberti-Violetti et al. & Emilio Berti

Case Reports > J Am Acad Dermatol. 2011 Nov;65(5):e155-7. doi: 10.1016/j.jaad.2011.06.039.

Cutaneous pseudolymphoma localized to black tattoo

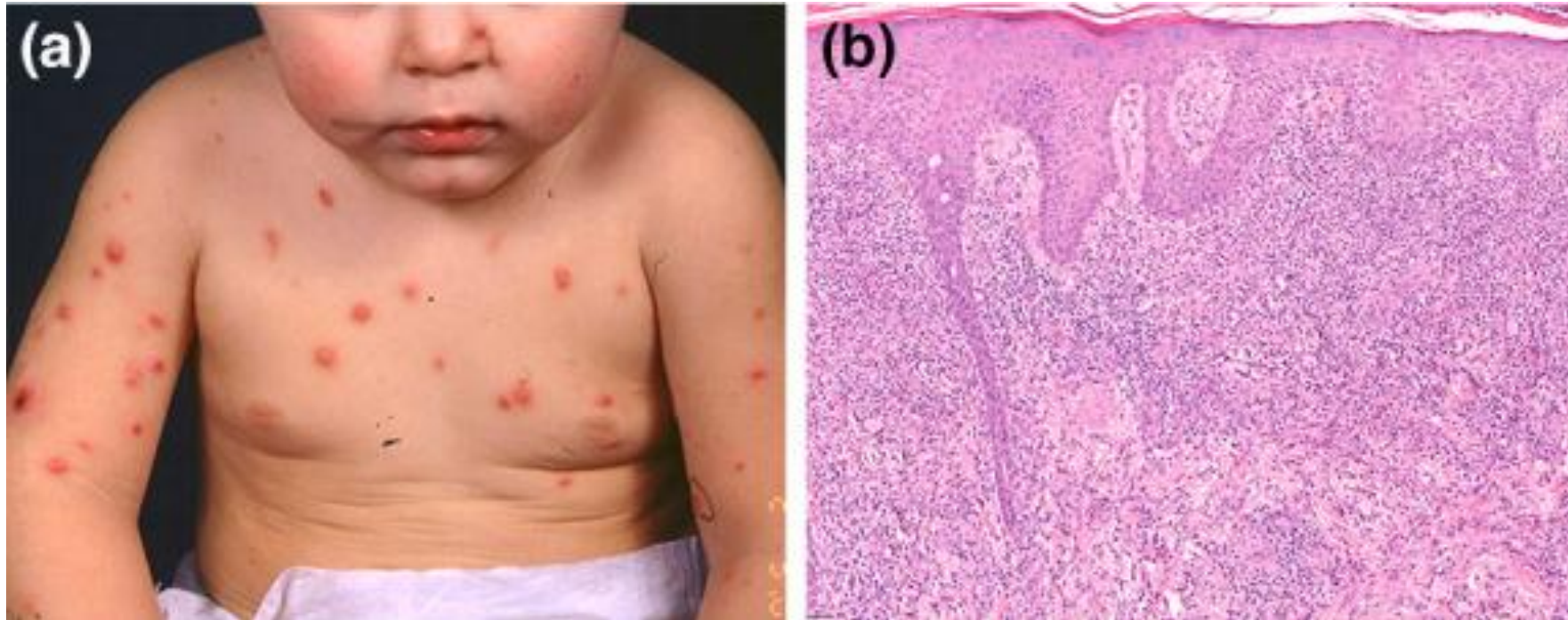
Piero Campolmi, Andrea Bassi, Paolo Bonan, Giovanni Cannarozzo, Massimo Gola,
Duccio Rossi Degl'Innocenti, Torello Lotti, Daniela Massi

PMID: 22000890 DOI: 10.1016/j.jaad.2011.06.039



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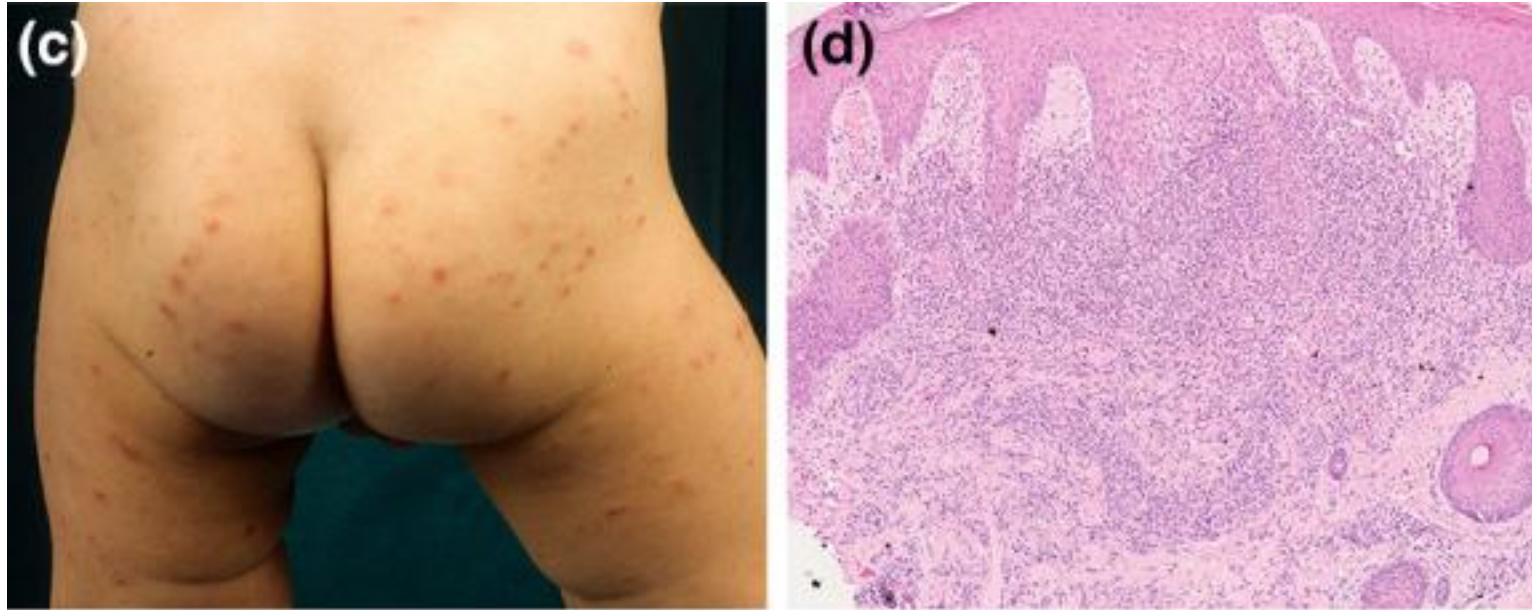
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- (a) Lymphomatoid papulosis. Generalized papular eruption. Some of these lesions show bullous and necrotic evolution.
- (b) Lymphomatoid papulosis, type A. Scattered and clustered large atypical cells, along with small lymphocytes, histiocytes and a few eosinophils.

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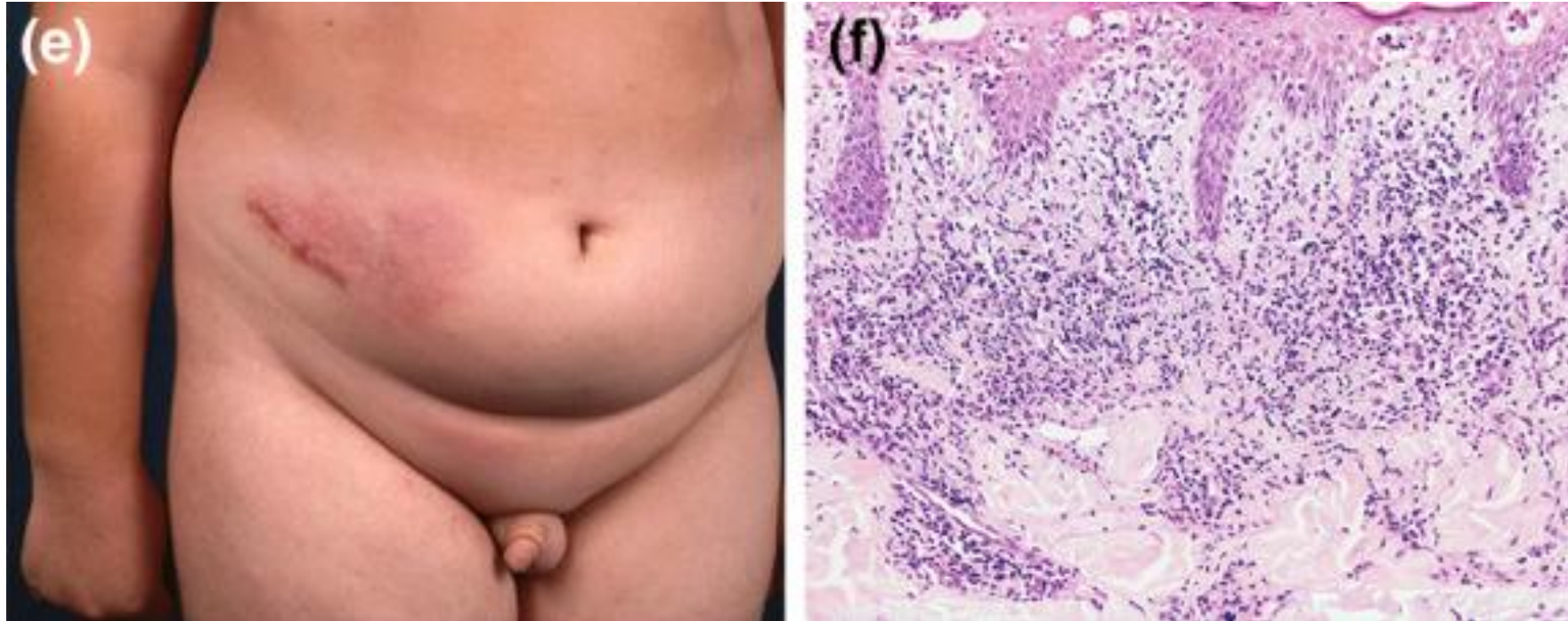
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- (c) Lymphomatoid papulosis. Generalized papular eruption in different stages of evolution.
- (d) Lymphomatoid papulosis, type A. Wedge-shaped infiltrate with perivascular and periadnexal involvement, characterized by several large, atypical cells admixed with some granulocytes.

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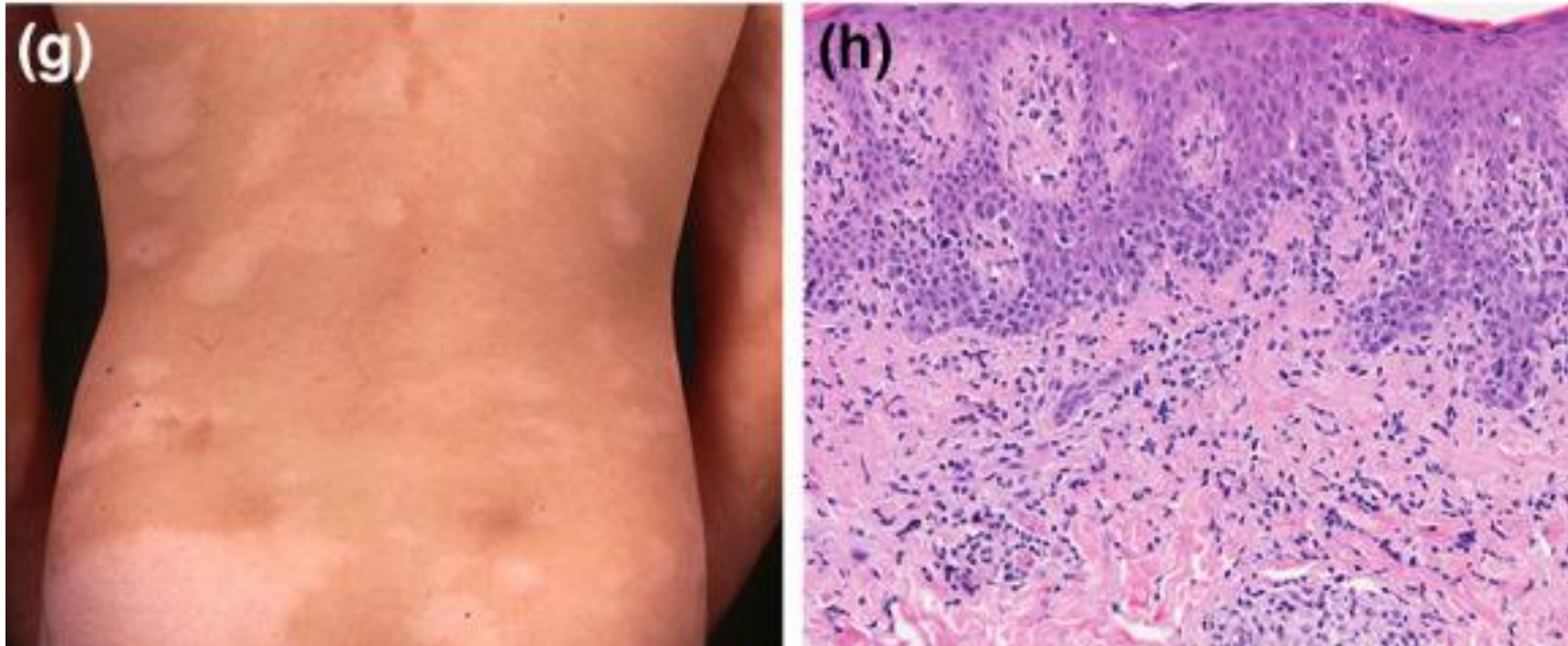
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- (e) Mycosis fungoides. Erythematous finely scaling plaque on the right side of the abdomen.
- (f) Mycosis fungoides. Band-like lymphoid infiltrate with prominent epidermotropism and intraepidermal collections of lymphocytes (Darier's nests).

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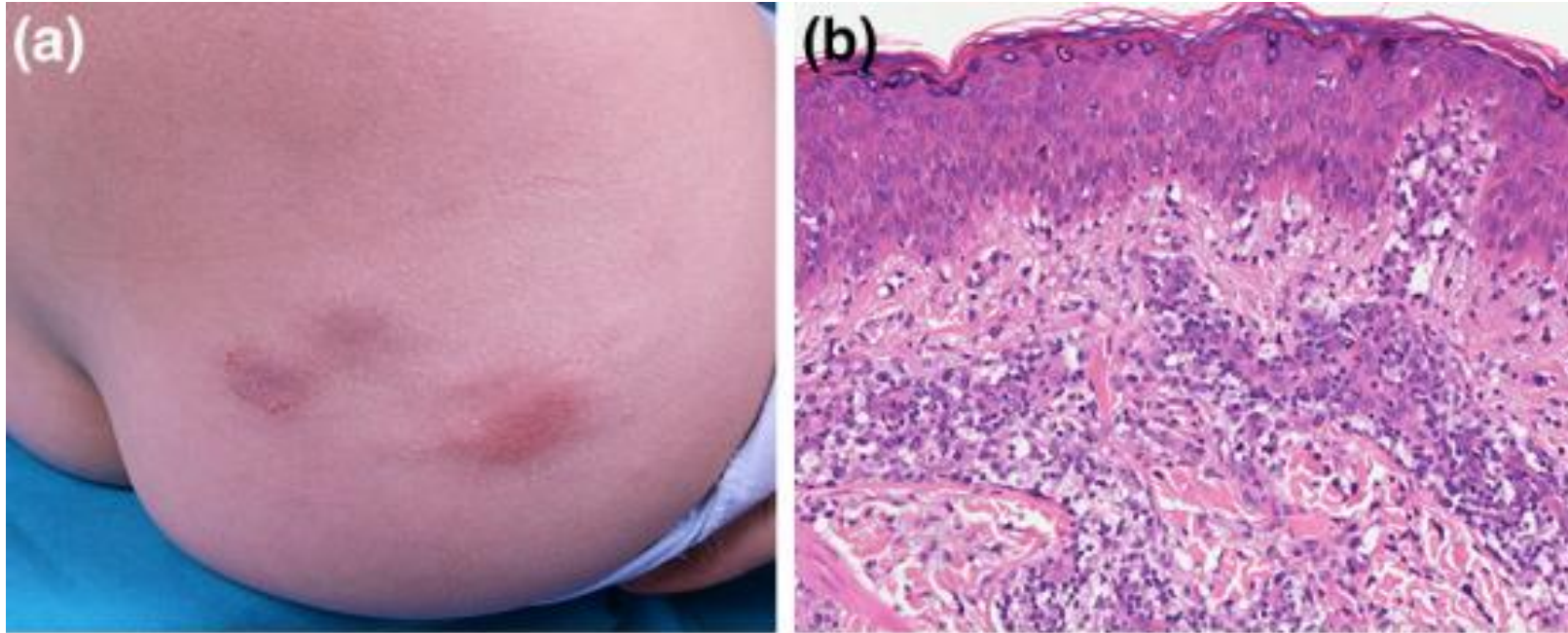


(g) Mycosis fungoides. Multiple hypopigmented patches.

(h) Mycosis fungoides. Epidermal hyperplasia and acanthosis with some necrotic keratinocytes associated with an infiltrate of atypical lymphocytes in the superficial dermis, showing epidermotropism.

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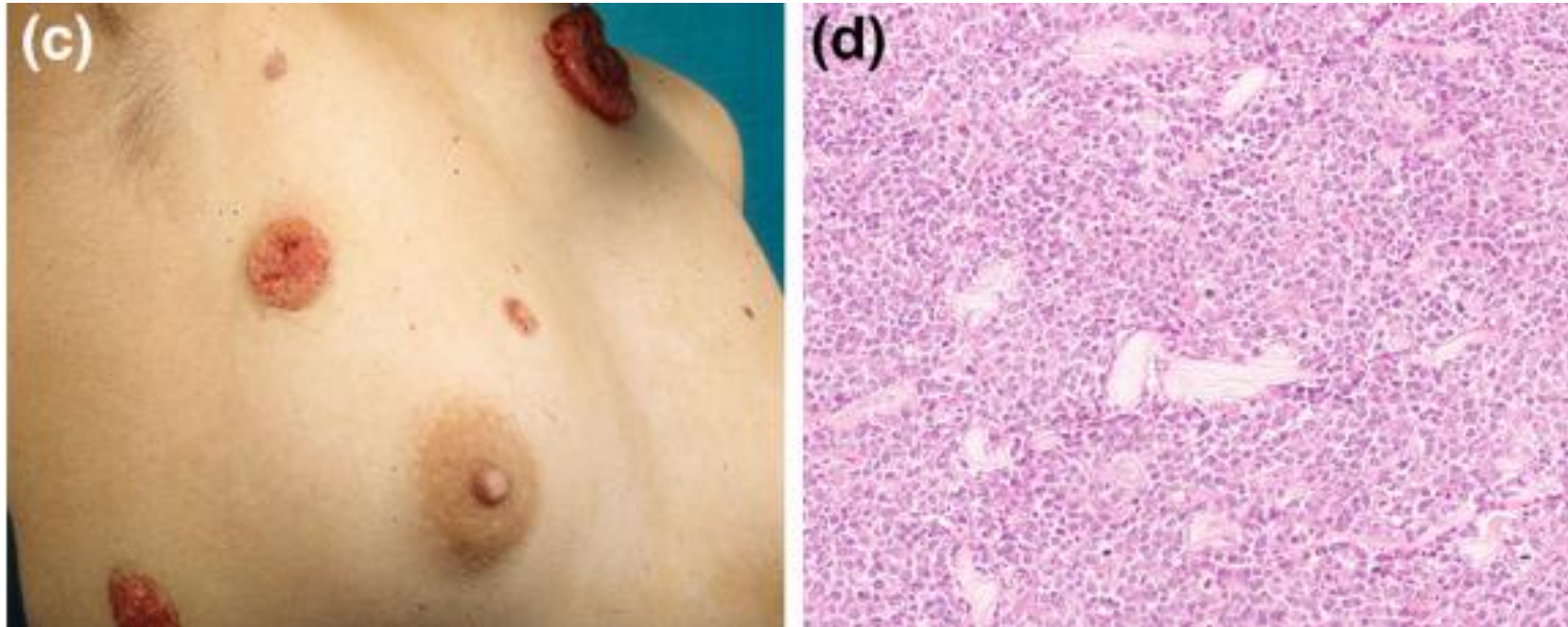
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- (a) Cutaneous peripheral T-cell lymphoma, not otherwise specified. Erythematous plaques on the buttock.
- (b) Cutaneous peripheral T-cell lymphoma, NOS. Perivascular and periadnexal atypical medium- and large-sized lymphoid infiltrate, with focal epidermotropism

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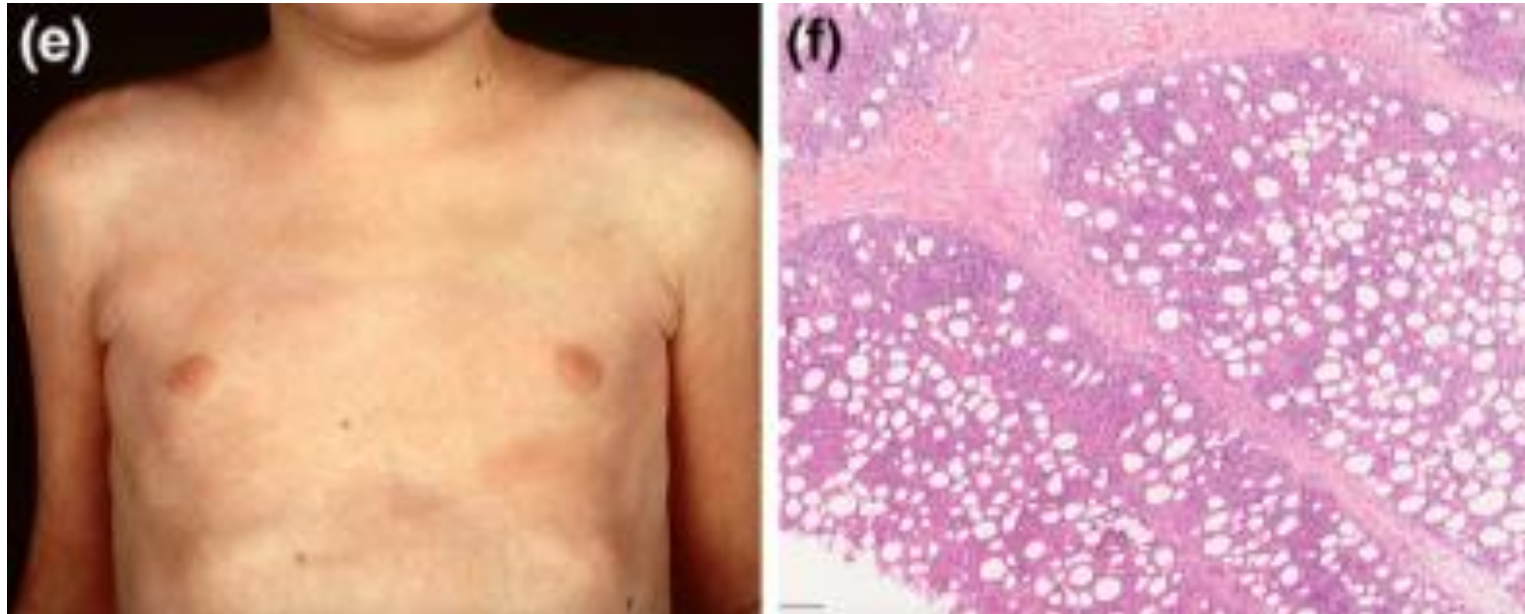


(c) Cutaneous anaplastic large-cell lymphoma. Multiple ulcerated tumours and plaques on the trunk.

(d) Cutaneous anaplastic large-cell lymphoma. Diffuse infiltrate characterized by cohesive sheets of large cells.

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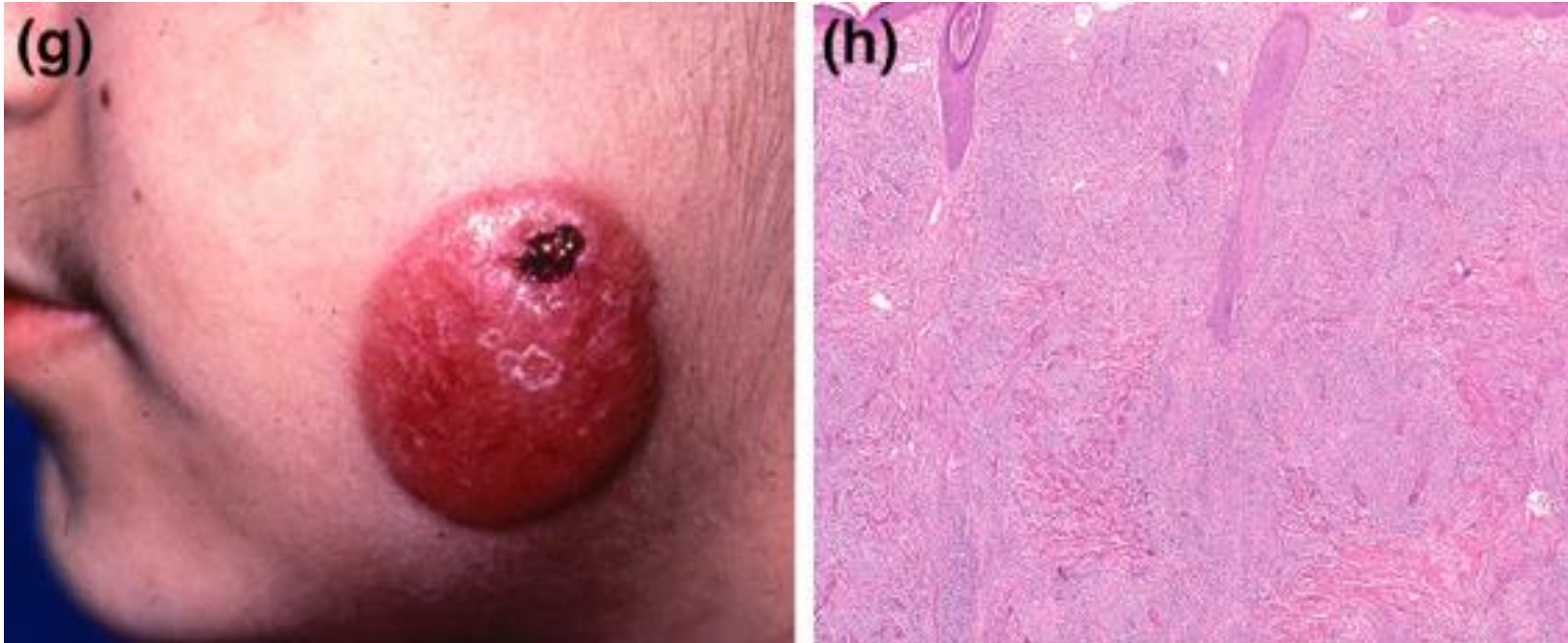
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- (e) Subcutaneous panniculitis-like T-cell lymphoma. Subcutaneous nodules, covered by slightly erythematous/brown skin, on the trunk.
- (f) Subcutaneous panniculitis-like T-cell lymphoma. A dense infiltration of small-medium-sized pleomorphic lymphocytes involving the subcutaneous fat.

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(g) Cutaneous marginal zone lymphoma. Solitary nodule on the cheek.

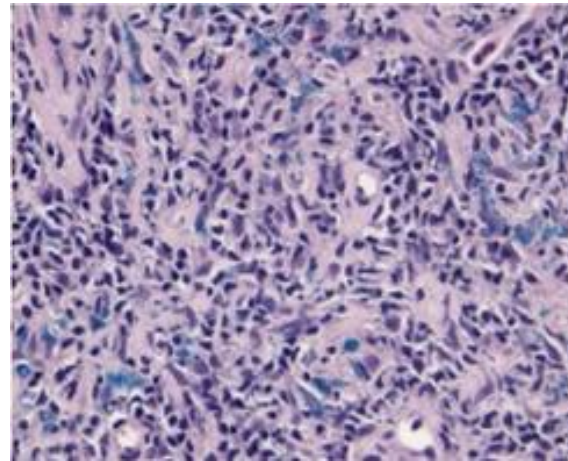
(h) Cutaneous marginal zone lymphoma. Marginal zone cells (‘centrocyte-like’) with abundant cytoplasm mixed with plasma cells, small lymphocytes and eosinophils.

Cutaneous pseudolymphoma localized to black tattoo

Piero Campolmi, Andrea Bassi, Paolo Bonan, Giovanni Cannarozzo, Massimo Gola,
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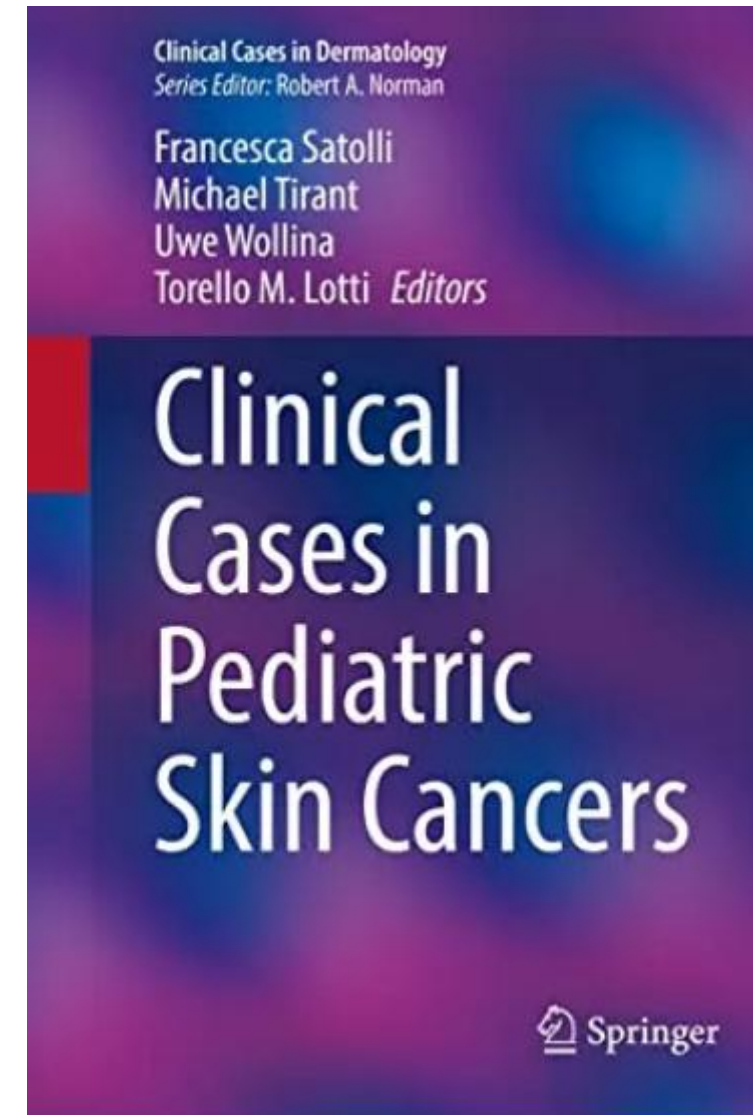
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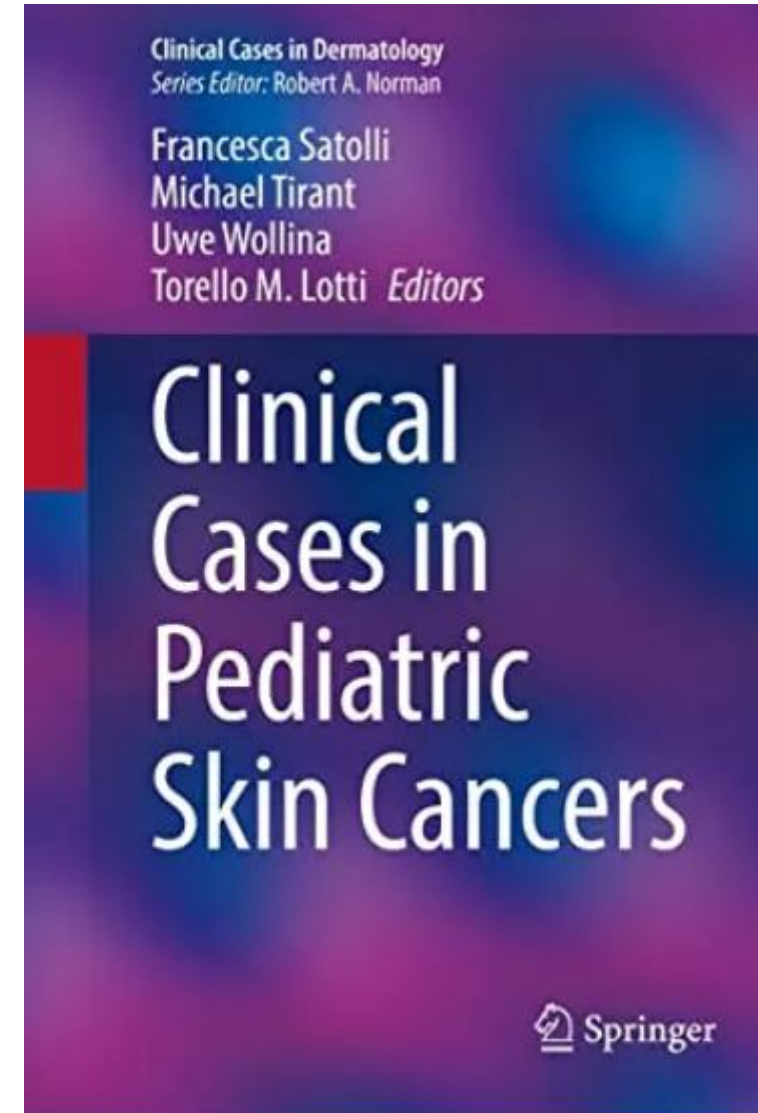
First line treatment of cutaneous lymphomas in paediatric age

The treatment choices should be influenced by their long-term risks and side-effects. In general, skin-directed therapies such as **phototherapy** with **narrowband-UVB light**, intermittent use of **topical steroids**, **topical retinoids**, **topical nitrogen mustard** and/or **tacrolimus** (calcineurin inhibitors as used in atopic dermatitis/eczema) **may be indicated**.



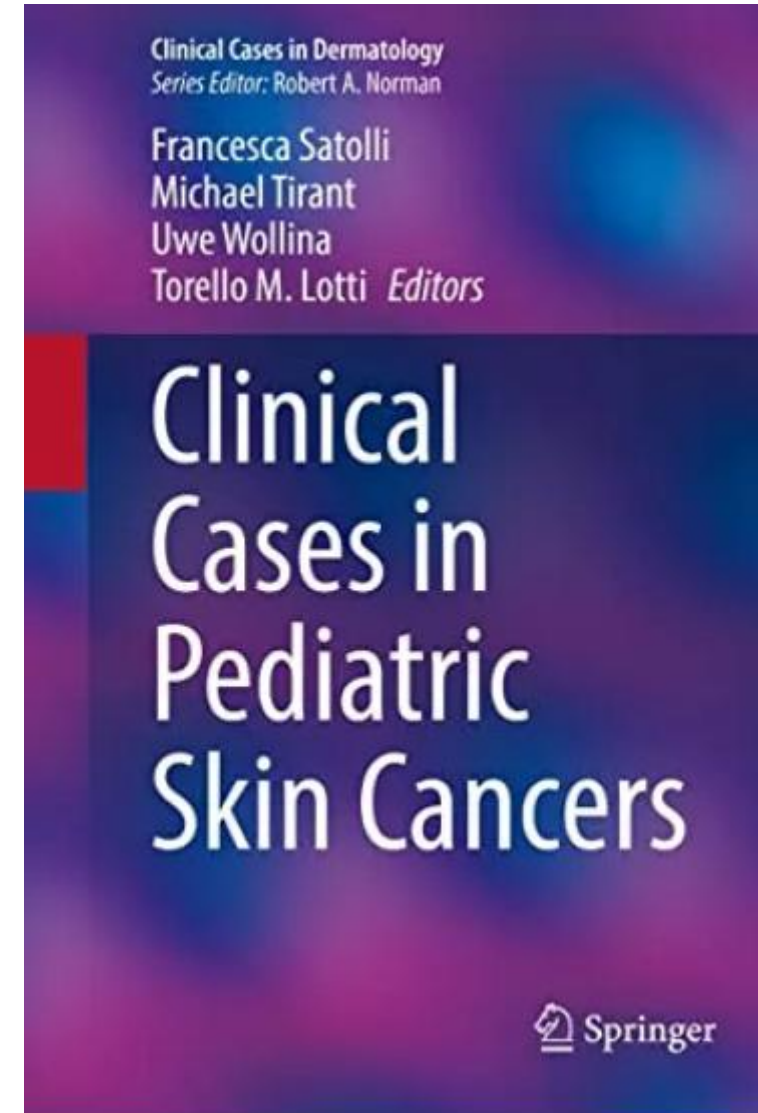
What monoclonal antibody is used to treat lymphoma?

- Rituximab, which sticks to a protein called CD20 on B-cell lymphomas;
- Obinutuzumab, which sticks to a protein called CD20 on B-cell lymphomas.



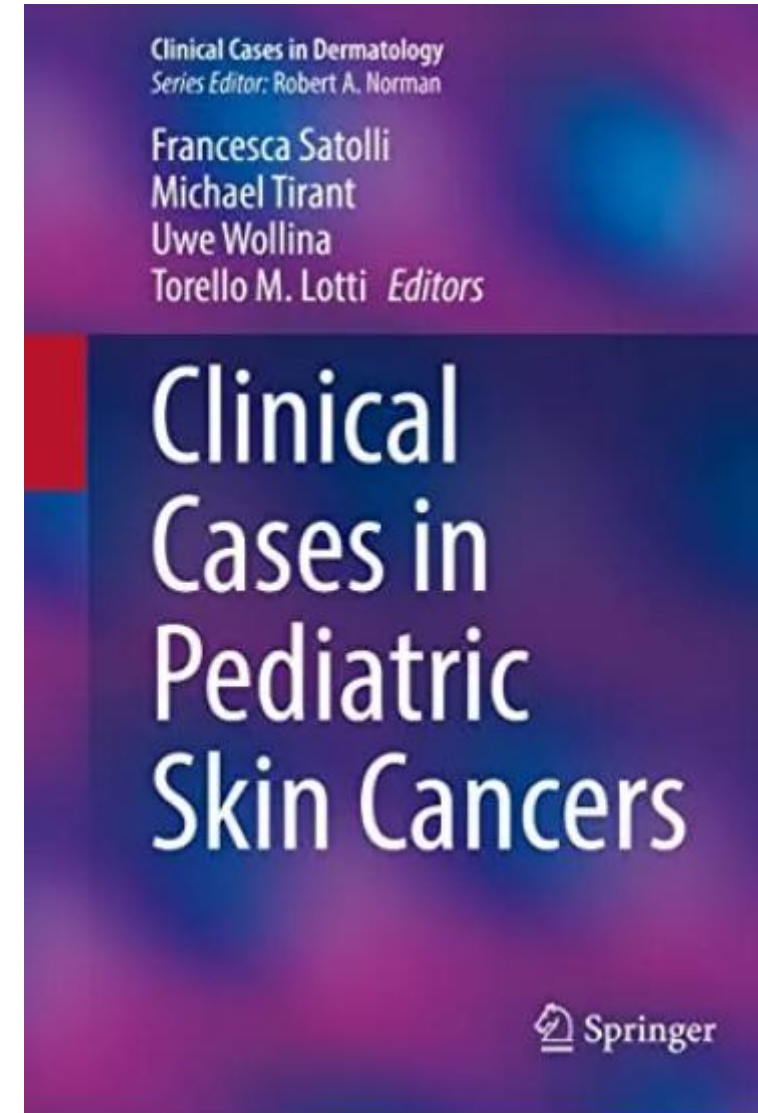
How do I treat pediatric DLBCL?

- Rituximab, has shown promise in improving outcomes in paediatric patients with high risk DLBCL



What monoclonal antibody is used to treat lymphoma?

- Brentuximab for T-cell lymphomas;
- Mogamulizumab for T-cell lymphomas.
- Still under evaluation

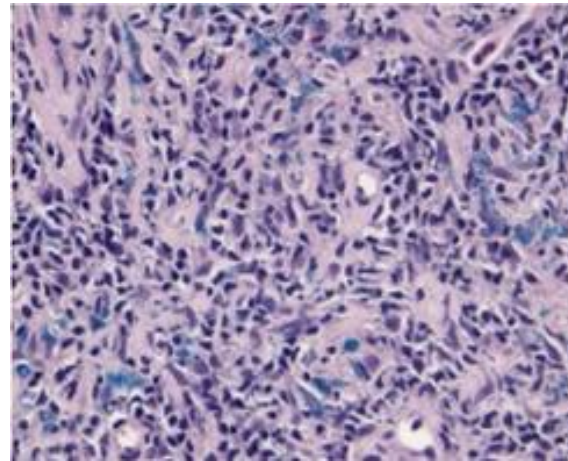


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2011
JAAD



WEB

Tattoos as a risk factor for malignant lymphoma: a population-based case–control study

- European prevalence above 20%
- U.S. prevalence is estimated at approximately 30%
- First tattoo at a young age
- Exposure to some chemical constituents of tattoo ink over almost the entire life course

Tattoos as a risk factor for malignant lymphoma: a population-based case–control study

- Chemicals in tattoo ink are classified as carcinogenic by the International Agency for Research on Cancer
- The translocation of tattoo ink seems to be very effective
- Translocation of tattoo pigments to human lymph nodes has been confirmed
- Depositions of metal particles from tattoo needle wear

Tattoos as a risk factor for malignant lymphoma: a population-based case–control study

- Tattooed individuals have a 21% increased risk of overall lymphoma relative to nontattooed individuals
- Laser treatment for tattoo removal modified the effect of exposure and resulted in a substantially higher risk estimate
- Increased risk of B-cell lymphoma and follicular lymphoma



HOW CAN I KNOW WHAT IS IN MY TATTOO INK?

Usually, all ingredients should be listed on the label of the ink bottle in decreasing order or at least provided in the safety sheet. However, because this information is not always complete and mislabelling is common, you cannot be sure about ingredients unless you get the ink tested.

There is no such thing as a “safe colour”

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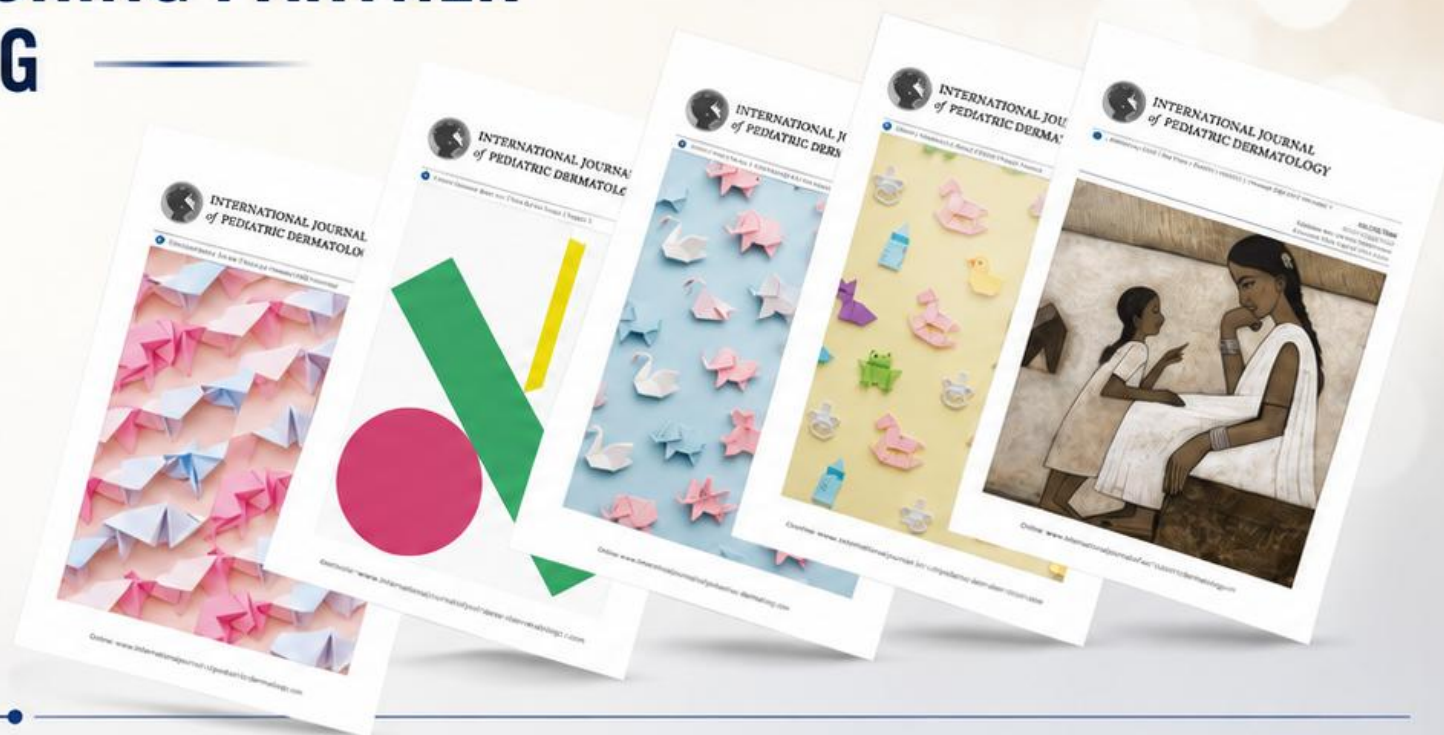
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attention**