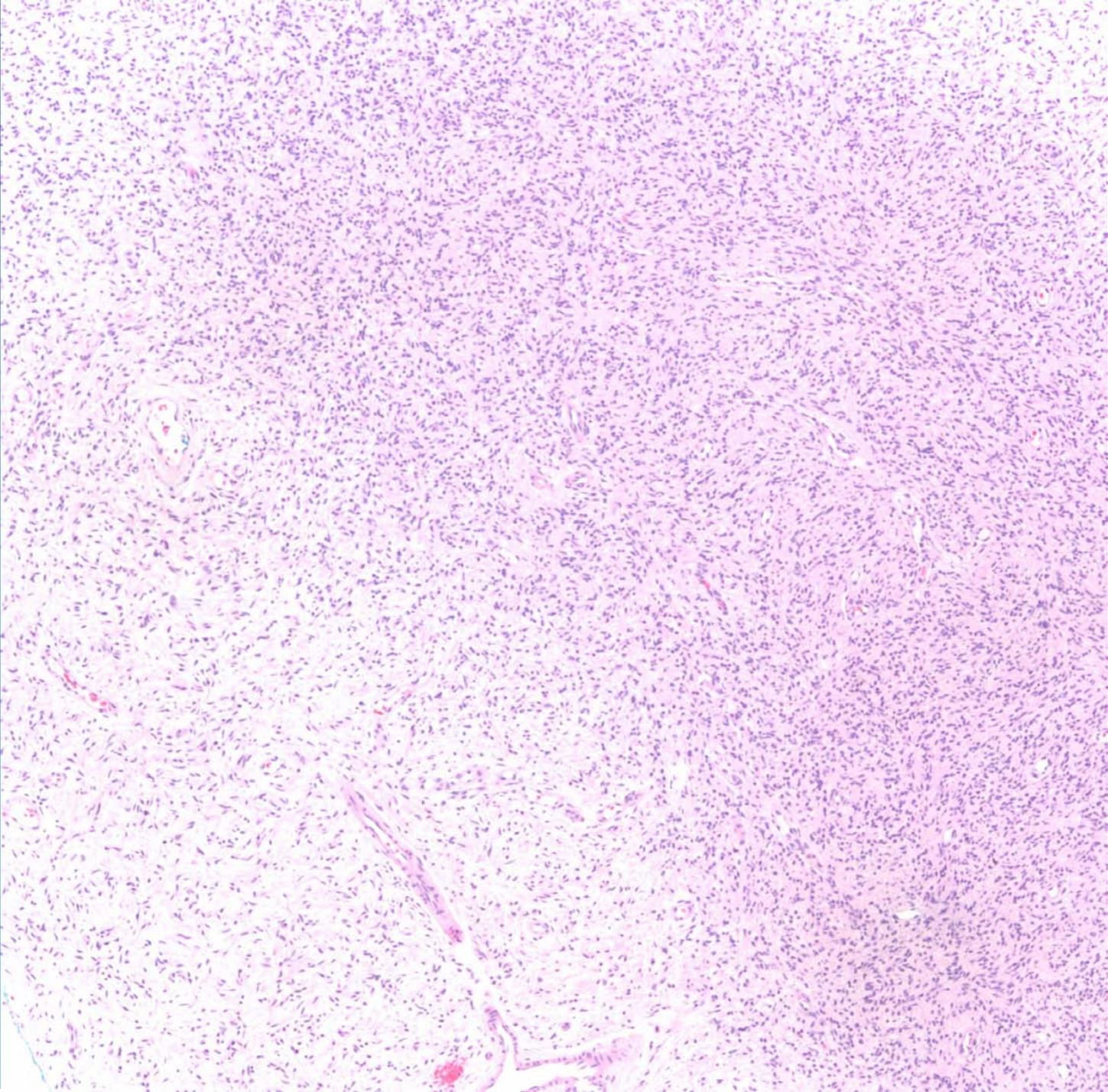
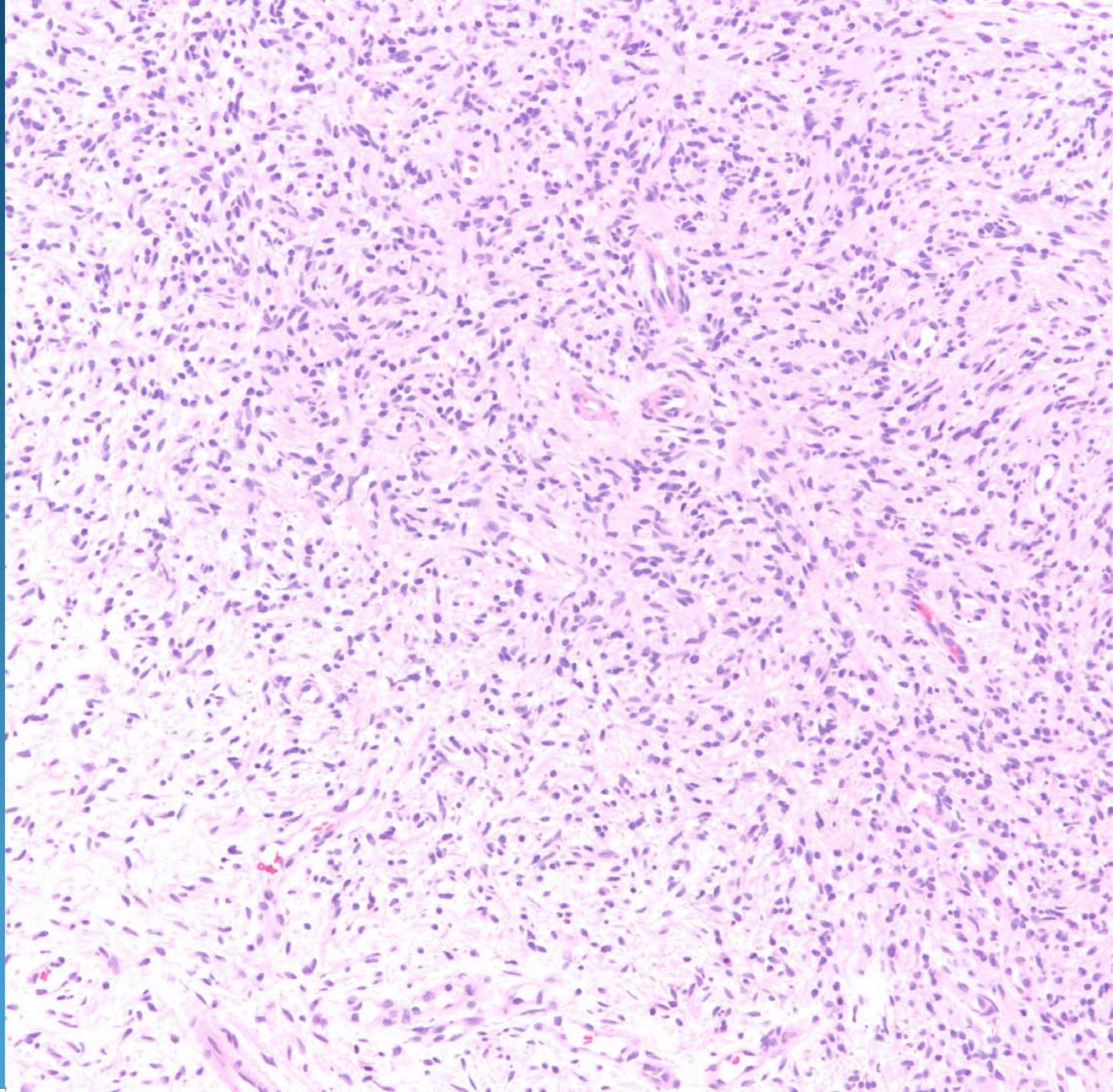


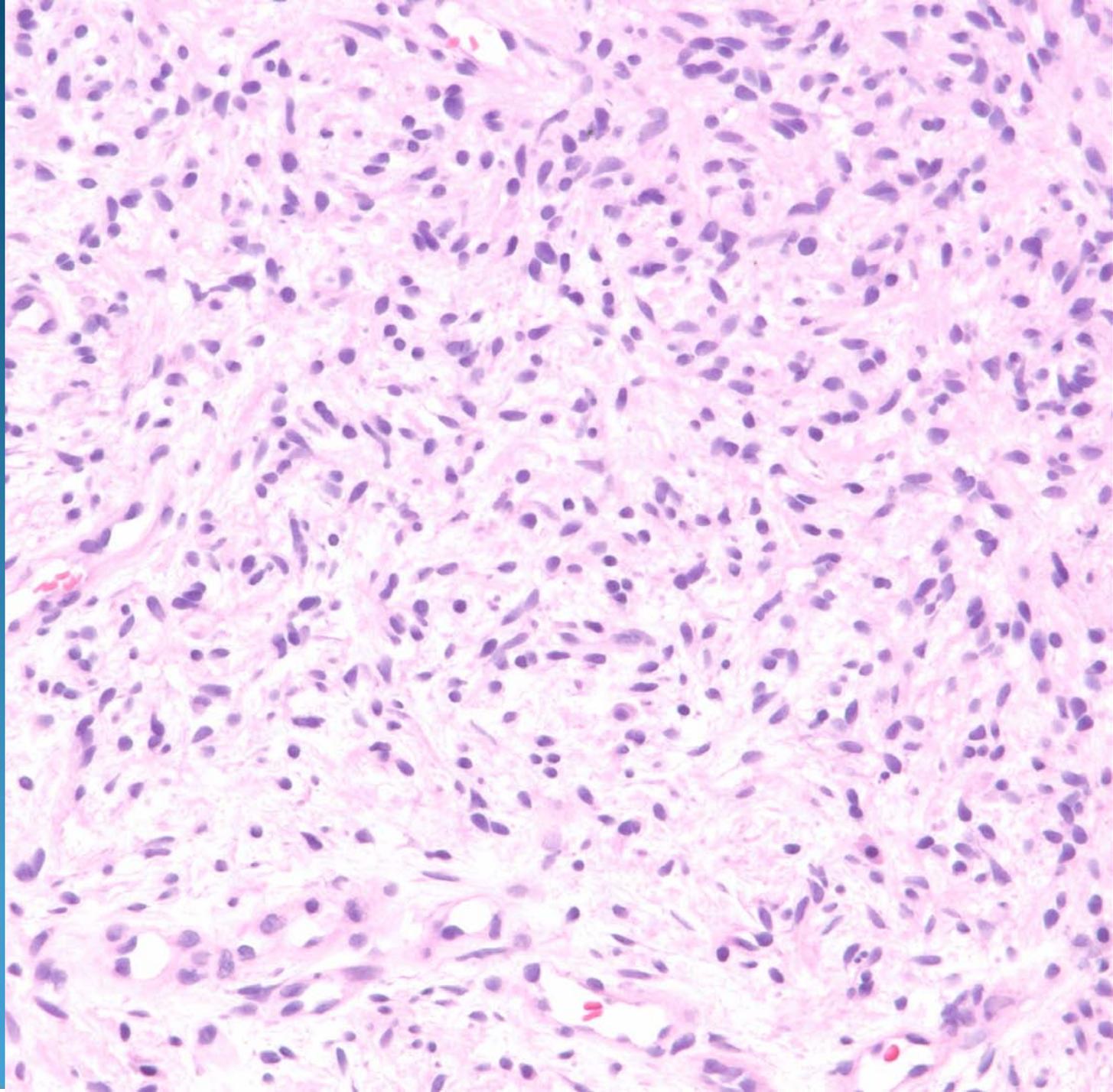
Dermatopathology Slide Review Part 61

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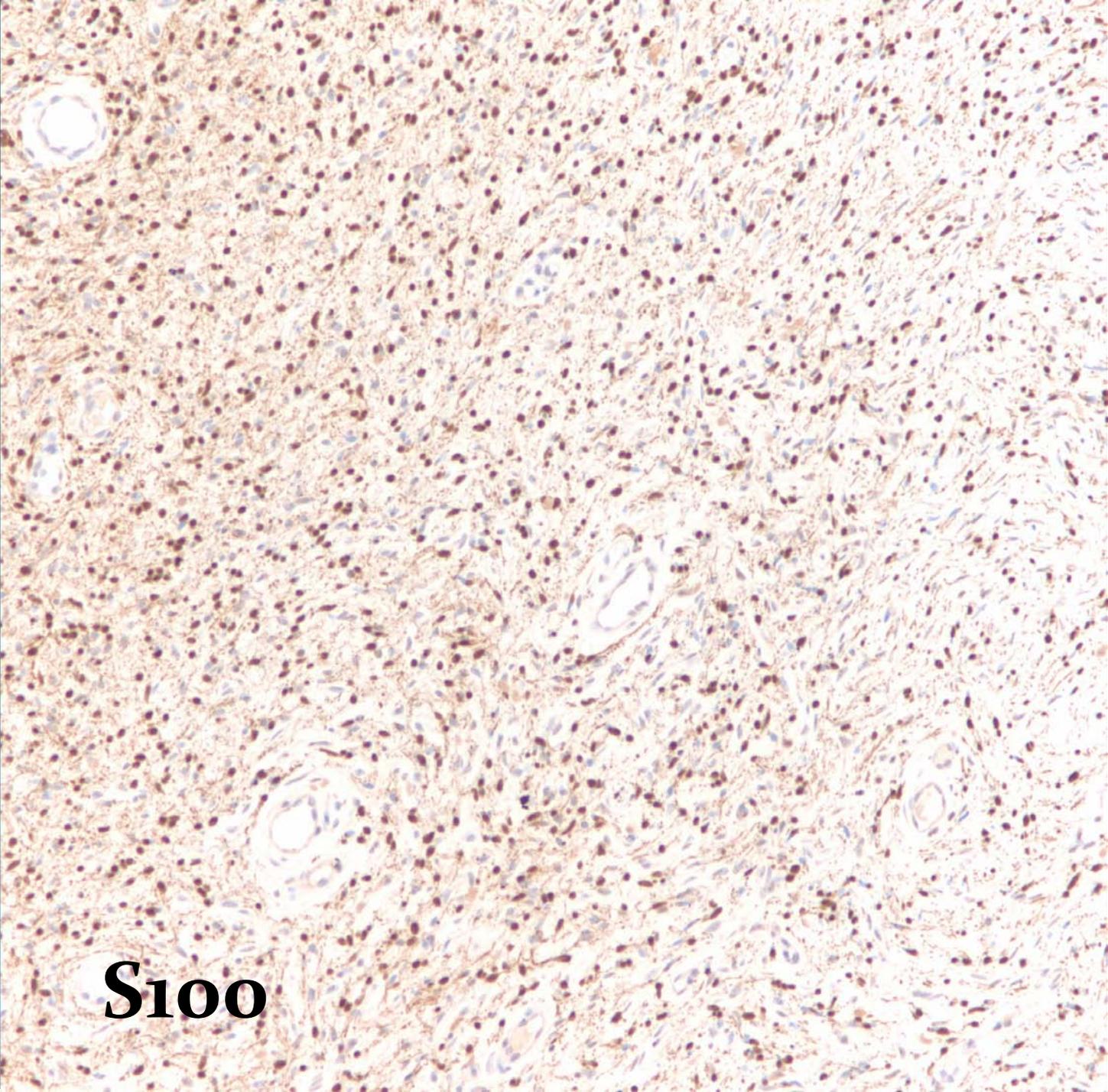




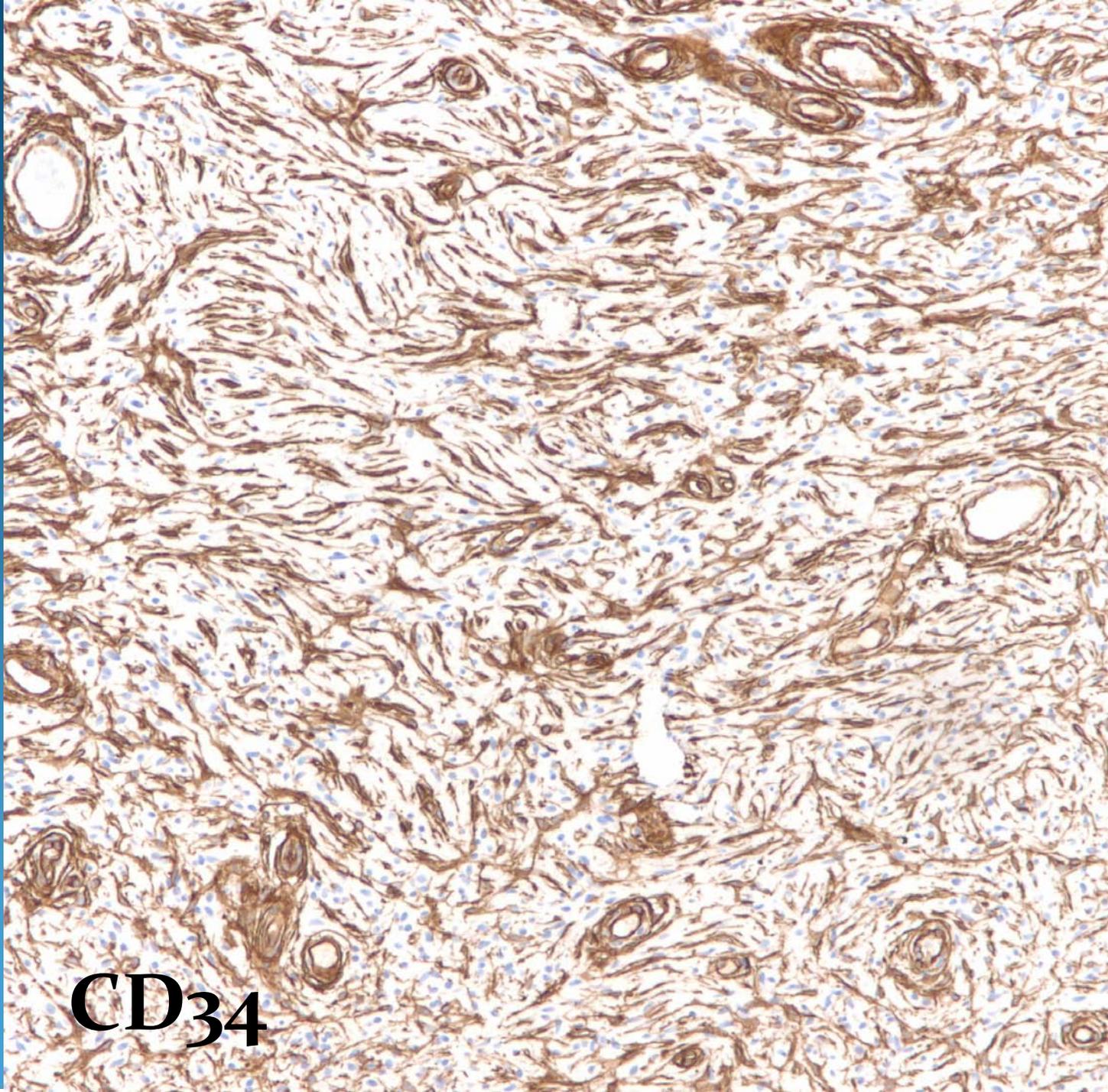




Neurofibroma

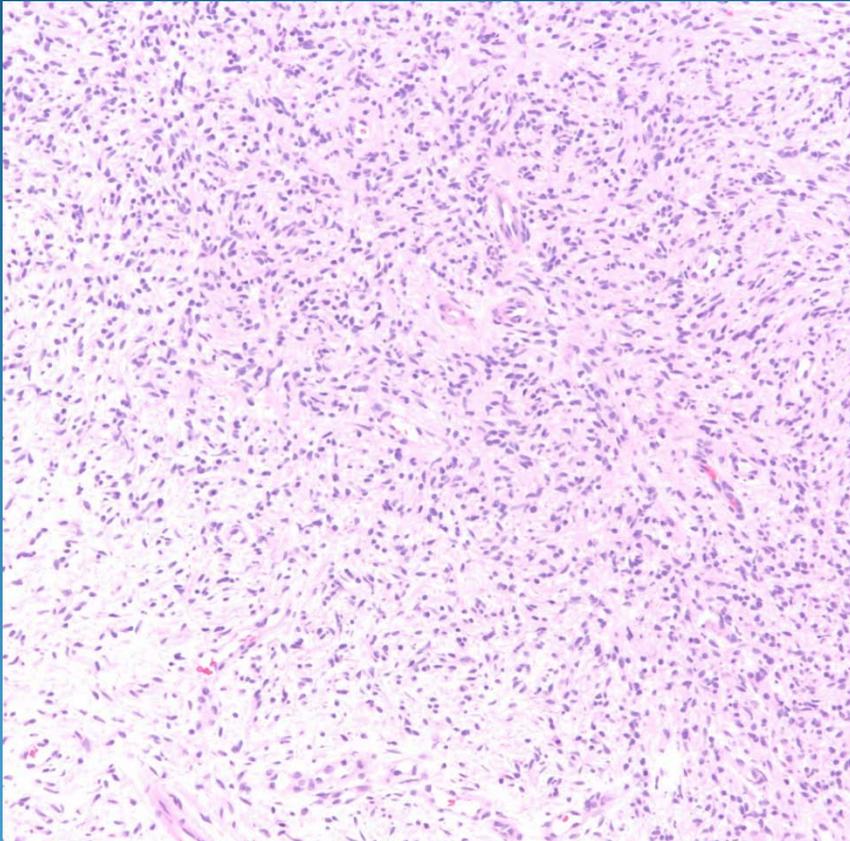


S100



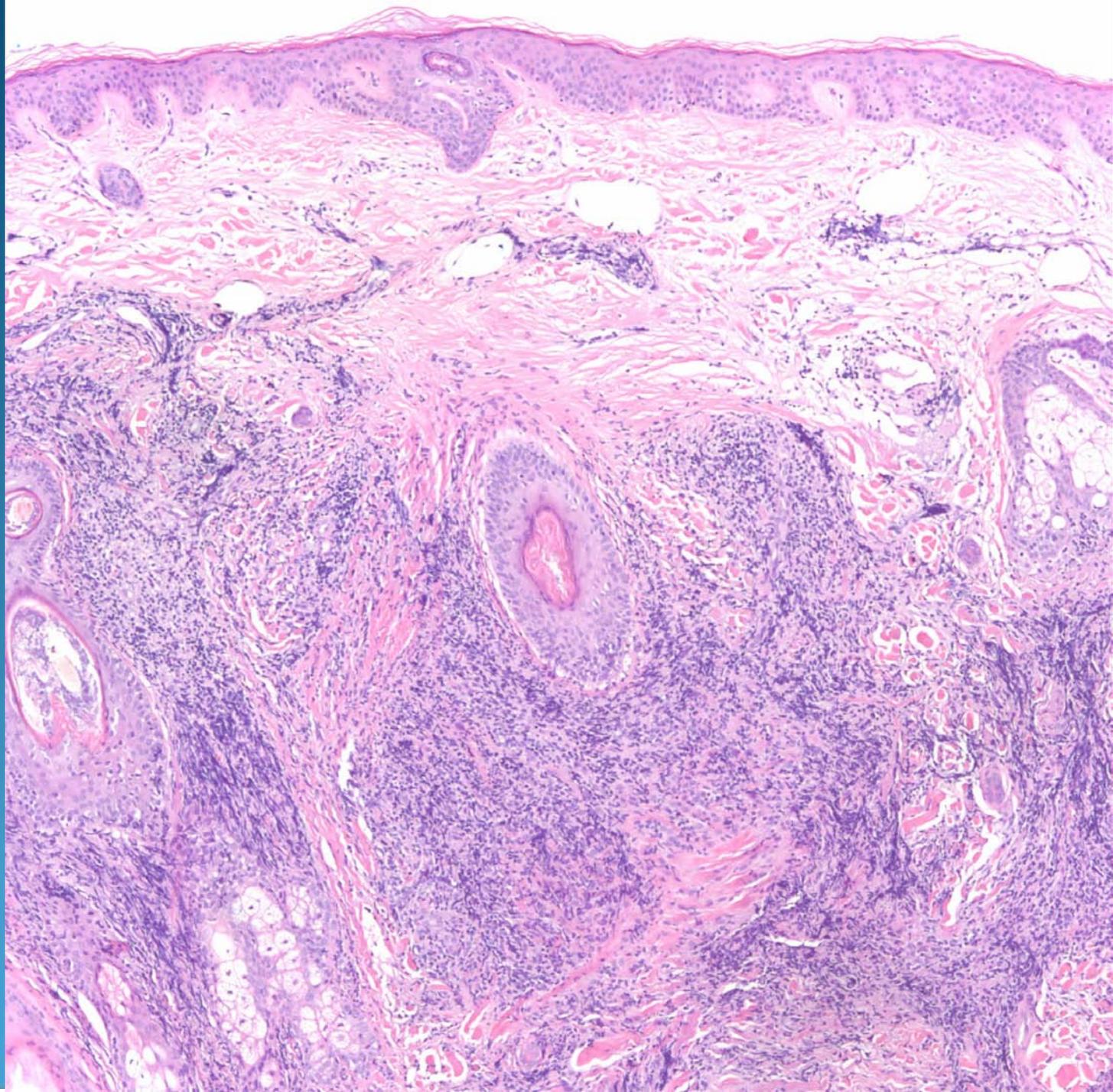
CD34

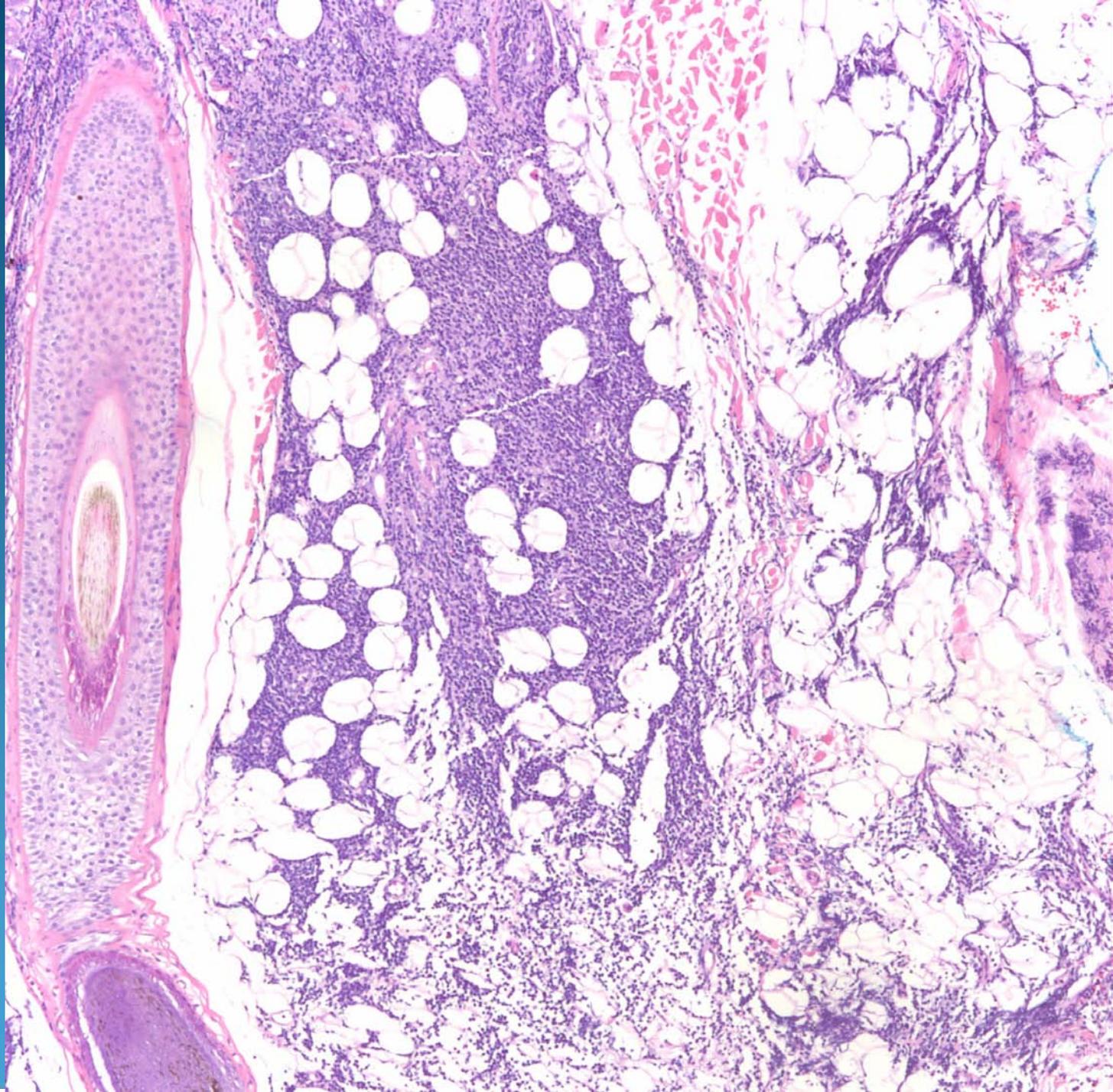
Pearls

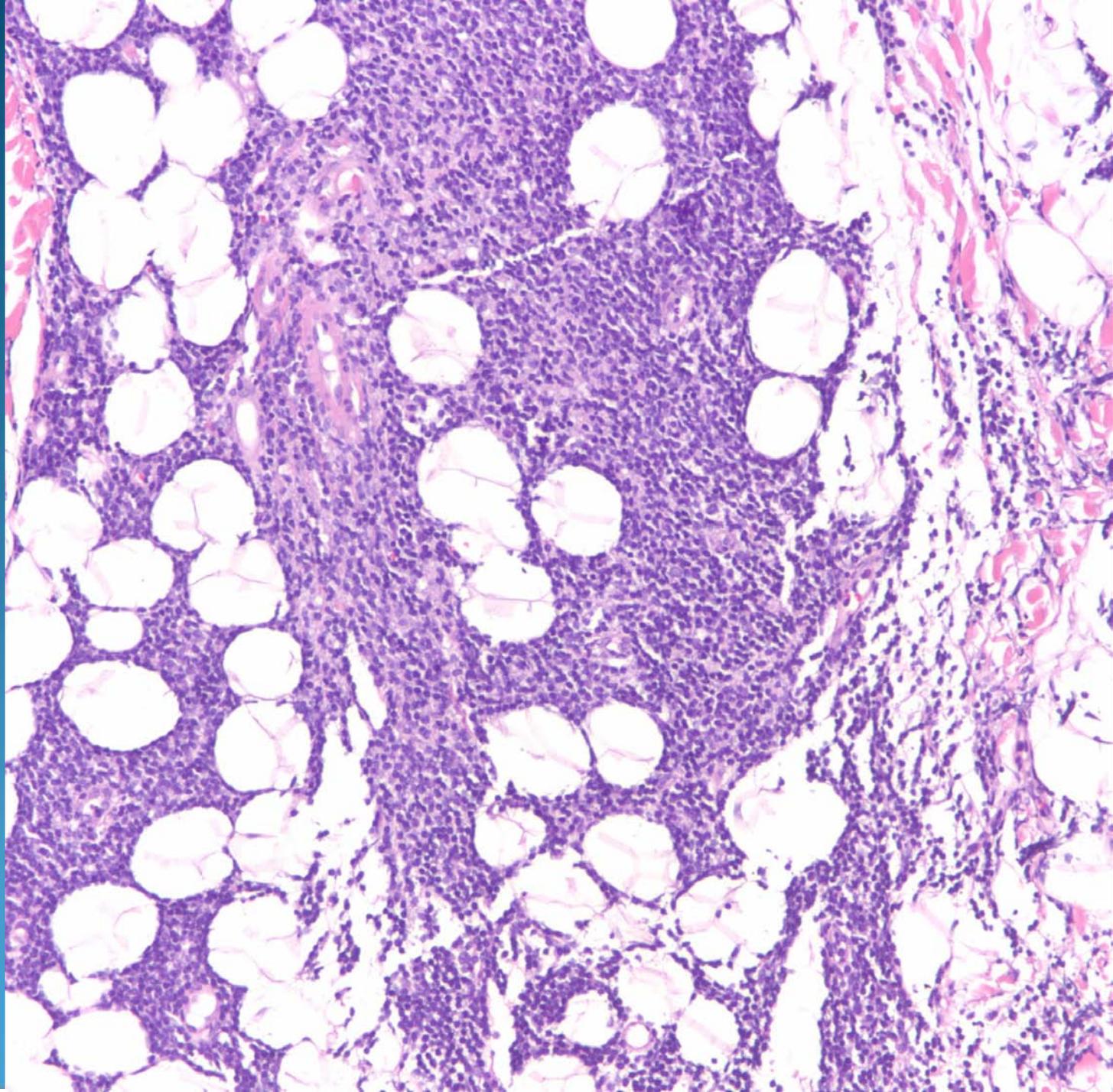


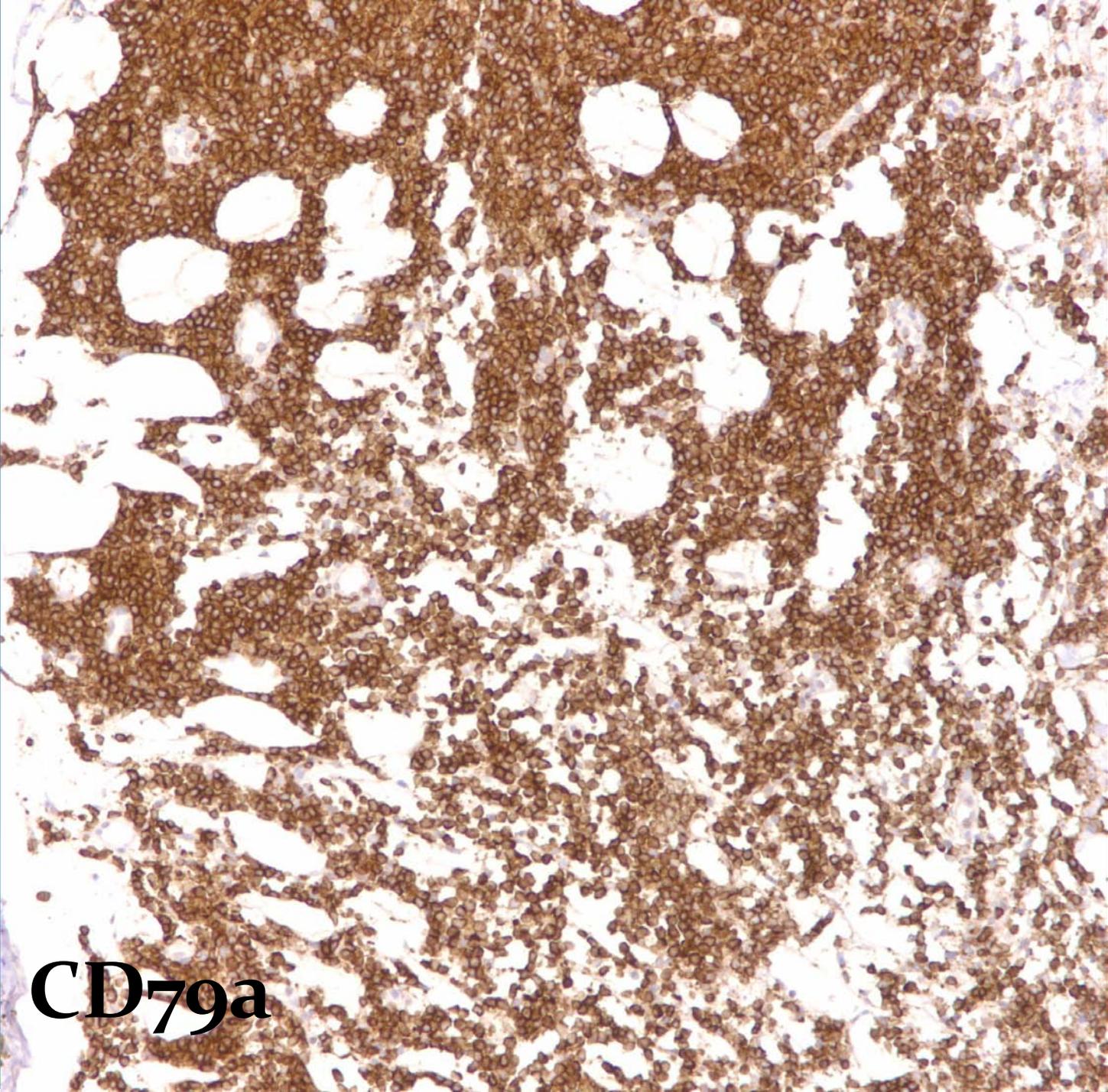
- Cellular dermal based nodule
- Wavy spindle cells, no atypia
- May see nerve rootlets
- Occasional entrapment of adipocytes-rule out DFSP
- IHC: S100+ and may be CD34+, beware DDX with DFSP







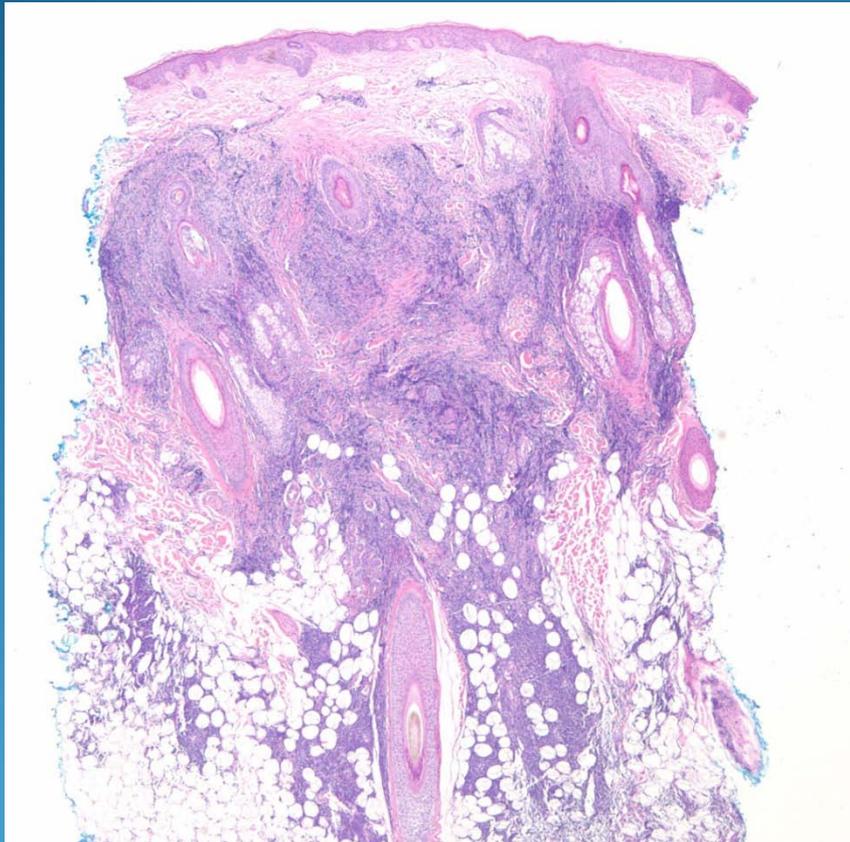




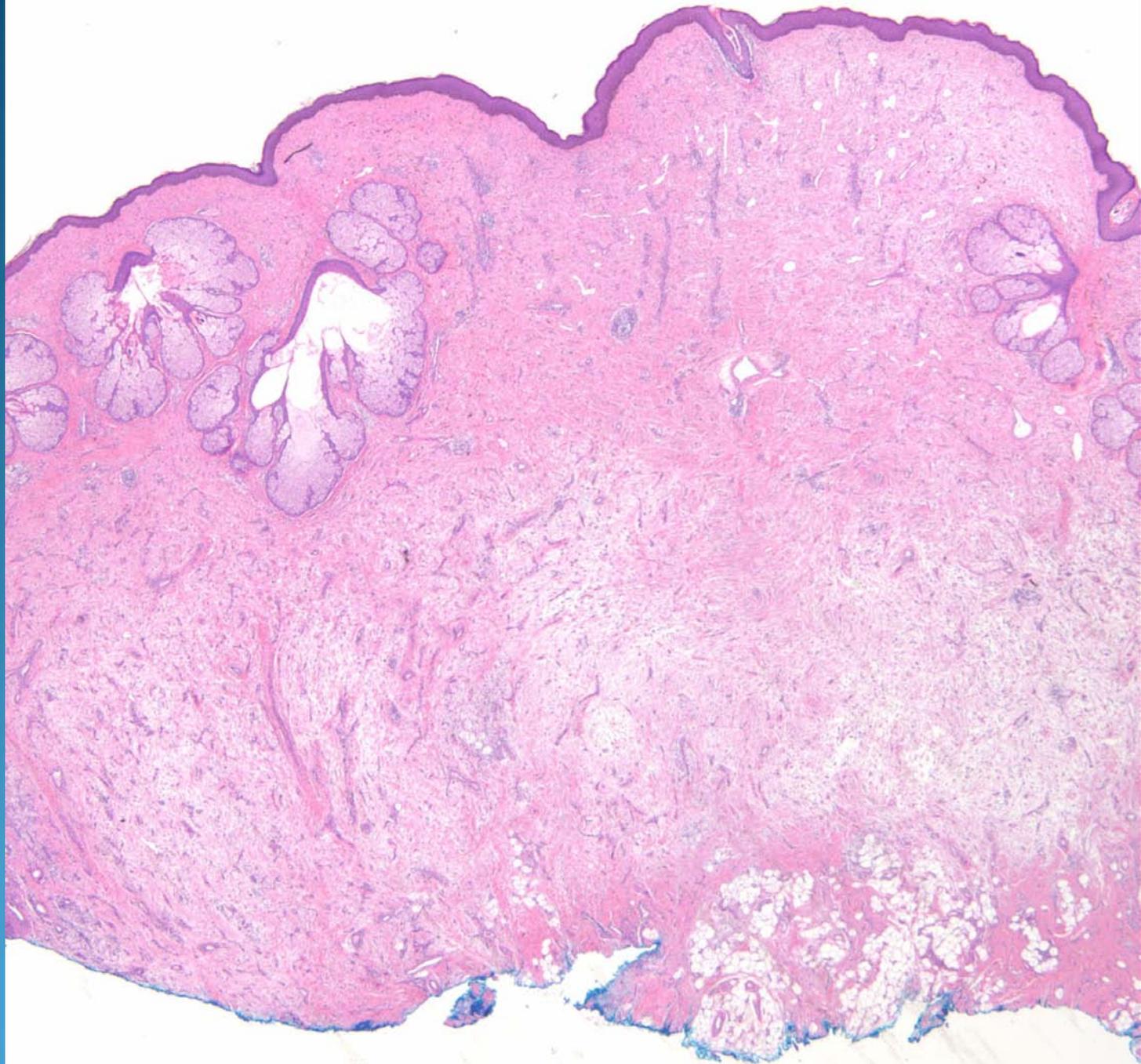
CD79a

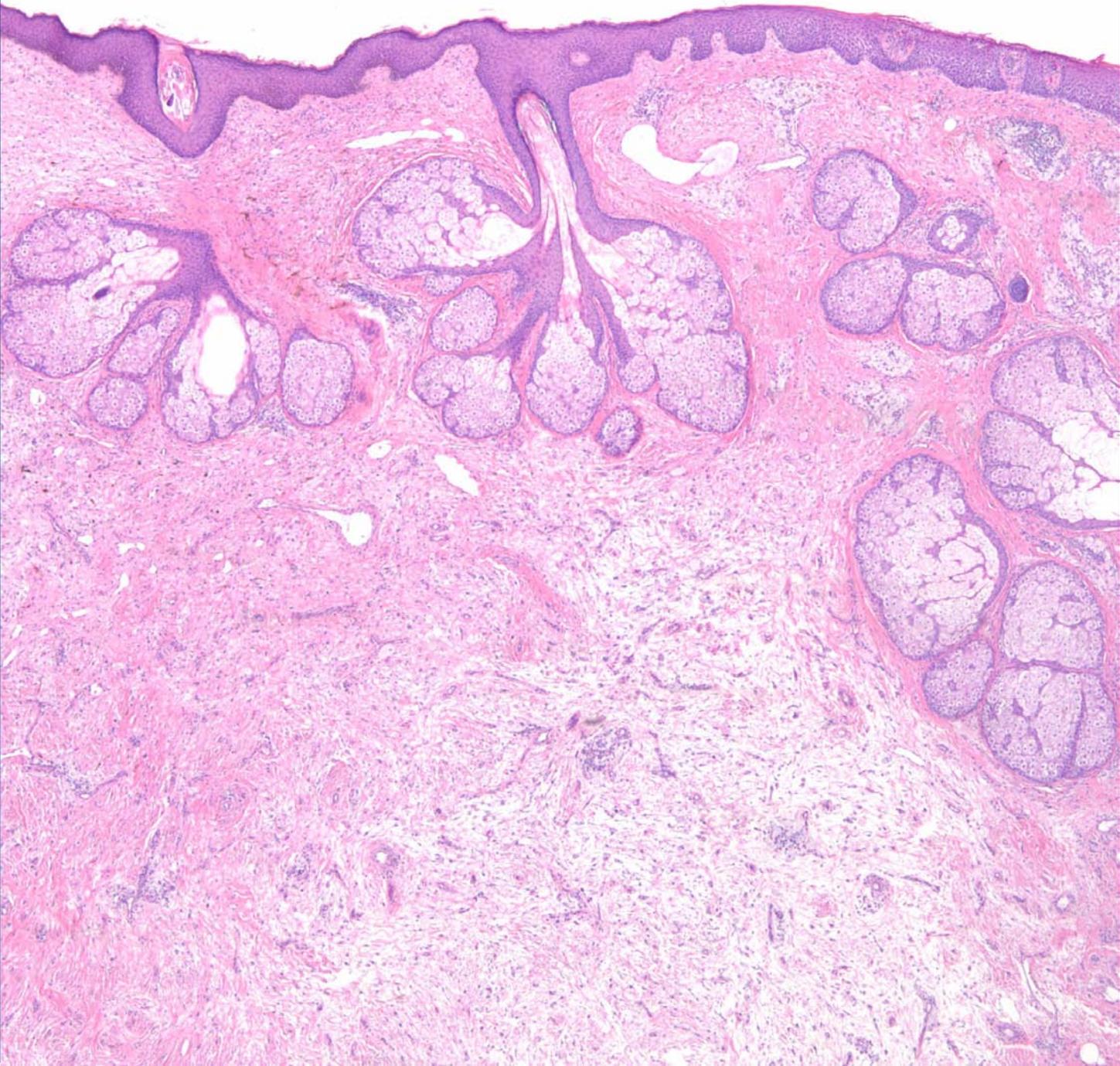
Cutaneous B-Cell Lymphoma

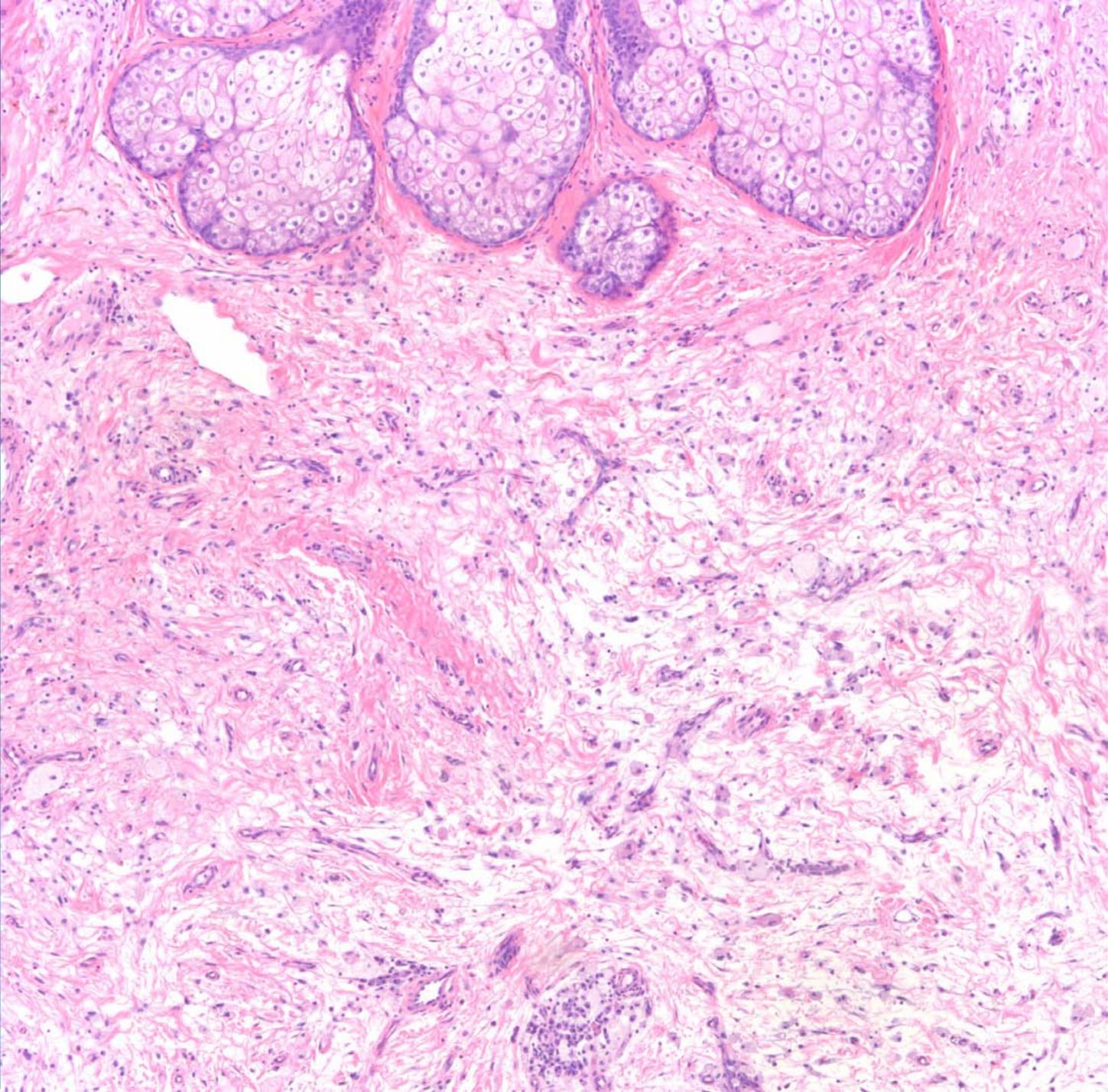
Pearls

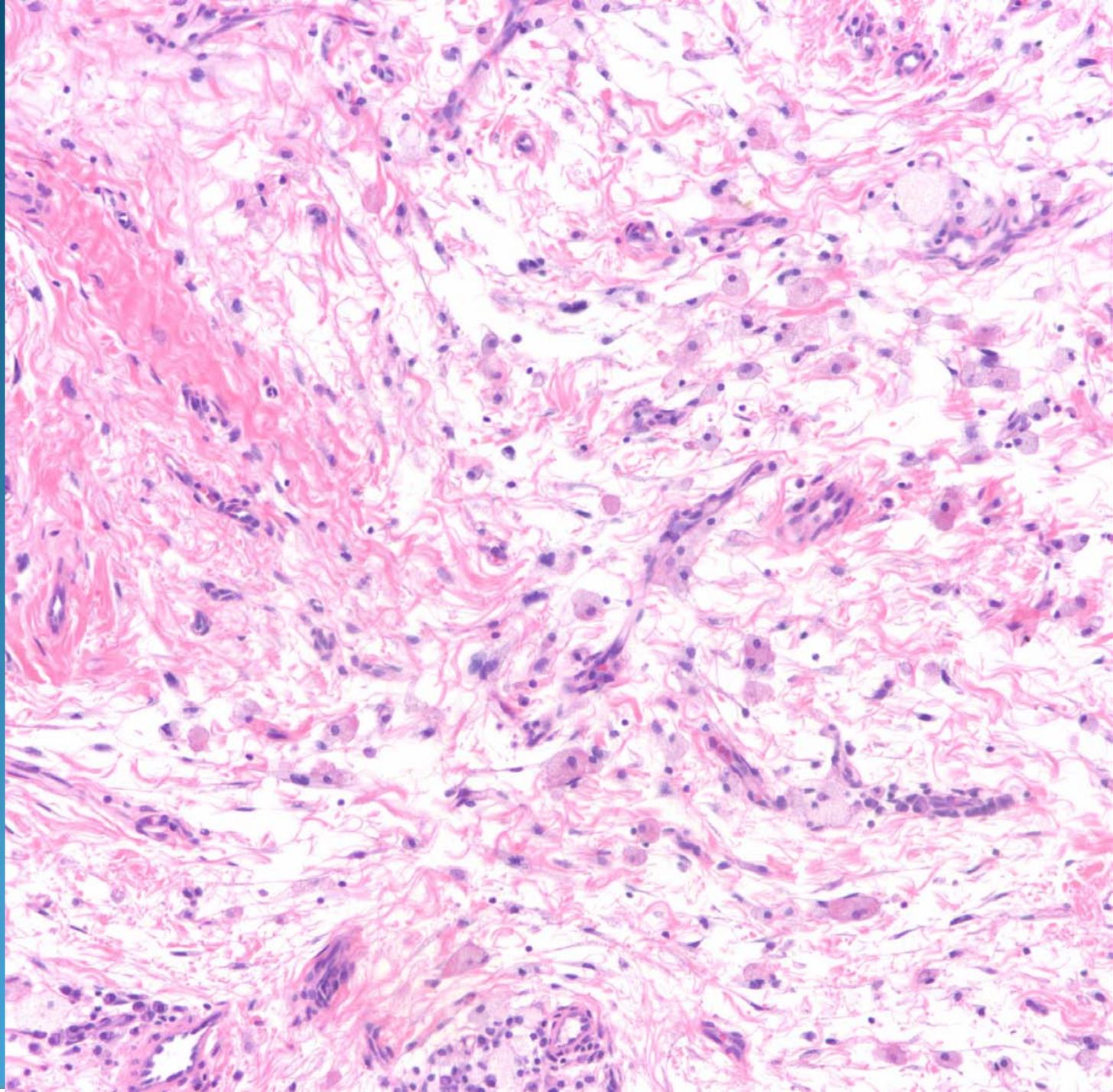


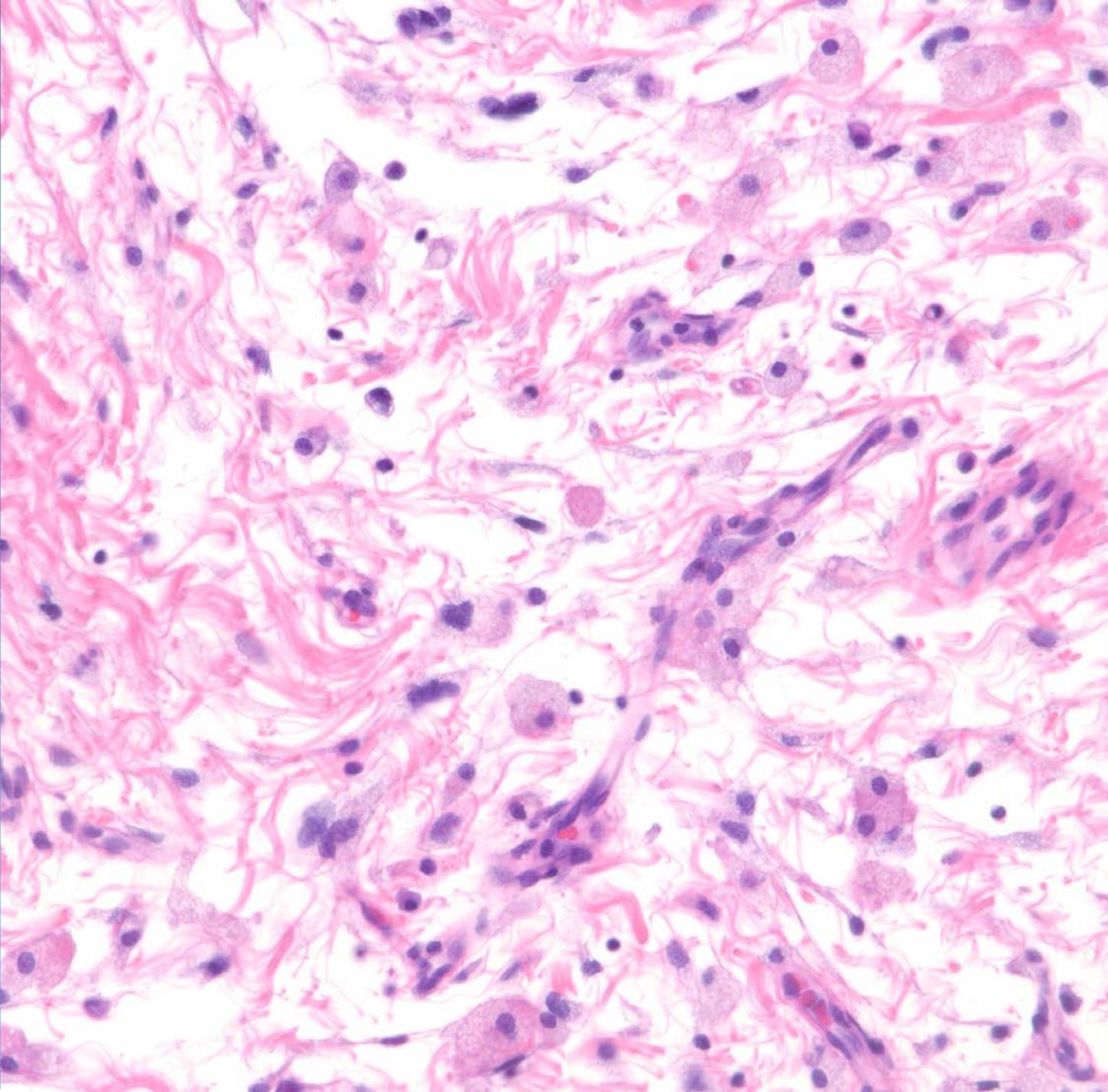
- Bottom heavy nodular and diffuse lymphocytic infiltrate, may extend into subcutaneous fat
- Grenz zone separating infiltrate from epidermis
- Confirm with IHC-CD20 and CD79+
- Subtype by morphology (size, cleaved contours, and IHC)





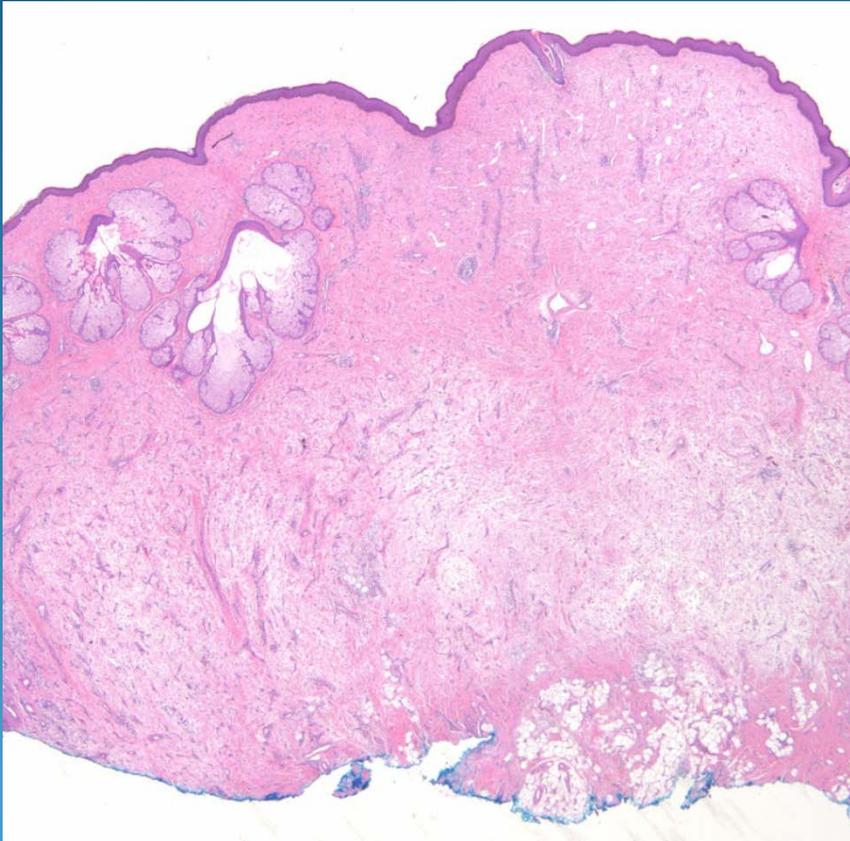




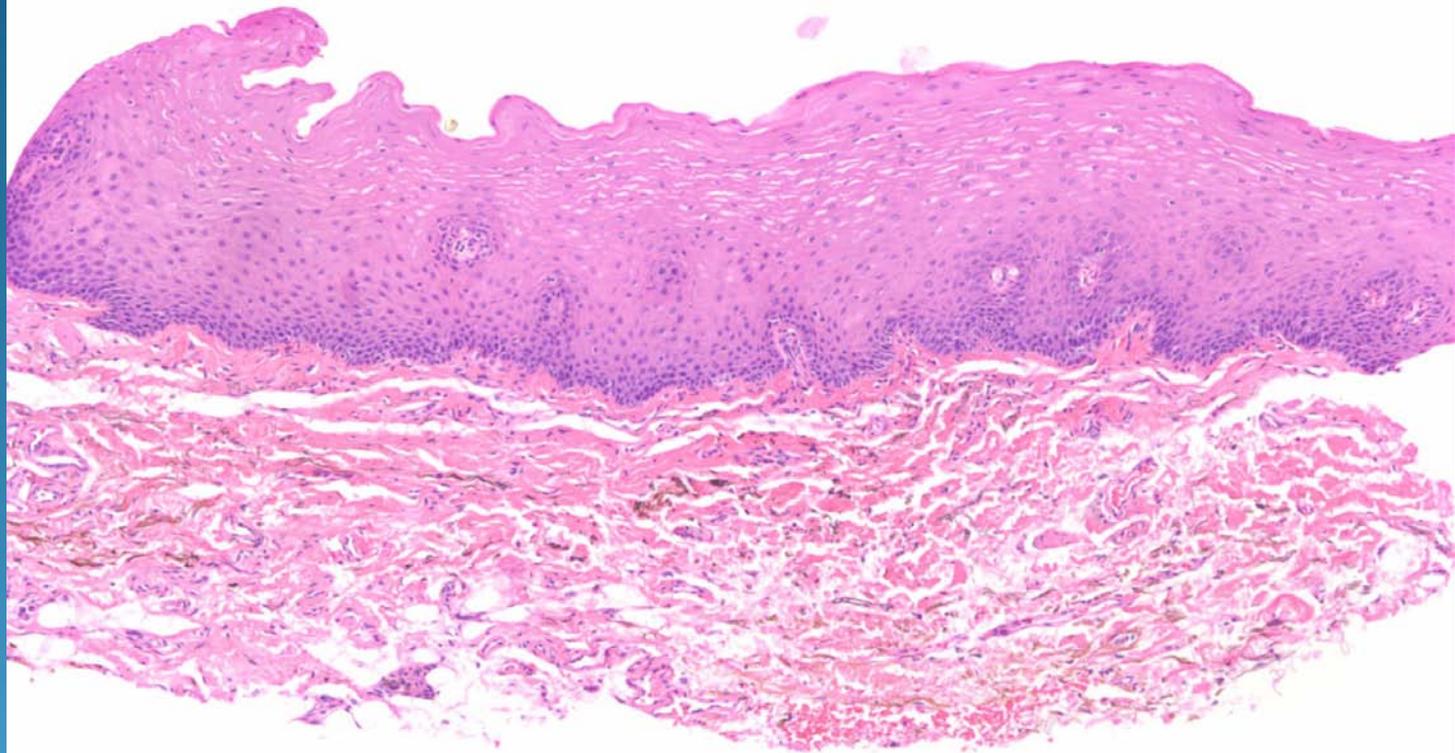


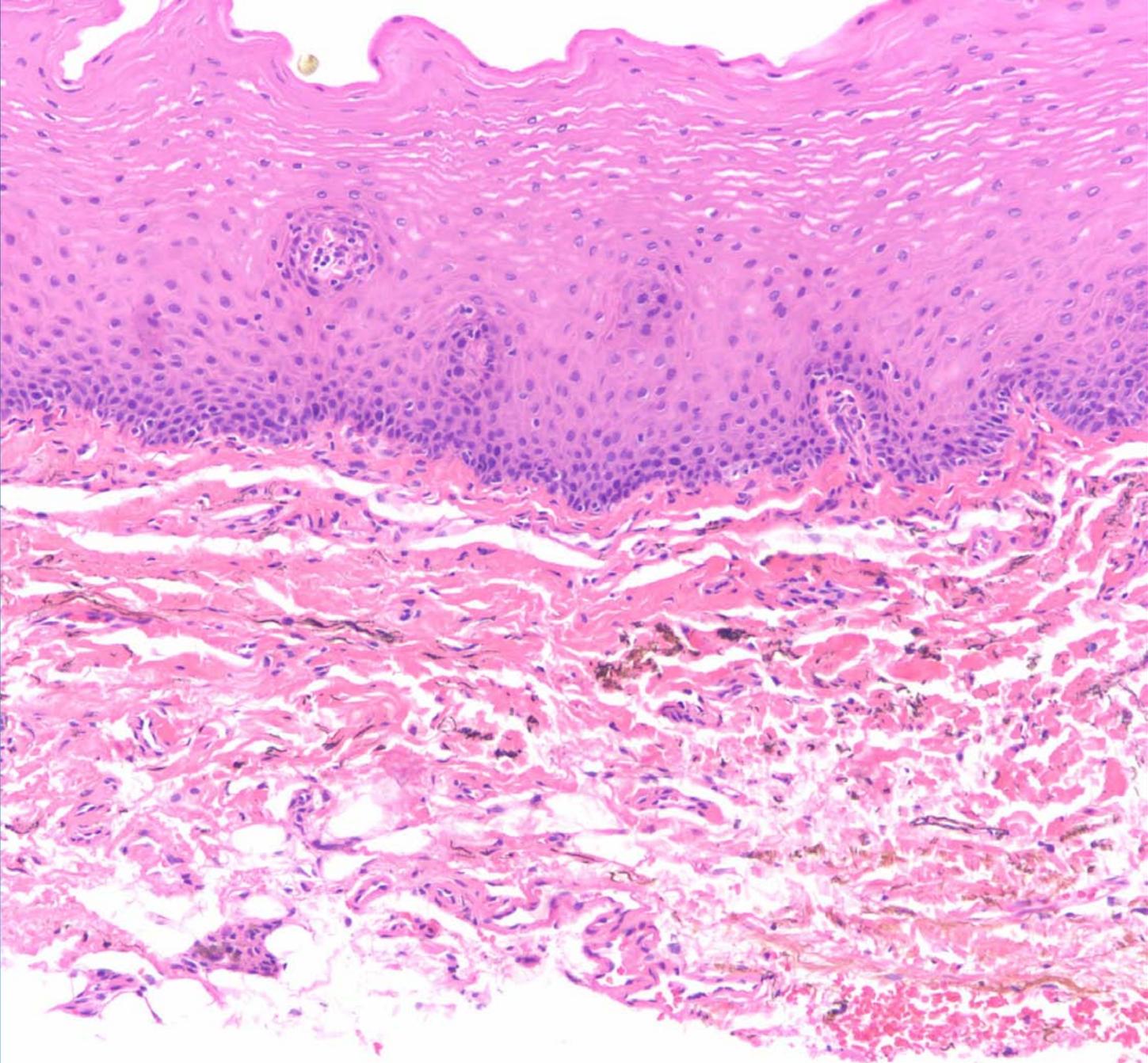
Rhinophyma

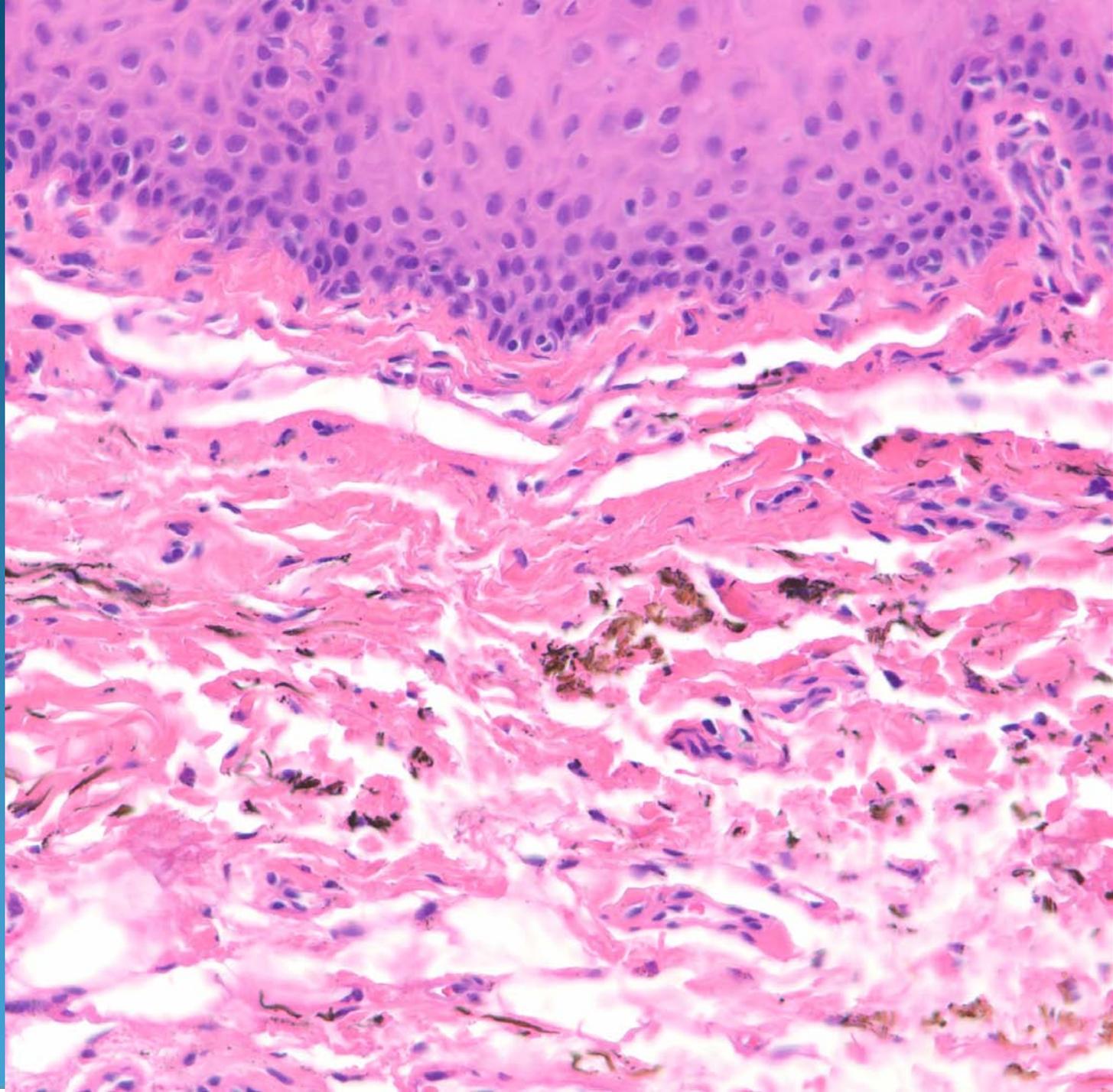
Pearls

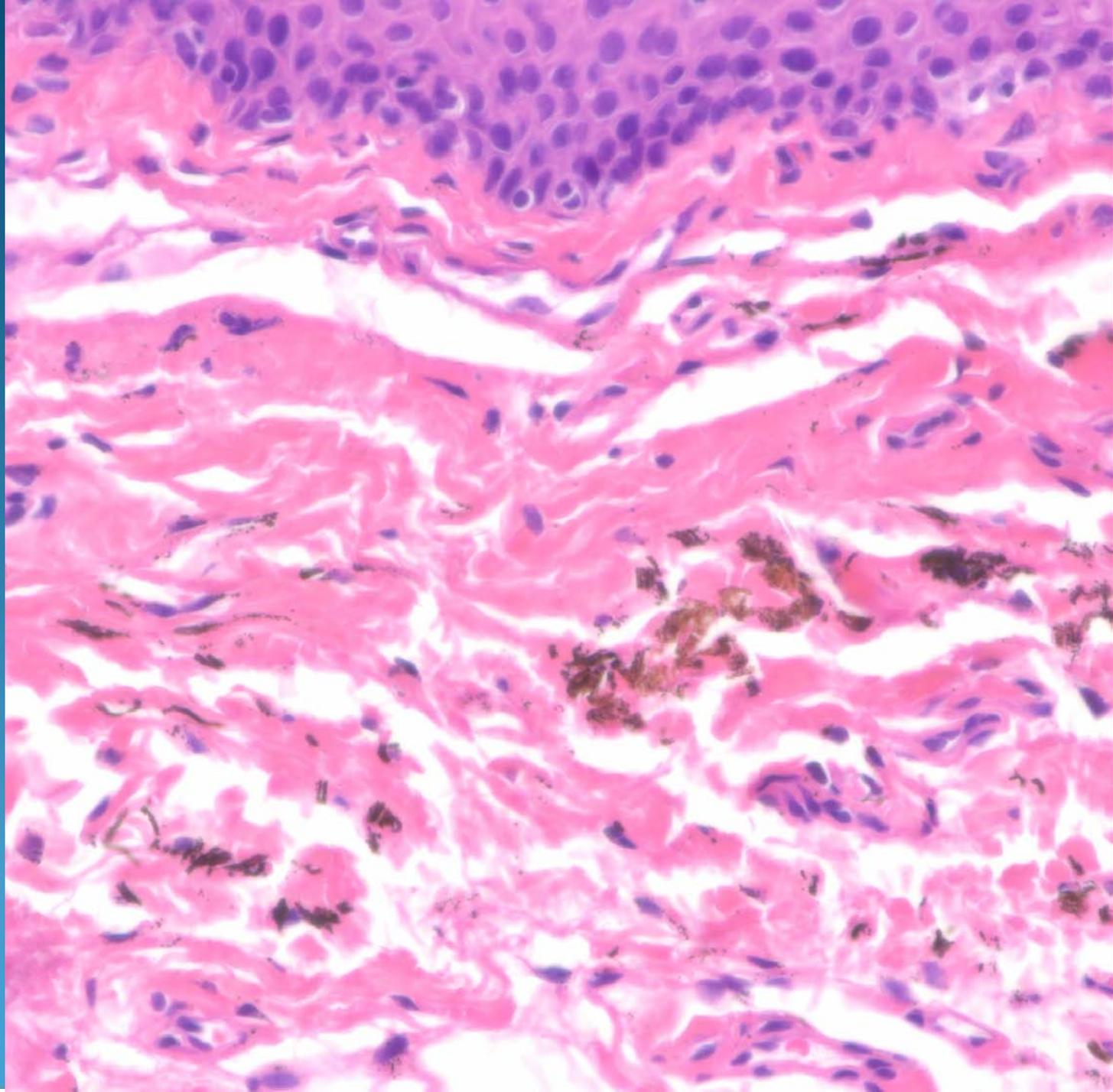


- Variable depending upon severity but usually polypoid
- Edema, scarring, and varying sebaceous gland hyperplasia
- Variable evidence of chronic folliculitis and rosacea



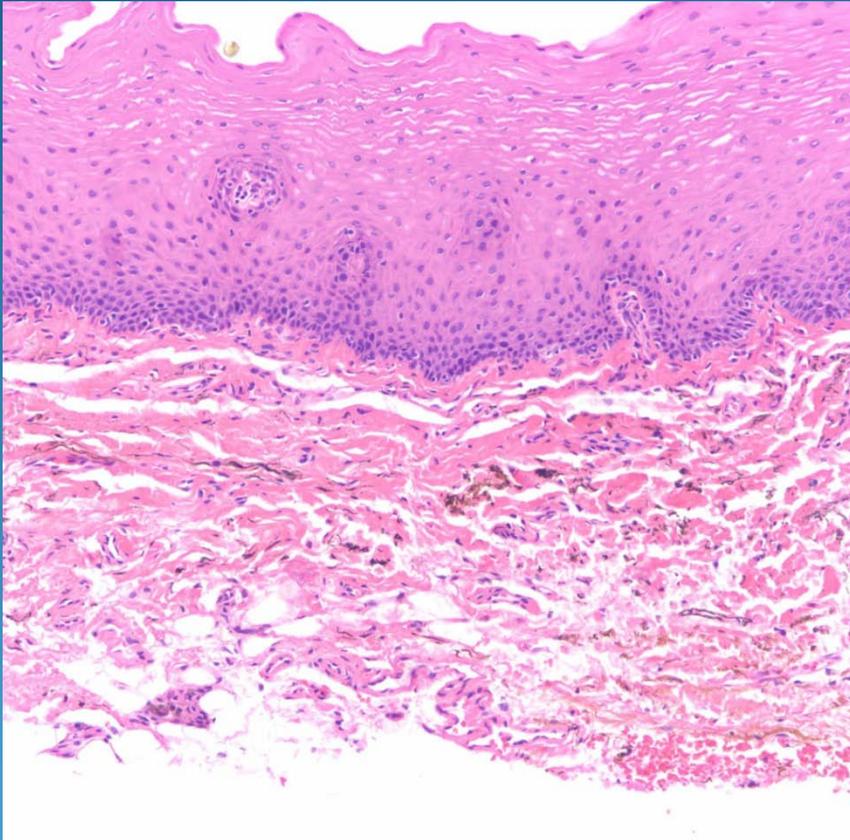




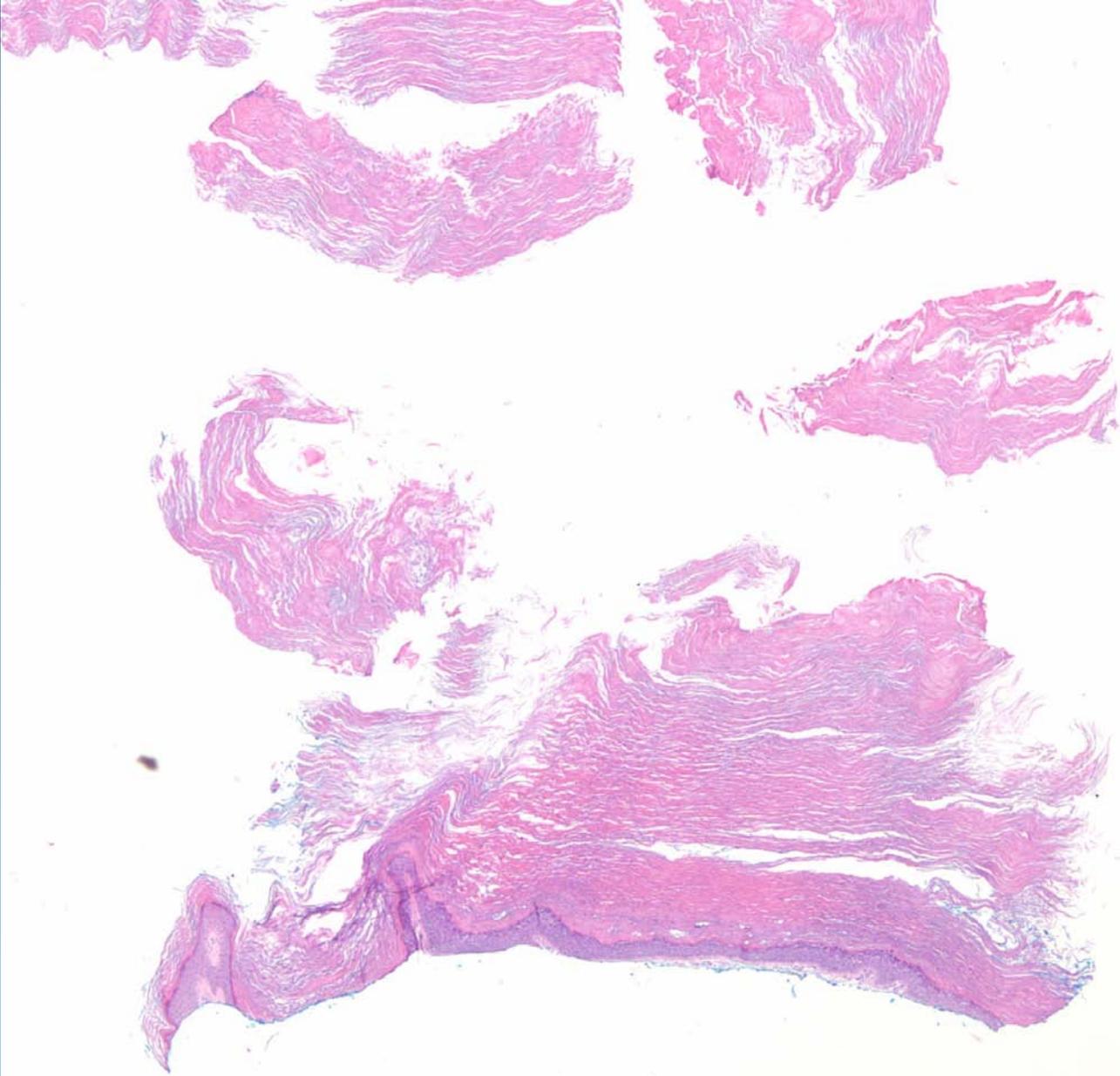


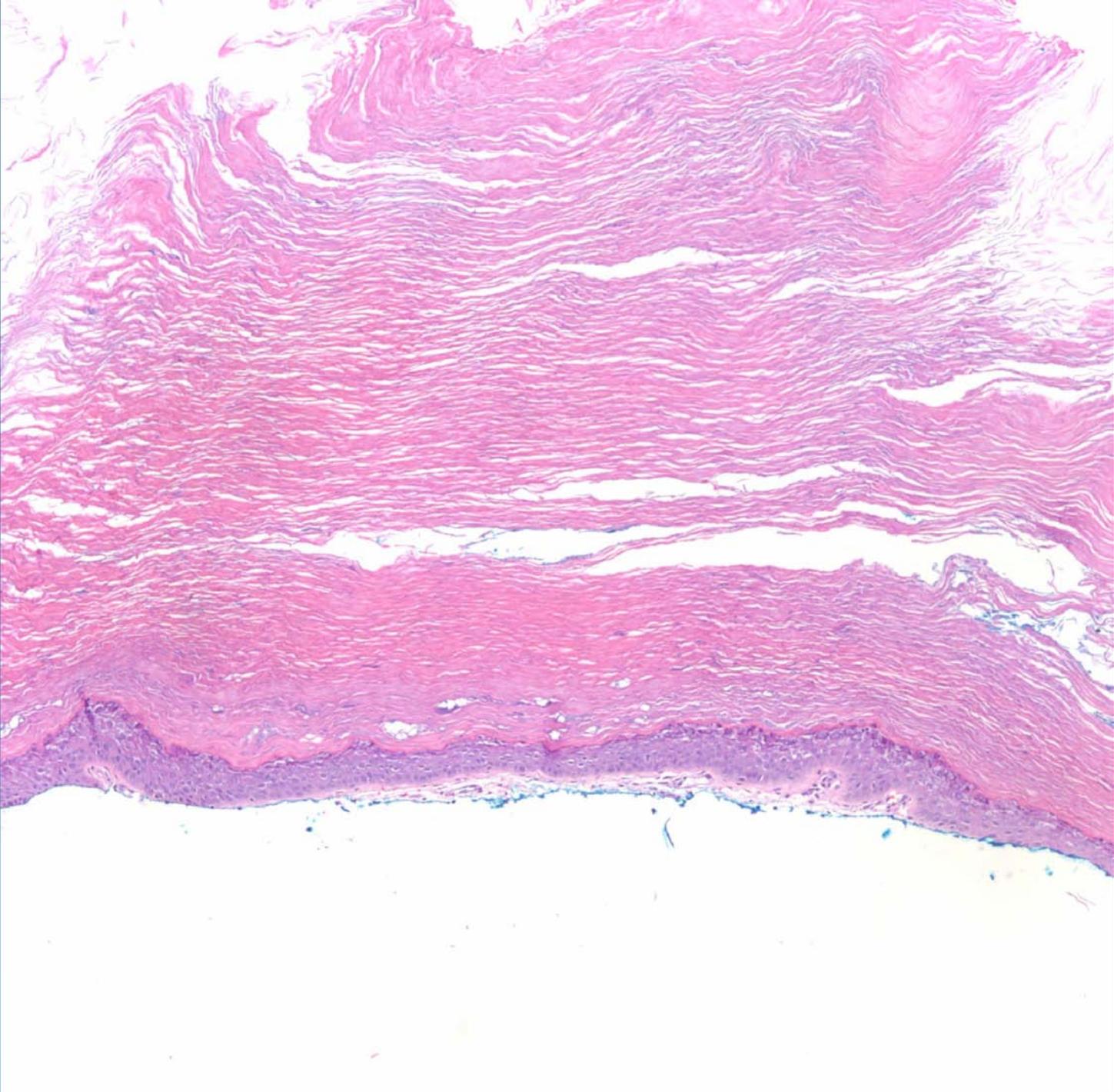
Amalgam Tattoo

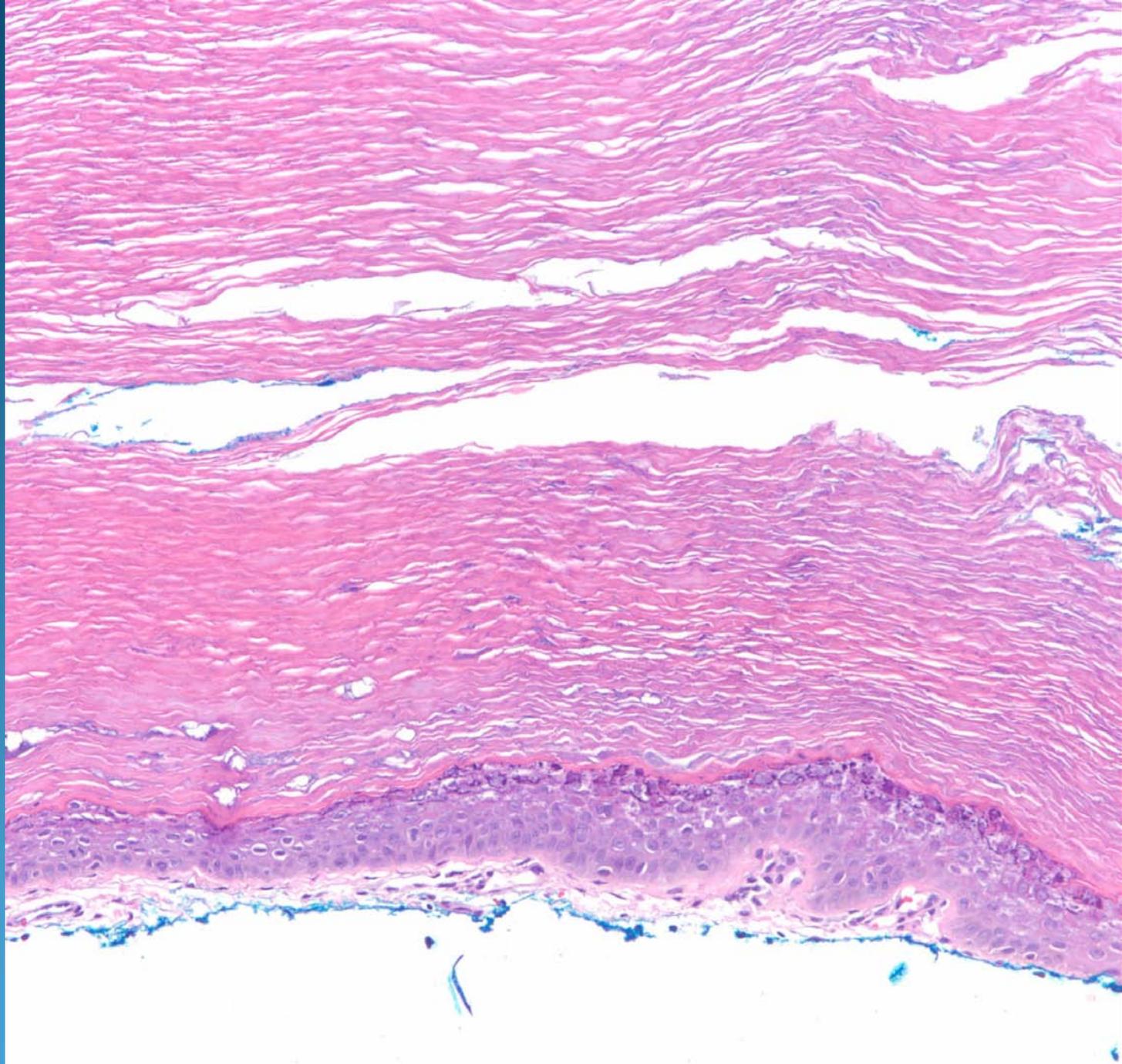
Pearls

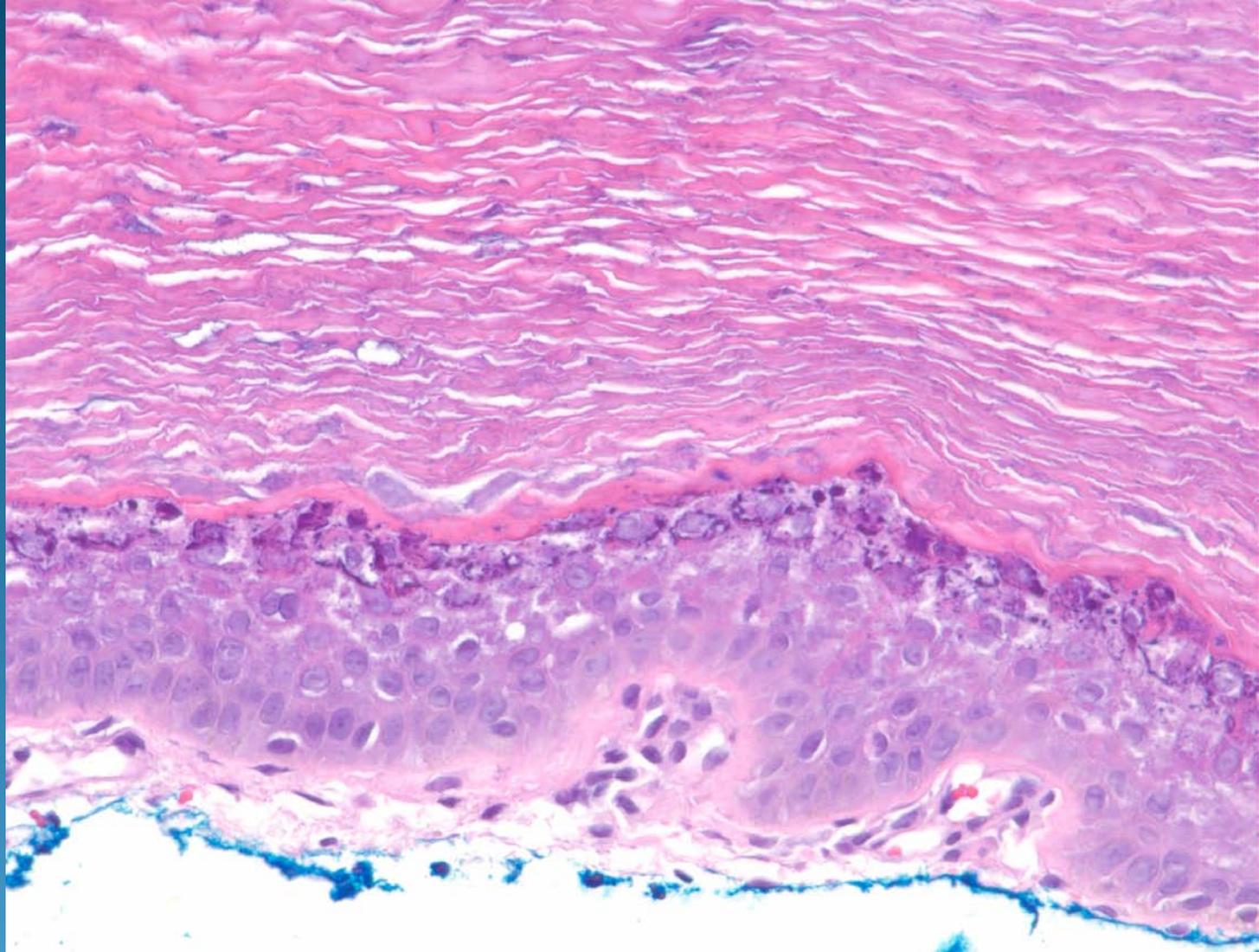


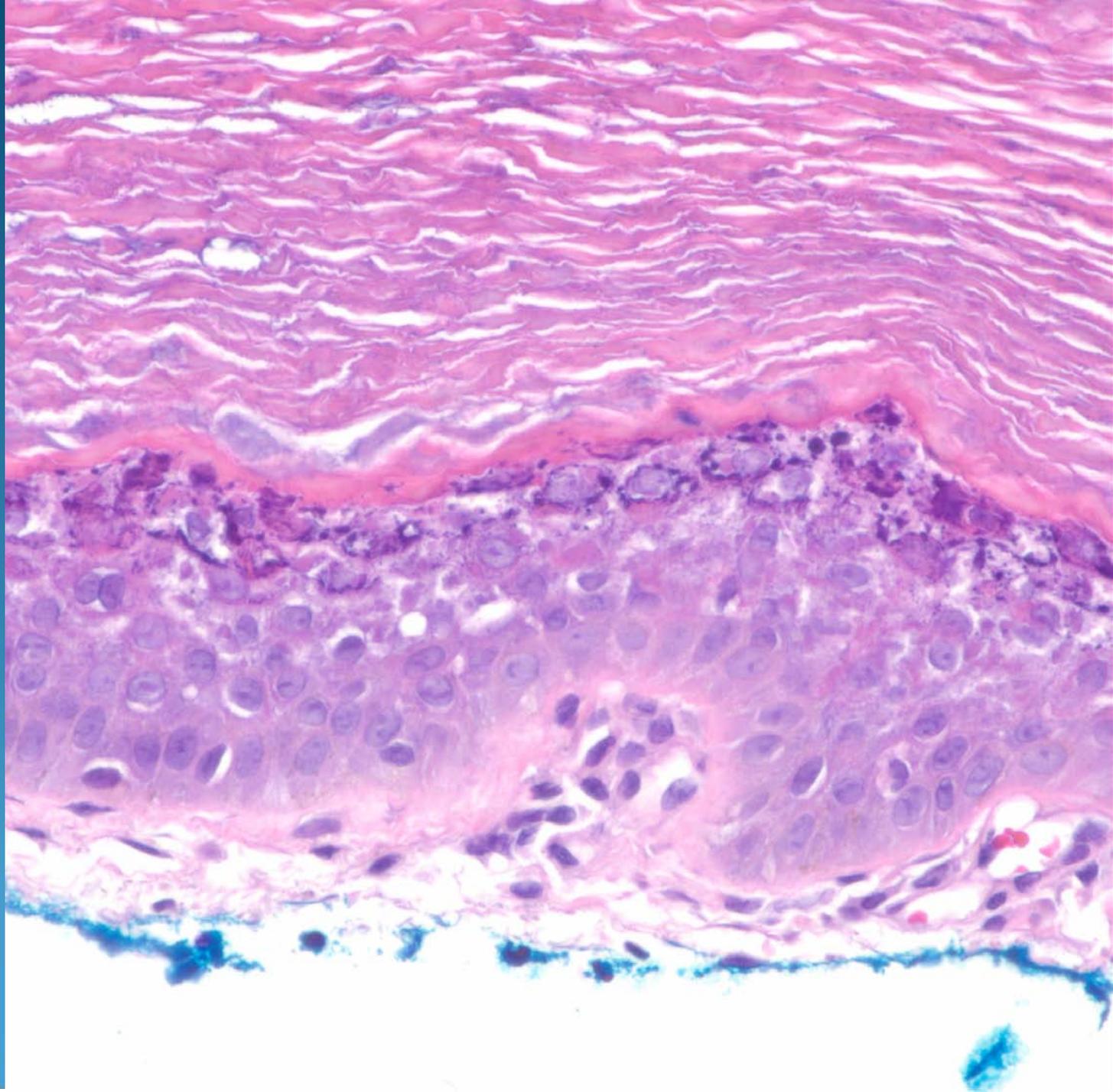
- Note oral squamous mucosa location
- Collections of dark pigment, usually arranged along fibroblasts or perivascular
- R/o melanocytic proliferation





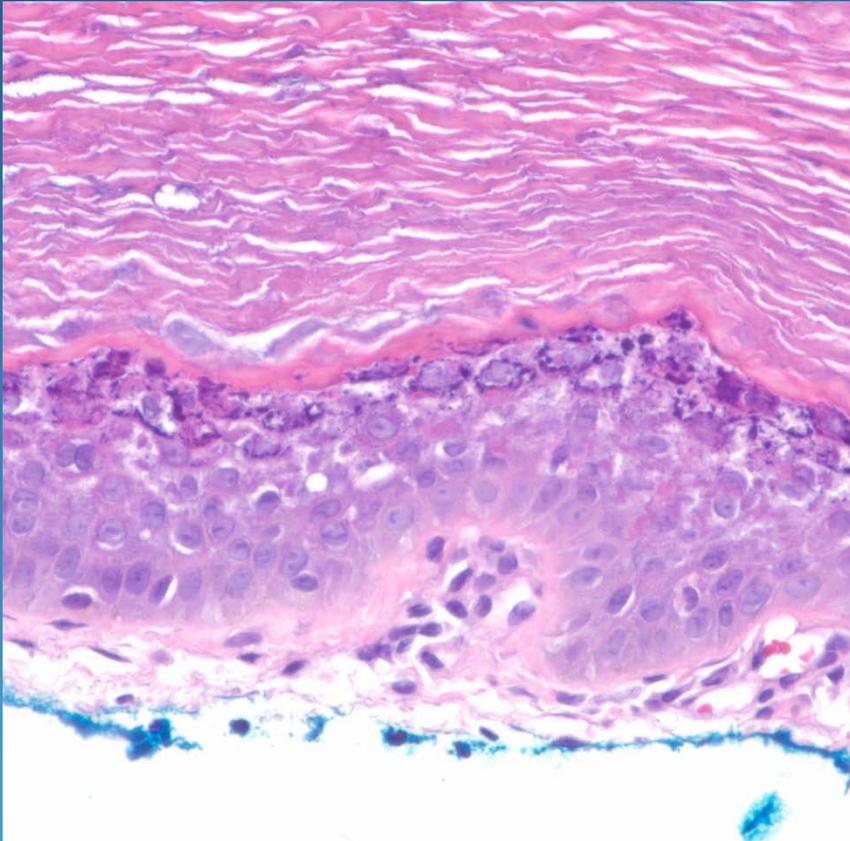






Epidermolytic Hyperkeratosis

Pearls



- Hyper -and parakeratosis
- Dissolution of the granular layer
- No koilocytes or epithelial dysplasia identified