ISSN : (Online): 3008-038X
Abbreviation: J Derm Cse Rep
DOI: 10.61705/jdcr.19.2.2026.123.131

Journal of Dermatological Case Reports

Scalp Nodules as the Presenting Sign of Occult High-Grade B-Cell Lymphoma: A Diagnostic Dilemma Amid Concurrent Infectious Illness

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Abstract:

Cutaneous scalp involvement as the initial manifestation of high-grade B-cell lymphoma, including diffuse large B-cell lymphoma (DLBCL), is rare and diagnostically challenging — particularly when a concurrent infectious illness produces overlapping systemic findings. We report a 58-year-old male from St. Kitts and Nevis with a history of diabetes mellitus type 2 who presented to the emergency department with tender scalp nodules and right periorbital papules. In the weeks prior, he had been hospitalized in St. Kitts with a leukemoid reaction (peak WBC 57,200/μL), fever, scleral icterus, and transaminitis, attributed to presumed Lyme disease and treated with IV ceftriaxone. On admission, examination revealed non-tender scalp nodules without erythema, bilateral cervical adenopathy, and hepatomegaly. Laboratory findings were notable for anemia (hemoglobin 9.1 g/dL), leukocytosis, elevated lactate dehydrogenase (440 U/L), a 20-pound weight loss, and prior night sweats. A comprehensive infectious workup — including blood cultures, HIV, viral hepatitis, CMV, EBV, Lyme serology, malaria PCR, and Quantiferon-TB Gold — was entirely negative, as was a myeloma screen. Imaging revealed scalp nodularity with punctate dermal calcifications on CT head, and CT abdomen/pelvis demonstrated a 2.0 cm exophytic pancreatic body mass, hepatomegaly, splenomegaly, and bilateral lymphadenopathy; MRI pancreas confirmed a suspected pancreatic neoplasm. Ultrasound-guided core biopsy of the left axillary lymph node established the diagnosis of high-grade B-cell lymphoma, and PET/CT was ordered for staging. This case highlights that scalp nodules and periorbital papules may serve as sentinel cutaneous manifestations of systemic DLBCL. Clinicians should maintain a broad oncologic differential when evaluating new scalp lesions accompanied by constitutional symptoms and lymphadenopathy, even when a competing infectious diagnosis appears compelling.

Keywords:

High-grade B-cell lymphoma; diffuse large B-cell lymphoma; scalp nodules; cutaneous lymphoma; lymphadenopathy; pancreatic lymphoma; scalp papules; periorbital lymphoma.

Received : 06-05-2026 **Revised : 10-05-2026** **Accepted: 20-05-2026** **Published : 29-05-2026**

ISSN : (Online): 3008-038X
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Introduction

Background

Diffuse large B-cell lymphoma (DLBCL) is the most common subtype of non-Hodgkin lymphoma, accounting for 30–40% of all lymphoid malignancies and approximately 150,000 new cases annually worldwide [1]. While DLBCL typically presents with rapidly progressive lymphadenopathy, extranodal involvement occurs in up to 40% of patients [2]. Cutaneous involvement by systemic DLBCL is reported in only 1.5–3.5% of cases, and disseminated cutaneous disease is especially unusual [3].

Scalp nodules are an underrecognized initial presentation of systemic high-grade B-cell lymphoma [4]. These lesions are frequently attributed to benign conditions such as cysts, lipomas, or dermatitis, making histopathological confirmation essential [5]. Diagnostic complexity is further heightened when cutaneous lymphomatous findings coexist with a concurrent infectious illness producing overlapping signs — including lymphadenopathy, hepatosplenomegaly, and constitutional symptoms. We present a case in which scalp nodules and periorbital papules were the initial findings prompting emergency department evaluation, ultimately leading to a tissue-confirmed diagnosis of high-grade B-cell lymphoma amid a competing infectious differential.

Case Presentation

Prior Clinical History

A 58-year-old male safari tour guide from St. Kitts and Nevis with a history of diabetes mellitus type 2, diabetic neuropathy, hyperlipidemia, and hepatic steatosis presented following a three-week preceding illness. He recalled a painful bite from a beetle-like insect on his waist. On March 7, 2026, he developed an acute right-sided facial droop and was diagnosed with Bell's palsy, treated with oral prednisone, valacyclovir, and a one-week course of doxycycline.

On March 25, 2026, he re-presented to JNF General Hospital in St. Kitts with fever (101.5°F), polyarthralgia of the neck, shoulders, and knees, scleral icterus, and dark urine. Laboratory workup was notable for leukocytosis (WBC 57,200/μL), thrombocytopenia (platelets 80,000/μL), hyperbilirubinemia, and markedly elevated liver enzymes (AST 136 U/L, ALT 327 U/L, LDH 1,209 U/L). Dengue serology showed a positive IgG and negative IgM, consistent with prior exposure; Lyme antibody testing showed elevated IgG (1,918) and negative IgM. He was treated with IV ceftriaxone, with normalization of WBC and platelets prior to discharge on April 2, 2026.

Emergency Department Presentation

On April 10, 2026, the patient presented to the emergency department with a four-day history of painful right periorbital bumps, increased right eye tearing, and tender, raised scalp nodules. He endorsed a 20-pound weight loss over the preceding five weeks and prior night sweats, and denied fever, chills, nausea, vomiting, abdominal pain, or chest pain. Vital signs were: temperature 97.9°F (36.6°C), heart rate 89 bpm, respiratory rate 18 breaths/min, blood pressure 119/78 mmHg, oxygen saturation 96% on room air, and BMI 29.92 kg/m².

Physical examination revealed non-tender raised nodules throughout the scalp without erythema or discoloration **(Figure 1)**, right periorbital erythema, mild scleral icterus, bilateral submandibular adenopathy with prominent right submental and left submandibular nodes, hepatomegaly, right elbow swelling with decreased range of motion, and facial asymmetry consistent with Bell's palsy.

Laboratory and Imaging Findings

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Admission laboratory data demonstrated anemia (hemoglobin 9.1 g/dL, hematocrit 27.4%), microcytosis (MCV 76.8 fL), elevated RDW (17.4%), leukocytosis (WBC 15.89 × 10^3/μL), and elevated LDH (440 U/L). Uric acid was mildly elevated at 7.7 mg/dL. Tumor markers (AFP, CEA, CA 19-9) were within normal limits, and a myeloma screen (SPEP, UPEP, serum free light chains) was negative. An extensive infectious workup — including blood and urine cultures, HIV, hepatitis A/B/C, CMV, EBV, VZV, Lyme IgG/IgM, syphilis screen, malaria PCR, Plasmodium PCR, AFB, and Quantiferon-TB Gold — was negative; procalcitonin was 0.24 ng/mL. Key findings are summarized in **Table 1**.

CT head without contrast demonstrated mild scalp nodularity and skin thickening with punctate dermal calcifications and no underlying osseous abnormality. CT abdomen/pelvis with contrast revealed a 1.5 × 1.7 × 2.0 cm exophytic solid lesion arising from the body of the pancreas, hepatomegaly (liver span 20 cm), splenomegaly (15 cm), and bilateral inguinal lymphadenopathy up to 1.6 cm. CT soft tissue neck with contrast showed mildly enlarged left submandibular lymph nodes up to 2 cm, and CT chest demonstrated enlarged bilateral axillary lymph nodes. MRI brain with and without gadolinium revealed no meningeal or leptomeningeal involvement. MRI pancreas with contrast confirmed an exophytic pancreatic body mass with heterogeneous enhancement on delayed imaging, with a radiologic impression of suspected pancreatic neoplasm.

Hospital Course and Diagnosis

The patient received multidisciplinary evaluation involving Infectious Disease, Hematology/Oncology, Gastroenterology, Otolaryngology/Head and Neck Surgery, Interventional Radiology, and Surgical Oncology. Infectious Disease initiated a 21-day course of IV ceftriaxone for presumed recent Lyme infection. Hematology/Oncology identified a suspected lymphoproliferative disorder based on generalized lymphadenopathy, hepatosplenomegaly, elevated LDH, prior leukemoid reaction, constitutional symptoms, and a negative myeloma screen.

On April 17, 2026, Gastroenterology performed endoscopic ultrasound-guided fine needle biopsy (EUS-FNB) of the pancreatic mass. On April 21, 2026, Interventional Radiology performed ultrasound-guided core biopsy of the left axillary lymph node (approximately 2.5 × 2 cm), yielding eight 18-gauge cores. Pathology confirmed high-grade B-cell lymphoma on April 28, 2026, and PET/CT was subsequently ordered for systemic staging. Full immunohistochemical profiling — including CD20, CD10, BCL-2, BCL-6, MUM1, MYC, Ki-67, and cell-of-origin subtype per the Hans algorithm — as well as EUS-FNB pancreatic pathology results, were pending at the time of this report.

Discussion

This case highlights the sentinel role that cutaneous findings can play in the diagnosis of systemic malignancy. Scalp nodules and periorbital papules were the presenting complaint that ultimately led to a tissue-confirmed diagnosis of high-grade B-cell lymphoma — illustrating how skin findings at an unexpected anatomic site can be the first window into widespread oncologic disease.

Scalp Nodules as Sentinel Cutaneous Signs of Systemic DLBCL

Subcutaneous scalp involvement by DLBCL is uncommon and frequently overlooked. Slater et al. described a 60-year-old male in whom a subcutaneous scalp mass was found to represent DLBCL only after excisional pathology, underscoring how these lesions can be mistaken for benign cysts or lipomas in the absence of histopathological evaluation [4]. In our patient, non-tender scalp nodules without erythema or discoloration were the primary reason for emergency department presentation and ultimately directed the systemic workup that uncovered the underlying malignancy. CT head corroborated the clinical findings, demonstrating scalp nodularity with punctate dermal

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calcifications — a non-specific but supportive radiologic correlate of infiltrative or neoplastic scalp involvement.

Cutaneous involvement by systemic DLBCL occurs in only 1.5–3.5% of cases [3]. When present, lesions typically appear as erythematous subcutaneous nodules or papules. In the primary cutaneous setting, DLBCL leg type (PCDLBCL-LT) accounts for approximately 20% of all primary cutaneous B-cell lymphomas, characteristically presenting as rapidly growing violaceous or red nodules on the lower extremities of elderly women [6]. Our case represents a distinctly different entity — secondary cutaneous involvement by systemic high-grade B-cell lymphoma — in which scalp and periorbital lesions were the first visible manifestation of widespread nodal and extranodal disease.

Distinguishing Secondary Cutaneous DLBCL from Primary Cutaneous Variants

The distinction between primary cutaneous DLBCL leg type (PCDLBCL-LT) and secondary cutaneous involvement by systemic DLBCL carries meaningful prognostic weight. Lee et al. analyzed 44 patients with cutaneous DLBCL and found that secondary cases were more frequently associated with advanced-stage disease, higher IPI scores, and extensive cutaneous lesions compared to PCDLBCL-LT [7]. In our patient, generalized lymphadenopathy, hepatosplenomegaly, and a suspected pancreatic mass at presentation are consistent with systemic disease, making secondary cutaneous involvement the most appropriate classification pending PET/CT staging. Awad et al. described a case of secondary cutaneous DLBCL presenting with cutaneous and subcutaneous nodules, noting that 5-year survival rates in secondary DLBCL (approximately 37%) are inferior to those of PCDLBCL-LT (approximately 50%) [8]. Once a cutaneous lymphoma diagnosis is confirmed, prompt systemic staging is therefore essential.

Constitutional Symptoms and LDH as Diagnostic Clues

The patient's 20-pound weight loss over five weeks and prior night sweats are classic B symptoms of lymphoma and should independently raise suspicion for an aggressive lymphoproliferative process. Elevated LDH is one of five components of the IPI and has long been recognized as one of the strongest independent predictors of outcome in DLBCL, consistently associated with advanced-stage disease and high tumor burden [9]. In this patient, an admission LDH of 440 U/L — with a prior peak of 1,209 U/L during the St. Kitts hospitalization — reflected a substantial and evolving disease burden. The concurrent anemia (hemoglobin 9.1 g/dL) and elevated RDW may additionally suggest bone marrow involvement or disease-related inflammation, though bone marrow biopsy had not yet been performed at the time of this report.

Diagnostic Complexity: Concurrent Infectious Illness

What made this case particularly challenging was the depth of the competing infectious differential. The patient's prior leukemoid reaction (WBC 57,200/µL), scleral icterus, transaminitis, positive dengue IgG, elevated Lyme IgG, and tropical travel history from an endemic region collectively painted a convincing — yet ultimately misleading — infectious picture. It was only after a comprehensive negative workup (blood and urine cultures, HIV, viral hepatitis, CMV, VZV, TB, malaria, syphilis, and repeat Lyme testing) that clinical attention shifted decisively toward malignancy.

This diagnostic challenge is well represented in the literature. Ferrão et al. described a case of DLBCL presenting with cutaneous findings that were initially attributed to an infectious process, highlighting how overlapping clinical features can defer the oncologic diagnosis [10]. Teresiak-Mikołajczak et al. reported a case of DLBCL misdiagnosed as facial erysipelas, in which a delayed skin biopsy prolonged the diagnostic workup [11]. Lee and Yun described DLBCL initially mistaken for a hematoma in a patient with periorbital swelling following trauma [12]. Taken together, these cases make a

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consistent point: new scalp nodules, periorbital lesions, or persistent soft tissue swelling in a patient with systemic symptoms require histopathological evaluation — regardless of how convincing the infectious picture appears.

Pancreatic Involvement by DLBCL

Pancreatic lymphoma is rare, representing fewer than 2% of all lymphomas and fewer than 0.5% of all pancreatic neoplasms, with DLBCL as the most common histological subtype [13]. In our patient, the exophytic 2.0 cm pancreatic body mass with heterogeneous enhancement on MRI and a negative CA 19-9 favored lymphoma over adenocarcinoma [14]. This distinction matters clinically — pancreatic DLBCL and adenocarcinoma share overlapping imaging features, yet differ dramatically in treatment and prognosis: pancreatic lymphoma is potentially curable with immunochemotherapy, while adenocarcinoma carries a markedly poor prognosis [15]. EUS-guided tissue biopsy, as performed in this case, remains the preferred strategy for preoperative diagnosis and should be pursued early when pancreatic lymphoma is suspected [16].

Dermatologic Vigilance and Early Recognition

This case reinforces that the scalp and periorbital region can serve as the initial — and most accessible — biopsy site in patients with suspected systemic lymphoma. Alhajri et al. described PCDLBCL-LT presenting with concurrent scalp and abdominal wall nodules, illustrating that lymphomatous scalp involvement spans multiple DLBCL variants [17]. Tavberidze et al. reported DLBCL NOS presenting as multiple subcutaneous nodules, further reflecting the breadth of cutaneous presentations possible with systemic disease. In each of these cases, skin biopsy was central to establishing the diagnosis [3].

In our patient, a scalp biopsy was not obtained prior to the axillary lymph node biopsy; however, the nodules represented an accessible dermatologic target that may have expedited diagnosis had it been pursued earlier. When new scalp nodules or periorbital papules arise alongside constitutional symptoms, lymphadenopathy, or elevated LDH, skin biopsy with immunohistochemistry — including CD20, CD10, BCL-2, BCL-6, MUM1, MYC, and Ki-67 — should be strongly considered. Dermoscopy or reflectance confocal microscopy may offer additional non-invasive corroborating information prior to biopsy in select cases [18].

Limitations

A key limitation of this case is the absence of a scalp biopsy. Without histopathological evaluation of the nodules themselves, cutaneous lymphomatous involvement remains presumed rather than confirmed — and coincidental benign lesions such as epidermal inclusion cysts or lipomas cannot be formally excluded. That said, the diagnosis of high-grade B-cell lymphoma was tissue-confirmed at an alternative site, and the scalp findings were supported by corroborating clinical and radiologic evidence: CT head demonstrated scalp nodularity with punctate dermal calcifications in a patient with generalized lymphadenopathy, hepatosplenomegaly, and an elevated LDH. This case therefore also serves as a cautionary reminder that accessible cutaneous lesions in patients with suspected systemic malignancy should be prioritized for early biopsy — both to expedite diagnosis and to avoid leaving the cutaneous component pathologically uncharacterized.

Conclusion

We report a case of high-grade B-cell lymphoma in which scalp nodules and periorbital papules were the initial dermatologic findings in a 58-year-old male with a complex concurrent infectious history. The cutaneous findings — non-tender scalp nodules without erythema or discoloration — preceded tissue diagnosis and were corroborated by CT imaging demonstrating scalp nodularity with punctate dermal calcifications. Diagnosis was ultimately established via ultrasound-guided core biopsy of an axillary lymph node. High-grade B-cell lymphoma should be included in the differential for new-onset scalp nodules, particularly when

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accompanied by constitutional symptoms, elevated LDH, generalized lymphadenopathy, and hepatosplenomegaly. Early dermatologic recognition and prompt biopsy of accessible cutaneous lesions — even when an alternative site is ultimately sampled for definitive diagnosis — may be the most direct path to diagnosis in an otherwise aggressive and time-sensitive malignancy.

Take Home Messages

1. Scalp nodules may be the initial cutaneous manifestation of systemic high-grade B-cell lymphoma even without erythema or violaceous discoloration; biopsy should not be delayed.
2. Secondary cutaneous DLBCL carries a worse prognosis than primary cutaneous DLBCL leg type and requires urgent systemic staging with PET/CT.
3. Elevated LDH, B symptoms, and generalized lymphadenopathy in a patient with new scalp lesions should prompt immediate consideration of a lymphoproliferative malignancy.
4. A concurrent infectious illness can create a compelling but ultimately misleading alternative diagnosis; a non-resolving or broadening clinical picture warrants oncologic re-evaluation.
5. Pancreatic involvement by DLBCL must be distinguished from adenocarcinoma — EUS-guided core biopsy is the preferred approach and should be pursued early.

Declarations

Patient Consent: Written informed consent was obtained from the patient for the publication of this case report and the accompanying clinical image.

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Figure Legends

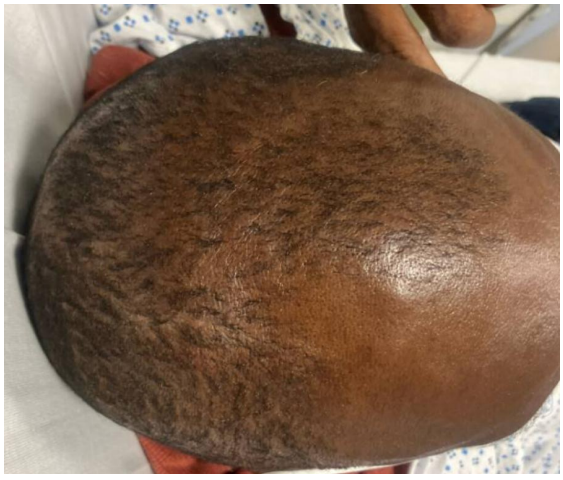

Figure 1. Clinical photograph of scalp nodules. Non-tender, raised, flesh-colored subcutaneous nodules distributed across the scalp without surface erythema, discoloration, or overlying skin changes.

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Tables

Table 1. Summary of Key Laboratory and Infectious Workup Findings

Test / Parameter	Result / Value	Clinical Significance
WBC	15.89 × 10^3/μL (↑)	Leukocytosis on admission; peak 57,200/μL during prior hospitalization, consistent with leukemoid reaction
Hemoglobin	9.1 g/dL (↓)	Microcytic anemia in the setting of systemic disease
MCV / RDW	76.8 fL / 17.4% (↑)	Microcytosis with elevated RDW
Platelets	180 × 10^3/μL	Normal on admission (thrombocytopenic 80,000 during prior hospitalization)
LDH	440 U/L (↑)	Elevated; key prognostic marker in lymphoma; prior peak 1,209 U/L
Uric Acid	7.7 mg/dL (↑)	Mildly elevated; consistent with high cellular turnover
Tumor markers (AFP, CEA, CA 19-9)	Within normal limits	Does not favor pancreatic adenocarcinoma or hepatocellular carcinoma
Myeloma screen (SPEP/UPEP/free light chains)	Negative	Plasma cell dyscrasia excluded
Infectious Workup		
Blood cultures ×2	No growth	No bacteremia
HIV	Negative	—
Hepatitis A IgM / IgG	IgM negative; IgG reactive	Prior exposure only
Hepatitis B / C	Negative / Not reactive	—
CMV IgM / IgG	IgM negative; IgG positive	Prior exposure
EBV VCA IgG / EA Ab	IgG positive; EA Ab positive	Prior or reactivated exposure; no acute primary infection
Lyme IgG / IgM	Negative (repeat)	Prior elevated IgG (1,918) in St. Kitts; repeat negative
Dengue IgG / IgM	IgG positive; IgM negative	Prior exposure; not acute
Syphilis screen	Negative	—
Malaria PCR / Plasmodium PCR	Not detected	—
Quantiferon-TB Gold	Negative	—
Procalcitonin	0.24 ng/mL	Not significantly elevated; acute bacterial sepsis less likely

Abbreviations: WBC, white blood cell count; LDH, lactate dehydrogenase; MCV, mean corpuscular volume; RDW, red cell distribution width; AFP, alpha-fetoprotein; CEA, carcinoembryonic antigen;

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CA 19-9, carbohydrate antigen 19-9; SPEP, serum protein electrophoresis; UPEP, urine protein electrophoresis; HIV, human immunodeficiency virus; CMV, cytomegalovirus; EBV, Epstein-Barr virus; VCA, viral capsid antigen; EA, early antigen; PCR, polymerase chain reaction; AFB, acid-fast bacillus.
↑ = elevated above reference range; ↓ = below reference range.