



JESSNER LYMPHOCYtic INFILTRATE

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Jessner lymphocytic infiltration of the skin is an uncommon benign skin condition that is characterized by a persistent, papular, plaque-like skin eruption that has a variable course, usually lasting months to years, with periods of remission and sometimes spontaneous resolution. The prevalence is unknown and usually affects adults younger than 50 years old. The gender predominance is debatable as some sources state there is a male predominance, while other sources disagree. There have been reported cases of familial occurrence.

The cause of Jessner lymphocytic infiltration of the skin is currently unknown although there are some proposed theories. Some studies indicate an association with the bacteria, *Borrelia*, while other data suggest that photosensitivity can be the cause. Some believe that this condition is a variant of lupus erythematosus.

Patients with Jessner lymphocytic infiltrate of the skin are usually asymptomatic but may present with some pruritus or burning. On clinical presentation, skin lesions appear as 2mm to 2cm, non-scaly, erythematous papules and plaques that typically present on the face, neck, and back but also in other areas such as the trunk and extremities. These lesions may expand peripherally and may be arranged in well demarcated rings with possible central clearing.

A thorough medical history is warranted due to the possible hereditary nature of this condition and also due to the association of the onset of lesions after sun exposure. Workup may include provocative phototesting which is when ultraviolet A and B radiation is used to elicit lesions which can lead to better guidance to treatment. A skin **biopsy** on a relatively new lesion may be needed to confirm the diagnosis and to rule out other similar conditions such as **discoid lupus erythematosus** and **polymorphous light eruption**. Some lab tests that may be considered to rule out other causes include a CBC, ANA, ESR, and anti-Ro and anti-La autoantibodies.

Treatment may not be warranted as the skin lesions may resolve spontaneously. For others, treatment options include excision of small lesions, **cryotherapy**, **lasers**, **photodynamic therapy**, **topical steroids**, **intralesional steroids**, **systemic steroids**, and some medications such as thalidomide and **methotrexate**. Antimalarials such as **hydroxychloroquine** have been shown to help lesions that are associated with photosensitivity. Cosmetic camouflage may be used to improve appearance. Sun avoidance and photoprotection is important to prevent worsening or new lesions. Regular follow up with a dermatologist is strongly recommended to monitor progress and treatment.

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