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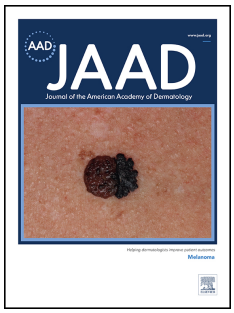

Dermoscopy of nodular/plaque-type primary cutaneous T- and B-cell lymphomas: a retrospective comparative study with pseudolymphomas and tumoral/inflammatory mimickers by the International Dermoscopy Society

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Article: Original article

Title: **Dermoscopy of nodular/plaque-type primary cutaneous T- and B-cell lymphomas: a retrospective comparative study with pseudolymphomas and tumoral/inflammatory mimickers by the International Dermoscopy Society**

Short title: **Dermoscopy of nodular/plaque-type PCLs and their mimickers**

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ABSTRACT:

Background: Limited data on dermoscopy of nodular/plaque-type T/B-cell primary cutaneous lymphomas (PCLs) is available.

Objective: To describe dermoscopic features of nodular/plaque-type PCLs, comparing them with those of clinical mimickers (pseudolymphomas, tumors, and inflammatory lesions) and investigating possible differences according to histological subtypes.

Methods: Participants were invited to join this retrospective multicenter case-control study by submitting histologically/immunohistochemically confirmed instances of nodular/plaque-type PCLs and controls. A standardized assessment of the dermoscopic images and comparative analyses were performed.

Results: A total of 261 lesions were finally included (121 PCLs/140 controls). Orange structureless areas was the strongest PCLs dermoscopic predictor on multivariate analysis when compared to tumors and non-infiltrative inflammatory dermatoses. On the other hand, a positive association was found between PCLs and either unfocused linear vessels with branches or focal white structureless areas when compared to infiltrative inflammatory dermatoses, whereas white lines were predictive of PCLs over pseudolymphomas. Differences in the vascular pattern were also seen between B- and T-cell PCLs and among B-cell PCLs subtypes.

Limitations: Retrospective design and the lack of a dermoscopic-pathological correlation analysis.

Conclusion: Nodular/plaque-type PCLs display dermoscopic clues which may partially vary according to histological subtype and whose diagnostic relevance depends on the considered clinical differential diagnoses.

Capsule summary:

- Our study increases the knowledge on dermoscopy of nodular/plaque-type cutaneous lymphomas by comparing their dermoscopic features with those of clinical mimickers and investigating possible differences according to histologic background.
- Significance of dermoscopic findings in nodular/plaque-type cutaneous lymphomas should be interpreted based on the considered differential diagnosis and histologic subtype.

INTRODUCTION

Primary cutaneous lymphomas (PCLs) are a heterogeneous group of T- and B-cell lymphomas localized on the skin with no evidence of extracutaneous involvement at the time of diagnosis.[1,2] Except for mycosis fungoides and lymphomatoid papulosis that display peculiar morphologic patterns, most types of PCLs manifest as nonspecific reddish-purple nodules or plaques, with a consequent wide list of possible differential diagnoses that includes tumoral and inflammatory conditions.[1-3] The most common forms of nodular/plaque-type T-cell PCLs are CD30+ anaplastic large cell lymphoma (CD30+ ALCL) and CD4+ small/medium lymphoproliferative disorder (CD4+ SMLD), while marginal zone lymphoma (MZL) and follicle-center cell lymphoma (FCL) represent the most frequent variants of nodular/plaque-type B-cell PCLs.[1,2]

Although the definitive diagnosis relies on histological and immunohistochemical analyses, growing evidence supports a possible role of dermoscopy in increasing the index of suspicion for PCLs besides clinical/anamnestic data.[4-12] However, while dermoscopic features of mycosis fungoides have been investigated by several case-control studies, data on cutaneous lymphomas manifesting as nodules and/or plaques are scarce, with few case reports/series and only one small case-control study published in the literature.[12] Additionally, little information is available on possible dermoscopic differences among PCLs and on the usefulness of dermoscopy for the differential diagnosis between nodular/plaque-type PCLs and either pseudolymphomas or clinically similar inflammatory lesions.[12]

The aim of this study was to investigate the dermoscopic morphology of different PCL subtypes manifesting as nodules or plaques and to assess the value of dermoscopic criteria for the discrimination of PCLs from clinical mimickers (including pseudolymphomas, tumors, and inflammatory lesions). The study was conducted in accordance with ethical guidelines and IRB

approval was obtained.

MATERIALS AND METHODS

This was a retrospective case-control study which was part of a larger project on PCLs launched by the *International Dermoscopy Society* (IDS) via an online call published on the IDS website (www.dermoscopy-ids.org).

PCLs diagnosed by histological and immunohistochemical analyses, clinically manifesting as single/multiple nodules or plaques were eligible for the current analysis (in case of multiple lesions in a single patient, we considered only the target lesion that was biopsied). Lymphomatous conditions presenting with either different clinical morphologies (i.e., lymphomatoid papulosis and mycosis fungoides, typically characterized by papules and scaly patches/plaques, respectively) or extra-cutaneous manifestations (i.e., leukemia cutis and systemic lymphomas with secondary cutaneous involvement) were therefore excluded from the study. Additionally, patients currently or previously treated were also not included to avoid biases resulting from possible modifications of dermoscopic patterns by therapies.

The control group consisted of nodular/plaque-type skin lesions for which PCL was included into the clinical differential diagnosis at the time of initial presentation; only untreated and histologically confirmed lesions were considered eligible (immunohistochemistry and molecular analyses were also required for pseudolymphomas diagnosis).

High quality clinical and dermoscopic pictures (captured at x10 magnification) as well as information on patients' age and gender, target lesion localization, and histological subtype (for PCLs group) were mandatory.

Two independent investigators (EE, AL), blinded to clinical presentation and final diagnosis, evaluated the images for the presence of predefined dermoscopic criteria. Interobserver agreement was evaluated through Cohen's kappa coefficient. Dermoscopic variables were selected according to the recent consensus document by the IDS on dermoscopy of infiltrative, infectious and inflammatory dermatoses, which includes five standardized basic parameters with several possible sub-items for each of them:[13] (I) vessels (morphology and distribution); (II) scales (color and distribution); (III) appendages findings; (IV) "other structures" (features other than vessels, scales and follicular findings) (including color and morphology); and (V) "specific clues" (features strongly suggestive of a dermatosis due to a strict correlation with highly specific/sensitive histological findings).

Statistical analysis:

All separate clinical and dermoscopic variables were included in the analysis. Categorical data are presented as numbers and frequencies and were compared using Pearson's chi-square test. Relative risks were calculated for all dichotomous variables. Crude and adjusted odds ratios and corresponding 95% confidence intervals (95% CI) were calculated by univariate and conditional multivariate logistic regression, respectively. Forward inclusion and backward elimination were used. Alpha level was set at 0.05 and an alpha level of 0.20 was used as cut-off for variable removal in the automated model selection for multivariate logistic regression. **Variables that were statistical significantly associated with diagnoses, were also controlled via multivariate logistic regression. Because a large number of predictors were to be included in the univariate analyses we employed the Bonferonni correction for multiple hypothesis testing (setting P<0.001 for 10-30 variables).** The Type I error probability associated with all tests in this study was set to 0.05. Statistical analyses were

performed using the statistical package for social sciences statistical software (version 24.0, IBM SPSS Statistics for Windows, Armonk, NY, USA: IBM Corp).

RESULTS

A total of 261 lesions provided by 16 different centers were finally recruited for the analysis, including 95 B-cell PCLs (44 MZL, 37 FCL, and 14 diffuse large cell B-lymphomas) and 26 T-cell PCLs (17 CD30+ ALCL and 9 CD4+ SMLD) in the lymphomas group (total cases: 121) and 33 pseudolymphomas, 56 tumors (17 basal cell carcinomas, 9 squamous cell carcinomas, 8 adnexal tumors, 4 Merkel cell carcinomas, 3 dermatofibrosarcoma protuberans, 3 seborrheic keratoses, 3 metastases, 2 amelanotic melanomas, 2 cellular dermatofibromas, 2 leiomyomas, 1 dermal nevus, 1 atypical Spitz tumor, and 1 Kaposi sarcoma), 29 infiltrative inflammatory dermatoses (21 granulomatous dermatoses and 8 histiocytoses), and 22 non-infiltrative inflammatory dermatoses (8 discoid lupus erythematosus, 6 granuloma faciale, 2 lupus tumidus, 2 persistent insect bites, 2 epidermoid cysts, 1 molluscum contagiosum, and 1 hypertrophic lichen planus) in the control group (total cases: 140).

Details on analytic results and comparative analysis of dermoscopic findings for cases and controls (as a whole and divided into clinical subtypes) are shown in Tables S1 and 1. The interobserver agreement for dermoscopic variables was high with Cohen's kappa ranging from 0.67 to 0.91.

The main vascular findings of nodular/plaque-type PCLs turned out to be unfocused linear vessels with branches (39.7%) followed by unfocused dotted (28.9%) and linear-curved (28.1%) vessels, while focal white and orange structureless areas (54.5% for both of them) along with white lines (total: 42.1%; unspecifically arranged: 25.6%) were the most common non-vascular features. Of note, all the aforementioned dermoscopic findings, along with orange

globules, resulted to be significantly more common in PCLs group compared to the control group. On the other hand, well-focused vessels (linear, linear with branches, and linear-curved), dotted vessels with white halos, diffuse white structureless areas, brown and blue globules, and brown, purple and yellow structureless areas were significantly more common in the controls. Nevertheless, only a few of the aforementioned criteria were found to represent robust diagnostic predictors in the univariate (Table S2) and multivariate analysis (Table 2). In detail, the latter revealed a positive association between nodular/plaque-type PCLs and the following findings: focal white (OR 2.35; 95%CI 1.29-4.28) and orange (OR: 3.96; 95%CI 2.13-7.34) structureless areas, orange globules (OR: 6.62; 95%CI 1.17-37.44), and white lines (total) (OR: 1.94; 95%CI 1.02-3.69) (Figure 1). Conversely, linear vessels with branches (well-focused) and purple structureless areas showed an inverse correlation (OR: 0.30; 95%CI 0.12-0.74 and OR: 0.18; 95%CI 0.04-0.85, respectively).

When it comes to the comparative sub-analysis between PCLs and each subtype of controls, several significant differences were observed (Table 1), with a variable correlation on univariate (Table S3) and multivariate (Table 2) analyses. In particular, multivariate positive predictors for nodular/plaque-type PCLs included orange structureless areas (when compared to tumors [OR: 65.01; 95%CI 6.86-616.10] and non-infiltrative inflammatory dermatoses [OR: 10.46; 95%CI 2.23-49.01]), focal white structureless areas (when compared to infiltrative [OR 9.47; 95%CI 2.03-44.12] and non-infiltrative inflammatory dermatoses [OR: 10.10; 95%CI 2.16-47.34]), unfocused linear vessels with branches (when compared to infiltrative inflammatory dermatoses [OR: 4.25; 95%CI 1.09-16.59]), and white lines (when compared to pseudolymphomas [OR: 2.50; 95%CI 0.99-6.24]) (Table 2; Figures S1-S2). On the other hand, diffuse white structureless areas, brown structureless areas, and purple structureless areas turned out to be negatively associated with PCLs (all of them when compared to tumors [OR:

0.05, 0.08, and 0.12, respectively] and only the last one when compared to infiltrative inflammatory dermatoses [OR: 0.02]) (Table 2; Figure S1).

The dermoscopic analysis according to histological PCLs subtypes revealed only one potent predictor for the differential diagnosis between B-cell and T-cell PCLs: the presence of unfocused dotted vessels (Table S4), which were significantly more common in T-cell PCLs (OR for B-cell PCLs: 0.31 (95%CI 0.12-0.79) in the multivariate analysis (Figure S2). Several differences were observed among the B-cell PCLs subtypes (Table S5), yet only the presence of unfocused linear vessels with branches resulted to be relevant on multivariate analysis, with an OR of 2.79 (95%CI 1.07-7.28) for MZL (Figure S2). Finally, no significant dermoscopic difference was found among T-cell histological subtypes (Table S6).

DISCUSSION

In line with available literature data, the present analysis confirms that orange and white focal structureless areas are the most common non-vascular dermoscopic findings of nodular/plaque-type PCLs (either B-cell or T-cell).[4-12] These features are supposed to correlate to the dense dermal cellular infiltrate ("mass effect") and either dermal reactive fibrosis or focally reduced "grenz zone" due to patchy, nodular, more superficial infiltrate in the papillary dermis, respectively.[8,11] Of note, the presence of orange color (either as globules or focal structureless areas) displayed the strongest positive association with nodular/plaque-type PCLs when compared to the entire control group, consistently with previous data.[4-12] Additionally, white lines and focal white structureless areas were also positively linked to nodular/plaque-type PCLs, whereas purple structureless areas and well-focused linear vessels with branches showed a negative association. Indeed, vascular structures in nodular/plaque-type PCLs were mainly blurred likely due to their location in deeper dermis with consequent scattering of light by

dermal collagen fibers,[14] which may be increased in such lesions.[8,11] Interestingly, dermal fibrosis might also be responsible for the presence of white lines, that turned out to be a relevant finding in our study.

Notably, compared to previous analyses,[4,5,8] we observed a lower prevalence of follicular plugs and a different predominant vascular pattern, with linear vessels with branches being the most frequent. It is possible that such differences are due to different sample size, different types of included lymphomas and variability of the lesions' duration, since the histological background may vary according to the lesion's evolution stage.[11] However, the latter hypothesis has never been investigated so far due to the difficulty to assess the precise onset of each nodule/plaque in multilesional instances.

We also compared dermoscopic features of nodular/plaque-type PCLs to those of each clinical category of mimickers, highlighting several relevant differences. Indeed, whereas orange structureless areas turned out to be strongly associated with PCLs when compared to tumors and non-infiltrative dermatoses, they were of no aid in distinguishing PCLs from infiltrative dermatoses and pseudolymphomas. This is because the latter entities are also histologically characterized by a dense cellular infiltrate giving rise to orange color on dermoscopy.[15,16] However, according to our findings, unfocused linear vessels with branches and focal white structureless areas predicted the diagnosis of nodular/plaque-type PCLs when compared to infiltrative dermatoses, whereas the presence of white lines is predictive of nodular/plaque-type PCLs over pseudolymphomas. These differences are related to the histological background, since infiltrative dermatoses, especially granulomatous dermatoses, are often typified by a dense cellular infiltrate that displaces the dermal vessels upwards, so that they appear sharper on dermoscopy (as they are closer to the skin surface).[15] On the other hand, the association between nodular/plaque type PCLs and both focal white areas and white

lines might be due to the higher prevalence of reactive fibrosis compared to infiltrative dermatoses and pseudolymphomas.[11,13,17] Of note, this is the first study highlighting a possible dermoscopic variability between PCLs and pseudolymphomas as previous analyses assessed such conditions together, without comparing their dermoscopic features.[8,12] The subgroup analysis between PCLs and other tumors also revealed three negative PCL predictors: white structureless areas (diffuse), purple structureless areas and brown structureless areas, with the first two usually encountered in keratinizing tumors and the last one typical of pigment-producing lesions (of either melanocytic or non-melanocytic derivation).

Finally, our analysis revealed a variability in the dermoscopic vascular pattern of PCLs according to their histological subtype. Specifically, unfocused dotted vessels predicted T-cell over B-cell PCLs, while unfocused linear vessels with branches predicted marginal zone lymphoma over other B-cell PCLs variants. No significant difference was found among T-cell PCLs subtypes. It is possible that the observed variability in vascular morphology might be due to different patterns of angiogenesis as it has been demonstrated that vessels growth in PCLs is influenced by tumor cell type, as well as different microenvironments.[18,19]

The main limitation of the present study is the retrospective design, which is prone to recall and observation biases, that were addressed by involving evaluators who did not contribute to sample collection. A large number of predictors have been included in the univariate analyses without correction for multiple hypothesis testing. In fact, we chose to analyze each predictor separately as several features are very likely to be statistically significant just by spurious association or chance given the amount of independent tests that were performed. Additionally, the p-value of each significantly flagged predictor is indicative of its value (with values $P<0.001$ demonstrating those of importance) and those predictors that remain statistically significant in the multivariate analyses are already adjusted for the effect

of other predictors and therefore **can be deemed statistically significant**. Finally, all mentioned dermoscopic-pathological correlations were based on previous studies or common reasoning and the possible influence of lesion duration on dermoscopic appearance was not considered. Consequently, our results should be interpreted with caution and future research including dermoscopic-histological analyses and analysis according to lesion stage are needed to confirm our findings.

In conclusion, our findings emphasize that nodular/plaque-type PCLs may display several vascular and non-vascular clues on dermoscopy and the diagnostic significance of dermoscopic criteria remarkably varies according to the clinical differential diagnosis. Additionally, some differences in terms of vascular dermoscopic pattern may be observed among PCLs subtypes. However, the decision to biopsy a specific lesion cannot rely only on dermoscopic features, but should be based on integrating anamnestic, clinical and dermoscopic findings, according to the "two-step" rule (clinical differential diagnosis followed by dermoscopic examination).[16] On the other hand, dermoscopy may guide clinicians in sampling the most informative lesion/area, as some dermoscopic features are likely to be related to more relevant histological findings (e.g., orange areas and compact lymphomatous cellular infiltrate).

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Figures legend:

Figure 1. Marginal zone B-cell primary cutaneous lymphoma (PCL): dermoscopy reveals the main clues, i.e., white (black arrow) and orange (white arrow) structureless areas, unfocused vessels with branches (white arrowhead), and white lines (black arrowhead) (A). Follicle-center B-cell PCL: dermoscopy shows orange globules, along linear (arrowheads) and linear-curved (arrows) unfocused vessels (B).

Figure S1. Marginal zone B-cell primary cutaneous lymphoma (PCL): dermoscopic assessment shows focal orange structureless areas, unfocused linear vessels with branches, and follicular plugs (A); dermoscopy of basal cell carcinoma also reveals linear vessels with branches, but they are sharper than those seen in PCL (B). CD30+ anaplastic large cell PCL: dermoscopic examination displays white lines and polymorphous vascular pattern (dotted, linear-curved and linear with branches vessels) along with both orange and white focal structureless areas (C); squamous cell carcinoma: diffuse white structureless area, purpuric structureless areas, and linear-irregular vessels are seen on dermoscopy (D). Follicle-center B-cell PCL: dermoscopy reveals both white and orange structureless areas as well as unfocused linear vessels with branches (E) (*reused with permission from J Eur Acad Dermatol Venereol 2021. doi: 10.1111/jdv.17219*); dermoscopic assessment of sarcoidosis also shows orange structureless areas and linear vessels with branches, yet they are more focused than those seen in PCL (F). Follicle-center B-cell PCL: dermoscopic examination displays both orange (arrow) and white (arrowhead) focal structureless areas along with unfocused linear/linear-curved vessels (G); dermoscopy of lupus tumidus reveals linear/linear-curved vessels with no orange area (H).

Figure S2. Dermoscopy of both marginal zone B-cell primary cutaneous lymphoma (PCL) (A) and B-cell pseudolymphoma (B) shows unfocused linear/linear-curved vessels and follicular

plugs, yet only the former also displays white lines. The main dermoscopic differences between B-cell (follicle-center variant – C) and T-cell (CD 30+ anaplastic large cell lymphoma – D) PCL regards the vascular pattern, with the latter being positively associated with dotted vessels. Considering the group of B-cell PCLs, marginal zone lymphoma (E) is more commonly associated with unfocused linear vessels with branches than other variants, as shown in figure F, in which follicle-center cell lymphoma mainly shows linear/linear-irregular vessels.

Table 1. Dermoscopic comparative analysis between nodular/plaque-type T and B primary cutaneous lymphomas and control subgroups (neoplastic lesions, infiltrative inflammatory dermatoses, non-infiltrative dermatoses, and pseudolymphomas), with prevalence data and statistical differences

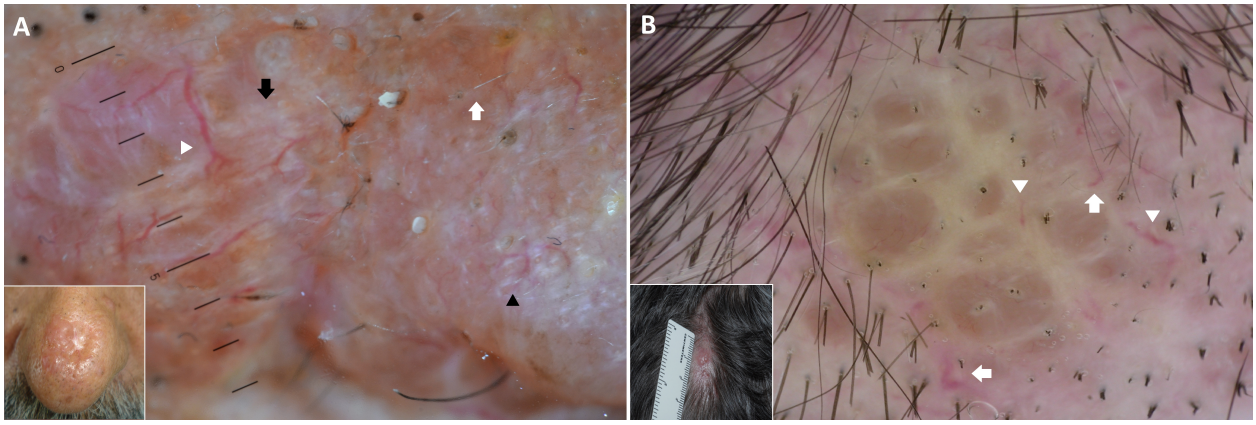
Dermoscopic variable	*Lymphomas (n= 121) N (%)*	*Neoplastic lesions (n=56) N (%)*	*Infiltrative dermatoses (n=29) N (%)*	*Non-infiltrative dermatoses (n=22) N (%)*	*Pseudolymphomas (n=33) N (%)*	*p-value**
Dotted vessels (unfocused)	34 (28.1)	8 (14.3)	4 (13.8)	5 (22.7)	9 (27.3)	-
Dotted vessels (with white halo)	0 (0.0)	**5 (8.9)**	0 (0.0)	0 (0.0)	0 (0.0)	*0.003*[§]
Dotted vessels (unspecific distribution)	24 (19.8)	6 (10.7)	**1 (3.4)**	1 (4.5)	7 (21.2)	*0.048*[§§]
Linear vessels (well-focused)	0 (0.0)	2 (3.6)	**3 (10.3)**	0 (0.0)	0 (0.0)	*0.007*[§§]
Linear vessels (peripheral distribution)	3 (2.5)	4 (7.1)	1 (3.4)	**3 (13.6)**	**4 (12.1)**	*0.047*[†] *0.038*[††]
Linear vessels with branches (well-focused)	11 (9.1)	**18 (32.1)**	**12 (41.4)**	0 (0.0)	1 (3.0)	*<0.001*[§] *<0.001*[§§]
Linear vessels with branches (unfocused)	48 (39.7)	**10 (17.9)**	**3 (10.3)**	9 (40.9)	15 (45.5)	*0.006*[§] *0.002*[§§]
Linear curved vessels (well-focused)	0 (0.0)	**3 (5.4)**	**3 (10.3)**	0 (0.0)	**2 (6.1)**	*0.031*[§] *0.007*[§§] *0.045*[††]
Linear curved vessels (unfocused)	35 (28.9)	14 (25.0)	**2 (6.9)**	6 (27.3)	4 (12.2)	*0.015*[§§]
White structureless areas (total)	69 (57.0)	34 (60.7)	**7 (24.1)**	**4 (18.2)**	17 (51.5)	*0.002*[§§] *0.001*[†]
White structureless areas (diffuse)	3 (2.5)	**9 (16.1)**	0 (0.0)	2 (9.1)	0 (0.0)	*0.002*[§]
White structureless areas (focal)	66 (54.5)	25 (44.6)	**7 (24.1)**	**2 (9.1)**	17 (51.5)	*0.004*[§§] *<0.001*[†]
Brown structureless areas (total)	1 (0.8)	**6 (10.7)**	0 (0.0)	1 (4.5)	1 (3.0)	*0.004*[§]
Orange structureless areas (total)	73 (60.3)	**1 (1.8)**	22 (75.9)	**4 (18.2)**	16 (48.5)	*<0.001*[§] *<0.001*[†]
Orange structureless areas (focal)	66 (54.5)	**1 (1.8)**	15 (51.7)	**2 (9.1)**	12 (36.4)	*<0.001*[§] *<0.001*[†]
Yellow structureless areas (total)	0 (0.0)	**3 (5.4)**	**3 (10.3)**	0 (0.0)	0 (0.0)	*0.031*[§] *0.007*[§§]
Purple structureless areas (total)	3 (2.5)	**7 (12.5)**	**4 (13.8)**	0 (0.0)	0 (0.0)	*0.012*[§] *0.026*[§§]
Brown globules	0 (0.0)	**4 (7.1)**	0 (0.0)	0 (0.0)	1 (3.0)	*0.009*[§]
Blue globules	0 (0.0)	**6 (10.7)**	0 (0.0)	0 (0.0)	0 (0.0)	*0.001*[§]
Orange globules	8 (6.6)	0 (0.0)	1 (3.4)	0 (0.0)	1 (3.0)	-
White lines (total)	51 (42.1)	**14 (25.0)**	12 (41.4)	**3 (13.6)**	**7 (21.2)**	*0.030*[§] *0.015*[†] *0.042*[††]
White lines (unspecifically arranged)	31 (25.6)	8 (14.3)	6 (20.7)	3 (13.6)	4 (12.1)	-

*Pearson's Chi Square test (statistical significance set at p<0.05); [§]Lymphomas *vs* Neoplastic lesions; [§§]Lymphomas *vs* Infiltrative dermatoses; [†]Lymphomas *vs* Non-infiltrative dermatoses; [††]Lymphomas *vs* Pseudolymphomas

Table 2. Multivariate (adjusted) dermoscopic predictors for nodular/plaque-type T and B primary cutaneous lymphomas when compared to the whole control group and different clinical subgroups (neoplastic lesions, infiltrative inflammatory dermatoses, non-infiltrative inflammatory dermatoses, and pseudolymphomas)

Dermoscopic variable	*p-value**	*OR***	*Low 95% CI*	*High 95% CI*
Lymphomas *vs* all controls				
Linear vessels with branches (well-focused)	0.008	0.300	0.123	0.735
White structureless areas (focal)	0.005	2.350	1.291	4.277
Orange structureless areas (focal)	0.000	3.957	2.132	7.342
Purple structureless areas (total)	0.030	0.180	0.038	0.850
Orange globules	0.033	6.618	1.170	37.437
White lines (total)	0.044	1.935	1.017	3.682
Lymphomas *vs* neoplastic lesions				
Linear vessels with branches (well-focused)	0.018	0.256	0.082	0.795
White structureless areas (diffuse)	0.025	0.047	0.003	0.681
Brown structureless areas (total)	0.028	0.083	0.009	0.760
Orange structureless areas (total)	<0.001	65.011	6.860	616.101
Purple structureless areas (total)	0.045	0.119	0.015	0.954
Lymphomas *vs* infiltrative inflammatory dermatoses				
Linear vessels with branches (unfocused)	0.038	4.245	1.086	16.589
White structureless areas (total)	0.004	9.473	2.034	44.118
Purple structureless areas (total)	0.002	0.021	0.002	0.229
Lymphomas *vs* non-infiltrative inflammatory dermatoses				
White structureless areas (focal)	0.003	10.103	2.156	47.339
Orange structureless areas (total)	0.003	10.464	2.234	49.011
Lymphomas *vs* pseudolymphomas				
White lines (total)	0.049	2.498	0.999	6.243

*p<0.05 deemed as statistically significant; **Odds ratios approximated via multivariate logistic regression.



Capsule summary:

- Our study increases the knowledge on dermoscopy of nodular/plaque-type cutaneous lymphomas by comparing their dermoscopic features with those of clinical mimickers and investigating possible differences according to histologic background.
- Significance of dermoscopic findings in nodular/plaque-type cutaneous lymphomas should be interpreted based on the considered differential diagnosis and histologic subtype.