cells were seen. He followed his case for many years and noticed that neither the patient developed any leukaemic manifestations, nor the skin lesions showed any change.

The second case was reported by Burckhardt in 1911 and showed a solitary nodule about 6 by 2 cm on the patient's arm . The microscopical appearence, however, resembled closely that of Jadassohn's case.

Kauffmann-Wolf in 1921 presented two children who had nodules on each side of the median raphe of the scrotum. On histological examination she found these lesions to be composed of lymphocytic tissue ,so, she termed the disease "lymphocytoma" and she was the first to use this term.

Epstein in 1935 classified lymphocytoma into five clinical and two histopathological types. The clinical types were:

(1) Lymphocytoma miliare faciei, this group included the great majority of the described cases.

(2) Lymphocytoma tumidum, a heading which includes the lymphadenoid tumours located particularly about the pinna.

(3) Lymphocytoma genitale of the scrotum.

(4) Lymphocytoma genitale of the labia majora.

(5) Lymphocytoma miliare faciei of the disseminated type .

The two histological types were the diffuse and the circumscribed forms.

Hallam and Vickers (1939) , stated that the onset of leukaemia has never yet been reported in all cases proved to be lymphocytoma.

Bafverstedt in 1943, presented an extetnsive report of a group of tumours of the cutis and subcutis composed of lymphoreticular tissue and characterized by a benign course, but for the most part they fell into the Spiegler-Fendt sarcoid group although others designated them as lymphocytomas. Spiegler described this condition in 1894, and Fendt described it in 1900 . Apparently Spiegler and Fendt felt that although clinically the entity resembled that of sarcoma, it behaves like a benign lesion, and they termed it a sarcoid.Although relationship to sarcoidosis was never suggested. Lewis (1935) was the first to emphasize the differentiation between the localised and disseminated types of Spiegler-Fendt sarcoid. Bafverstedt (1943) attempted to shed further light on the situation. He lumped together Spiegler-Fendt sarcoid and

"lymphocytoma" , because both conditions were identical, coining the term lymphadenosis benigna cutis. He concluded after studying 41 cases of lymphocytoma cutis that, this disease can occur in all age groups, but affects females more commonly than males. He described two forms of the disease. The first consisting of isolated tumours most commonly appearing on the face, earlobes, nipples and scrotum. This typs grows slowly and seldom recurs after treatment with X-ray . The second form consisting of multiple disseminated tumefactions. This type is rare, rapidly growing and usually recurs after treatment. Bafverstedt (1943) stated also that there was no malignant degeneration occuring in the lesions of lymphocytoma cutis.

Ormsby and Montgomery (1948) reported that there is no haematological changes in cases of lymphocytoma cutis, and such cases may simulate histopathologically follicular lymphoblastoma suggseting a close relationship between the two conditions.

Montgomery (1951) stated that the so-called Spiegler Fendt sarcoid and some, if not all, follicular lymphoblastomas, (giant follicle lymphomas) , and most cutaneous lymphocytomas, represent variants of reticulum-cell and lymphocytic types of lymphosarcoma. In the same discussion, Montgomery further

stated that lymphosarcoma may have a primary autochthonous origin and may run a relatively benign course, as is true also of certain types of Spiegler-Fendt sarcoid, cutaneous lymphocytoma and follicular lymphoblastoma.

Pillsbury et al (1956), in his text considered cases with localized forms of Spiegler-Fendt sarcoid as follicular lymphomas and reclassified the disseminated forms as reticulum cell sarcomas.

Mach and Wilgram (1966) after studying 115 cases of lymphocytoma cutis histopathologically found that there is a characteristic histopathological finding that is common to all cases which is the presence of large reticulum cells containing one or more rounded polychrome bodies. They did not consider lymphocytoma cutis as a tumour. Their investigations favoured the view that lymphocytoma is caused by a localised hyperplasia of pre-existent lymphoreticulor tissue that frequently can be elicited by external factors. For this reason they preferred the term "cutaneous lymphoplasia", because it characterizes the essential pathology of the disease.

Caro and Helwig, in 1969, introduced a broader term "cutaneous lymphoid hyperplasia", and this term included lymphocytoma cutis, insect bite granuloma and some cases of

benign lymphocytic infiltration of the skin described by Jessner and Kanof (1953). However, lymphocytic infiltration of the skin considered now as a separate entity (Beare and Cunliffe 1979),