MYCOSIS FUNGOIDES WITH UNUSUAL FEATURES

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A case of mycosis fungoides had unusual features such as non-pruritic nodulo-ulcerative lesions following a febrile episode, appearance of many lesions in subsequent episodes in the margins of scars of previous lesions, along with a cyclic course. Histopathology of the skin and lymph node showed a typical picture of mycosis fungoides. The response to a combination of cyclophosphamide 150 mg/day, methotrexate 12.5 mg/week and prednisolone 40 mg daily was satisfactory and the patient left hospital in partial remission.

Key words : **Mycosis fungoides. (M. F.)**

Mycosis fungoides can present in many unusual ways like the lesions can be acneform, bullous, papillomatous, hypopigmented or hyperkeratotic.[1] We are reporting a case with many atypical clinical features.

Case Report

A 50-year male patient had multiple nodulo-ulcerative lesions all over the body of five months duration. The skin lesions had started appearing five days after the subsidence of a 2-week long spell of high grade fever which subsided without any treatment. To begin with, there was a single painful, non-pruritic nodular lesion on the outer aspect of the right thigh (Fig. 1). Other areas like proximal parts of extremities, trunk and scalp were involved by similar lesions in a month's time. The lesions used to increase in size gradually, then ulcerate with a heavy serosanguinous discharge and slowly heal leaving shiny atrophic areas (Fig. 2). Then new lesions would appear at the margins of the healed areas. He was anemic and weak with generalised lymphadenopathy. The lesions of varying sizes were present almost all over the body except the face, palms, soles and mucosae. These were painful and soft to firm in consistency. Healed lesions were scarred with a hypopigmented halo around the scars which would become the site for fresh lesions. Four episodes of remission and relapse were noticed during $4\frac{1}{2}$ months stay of the patient in the hospital, each relapse lasting 2-3 weeks. Previously uninvolved areas like face and palms were increasingly involved in subsequent episodes while lymphadenopathy progressively subsided. Complete hemogram, peripheral blood film for abnormal lymphocytes, bone marrow examination, liver and renal function tests and chest skiagram were normal. Repeated smears from skin lesions grew gentamicin-susceptible *Klebsiella pneumoniae* or *Staphylococcus aureus*. Biopsies taken from early erythematous lesion, healed margin of an old lesion and from nodular skin lesions showed characteristic features of MF

Fig. 1. Nodulo-ulcerative and atrophic hypopigmented scars.

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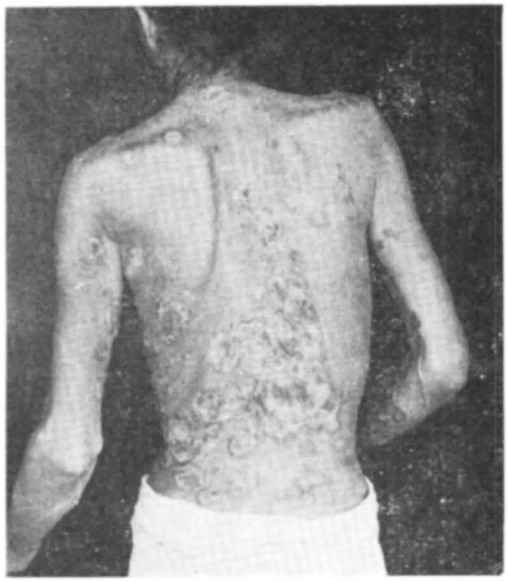

Fig. 2. Multiple lesions of MF on the back and arms.

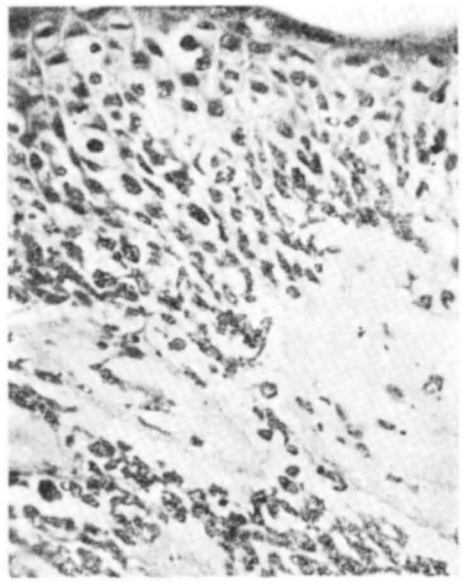

Fig. 3. Histopathology of sikn lesion depicting epidermotropism (H and E x 400).

(Fig. 3). There was thinning of epidermis with spongiosis and spongiotic vesicles containing large atypical mononuclear cells, and basal layer degeneration. The upper dermis showed oedema and pigmentary incontinence. The dermal infiltrate was composed of atypical lymphocytes or mycosis cells along with occasional plasma cells in a patchy manner. Biopsy from healed margin of a lesion showed mild dermal infiltrate with a few atypical cells. Lymph node biopsy showed infiltration by mycosis cells. A combination of cyclophosphamide 150 mg/day and methotrexate 12.5 mg/week for two weeks along with 40 mg of prednisolone daily in two monthly courses resulted in some improvement in his skin lesions. He left hospital due to personal problems in partial remission and did not report for a follow-up. He died 2 years later at his native place.

Comments

Mycosis fungoides affects predominantly males in their fifth decade.[2] Though the cutaneous lesions are an early manifestation, these are non-specific in nature and may persist for long periods.[3] Our case had some outstanding clinical features such as absence of pruritus, onset as nodulo-ulcerative skin lesions, waxing and waning of lesions and appearance of fresh lesions on the margins of scars of previous lesions. Pruritus is the usual symptom irrespective of the type of MF. This may be initially mild and easily controlled but frequently becomes very severe in long-standing disease.[4] But our case remained completely free of this symptom. Appearance of skin lesions in a cyclic or rhythmic manner is known in lymphomatoid papulosis,[5] but not in MF. The appearance of fresh lesions at the margins of scars of previous lesions is not documented in the literature. Similarly, the relationship, if any, of the preceding febrile episode to development or triggering of skin lesions remains obscure since he took no treatment for this illness.

Extra-cutaneus involvement is known to occur in MF. However, in this case only lymph nodes were found to be infiltrated with mycosis cells. Bone marrow examination showed no such abnormality and there was no evidence of visceral involvement.

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