HYPOPIGMENTED MACULES IN MYCOSIS FUNGOIDES

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A middle aged male with hypopigmented macules was initially misdiagnosed as indeterminate leprosy and later proved on histopathology to be mycosis fungoides.

Key words ; Hypopigmentation, Mycosis fungoides.

Hypopigmentation, presenting as the first clinical symptom in mycosis fungoides (MF) is unusual. We observed an adult male in whom the diagnosis had been initially missed and later confirmed by biopsy.

Case Report

A 59-year-old male had scaly, red patches over the body which started 4 years ago as a light-coloured asymptomatic macule over the right leg. A few weeks later, the other leg was also involved, and in a period of 4 to 5 months the lesions spread over the trunk. Sensory loss was very minimal and he was diagnosed in our clinic as indeterminate leprosy; the biopsy had revealed a normal epidermis with a mild dermal infiltrate, and no acid-fast bacilli. An 18-month course of dapsone 100 mg/day showed no improvement, Subsequently, he reported elsewhere and was diagnosed as early vitiligo. PUVASOL was given and after 8 months some of the patches had regressed leaving minimal hypopigmentation. Over the course of a few months, the lesions over the trunk and extremities gradually increased in size and number, and also appeared for the first time over the face. Some lesions became red, scaly and raised when he again sought our advice. The lesions at this time were irregular or oval, circumscribed, erythematous, scaly plaques over the extremities, trunk and back. At many places, the erythematous macules had coalesced to form figurate patterns. The scrotal skin and buttocks were also involved; erythematous induration was present over the forehead, right ear-lobule and right cheek. A few scattered hypopigmented macules were seen over the front and back. Lymph nodes were not involved at any stage. Systemic examination revealed no abnormality.

Complete hemogram, peripheral smear for abnormal cells, bone marrow puncture, urinalysis, renal and liver function tests, and chest skiagram were normal. Slit-skin smears for acid-fast bacilli were negative. Histopathology (H and E) of an indurated lesion showed a diffuse infiltrate in the upper dermis composed mainly of histiocytes, lymphocytes, eosinophils and plasma cells. Typical mycosis cells were seen in some of the dermal papillae and Pautrier's microabscesses composed of tiny groups of mononuclear cells were seen in the lower epidermis.

Comments

Hypopigmented skin lesions are occasionally seen in early MF[1] and have been reported mainly in the coloured people.[2-4] Interestingly, a similar clinical presentation has also been documented recently in a middle-aged black woman with the epidermotropic form of MF, Woringer Kolopp disease.[5] Such lesions have been mistaken for pityriasis alba,[2] vitiligo[3] and leprosy as in the present case. All these three conditions are common in coloured people and in the absence of specific clinical markers to differentiate them from MF, skin biopsy must be done in patients when the lesions are persistent or recur after therapy. It has been adequately

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emphasised that MF must be included in the differential diagnosis of hypomelanotic disorders.[3,4] Electron microscopic studies have revealed a variety of abnormal changes in the melanocytes[4] which are said to account for the hypopigmentation. Nevertheless, no explanation has been advanced for the lack of observation of this mode of presentation in white-skinned persons. Though it is too early to make any comment, we feel that in white people the hypopigmented macules may escape detection and the patients are likely to report to the clinic only when erythema and/or infiltration set(s) in.

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