POIKILODERMATOUS MYCOSIS FUNGOIDES

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A 35-year-old woman presented with generalised poikiloderma of 2 years duration and multiple plaques, some of which had undergone ulceration of 1 year duration. Biopsy of the plaque showed a picture of lichenoid dermatitis with mononuclear cells infiltrating the entire dermis. Some of the cells showed atypicality. There was no epidermotropism or visceral involvement. A diagnosis of poikilodermatous mycosis fungoides was made and the patient was given chemotherapy.

Key words: Poikiloderma, Mycosis fungoides

Introduction

Depending on the nature of the neoplastic cell lymphoma can be broadly divided into T-cell lymphoma and B-cell lymphoma. Involvement of the skin is common and prominent in T-cell lymphoma. Cutaneous T-cell lymphoma includes mycosis fungoides, sezary syndrome, Woringer-Kolopp disease and newer T cell disorders like adult T-cell leukemia and Pinkus tumor.[1]

Case Report

A 35-year-old woman presented with generalised itchy pigmented skin lesions of 2 years duration. They started as asymptomatic hypopigmented lesions confined to the face, but later spread to involve rest of the body over a period of 1 year. Later some of the areas became pigmented. Patient experienced burning sensation on exposure to sunlight. One year after the onset of the complaints patient developed a raised plaque over the suprapubic area which ulcerated and refused to heal. Later she developed similar ulcerated plaques over the breasts. There was history of diffuse hair loss.

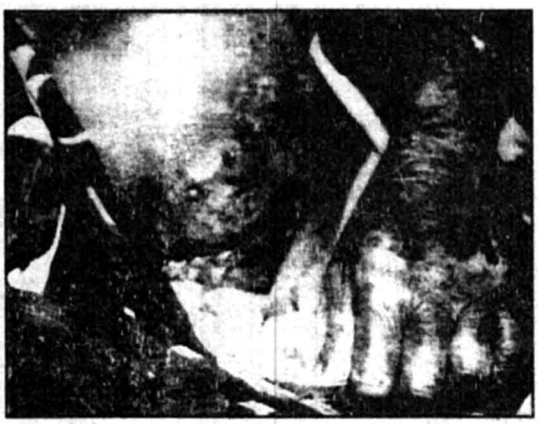

Fig.1. Ulcerated plaque over the suprapubic area. Note poikilodermatous changes of dorsum of hand.

Examination revealed generalised poikiloderma. Ulcerated plaques were seen over suprapubic area, left and right breast and measured 1.2 x 1cm, 5x4 cm and 6x4cm respectively (Fig.1) They were not attached to the underlying structures. Scalp showed diffuse hair loss. Nails and mucosae were normal.

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Peripheral blood examination revealed a normocytic normochromic anemia. WBCs were normal. No atypical cells were made out. ANA was negative. Biopsy of the skin lesion revealed a picture of lichenoid dermatitis with an atrophic epidermis, basal cell degeneration and dense band-like infiltrate of mononuclear cells occupying the entire dermis. Some of the mononuclear cells were atypical. Papillary dermis showed dilated blood vessels. The picture was consistent with a diagnosis of poikilodermatous variant of mycosis fungoides.[2] Bone marrow aspiration study did not reveal any atypical cells infiltrating the marrow. Patient was started on chemotherapy.

Discussion

Classically mycosis fungoides is divided into 3 stages: erythematous patch stage where there may be irregular erythematous patches with or without scaling. The lesions may sometimes show atrophy also. Plaque stage as in our patient shows irregularly shaped, well- demarcated, indurated plaques from pre-existing patches or normal skin. Later some of the patients may develop irregularly shaped raised tumors of red or brown colour. These tumors may occur denovo without the preceding stages-tumor d emblee. Less common variants are poikilodermatous MF and erythrodermic MF.

In poikilodermatous MF[1] patients develop widespread poikiloderma rather than frank plaques and nodules. The trunk is usually involved and the breasts and buttocks may be severely affected. A burning sensation than itching is the main complaint. Mycosis fungoides develops subsequent to a prereticulotic poikiloderma. Histology of these lesions show lichenoid dermatitis. Epidermotropism is absent. Samman refers to this as lichenoid type of MF and suggests a better prognosis.[2]

Thus our patient with features of poikiloderma and histology of lichenoid dermatitis without epidermotropism is an example of this less common variant-Poikilodermatous MF. We would like to stress the point that epidermotropism though characteristic of MF need not be present in all the cases and its absence does not exclude mycosis fungoides.

References

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