A Case of Papular Mycosis Fungoides: A New Clinical Variant of Early Mycosis Fungoides

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Dear Editor:

Mycosis fungoides (MF) is the most common form of cutaneous T-cell lymphoma. Currently, many clinicopathologic variants of MF have been described¹. We describe here a patient who was diagnosed with papular MF (PMF) characterized by the presence of papules instead of the typical scaling patches.

A 73-year-old man presented with a 7-year history of persistent grouped yellowish papules which were distributed symmetrically on both thighs and buttocks (Fig. 1A, B). Biopsy of the papule revealed a band-like lichenoid infiltration of the lymphocytes within a thickened papillary dermis and several epidermotropic lymphocytes (Fig. 1C, D). Immunohistochemistry confirmed that the intraepidermal cells were T cells (CD3+, CD4+, CD5+, CD8-, CD20-) and only a few infiltrating cells in the dermis were CD8+ T cells and CD20+ B cell. Gene rearrangement by polymerase chain reaction showed the presence of monoclonal-type T cells. Complete blood count and peripheral blood smear revealed no abnormalities. He was diagnosed with papular variant of MF based on these findings. Patient received narrow-band ultraviolet B treatment and applied topical high-potency corticosteroid daily. He had a very good response and has maintained at 3 years follow up.

PMF presents discrete, erythematous, tender or asymptomatic papules, ranging from 1 to 10 mm without antecedent patches of classic MF. The papules are distributed symmetrically in well-defined areas ranging from 3 to 5 cm on the trunk, upper arms and thighs¹. Clinically, the

papules are scattered within defined areas or partly confluent^{2,3}. Thus far, to our knowledge, only 15 patients with PMF, including our patient, have been reported in the literature²⁻⁵. Papular lesions of MF can be classified into two types according to the onset of papules. If patients who have preexisting typical MF lesions develop papular lesions, a more aggressive course and poor prognosis would be expected. Thus, these papules are considered sign of progression, similar to the onset of plaque or tumors. On the other hand, papules of the PMF, as noted above, may occur at the onset of MF without any evidence or history of preceding patches. These papules seem to represent an early manifestation of MF with a prognosis similar to that of the patch stage of the disease. PMF should be distinguished from lymphomatoid papulosis type B (LyP type B) and follicular MF, because histopathologic features of LyP type B can be similar to those observed in papular MF^{1,3}. However lesions show variable positivity for CD30 and are characterized by waxing and waning papules and spontaneous resolution¹. Follicular MF presents as papules similar to PMF. However, histologically it shows folliculotropism by neoplastic T cells and mucin deposition within hair follicles¹. Clinical remission in such PMF cases is obtained with nonaggressive therapies such as topical high-potency corticosteroid, and phototherapy².

In conclusion, we reported a new clinical variant of MF manifested as grouped papules. Even though it is a rare disease, if patients have persistent and symmetric papules on covered areas, we have to consider PMF as a differential diagnosis.

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Fig. 1. (A, B) Multiple discrete yellowish papules were grouped roundly and distributed symmetrically on both buttocks and both thighs. (C) Histopathologically, lesion on right thigh showed band-like lichenoid infiltration of the lymphocyte in the upper dermis with vacuolar interface changes (H&E, $\times 100$). (D) Infiltrates of small-to-medium atypical lymphocytes with epidermotropism and coarse bundles of collagen in the upper dermis (H&E, $\times 200$).

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