Case Letter

Granulomatous Mycosis Fungoides With Clinical Features of Granulomatous Slack Skin

To the Editor:

Granulomatous slack skin (GSS) and granulomatous mycosis fungoides (GMF) are rare diseases with an annual incidence of 2 cases per million individuals in North America.[1] These diseases exhibit overlapping histologic features; thus clinicians must rely on clinical correlation to make the diagnosis.[2] We present a case of GMF that exemplified clinical features of both GSS and GMF.

An 82-year-old woman presented with a mild pruritic eruption of 3 months' duration that started in the inguinal region and progressed to involve the bilateral axillae, trunk, and extremities. On examination, erythematous patches and plaques with fine scales were noted on the lower back, buttocks, abdomen, and thighs, while atrophic poikilodermatous plaques were noted in the groin and axillary regions (Figure 1). Her medical history was notable for breast cancer that was treated with a bilateral mastectomy and chemotherapy.

Cutaneous biopsies were obtained from the left thigh, right side of the abdomen, and lower back. The biopsy of the thigh revealed granulomatous dermatitis with elastophagocytosis (Figure 2). However, biopsies of the abdomen and lower back showed epidermotropism and partial loss of CD7. T-cell receptor gene rearrangement studies were negative. Clinical and histopathologic data were most consistent with GMF. To date, the patient has achieved an 80% improvement with topical desoximetasone ointment 0.25% and narrowband UVB treatment.

Our case illustrated several histologic features shared by GSS and GMF, including the presence of multinucleated giant cells, granuloma formation, and elastophagocytosis. Elastophagocytosis can be observed histologically in any granulomatous cutaneous T-cell lymphoma and clinically manifests as redundant skin folds, most commonly involving the axillae and groin.

An indistinguishable histologic appearance forces one to rely on clinical features of the patient to make the diagnosis. In our patient, the hanging skin folds, which are classic of GSS, were concurrently observed with the classic extremity and trunk patches and plaques of GMF. Clinical and histologic data were most consistent with GMF. To arrive at this rare diagnosis, clinicopathologic correlation and

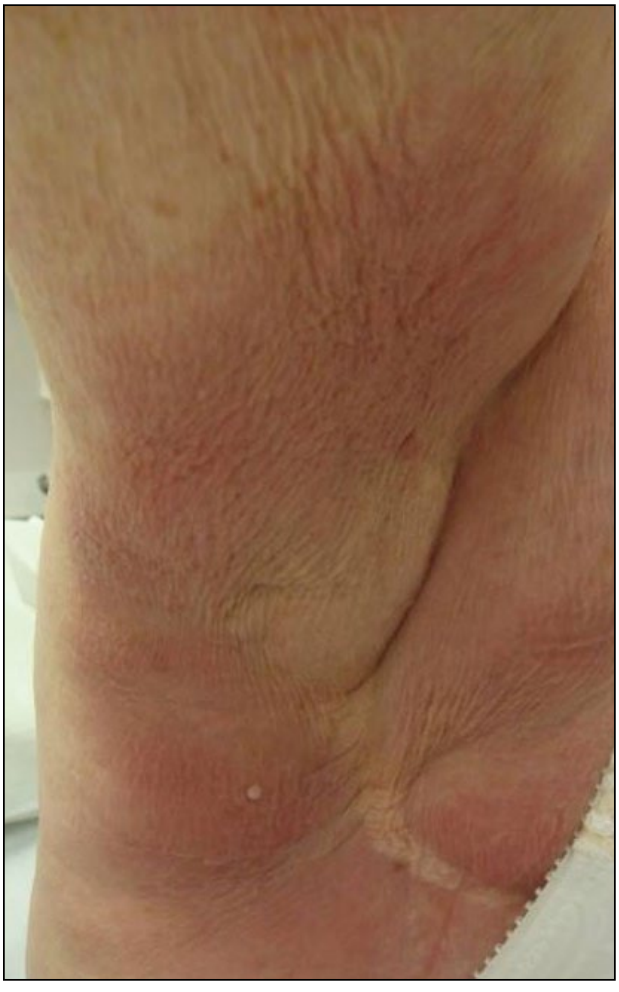

Figure 1. Hanging skin folds in the axillary region.

From the Department of Dermatology, Saint Louis University School of Medicine, Missouri.

The authors report no conflict of interest.

Correspondence: Adam R. Mattox, DO, Department of Dermatology, Saint Louis University School of Medicine, 1402 S Grand Blvd—ABI, St. Louis, MO 63104 (amattox@slu.edu).

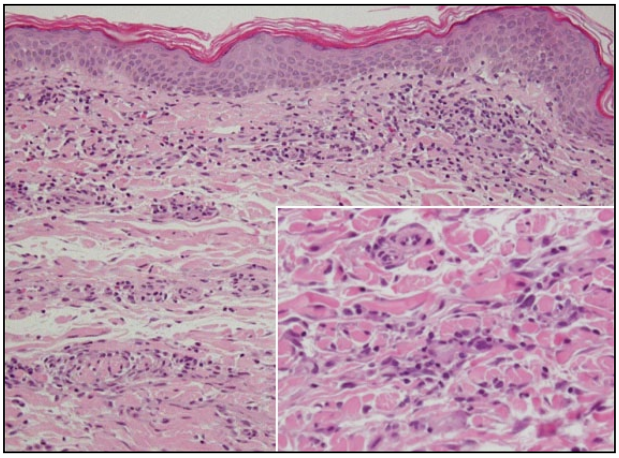

Figure 2. A cutaneous punch biopsy showed granulomatous dermatitis with elastophagocytosis (H&E, original magnification ×100 [inset in bottom right corner, original magnification ×200]).

accurate histologic evaluation of multiple biopsies was necessary.

Granulomatous cutaneous T-cell lymphomas typically have a therapy-resistant, indolent course. Although no known cure for GSS exists, its 5-year survival is estimated to be more than 80%.[1] The literature reports complete GMF tumor regression in only 20% of patients, and the disease-specific, 5-year survival rate is 66%.[2] The mainstays of treatment for these conditions are psoralen plus UVA, interferon, and topical mechlorethamine hydrochloride. The combination of topical steroids and narrowband UVB, as used in this case, may present a well-tolerated, minimally invasive, alternative treatment option.

Adam R. Mattox, DO
Tricia A. Missall, MD, PhD
Aibing Guo, MD

REFERENCES

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