

MYCOSIS FUNGOIDES – CASE PRESENTATION

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Sir,

Mycosis fungoides (MF) is a neoplastic disease of the lymphoreticular system with substrate of T lymphocyte hyperplasia and multifactorial etiology. Usual onset is around age 50, with skin lesions, and in advanced stages affects the internal organs.

Mycosis fungoides has specific histological feature: polymorphous infiltrate located in the papillary dermis which ends abruptly in the middle dermis.

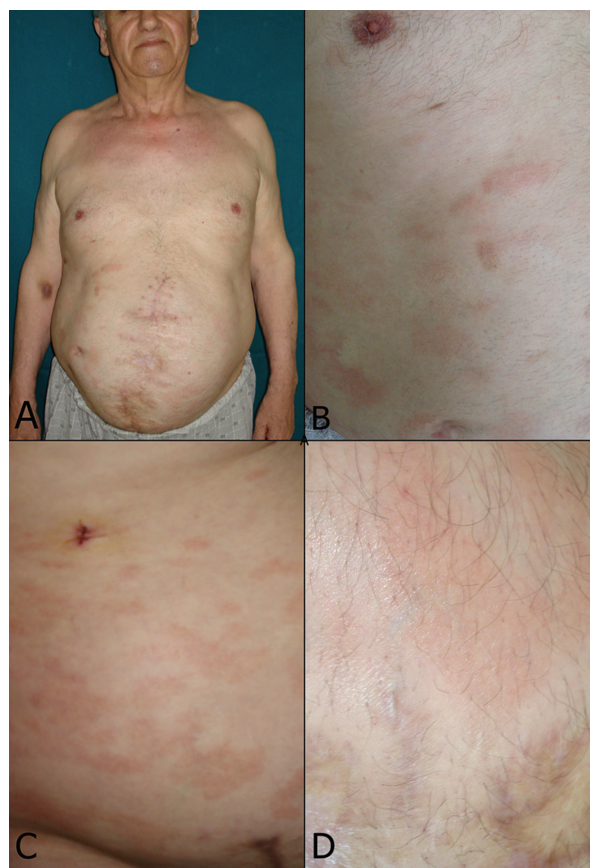
Case Report

A 72 years old male, pensioner, from urban area, with insignificant heredo-collateral hystory, presented with multiples erythemato-squamous patches, with no pruritus, for six months. The lesions were located initially on the abdomen, with a digitiform aspect and then were extended on the trunk and limbs (Figs 1A - D). There was no improvement under long-term use of corticosteroides, antifungal and antibacterian ointments. Patient had no personal hystory of atopic dermatitis, causative drug intake or psoriasis. Eleven years ago he was diagnosed with internal and external hemorrhoids and within the last two years he suffered 11 surgeries for appendectomy complicated with peritonitis and eventrations. He was using girdle to sustain the abdomen.

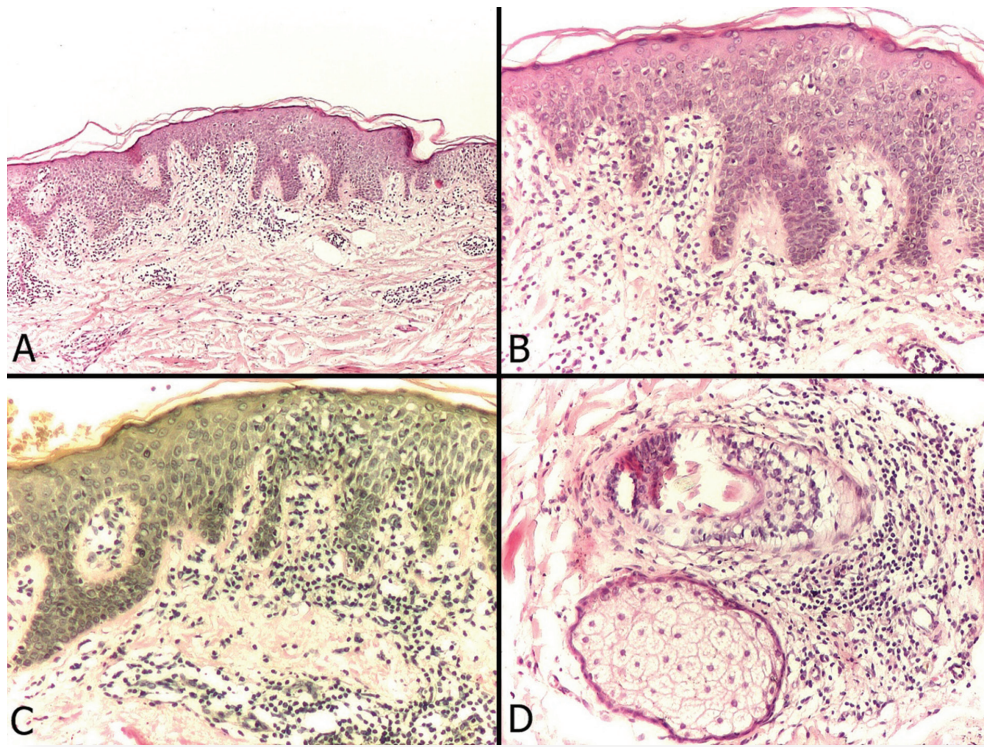
The general examination revealed an enlarged abdomen, with generalized tenderness probe and multiple postoperative keloid scars, with difficult defecation and sometimes hematochezia. Routine investigations: normal blood and urine tests. Chest X-ray was normal. Abdominal ultrasound: massive aerocolie.

Skin biopsy showed: moderate lymphocytic infiltrate in the superficial dermis. Epidermo-tropism with some intraepithelial halo-Ly and tendency to aggregate (Figs 2A - D).

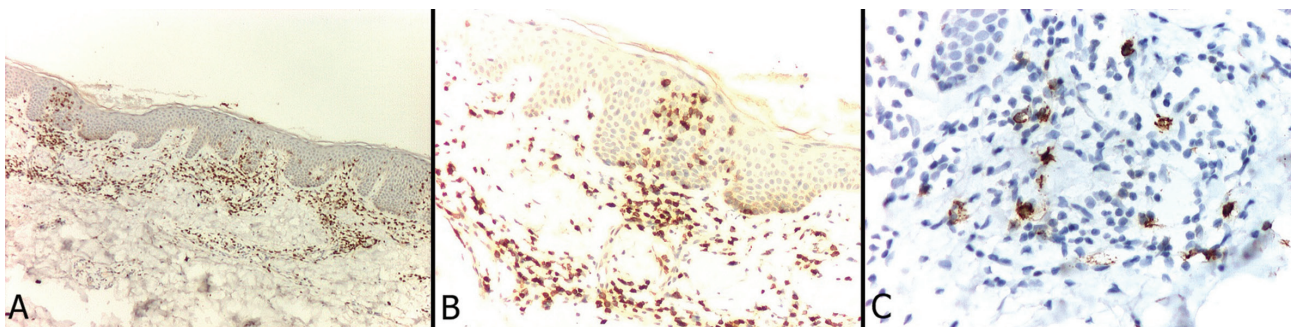
Immunohystochimie: CD20, CD3, CD4, CD8 Ly present in the dermis and rarely in the epidermis (Figs 3A - C).



Figures 1. Clinical images. (A). Enlarged abdomen, with multiple postoperative keloid scars; (B). Enlarged abdomen, with multiple postoperative keloid scars (detail); (C). Foto 3 Multiples erythemato-squamous patches disseminated on the abdomen; (D). Foto 4 Erythematous and scaly plaque, with digitiform aspect, located on the abdomen (detail).



Figures 2. Histopathology. (A). Acanthosis, with epithelial crisis hiperplasia and reduced ortokeratosis. H & E 4; (B). Histological examination reveal moderate dermal edema and lymphocitar inflammatory infiltrate, H & E x 10; (C). Moderate exocitosis with lymphocytes, Van Gieson stain, x 10; (D). Chronic perifollicular inflammatory infiltrate, H & E x 10.



Figures 3. Immunohistochemistry. (A). Foto 9 Imunohistochemistry reveal inflammatory infiltrate predominant CD3 positiv, x 4; (B). Imunohistochemistry reveal inflammatory infiltrate predominant CD3 positiv, x 10; (C). Foto 11 Imunohistochemistry show isolated, reactive B lymphocyte, x 20.

Conclusion

Based on the clinical examination and histopathological tests the diagnostic was Micosys Fungoides stage IB. The neoplastic disease appears to a patient with 11 post-operative eventrations shortly after the last abdominal wall plasty, which first is mistaken for a contact dermatitis to the girdle. As a feature of this case is the relatively sudden onset, pure asymptomatic, in a patient exposed to a continue surgical stress durring the past two years, malign illnes which does not keeps in with the completly normal laboratory tests, presenting just a bulky abdomen with an important aerocolie which makes imposible the ultrasound investigation of the abdomen.

Following a topical therapy properly conducted according to the lesions stage skin resolve almost completely, but the prognosis remains reserved.

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