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Prognostic Implications of Dominant T-Cell Clones in Early Mycosis Fungoides

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Introduction

Infiltrated plaques, nodules, hypopigmented or erythematous patches, and esh-colored follicular papules are typical signs of FM, a rare idiopathic skin condition. Alopecia areata-like side effects, scarring alopecia, folliculitis, acneiform emissions, direct injuries that follow Blaschko lines and urticaria-like follicular mucinosis are instances of strange introductions. The face, head, and neck are frequently affected in primary FM, while the trunk and limbs show extensive lesions. However, clinical characteristics are insufficiently specific to distinguish between the benign primary type and the secondary form associated with mycosis fungoides. As a result, follow-up is essential. A 16-year-old girl had an erythematous and somewhat irritating patch on the right side of her forehead that had grown steadily over the past two years. The patient had normal upbringing and medical history. During a dermatological examination, a well-defined, alopecic, and erythematous patch measuring 1 by 2 cm was discovered with significant follicular plugs in the middle [1].

Description

A small band of skin with a slight hypopigmentation was visible around the lesion. Nothing unusual was found during a thorough physical examination. The liver and kidney function tests, a complete blood count, an erythrocyte sedimentation rate, and a urinalysis were all within the normal range. On the chest x-ray and belly ultrasound, there were no organomegaly, enlarged lymph nodes, or other abnormal signs. A skin punch biopsy was carried out. A mixed inflammatory infiltration, primarily composed of lymphocytes, included and surrounded the follicular epithelium in a portion of the sample that was stained with Hematoxylin and Eosin (H&E), as well as a minor focal follicular spongiosis. Alcian blue staining revealed the infiltration's mucinous nature in the follicular epithelium. The characteristics of FM were discovered by histopathology. Based on the results of the clinical and histological testing, an accurate diagnosis of follicular mucinosis was made [2].

In 1957, Pinkus was the first to identify FM as alopecia mucinosa. It mimics folliculitis, alopecia areata, scarring alopecia, chronic eczema, acne, urticaria, and erythrodermic forms by causing mucin deposition within the hair follicles and sebaceous glands of the pilosebaceous unit in addition to a superficial and deep perivascular. The cause of this rare idiopathic disorder is unknown. Dermatosis manifests in two distinct clinical ways. The most common type of FM, also known as primary or benign FM, typically affects young people. Primary FM, which resolves on its own, is thought to be a short-term condition that typically goes away within a few years. Mycosis fungoides (MF), the most common malignancy, is linked to underlying inflammatory and malignant processes in secondary FM, which typically affects older patients and manifests as widespread lesions [3].

MF is the lymphoma that is most frequently associated with Hodgkin disease, even though it has been reported in children and young adults with longer follow-up periods. Using clinical and histological criteria, it is necessary to distinguish between primary and secondary variations; however, patient follow-up is required because these criteria are insufficiently precise. A clonal T-cell receptor gene rearrangement has also been proposed as a potential method for distinguishing FM from FM associated with cancer. Idiopathic FM may be one of the variant forms of MF that have a protracted, non-aggressive clinical course, and there are no definitive criteria for distinguishing it from FM associated with lymphoma. Over a prolonged period of time, patients with "idiopathic FM" should be closely monitored [4].

Topical, intralesional, and systemic corticosteroids, topical and systemic retinoids, dapsone, methotrexate, cyclophosphamide, minocycline, hydroxychloroquine, interferons, indomethacin, topical pimecrolimus, ultraviolet A, and superficial radiation have all been tried as anecdotal evidence-based treatments for primary FM. The lesion's appearance has improved [5].

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Conflict of Interest

None.

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