Treatment of childhood mycosis fungoides with narrow-band phototherapy

Mycosis fungoides (MF) is a form of cutaneous T-cell lymphoma, usually arising in mid to late adulthood. It is rarely described in children. The most common presentation of MF diagnosed during childhood and adolescence is limited or generalized patch-stage disease without lymph node enlargement or with histologically negative nodes. Herein, we present a patch-stage MF case in a Turkish girl who was treated successfully with narrow-band phototherapy.

A 4-year-old girl is presented with disseminated asymptomatic hyperpigmented macules on her trunk. The lesions were first identified at the age of 18 months and further developed despite treatment with topical corticosteroids. Upon physical examination, she had erythematous, slightly scaly, irregularly bordered macules and patches of size 2–10 cm in diameter on her abdomen, flank, and left thigh. Sensation was normal and the lesions were not palpable (Figs 1 and 2). The result of a potassium hydroxide examination of the scale was negative. The histopathologic examination results revealed lymphocytes with darkly stained nuclei, either single or grouped, with extension along the dermo-epidermal junction and a bandlike infiltrate of large lymphocytes in papillary dermis (Fig. 3). Systemic examination and laboratory findings were found to be normal. Neither lymphadenopathy nor organomegaly were detected on clinical examination. According to the TNM (tumor, node, metastases) classification, the patient was in stage 1A (patch/plaques < 10% body surface area with no palpable lymph nodes). She received narrow-band ultraviolet B (UVB) three times a week and had clinical and histological remission after a total of 30 sessions (total = 27 J/cm²) over 2.5 months. She was then maintained on a regimen of once weekly for 5 months.

There are few reports regarding MF in younger patients. Only 0.5% to 5% of all MF cases begin during childhood and adolescence. Koch et al. performed a retrospective study in a population of 228 patients and found that only 12 of these...
patients (5.8%) had an onset of MF before the age of 20. Patients diagnosed with MF in young adulthood often report onset of their first symptoms in their teenage years. Many of the reported cases of childhood-onset MF were not diagnosed until biopsies were performed in adulthood. It is reported that the median time from symptom onset to diagnosis was 5.3 years. In our case, the lesions were first noticed at the age of 1.5, and biopsy specimens were obtained 3 years after onset of disease. Although MF may present in childhood with a variety of clinical findings including papules, plaques, poikiloderma, and hypopigmented macules, the most common presentation is limited or generalized patch-stage disease. Our patient had this presentation with a predilection for the abdomen and lower limbs. According to a review of nine children with MF, Tan et al. suggested that the majority had early stage of disease. Our case had also disease classified as stage T1. There were no established treatment protocols specially designed for children. Psoralen and ultraviolet A (PUVA) and UVB phototherapy are commonly used. Narrow-band phototherapy is more effective than broad-band phototherapy. A good response with topical PUVA treatment is also reported. Our patient received narrow-band phototherapy because of the adverse effects of systemic psoralen.

In conclusion, we suggest that persistent skin lesions especially in childhood should be considered in the differential diagnosis of MF, although the biopsies are less likely to be performed in children, and narrow-band phototherapy may be appropriate for the management of childhood MF.

A giant variant of acquired reactive perforating collagenosis associated with hydronephrosis: successful treatment with allopurinol

Patients with renal disease or diabetes mellitus often have an acquired perforating disease of the skin characterized by hyperkeratotic papules with transepidermal elimination of degenerated material. Four diseases included in this category are Kyrle’s disease, perforating folliculitis, elastosis perforans serpiginosa and reactive perforating collagenosis (RPC). RPC is characterized by transepidermal elimination of altered collagen. The childhood form is usually inherited whereas acquired RPC (ARPC) is associated with diabetes mellitus, renal disease, and other systemic diseases.

We describe a patient with a giant variant of ARPC associated with diabetes mellitus, renal failure and a left sided hydronephrosis. The patient had significant improvement of his lesions following treatment with allopurinol.

A 57-year-old man presented with itchy skin lesions over his face, trunk, arms, and legs of 5 years’ duration with summer exacerbations. He had Type II diabetes mellitus for 10 years.

References

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