Sudden aggravated CD8$^+$ mycosis fungoides accompanied by hidden adenocarcinoma of the colon

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Key words: CD8+ mycosis fungoides; colon adenocarcinoma; cutaneous T-cell lymphoma; hidden malignancy; mycosis fungoides; paraneoplastic syndrome.

INTRODUCTION

Mycosis fungoides (MF) is the most common type of cutaneous T-cell lymphoma (CTCL). The neoplastic T cells in MF are usually mature CD4$^+$ T cells, and CD8$^+$ phenotype expression is rarely observed.[1] There are 2 categories of CD8$^+$ CTCL, one with aggressive behavior and one with indolent behavior.[2] We report a rare case of suddenly aggravated CD8$^+$ MF that was found to be associated with a hidden adenocarcinoma in the colon.

CASE REPORT

A 40-year-old woman visited our clinic because of erythematous and poikilodermatous patches of various sizes on the extremities and trunk of 1 years' duration (Fig 1, *A* through *D*). The affected body surface area was calculated by 2 dermatologists to be 40%. Skin biopsy examination of the lesions indicated atypical lymphocytes that were surrounded by a clear halo located along the dermoepidermal junction and on the epidermis (Fig 2, *A* and *B*). The skin lesions remained stationary during low-dose systemic steroid treatment. However, they were suddenly aggravated and increased size, and vegetative plaques were seen 2 months later (Fig 3, *B* through *D*). Because of the aggravation of the lesions, an additional skin biopsy found similar features of the previous condition (epidermotropism with haloed cells). Immunohistochemical analysis found CD4 negativity and CD8, CD30, and Ki-67 positivity (Fig 2, *C* and *D*). Monoclonality of the T-cell receptor gene rearrangement was found, and CD8$^+$ MF was diagnosed. Although the patient had been treated with phototherapy, a systemic retinoid, and methotrexate for 2 months, the skin lesions were more aggravated and had a thick crust with eroded and vegetative plaques. The patient underwent further examinations to determine systemic involvement of extracutaneous lymphoma. Bone marrow biopsy results showed no evidence of lymphoma involvement, but a sigmoid colon mass was detected by abdominal computed tomography (Fig 3, *A*); biopsy of the mass found an adenocarcinoma. Stage IIIc sigmoid colon cancer with stage IB of MF was finally diagnosed and she underwent surgical resection and treatment with 12 cycles of FOLFOX chemotherapy (folinic acid, fluorouracil, oxaliplatin). After colon cancer treatment, the aggravated skin lesions improved and the vegetative plaques resolved to brownish patches, similar to their appearance during the first visit. Since then, her MF has been well controlled with phototherapy.

Abbreviations used:

CTCL:	cutaneous T-cell lymphoma
FOLFOX:	folinic acid, fluorouracil, oxaliplatin
MF:	mycosis fungoides

DISCUSSION

MF is the most common type of CTCL. It is clinically categorized in patch, plaque, and tumor stages. During the early patch stage, there are single or multiple erythematous macules and patches that vary in size and

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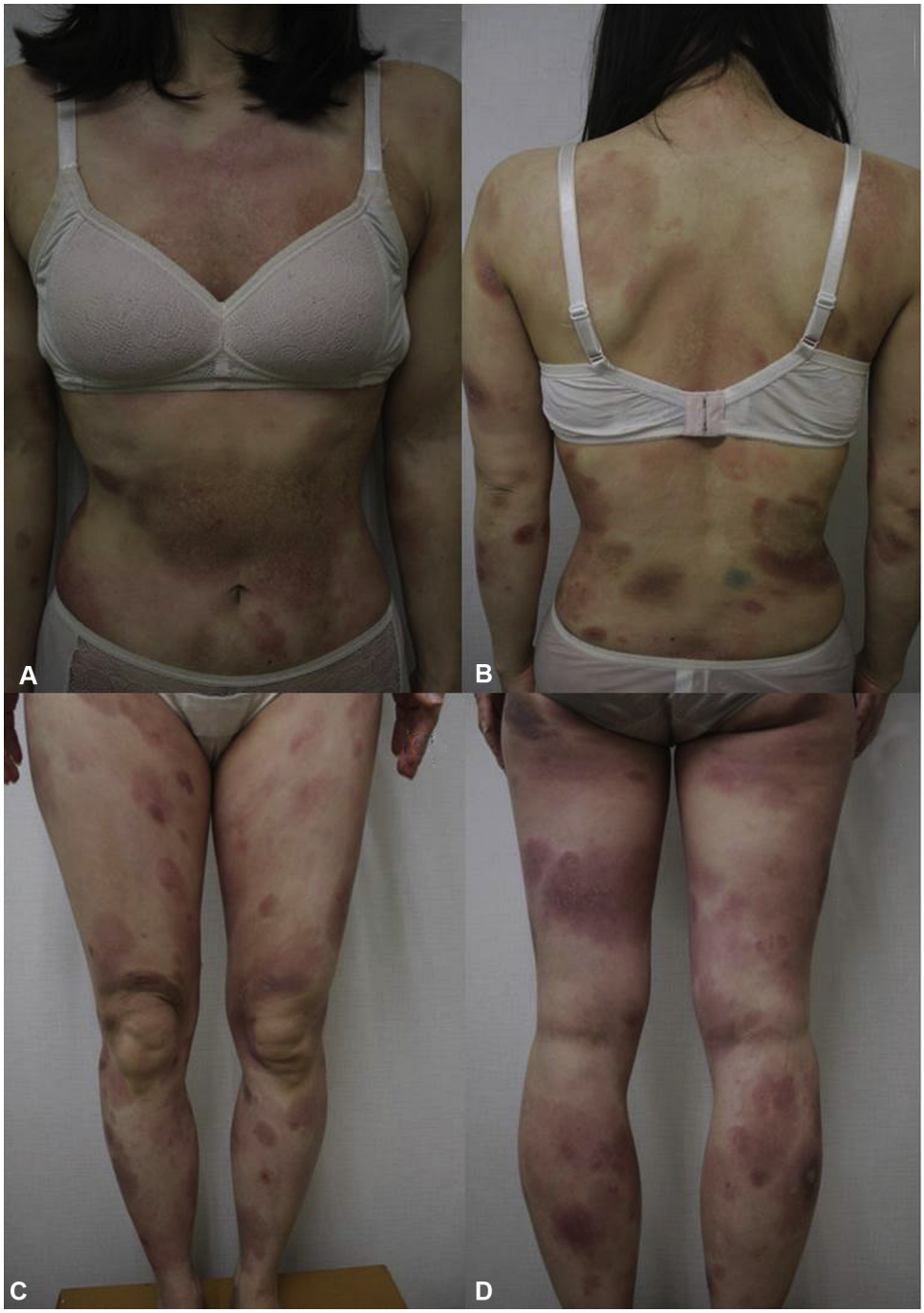

Fig 1. Multiple erythematous and poikilodermatous patches on the entire body.

color.[1] Histologically, the epidermis shows epidermotropism, which comprises small to medium atypical lymphocytes with enlarged hyperchromatic and clear cytoplasm (haloed cells). The neoplastic T cells in MF are usually mature $CD4^+$ T cells, and approximately 20% of cases of early MF involve the $CD8^+$ phenotype.[2] The clinical behavior of $CD8^+$ MF is similar to that of the $CD4^+$ type, which is indolent.[1] The condition may remain in the early patch stage or plaque stage for months or years before progressing to the tumor stage. Therefore, the diagnosis of early-stage MF is often challenging because of its overlapping clinical and histologic findings with various reactive dermatoses.[1] In contrast to the indolent course, according to the World Health Organization– European Organisation for Research and Treatment of Cancer classification,[2] there are $CD8^+$ cutaneous lymphomas with aggressive behavior and poor prognoses that are categorized as primary aggressive epidermotropic $CD8^+$ cytotoxic CTCL.

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