



Internal Medicine Flashcard

Worsening alopecia in an elderly woman

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1. Case description

A woman in her 70s presented with a worsening alopecia and multiple erythematous plaques involving the scalp, the frontal area and the eyebrows (Fig. 1A and B). Pruritus was a significant feature. A

careful dermatological examination of the whole body, palpation of the lymph nodes and laboratory investigation were unremarkable. In her past medical history, there was a HCV-chronic hepatitis. A 5 mm skin biopsy was taken from one lesion on the scalp.

Histopathological examination showed a discrete lymphocytic in-

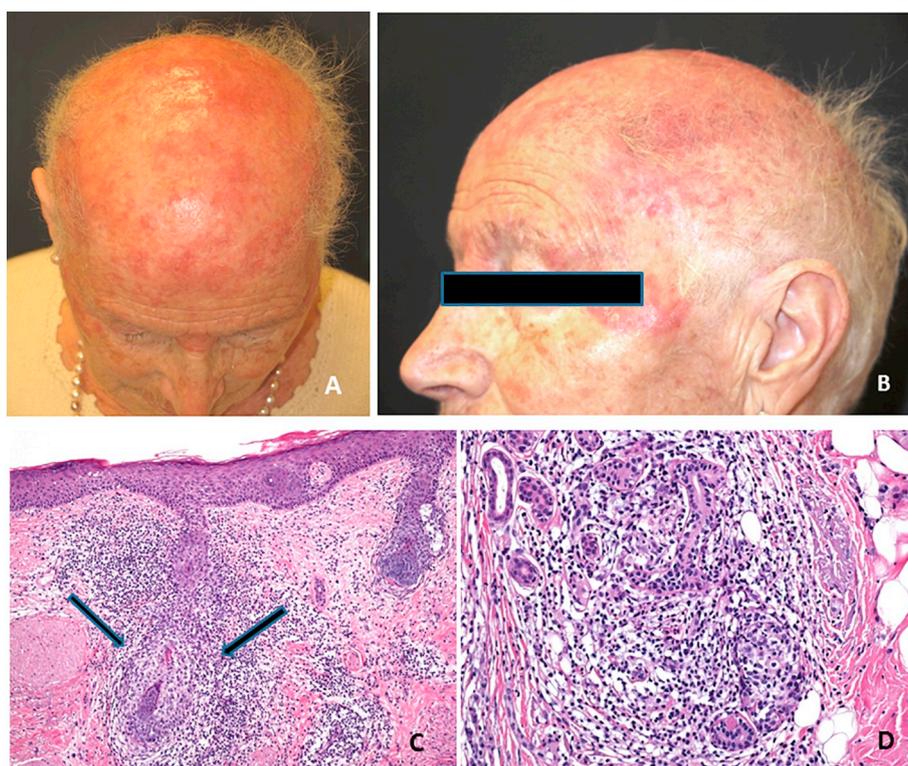


Fig. 1. A,B. Multiple coalescent erythematous plaques are observed on the parietal areas and eyebrows. C. Hair follicle epithelium is infiltrated by small sized lymphocytes. D. The eccrine gland is involved by the lymphocytes.

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filtration of the skin, exclusively located around follicles and sweat glands and often extending to the follicular (Fig. 1C) and eccrine epithelium (Fig. 1D). Lymphocytes were small sized, with irregular and hyperchromatic nuclei. On immunohistochemistry, they showed a T phenotype (CD3+, CD4+, CD20-, CD8-). No CD30+ lymphoid elements were present.

No mucin deposits were found in the dermis and the epidermis was completely uninvolved by the lymphoid proliferation. The patient underwent a bone marrow biopsy, with negative results.

What is the diagnosis?

2. Discussion

Folliculotropic mycosis fungoides (FMF) is a distinct variant of mycosis fungoides, preferentially involving head and neck area. It can present a wide spectrum of clinical appearances, such as comedones, cysts, alopecia, plaques and pseudotumors, mostly associated with pruritus [1]. Although skin lesions are most pronounced in the head and neck area, most patients (up to 86%) present generalized lesions, involving several body sites.

It is accepted that FMF carries a more severe prognosis than classic MF and responds poorly to standard treatment [1,2], but it has been hypothesized that FMF prognosis may depend on diagnostic latency due to subtle clinicopathological findings in early stages or on different histologic inclusion criteria in large studies. Histologically, FMF is characterized by lymphocytic infiltration of hair follicles, sometimes

associated with cyst and granulomatous features. Follicular mucinosis is a frequent finding. In about 50% of cases, epidermotropism typically seen in classic mycosis fungoides is absent. As in the present case, lymphocytic infiltration of sweat glands (syringotropism) is often seen in most patients (up to 57%) confirming that folliculotropic and syringotropic MF can be considered a part of a spectrum of adnexotropic MF [3].

Scarring alopecia due to lupus erythematosus and lichen planopilaris must be ruled out.

Due to its attitude to simulate other diseases, FMF can often be overlooked. Correct diagnosis and prompt treatment are critical in preventing its spontaneous evolution.

Declarations of interest

None.

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