## Dermoscopy in folliculotropic mycosis fungoides—A possible mimicker of follicle-based inflammatory and infectious disorders

*To the Editor*: We read with interest the article by Durdu et al[1] on the diagnostic accuracy of dermoscopy in various types of folliculitis. The authors evaluated dermoscopic features in follicular lesions of different etiologies and found high specificity for some features in certain forms of folliculitis. Cutaneous lymphoma is another possible etiology of follicle-based lesions.

Folliculotropic mycosis fungoides (FMF) is a distinct clinicopathologic variant of mycosis fungoides (MF) caused by folliculotropic infiltration of atypical T lymphocytes and characterized clinically by a variable combination of follicular lesions that frequently involve the head and neck. Early-stage FMF presents as localized or more extensive follicular papules, patches, or thin plaques that may also have a spiky or acneiform appearance. Advanced-stage FMF presents as infiltrated thick plaques and tumors. The lesions frequently demonstrate hair loss and may be secondarily infected by bacteria or fungi.

FMF lesions can mimic a variety of follicle-based dermatoses, including infectious (eg, bacterial folliculitis, abscesses, and tinea capitis) and noninfectious disorders (eg, acne vulgaris, lichen spinulosus, keratosis pilaris, and some forms of alopecia). Given its broad clinical spectrum, FMF diagnosis is challenging, and clinical and pathologic correlation is required.

Dermoscopic patterns of MF and its variants have been described in only a few small studies describing numerous and occasionally overlapping features. Although the literature is sparse, numerous dermoscopic features have been described in patients with FMF: perifollicular accentuation seen as a white halo around the follicle,[2] comedo-like openings, white structureless areas, and dotted/fine linear vessels.[3] Milky-white globules and black dots/broken hairs, as well as keratotic cone-shaped spicules, were reported in a patient with extensive scalp alopecia caused by FMF and in a patient with spiky MF, respectively.[4,5]

Our experience from a cutaneous lymphoma clinic in a referral cancer center supports these observations of heterogenous dermoscopic presentations in FMF, which goes together with the broad clinical spectrum of FMF and follicular lymphoproliferative disorders. Fig 1 demonstrates the variability in clinical and dermoscopic manifestations in 4 patients with a diagnosis FMF or follicular lymphoproliferative disorder as confirmed by histologic evaluation of the imaged lesion. Our case-series presented here demonstrates the clinical and dermoscopic overlap between FMF and

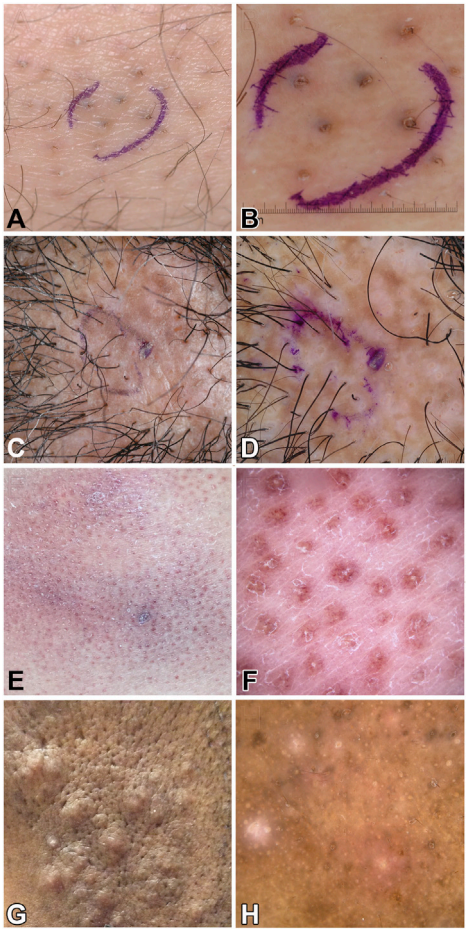


**Fig 1.** Dermoscopy of (**A-F**) folliculotropic mycosis fungoides and (**G** and **H**) folliculotropic lymphoproliferative disorder. **A**, Follicular papules with alopecia on the thigh. **B**, Dermoscopy demonstrates orange-pink perifollicular clods with peripheral scale and central broken hairs. **C**, Erythematous plaque with alopecia on the scalp, with (**D**) dermoscopic examination showing perifollicular halos and broken hairs. **E**, Erythematous follicular papules with central scale (keratosis pilaris-like) on the buttocks. **F**, Short fine vessels and perifollicular scale overlying a yellowish background, surrounding central keratotic plugs is seen with dermoscopy. **G**, Facial erythematous follicular papules, showing (**H**) white and hyperpigmented halo around the follicles and perifollicular scale and white clods under dermoscopy.

follicle-based inflammatory and infectious entities including certain folliculitis types.

Interestingly, some of the dermoscopic features that are seen in FMF lesions were reported to be highly specific for certain folliculitis types in the study by Durdu et al[1] (eg, broken hairs/black dots in fungal folliculitis caused by dermatophytes). Additional studies are needed to further evaluate the prognostic value of dermoscopy in FMF. For the time being, the highly variable clinical and dermoscopic presentations of FMF require clinicians to keep an open mind and to consider a biopsy in cases of follicular lesions that do not respond to treatment or behave unexpectedly.

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**REFERENCES**

1. Durdu M, Errichetti E, Eskiocak AH, Ilkit M. High accuracy of recognition of common forms of folliculitis by dermoscopy: an observational study. *J Am Acad Dermatol*. 2019;81:463-471.
2. Toncic RJ, Drvar DL, Bradamante M, et al. Early dermoscopic sign of folliculotropism in patients with mycosis fungoides. *Dermatol Pract Concept*. 2018;8:328-329.
3. Ghahramani GK, Goetz KE, Liu V. Dermoscopic characterization of cutaneous lymphomas: a pilot survey. *Int J Dermatol*. 2018;57:339-343.
4. Souissi A, Bellagha I, Jendoubi F, Drissi H, Chelly I, Mokni M. Spiky follicular mycosis fungoides: a trichoscopic feature. *J Eur Acad Dermatol Venereol*. 2019;33(7):e252-e253.
5. Slawinska M, Sobjanek M, Olszewska B, Nowicki R, Sokolowska-Wojdylo M. Trichoscopic spectrum of folliculotropic mycosis fungoides. *J Eur Acad Dermatol Venereol*. 2018;32:e107-e108.

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