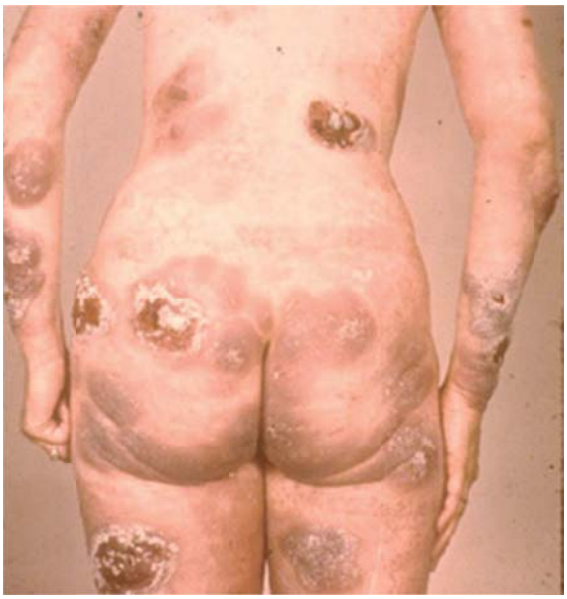
CASE 37-3

A 70-year-old patient has a 9-month history of persistent mildly pruritic plaques that have not completely cleared with the use of clobetasol ointment. Some of the plaques have become thicker and have developed erosions and crusts.



What is the one most likely diagnosis?

(A) Psoriasis

(B) Urticaria

(C) Nummular dermatitis

(D) Tinea corporis

(E) Cutaneous T-cell lymphoma (mycosis fungoides)

The correct answer is (E), cutaneous T-cell lymphoma (mycosis fungoides).

Mycosis fungoides (MF) classically starts as erythematous patches in the bathing suit distribution (ie, flanks, lower back, buttock, and proximal lower extremities). The patches can progress to plaques and nodules later in the disease course. The patches in early stage MF may be clinically indistinguishable from other inflammatory dermatoses such as dermatitis or psoriasis. The image alone in this case may not be adequate to differentiate this condition from psoriasis or nummular eczema. However, the fact that the eruption in these characteristic locations has not responded to long-term treatment with a super-potent topical corticosteroid suggests the diagnosis of MF. A biopsy is warranted for further evaluation.

Urticaria can usually be distinguished morphologically from MF, with evanescent, edematous papules and plaques without scale or other epidermal change. Tinea corporis is an important diagnostic consideration for a rash in the bathing suit distribution. Unlike MF, tinea corporis will not only be unresponsive to high potency topical steroids, but may actually be exacerbated by this treatment, resulting in a papular eruption known as Majocchi’s granuloma.