
Editor: 

Fungoides de policotiticas Micosis 

Severe and Lethal Presentation 

CASE AND RESEARCH LETTERS
The Detection Folliculotropic
The Ishibashi CASE also variant forms European affects similar in this eyebrows. Follicular head has disease (WHO-EORTC) indicates 3 of DNA; MW instead of view of the follicular epithelium by numerous lymphocytes, some of which are atypical. Immune staining and immunophenotyping of these lymphocytes shows CD3\(^+\), with partial loss of CD2 and CD7, and a CD4:CD8 ratio of 4:1.

Follicular or folliculotropic mycosis fungoides is a rare variant of this type of T-cell cutaneous lymphoma, which affects the hair follicles and generally does not affect the epidermis. The World Health Organization and the European Organization for Research and Treatment of Cancer (WHO-EORTC) consider it to be a variant of mycosis fungoides. Folliculotropic mycosis fungoides affects the head and neck in 85% of cases, in the form of pruritic follicular papules, acniform lesions, or cysts, associated with alopecia, and often with involvement of the eyebrows. The lesions tend to be local and generalized forms are extremely rare. The manifestation of facies leonina has been described in folliculotropic mycosis fungoides, although it is rare; a 2015 systematic review found only 24 patients with this association. Ishibashi et al. reported the case of a patient who also had a severe presentation of this disease with facies leonina, images of which are very similar to the patient described by us. The folliculotropic variant tends to be more aggressive than the plaque phase in mycosis fungoides and the mortality rate is similar to that of the tumoral phase. Folliculotropic mycosis fungoides is also more refractory. Molecular clonality testing can be of considerable help in determining the diagnosis in cases such as this, where diagnosis is difficult. The test can be performed on samples of skin, lymph node, bone marrow, or peripheral blood. Detection of one or more clones does not necessarily indicate neoplasia and the test results should therefore be assessed together with the clinical, histologic, and immunophenotyping findings.

In conclusion, we report the case of a patient with folliculotropic mycosis fungoides confirmed by means of skin biopsy, immune staining, and molecular biology study, with severe and generalized presentation involving more than 90% of the body surface and associated with facies leonina. The skin disease led to a bacterial superinfection, which is frequently reported with this entity, followed by sepsis and death of the patient. This case is perhaps one of the most severe and aggressive forms of the disease reported to date.

Conflicts of Interest
The authors declare that they have no conflicts of interest.
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References


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Spontaneous Regression of Medium-Sized Congenital Melanocytic Nevi: Report of 3 New Cases

Regresión espontánea de tres nevos melanocíticos congénitos medianos

To the Editor:

Congenital melanocytic nevi (CMN) are genetically determined benign proliferations of cells that arise from the neural crest and which are present from birth or the first weeks of life.1-3 They may remain unchanged or present a dynamic course.1,3 Regression is a rare process that causes progressive loss of pigment and may occur in different ways.1-5 It is frequently associated with the formation of distant achromic lesions.2,4

Case 1

An 8-year-old boy was examined for changes in CMN lesions, which had appeared on his left leg 3 years earlier. These changes began with a halo and subsequent disappearance of pigment on the surface and of the hair covering the lesion. At the same time, the patient developed distant achromic lesions (in the region of the right iliac fossa and in the occipital region of the scalp) (Fig. 1A–C). Topical treatment was instated with mometasone furoate for 3 weeks, followed by tacrolimus 0.1% ointment, and repigmentation was achieved by sectors of both the nevus (Fig. 1D) and the distant achromic lesions, though without changes to the poliosis.

Case 2

A 5-year-old girl was examined due to changes in CMN lesions, which had appeared a month earlier. Physical examination revealed a brown lesion measuring 9 × 5 cm; the lesion was brown with a whitish central area, a corrugated surface, and a fibrous appearance, and had white hairs on the surface (Fig. 2A). At the same time, an achromic macule appeared on the upper left eyelid. Treatment was instated with tacrolimus 0.03% ointment for both lesions. The patient did not return.

Case 3

A 5-year-old girl was examined due to progressive depigmentation of her CMN lesions; this process had begun with a halo and gradual reduction of the pigment on the surface of the halo. At the same time, the patient developed achromic lesions on the upper eyelids. In the following years, she