

In this issue...

Parapsoriasis can go into complete remission and early mycosis fungoides benefits from bath PUVA

Drs Liisa Väkevä (pp. 318) and colleagues publish an interesting retrospective study on 105 patients with “pre-mycosis fungoides” or “parapsoriasis – a term introduced in Brocq’s classification of these diseases in 1905. Although this term is used less and less, I like it as it describes a psoriasis-like skin rash of chronic nature. You don’t need to tell your patient anything about “lymphoma”, which leads to anxiety and potential social consequences (insurance etc). Is Parapsoriasis part of the cutaneous T-cell lymphoma diseases? This has been extensively discussed as also mentioned in the article (see their ref. 2 and 3). Their findings are quite interesting: Only 1/3 or less goes into mycosis fungoides and nearly half of the patients have a full remission (within the observation period). And the really surprising thing is that this happens – irrespective of UV therapy or not. It is not my clinical impression that half of patients with parapsoriasis go into clinical remission, but I haven’t done a similar careful study as the Finnish colleagues. The patients often continue to have symptoms with varying intensity. Thus, I know of several patients, who have been followed for years because of parapsoriasis, but where the histology never showed MF. A practical consequence of this retrospective study is likely that we should be more restrictive using the UV therapy option, but instead use topical steroids as this is much easier for the patient and cheaper for society. Or maybe no treatment at all but emollients? And don’t call “parapsoriasis” lymphoma – until you have this diagnosis.

Drs. Weber et al. (pp. 329) publish a study on the efficacy of bath PUVA and show that this treatment option is very efficacious as all 16 patients went into complete remission having a mean time of remission on 45 weeks - almost 1 year. This is clearly a significant therapy. But the draw-backs are that you need bath facilities next to your light therapy unit - making it a treatment option for university clinics, but not private practise.

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Even Common Diseases Might Reflect an Underlying Malignancy

One of the most feared conditions in medicine is a diagnosis of cancer. Often when patients come to visit a dermatologist’s office they have on the mind either

overtly or in their subconscious this fear. They wonder whether their rash or lesion is a malignancy or might reflect an internal malignancy. Eczema and papular pruritic eruptions are commonplace in the practice of dermatology and are usually not associated with serious internal disease. In this issue however, there are two reports of the associating eczema craquele with a variety of lymphoma types and a non-specific papular pruritic eruption with Hodgkin’s disease (Sparsa et al, p.338). In all instances there were clues that the skin condition was different than usual eruptions. In the patients reported by Sparsa et al all had disease that either failed to respond or responded poorly to usual treatments with emollients and topical corticosteroids. They were able to identify 3 similar cases that had been reported in the literature previously. Kapilin and colleagues (p.345) report 3 patients with papular eruptions that clinically simulated pityriasis lichenoides, lymphomatoid papulosis or prurigo nodularis two who eventually were diagnosed with Hodgkin’s disease 2 and 3 years after the onset of the eruption. Their third patient had a diagnosis of Hodgkin’s disease prior to the onset of the eruption. It is well known that Hodgkin’s disease is associated with intense pruritus, but traditionally these patients have additional symptoms and frequently do not develop cutaneous lesions of any sort.

What should dermatologists do when confronted with patients who develop non-specific pruritic eruptions? Ever since I identified several patients with pruritic eruptions that were reflective of lymphoma (1), it has become my practice to consider the possibility of lymphoma in all such patients. I personally examine them for lymphadenopathy, hepatomegaly and/or splenomegaly during my office visit. These aspects of the physical examination are not difficult and I believe should become routine in patients with unexplained pruritus, eczema or prurigo nodularis. In addition, I routinely obtain a chest roentgenogram to assess for the possibility of hilar adenopathy. Although the patients reported by Sparsa et al mostly had a poor outcome, and we are not told if there was a delay in diagnosis, it is possible that with earlier diagnosis and earlier treatment the outcome might have been different.

REFERENCE

1. Callen JP, Bernardi DM, Clark RA, Weber DA. Adult-onset recalcitrant eczema: a marker of noncutaneous lymphoma or leukemia. *J Am Acad Dermatol* 2000; 43: 207–10.

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