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PSORIASIS CLINICALLY MIMICKING MYCOSIS FUNGOIDES, WITH RAPID RESPONSE TO INTRAMUSCULAR STEROIDS- A CASE REPORT

Dermatology

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ABSTRACT

Psoriasis, a close differential of mycosis fungoides will respond to treatment while mycosis fungoides itself will not generally respond to the conventional therapies of psoriasis. The usage of steroids in psoriasis has always been controversial. Here we report a patient clinically diagnosed with mycosis fungoides but histopathologically made out to be psoriasis, who responded very well to intramuscular steroids.

KEYWORDS

Psoriasis, Mycosis fungoides, intramuscular steroids, improvement

Introduction:

Psoriasis, a chronic immune mediated inflammatory disease[1] may mimic the psoriasiform plaques of mycosis fungoides[2] and vice versa. The usage of steroids in psoriasis has not been advocated but has been found beneficial[3] as seen in this case of psoriasis mimicking mycosis fungoides, where the patient showed marked improvement of the lesions.

Case report:

A 45-year-old male patient presented to the skin outpatient department with complaints of multiple, itchy, raised, red, scaly lesions over the trunk and extremities for the past 5 years. No history of fever or other constitutional symptoms. Patient gave a positive history of topical steroid usage as well as oral methotrexate 7.5mg once a week but with no signs of clinical improvement. On dermatological examination, multiple, erythematous scaly plaques were seen over the trunk and extremities, predominantly over the back. Bilateral cervical lymph nodes were enlarged but not tender. Scalp, nails, oral mucosa and genitalia were devoid of any lesions.

Clinically, a diagnosis of mycosis fungoides was made based on the clinical features as well as the refractory nature of the lesions, but histopathology revealed a picture of hyperkeratosis, parakeratosis, hypogranulosis, regular elongation of Rete ridges, dilated papillary capillaries surrounded by lymphocytes, all classical features of psoriasis.

Moreover, intramuscular injection of 40mg triamcinolone was administered and the patient showed marked improvement of the lesions within one week, which corroborates the histopathological diagnosis of psoriasis while mycosis fungoides will not show any such improvement.

Discussion:

Psoriasis vulgaris is a chronic inflammatory disease with increased proliferation and decreased differentiation of the skin usually associated with systemic co-morbidities. It presents as silvery white scales on an erythematous base commonly over the extensor aspects of the body.

Mycosis fungoides, commonest of the primary cutaneous T-cell lymphomas[4] mimics a number of dermatological conditions and the commonest presentations vary from erythematous patches to infiltrative scaly plaques[5]. Mycosis fungoides usually presents in 3 stages: patch, plaque, tumour and rarely a tumour d'emblee stage.

Histopathologically, psoriasis exhibits hyperkeratosis, parakeratosis, hypogranulosis, regular elongation of Rete ridges, dilated papillary capillaries with lymphocytic infiltrate, spongiform pustule of Kogoj and Munro's microabscess while mycosis fungoides has an entirely different histopathological picture. Mycosis fungoides will show atypical lymphocytes with cerebriform nucleus and the density depends on the stage. Epidermotropism is the movement of inflammatory cells into the epidermis without spongiosis and this is classically seen in mycosis fungoides. These atypical lymphocytes will form nests in the epidermis and these are known as Pautrier's microabscess.

While psoriasis responds to various modalities of treatment like narrow band ultraviolet B light, topical steroids, oral methotrexate, cyclosporine , acitretin, small molecules, biologics to name a few, mycosis fungoides will remain refractory to the same treatment and requires chemotherapy.

Despite the lack of proper guidelines for the administration of steroids in psoriasis, its use has been found to be beneficial in bringing down inflammation and to tide over the metabolic crisis[3]. To avoid the side effects of long term oral steroids, intramuscular injection of 40 mg triamcinolone once every 3 weeks is used as an adjuvant and this has been found to give favourable results[3].

Conclusion

A diagnosis of mycosis fungoides should be kept in mind, when a patient presents with refractory skin condition especially psoriasis. While many authors disapprove the usage of steroids in psoriasis due to its various side effects, intramuscular steroid injections pose less of a risk and are found to be advantageous, as seen in this patient.

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Conflict of interest: The authors declare that they have no conflict of interest.

LEGENDS TO FIGURES

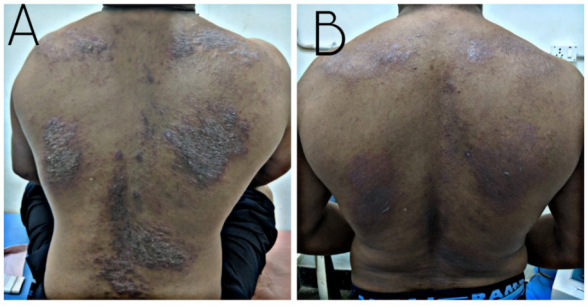

Figure 1:
Picture A shows psoriatic plaques on the back prior to injection of 40mg intramuscular triamcinolone

Picture B shows the same patient 1 week after the administration

of intramuscular triamcinolone, exhibiting consideration reduction of erythema and improvement of lesions

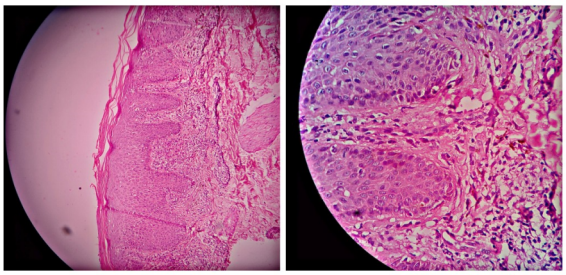

Figure 2: Histopathology showing parakeratosis, hyperkeratosis, hypogranulosis, regular elongation of Rete ridges and dilated papillary capillaries with lymphocytic infiltration.

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