ABSTRACT

Clinical case: Our patient was a 37-year-old male with palpebral mycosis fungoides, the most common T-cell cutaneous lymphoma. He had been treated previously with topical corticosteroids. We treated him with Imiquimod cream (5%) three times a week.

Discussion: A clinical improvement was obtained with this drug, so we believe immuno-modulating agents need to be considered in the treatment of palpebral mycosis fungoides, especially because of its capacity of being a reflection of leukaemia (Arch Soc Esp Oftalmol 2006; 81: 221-224).

Key words: Mycosis fungoides, Imiquimod, T-cell lymphomas.

RESUMEN

Caso clínico: Presentamos el caso de un varón de 37 años de edad que presentaba una micosis fungoide, el más frecuente de los linfomas T cutáneos, con localización exclusivamente palpebral que había sido tratado previamente con corticoides tópicos. Se instauró un tratamiento con Imiquimod al 5% en crema tres veces semanales.

Discusión: Con el uso de este medicamento, se consiguió una gran mejoría clínica del paciente, por lo que consideramos muy importante tener en cuenta este inmunomodulador para el tratamiento de esta enfermedad, de importancia por su capacidad de leucemización.

Palabras clave: Micosis fungoide, Imiqimod, Linfoma T cutáneo.
INTRODUCTION

T-cell cutaneous lymphomas are the most frequent skin proliferative lymphatic processes (1). They are malign conditions without extra-cutaneous extension in diagnosis and exhibit clonal proliferation of T-cells. The most frequent is mycosis fungoides, with a prevalence of 0.5-1 /100,000 inhabitants (1).

Fungoid mycosis is characterized by the successive appearance of eritematous maculae, raised plates and tumoration. When it leukemizes, it is called Sezary syndrome. There are several types such as follicular fungoid mycosis in head and neck with follicular acne-shaped lesions, hair loss and pruritus (2); or pagetoid reticulosis in the limbs. Exclusively palpebral localization is exceptional.

This communication presents a case of palpebral mycosis fungoides which responded to treatment with Imiquimod.

CLINICAL CASE

A 37-year old male without history who went to the practice with a lesion in the medial edge of the upper left eyelid, without pruritus, which had evolved for four months. It had been treated with topical corticoids. The exploration revealed an eritematous shiny plate with millium cysts measuring 1.7 cm diameter (fig. 1). No other alterations were present.

The differential diagnosis was between eczema, mycosis fungoides or millium on plate (3). A skin biopsy was made, which revealed the existence of inflammatory infiltrate in the papillary skin, made up of small and medium-size lymphocytes mixed with histiocitary and eosinophile cells. Sometimes the inflammatory infiltrate made contact with the basal skin layer (which did not show signs of alterations with the exception of isolated areas of vacuolization and lymphocitary exocytosis) (fig. 2).

Imunoperoxidase techniques revealed that the proliferating lymphocyte cells were predominantly atypical T-type (UCHL-1 and CD-3 positive), thus confirming the diagnostic of skin lymphoma T of the mycosis fungoides type.

The supplementary tests (biochemical, hemogram, urine sediment and extension study) gave normal results. Treatment was established with Deflazacort 30 mg in descending pattern for one...
month. In the next visit, the erithematous plate had increased to reach a diameter of 2 cm and more millium cysts had appeared, as well as a new lesion in the upper right eyelid. The oral corticoid was suspended and treatment was established with 5% Imiquimod cream, at a rate of 3 applications per week. Diclofenaco eye drops were given to avoid the conjunctivitis which the Imiquimod could produce.

Two months after treatment began, the inflamed palpebral area exhibited improvements, together with a reduction in the number of millium cysts. At three months of treatment, only 3 cysts were found without palpebral inflammatory reaction. At five months the cutaneous residual lesions were removed. The anatomic and pathological report referred to a lymphocyte inflammatory infiltrate around some hair follicles with millium-shaped cysts. The epithelium exhibited exocytosis with small groups of lymphocytes, without evidence of Poirtier micro-abscesses. Through immunoperoxidase techniques it was seen that the infiltrate was positive with T-markers (UCHL-1 and CD3). Accordingly, the diagnostic was follicular mycosis fungoides.

**DISCUSSION**

*Mycosis fungoides* is considered to be an indolent lymphoma originating from recirculating CD4+ lymphocytes with intense cutaneous affinity, particularly with the epidermis. It predominates in adults. Clinical signs begin with the appearance of inflammatory, erithematous macular lesions with pruritus, difficult to distinguish from eczema. In this case, the diagnostic was complicated due to the exclusively palpebral manifestation.

In the initial phases, the Mycosis fungoides diagnostic is based on a good clinical-pathological correlation. Immune histochemistry and the presence of monoclonality in the genetic order represented highly useful tests (4).

There is no definitive healing treatment; instead, there is a variety of therapeutic approaches to choose from with the aim of selecting the most adequate for each patient according to the type and place of the lesions, their extension and stage of the lymphoma (4). In our case, the place of the lesion hinders its treatment because it is not possible to sustain the use of topical corticoids, topical chemotherapy or phototherapy. The use of systemic treatment is reserved for more advanced phases. Local radiotherapy can also be utilized (4).

Suchin et al published a successful treatment with Imiquimod 0.5% cream on two patients with plate mycosis fungoides (5). Imiquimod (Aldara®, 3M España S. A., Madrid,Spain) is an immunomodulator which stimulates TH1 cytokines, including alpha and gamma interferon and interleukin 12. It also increases the activity of NK cells and the expression of the Tumoral a Nerosis Factor (5). In our patient, Imiquimod reduced the lesions and eliminated the inflammation, although some millium cysts persisted from the clinical viewpoint, and a perifollicular inflammatory infiltrate from the histological viewpoint.

To conclude, this communication presents a case of exclusively palpebral follicular mycosis fungoides which responded positively to treatment with Imiquimod. Considering the clinical importance and the possibility of these diseases developing leukemia we must emphasize the importance of following up chronic palpebral lesions and including mycosis fungoides in the differential diagnostics. In this way, an adequate clinical-pathological correlation can be established to differentiate this pathology from other more frequent and less severe pathologies found in this area such as eczema.

**REFERENCES**