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We report a case of cutaneous T-cell lymphoma (mycosis fungoides) with palmar lesions only, resolved after treatment with methotrexate.

CASE REPORT
A 73-year-old patient was seen in 1995 for scaly hyperkeratotic plaques that had appeared 3 years previously on the palms, with lesions of dry pulpitis on 2 fingers (Fig 1). The plaques were well-defined and had a main diameter of 2–5 cm. Topical treatments (high-potency corticosteroids, emollients, keratolytic agents) made no significant improvement. Pruritus was moderate to severe. No other skin lesion was seen; the soles were not affected. The patient was not atopic and had never suffered from contact dermatitis; he took spironolactone for arterial hypertension and gliclazide for non-insulin-dependent diabetes. There was no personal or familial history of psoriasis or palmoplantar keratoderma. There was evidence of an old nicotinic intoxication (one pack a day for 42 years) that disappeared in 1981 when the patient stopped smoking.

The biopsy showed a hyperkeratotic epidermis, with acanthosis and hypertrophy of interpapillary ridges. A lymphoid proliferation was observed in the superficial dermis, with exocytosis and beginning epidermotropism. Most of the lymphocytes had an irregular and cerebriform nucleus suggestive of Sézary cells. The bigger lymphoid cells had nuclei with nucleoli and showed an immunoblastic form. No Pautrier’s pseudo-abscess was visible. Immunolabelling evidenced a proliferation of CD3(+) and CD4(+) T lymphocytes. The diagnosis of palmar mycosis fungoides was established.

The patient was lost to follow-up. A second biopsy, performed 2 years later, produced the same images, with a larger number of large-sized cells. General examination was reassuring. The treatment included a betamethasone dipropionate ointment and a topical PUVA therapy. Since this protocol was too difficult for the patient, it was replaced by topical mechloretamine. Again, the patient stopped this treatment after a few applications. New thorough investigations were carried out in 2000. The clinical aspect was identical to that of previous visits. The biopsy was similar to the first two biopsies, with a more perivascular lymphoid infiltrate (Figs 2 and 3). The majority (80%) of cells expressed CD3, CD2, CD5 and CD7 markers, and included small, medium and large cells, some of which showed a cerebriform nucleus. Some cells were also observed in the epidermis, but always isolated. Only a small percentage of cells were of the CD8(+) and T-cell intracellular antigen-1 (TiA-1)(+) types. The lymphoid infiltrate was accompanied by a Langerhans’ cell hyperplasia and a macrophage hyperplasia. Haematopoietic marrow was normal (conventional histology and immunohistochemistry). General condition was good, without lymph nodes. The patient requested treatment, this time stating that he was determined to follow it. Oral methotrexate (7.5 mg once a week) gave complete

Fig. 2. Infiltrate of small lymphocytes with exocytosis (Haematoxylin-Eosin stain ×10).
With regard to treatment, the literature has reported successes with topical or intralesional corticosteroids, mechlorethamine, PUVA therapy, electron therapy, radiotherapy, laser CO₂, surgery of circumscribed lesions (14, 17). Salicylate ointments are sometimes added to the treatment.

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