Abstract
Mycosis fungoides (MF) is the commonest form of cutaneous T-cell lymphoma. Many clinical subtypes and variants of MF have been described, one of which is poikilodermatous MF variant. Erosions and bullous lesions in a patient with poikilodermatous MF is a rare presentation. We present one such rare case of poikilodermatous MF with erosive lesions in a 40-year-old male.

Key Words: Erosive lesions, poikilodermatous mycosis fungoides, rare presentations

Introduction
Mycosis fungoides (MF) is the commonest form of cutaneous T-cell lymphoma (CTCL). The subtypes as mentioned by the European Organization for Research and Treatment of Cancer classification include pagetoid reticulosis, granulomatous slack skin syndrome, and folliculotropic MF. Other variants described in literature include follicular, vesicular, poikilodermatous, hypopigmented, hyperpigmented, and pigmented purpura-like lesions. Poikilodermatous MF, a rare form of CTCL, is characterized, clinically, by localized or diffuse patches consisting of telangiectasias, mottled hyper- and hypo-pigmentation, and atrophy. Presenting predominantly in males, poikilodermatous MF has a good prognosis. Erosive and bullous lesions in a patient with poikilodermatous MF is a rare presentation, with only one case reported previously. Such a rare case of poikilodermatous MF with associated erosive lesions is presented here.

Case Report
A 40-year-old male patient presented with pruritic, erythematous-to-violaceous scaly plaques all over the body. The initial lesions started 10 years back, over the abdomen gradually involving the trunk and extremities. Within these areas, erosions with hemorrhagic crusting were observed over the back, chest, abdomen, and shoulders. Diffuse, nonscarring alopecia was noted on 9 months, which progressed to erosions on the trunk showing a little tendency to heal.

There was a history of photosensitivity and oral raw areas. Although the patient also had a history of generalized weakness with intermittent low-grade fever and arthralgia involving bilateral knee joints, ankles, and elbows, there was no associated muscle weakness. The patient also denied any systemic or topical medication prior to the onset of skin lesions. Previously, the patient had been treated as a case of psoriasis vulgaris, with methotrexate for 4 years, and acitretin intermittently with partial resolution of lesions followed by reappearance.

General physical examination as well as systemic examination was unremarkable. There was violaceous reticulate pigmentation with atrophy and telangiectasia over both cheeks. Generalized, erythematous, thin plaques with fine scales involving >80% of the body surface area were observed on the upper and lower extremities, trunk, and flexural surfaces. Within these areas, erosions with hemorrhagic crusting were observed over the back, chest, abdomen, and shoulders. Diffuse, nonscarring alopecia was noted on
the scalp, bilateral eyebrows, and moustache. Oral cavity, genitalia, and nails were normal.

Based on history and clinical examination, a differential diagnosis of lupus erythematosus-lichen planus overlap, lichen planus pemphigoides, and poikilodermatous MF was kept. Complete blood count; lactate dehydrogenase level; creatine phosphokinase-MB level; and liver, renal, and thyroid function tests were normal. Peripheral blood smear for Sézary cells was negative as was the antinuclear antibody.

An initial skin biopsy showed an intraepidermal bullous lesion with large epidermal cells [Figure 5]. This corroborated with the history of bullous lesions though no bullous lesions were seen at the time of examination. The large cells stained positively for CD3 and CD30 but were negative for CD20. The skin biopsy was reported to marginally favor an MF with large cell transformation. A correlation with clinical features and a second biopsy from a nonbullous lesion were advised by the pathologist.

The second biopsy showed epidermotropism with spongiosis of the overlying epidermis, along with a dense dermal infiltrate of admixed population of lymphoid cells composed of intermediate-to-large mononuclear cells and scattered melanophages [Figure 6]. On immunohistochemistry, the atypical lymphoid cells were positive for CD3 and CD7 [Figures 7 and 8]; occasional cells showed positivity for CD30, while negativity for CD20, ALK-1, and CD8. This was reported to be consistent with cutaneous T-cell lymphoproliferative disorder with a possibility of MF. Multiplex polymerase chain reaction was performed, but results were uninterpretable for TCR and IgH gene rearrangement.

Computed tomography scans of the chest and ultrasonography of the abdomen and pelvis were within normal limits. Computed tomography of the abdomen showed a subcentimeter-sized calcified granuloma in segment VII of the right lobe of the liver.

Considering the clinical, laboratory, histopathological, and immunohistochemical findings, connective-tissue...
disorders were ruled out and the patient was diagnosed with poikilodermatous MF, tumor, node, and metastasis Stage IIIA (T4N0M0). The patient was transferred to the oncology department for further management.

Discussion

MF is the most common type of CTCL. Classic MF presents with erythematous, atrophic, and wrinkled fine scaling patches on nonsun-exposed skin. Further progression results in plaques, nodules, and tumors. Poikilodermatous MF, a rare clinical variant of patch stage of MF, was previously termed as poikiloderma vasculare atrophicans or parapsoriasis variegata. Initially, it was believed to be a separate clinical entity or a premalignant condition. Poikiloderma may be localized or diffuse and often is noted on the breasts, hips, buttocks, and flexural areas. It may coexist with patches of classic MF in some patients. Poikilodermatous MF is predominantly seen in males, with a younger age at presentation, as seen in our patient. A longer duration of clinical symptoms before diagnosis has been reported in poikilodermatous MF (median 10 years) as opposed to classical MF (average of 6–7 years), which has also been encountered in our patient.

Poikilodermatous MF is characterized clinically by localized or diffuse patches consisting of telangiectasias, mottled hyper- and hypo-pigmentation, and atrophy. Erosions, as seen in our patient, are not known to be a feature of poikilodermatous MF. Erosions and ulcerations in MF are known to occur post bulla formation due to excessive epidermotropism or due to methotrexate use in MF.

The differential diagnosis of poikilodermatous MF includes other conditions, in which poikiloderma is prominent. These include large plaque parapsoriasis; connective-tissue diseases, such as lupus erythematosus and dermatomyositis; poikiloderma of Civatte; overuse of topical glucocorticoids; radiation dermatitis; graft-versus-host disease; and genodermatoses, such as Rothmund–Thomson syndrome.
Poikilodermatous MF is one of the rare clinical variants of MF. Rarer still is the association of erosions with poikilodermatous MF. As with other MF, the histopathological and clinical features of the early stages of MF are often subtle or mimic other dermatoses. Thus, multiple biopsies and immunohistochemistry may be essential for obtaining an accurate diagnosis. A high index of suspicion and clinicopathological correlation is essential to make a precise diagnosis of MF.

**Declaration of patient consent**
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**
There are no conflicts of interest.

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