IJMS
Vol 34, No 2, June 2009

Letter to the Editor

Demographic and Clinical Features of Mycosis Fungoides in Tabriz, Iran

Dear Editor,

Mycosis fungoides is the most common type of cutaneous T cell lymphoma with a reported incidence of 0.5 cases per 100,000 people per year.[1] The cause of mycosis fungoides is still unknown; however genetic and environmental factors have been implicated as possible pathologic factors.[2] The disease might also be associated with human T cell lymphotropic virus type 1,[3] which is endemic in Iran, Kuwait, and possibly Iraq.[4] Mycosis fungoides is usually observed in mid-to late adulthood. Only 0.5% to 5% of patients with mycosis fungoides are in childhood and adolescence period.[5]

The most common skin lesions of mycosis fungoides are pruritic, erythematous, and scaly patches and plaques. Standard staging defines stage IA disease as patches and plaques involving less than 10% of the body surface. Extension of the lesions, presence of lymphadenopathy and/or tumors and erythroderma denote higher stages.[6,7]

Several skin-directed and systemic therapies have been suggested for the treatment of mycosis fungoides. They include photochemotherapy, laser therapy, systemic retinoids (Bexarotene), and topical nitrogen mustard.[8]

The prognosis of patients treated for stage IA of mycosis fungoides is good because 90% of such patients never progress and their survival is similar to age-matched controls.[9] Therefore, early diagnosis of the disease might greatly prevent the morbidity and mortality.

During a 6-year period from 1997 to 2003, a total of 43 patients with mycosis fungoides in whom the diagnosis of the disease was confirmed by histopathologic examination were included in the present study. Clinical characteristics of hospital inpatients were documented from the medical records and sheets of biopsy samples. Data analysis was performed using SPSS software (Version 13). Twenty-four (55.8%) patients were men and 19 (44.2%) were women. Similar to other studies, there was a slight male predominance.[10] Median age of the patients was 50.5 years (range 15 to 77). Only one patient was adolescent. Most of the patients (60.46%) were in patch stage at the time of diagnosis (26 in patch, 13 in plaque, three in erythrodermic, and one in tumoral stages). The most common anatomic sites of involvement were trunk and extremities with involvement of both in 65.3% that are similar to other studies.[10]

Mean interval time since the first cutaneous involvement to the diagnosis was 2.8±0.82 years (2 weeks- 20 years). Of the patients, 39 (63.2%) were from Tabriz. This finding corresponds with other reports that the incidence is correlated with high physician density in urban regions.[10] The clinical characteristics of our patients were similar to other reports. Since the lesions of mycosis fungoides are similar to psoriasis, dermatophytic infections, and other inflammatory dermatoses, if a patient has recalcitrant cutaneous inflammatory dermatosis particularly on the trunk and extremities including palms and soles, mycosis fungoides should be suspected and histopathologic studies should be performed for early diagnosis.[7]

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Received: 6 November 2008
Revised: 24 January 2009
Accepted: 12 March 2009

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