cm x 10 cm in size, ulcerated in the center and covered with greenish slough were seen over the medial aspect of both arms [Figure 1], and left forearm, left thenar eminence, and medial aspect of the left flank. The edges of the ulcers were raised and overhanging. The surrounding skin was violaceous and indurated. Two unulcerated nodules were also seen over the back. There was no significant regional lymphadenopathy. Systemic examination was unremarkable and no organomegaly was noted.

Histological examination of the skin lesion on the left arm showed a dense infiltrate of mononuclear cells throughout the dermis and subcutis with prominent epidermotropism, with lymphocytes lying singly as well as in groups. Large cell transformation was seen. Immunohistochemistry revealed the tumor cells to be CD3 and leukocyte common antigen positive while being negative for CD30 and CD20. Haemogram, routine blood biochemistry, ultrasound of the abdomen and computerized tomography scan, chest X-ray and urine analysis were normal. Peripheral blood smear, bone marrow aspiration cytology and biopsy examination were negative for atypical cells. Retroviral serology was negative. Pus swab culture and skin biopsy specimen sent for culture from the ulcer grew *Pseudomonas aeruginosa* sensitive only to amikacin.

Based on the clinical and histopathological findings, a diagnosis of tumor d’emblée type of MF (Stage IIb) was made. The patient was treated with a course of antibiotics and daily wet dressing. Subsequently, he was started on single-agent chemotherapy with methotrexate (0.25 mg/kg) weekly along with prednisolone (1 mg/kg) daily. The skin lesions improved slowly and steadily, and after 1 month of treatment, the patient showed regression of more than 70% of the lesions [Figure 2]. On follow-up after 4 months, only two ulcers remained, which were also healing well without any evidence of dissemination.

Primary cutaneous lymphomas represent the second most common extranodal site for non-Hodgkin’s lymphoma. CTCL is a heterogeneous group with diverse clinical manifestations, which represents about 80% of all primary cutaneous lymphomas. The most common CTCL is MF. However, other lymphoproliferative diseases also involve the skin, including Ki-1+ anaplastic large cell lymphoma, peripheral T-cell lymphoma, cutaneous B-cell lymphoma, adult T-cell leukemia/lymphoma, T-cell lymphoma.

**Tumor d’emblée responding to methotrexate and prednisolone**

Sir,

In 1885, Vidal and Brocq[1] described a rare and unusual variant of mycosis fungoides (MF) called the tumor d’emblée (sudden) type.[1,2] In this type of MF, the tumors develop suddenly without the usual progression from eczematous to plaque and then tumor stage. Tumors are the initial presentation in approximately 10% of the patients.[1] We herewith report an 83-year-old man presenting with nodular and ulcerative cutaneous T-cell lymphoma (CTCL) with a relatively benign course responding to methotrexate and prednisolone.

An 83-year-old man presented with multiple ulcerated lesions on his arms, chest, back and legs of 1 year duration. He noticed multiple nodules that progressively increased in size and ulcerated spontaneously in the center. There was no history suggestive of any preceding skin change or dermatitis. He was initially treated in another hospital as pyoderma gangrenosum with prednisolone (1 mg/kg) to which he had a partial response, but lesions recurred and continued to increase in size and ulcere. His past medical history was unremarkable. He was a chronic smoker. There was no history of anorexia, weight loss, fever or night sweats.

On cutaneous examination, multiple, irregular, hard, mobile, noduloulcerative lesions, largest measuring 13
chronic lymphoid leukemia and cutaneous Hodgkin’s disease.[1,3]

Tumors in MF are usually seen as disease progresses and occur at sites of previous plaque-stage involvement. This progression probably reflects local proliferation and evolution of more aggressive clones. When tumors appear de novo, without preceding plaque or patch disease, they are called tumor d’emblee.[4] It is associated with faster progression and worse prognosis. This was the mode of presentation of our case. Nodular MF that has undergone large cell transformation needs to be closely distinguished from large cell CD30-negative cutaneous lymphoma (peripheral T-cell lymphoma – unclassified). These tumors also appear suddenly as nodules without pre-existing plaques or patches of MF. On histology, prominent nodular or diffuse infiltrates of medium to large pleomorphic T-cells and immunoblasts are seen but epidermotropism is usually absent. Presence of large CD30-negative pleomorphic T-cells in our case was due to large cell transformation (defined as more than 25–50% of large cells [CD30 positive or negative] within the dermal infiltrate or the development of microscopic dermal nodules of pleomorphic, anaplastic large cells). Transformation has been reported in the range of 8–55% of tumor type of CTCL.[5] Prominent epidermotropism rules out the presence of large cell CD30-negative cutaneous lymphoma (peripheral T-cell lymphoma – unclassified) in our case.

Primary cutaneous (anaplastic) CD30+ large cell lymphomas clinically present with ulcerated nodules mostly on the trunk and can resemble nodular MF but, on histology, no epidermotropism is seen and there is a dense infiltrate of large atypical anaplastic T-cells with CD30+ and frequent mitoses. However, in our case, the cells were CD30 negative and there was no evidence of any systemic involvement thus differentiating this tumor from the anaplastic large T-cell lymphoma. This difference is important to make as the prognosis for a primary cutaneous CD30+ T-cell lymphoma is good as against the large cell transformation of MF.[5]

The term “tumor d’emblee” is now falling into disrepute and these tumors may, in fact, be pleomorphic (small to medium) CD30-negative cutaneous T-cell lymphoma (peripheral T-cell lymphoma), which have undergone large cell transformation.[5]

Systemic chemotherapy based on methotrexate with prednisolone was offered to the patient keeping in mind the indolent nature of the disease and the age of the patient, resulting in 70% resolution of lesions. Single-agent chemotherapy with an alkylating agent or methotrexate produces a complete remission rate of 32% and objective remission rate of 63%, with a median duration of remission of 3–22 months.[1] Combination chemotherapy is associated with greater remission rates of up to 80%, but is associated with greater toxicity.[3]

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Initially, the eruptions started as papules, which evolved into pustules and then crusted lesions. There was no history of fever, arthralgia or abdominal pain. The patient had not taken any medications for any other illness for at least 3 months before the onset of these skin eruptions. He had not suffered from any major medical or surgical illness in the past. There was no history of similar episode in the past. However, he gave history of multiple heterosexual, unprotected exposures with commercial sex workers in the past, which were not followed by urethral discharge or genital sores.

The emaciated individual had inguinal and axillary lymph adenopathy (discrete, mobile, firm and non-tender nodes). Systemic examination was unremarkable. Cutaneous examination revealed multiple crusted lesions covered with dirty-looking, adherent and heaped-up crusts distributed mainly on the face and limbs [Figures 1 and 2]. Multiple non-tender ulcers were seen on the palate, while small scattered similar lesions were noted on the trunk and genitalia.

**Figure 1:** Rupioid lesions over the face

**Figure 2:** Rupioid lesions over the leg

**Rupioid syphilis in a HIV patient**

Sir,

Syphilis, "The Great Imitator" is among the most fascinating skin diseases. Syphilis, in the presence of human immunodeficiency virus (HIV) infection, has varied clinical manifestations, often presenting in secondary stage.[1] Hyperkeratotic, crusted limpet-like and discolored lesions called "rupia" are uncommon and are usually seen in relapsing secondary syphilis. In pustular syphilis, as a result of endarteritis obliterans and diminution of blood supply, the papules and pustules undergo central necrosis, which extend deep and they present with a central core of necrotic tissue giving rise to "limpet-like" crusts resembling an "oyster shell," which may be discolored with altered blood. Face is the common site. Progression is rapid and may be associated with toxicity, fever, arthralgia and occasionally hepatitis. This rapidly evolving course of secondary syphilis is called as Lues Maligna. [2] With the spread of the HIV epidemic, atypical mucocutaneous manifestations of secondary syphilis may be seen more frequently than before and may pose problems in the diagnosis.[3] Here, we report a case of rupioid syphilis.

A 48-year-old married man, HIV positive since 4 years, not on antiretroviral treatment (ART), presented with multiple asymptomatic crusted lesions over the face, extremities, genitalia and trunk of 3 months duration.

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