How does Mr Mills' case align with typical descriptions of mycosis fungoides (MF)?

1. Patient characteristics?
Few epidemiologic studies have been conducted. But, identified risk factors include male gender and advanced age.[1]

2. Lesion characteristics?
- Typically, numerous and of longstanding duration (months to years)[2]
- Usually located in sun-protected sites (e.g. the trunk, buttocks, or thighs)[3–5]
- Form: patches, plaques, tumours and erythroderma are all described for MF disease[3,4]

3. Response to steroids?
Trials of topical corticosteroids may have seen some degree of response, or have even cleared very early lesions, but more typical is that the lesions either incompletely clear or recur as soon as treatment is withdrawn or continue to develop in untreated areas.[6]

4. Lymph node involvement?
An important presenting site of extracutaneous disease in MF and Sézary Syndrome (SS) is the peripheral lymph node.[7]

5. Blood involvement?
Even though MF presents most overtly in skin, the disease may not be limited there. Even less advanced MF has been found to include blood[8] and lymph node[9] involvement and total blood tumour burden may be relevant for prognosis and treatment in MF.[10,11] For example, around one-in-five patients with early-stage MF have blood involvement.[12]

6. Advanced stage disease?
Advanced stage disease includes both advanced MF and Sézary Syndrome (SS);[13] these clinical entities being malignancies of different T-cell subsets.[14] SS is a rare, aggressive and leukaemic CTCL variant accounting for around 5% of all CTCLs.[15] The median overall survival for SS is 63 months and 5-year survival can be as low as 28%.[16] SS is traditionally defined by the triad of pruritic erythroderma, generalised lymphadenopathy, and significant blood tumour burden.[11,17] Patients presenting with SS are typically 55-60 years old and, as mentioned previously, exhibit erythroderma (>80% BSA [Body Surface Area] affected), lymphadenopathy, and blood involvement with clonally-related neoplastic T cells.[17]

If you would like more information about CTCL please contact your local Kyowa Kirin representative or visit **www.international.kyowa-kirin.com**

References
1. Aschebrook-Kilfoy B et al. *J Natl Cancer Inst Monogr* 2014;45:98–105.
2. Hwang ST et al. *Lancet* 2008; 371:945–57.
3. Kelati A et al. *Int J Women Dermatol* 2017;3:100–106.
4. Harvey NT et al. *J Hematopathol* 2015;8:209–23.
5. Hughes CF et al. *Aust J Dermatol* 2016;57:182–191.
6. Pimpinelli N et al. *J Am Acad Dermatol* 2005;53(6):1053–1063.
7. Pai RK et al. *Cancer* 2008;25:114(5):323–32.
8. Ferenczi K et al. *J Invest Dermatol* 2002;119:1405–1410.
9. Fraser-Andrews EA et al. *Br J Derm* 2006;155:756–762.
10. Agar NS et al. *J Clin Oncol* 2010;28:4730–4739.
11. Scarisbrick J. *EMJ Hematol* 2018;6(1):92–100.
12. Scarisbrick J et al. *Br J Dermatol* 2019;181:350–357.
13. Olsen EA et al. *J Clin Oncol* 2011;29:2598–2607.
14. Campbell JJ et al. *Blood* 2010;116(5):767–771.
15. Trautinger F et al. *Eur J Cancer* 2017;77:57–74.
16. Pulitzer M. *Clin Lab Med* 2017;37(3):527–546.
17. Willemze R et al. *Blood* 2019;133(16):1703–1713.

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