INTRODUCTION
Cutaneous T-Cell Lymphoma (CTCL) is a group of lymphoproliferative disorders characterized by malignant proliferation of T-lymphocytes that primarily involve the skin. WHO and EORTC (European Organization for Research and Treatment of Cancer) have classified the CTCL into two categories, Indolent (low-grade/ slow growing) clinical behaviour and aggressive clinical behaviour.

OBJECTIVES
To determine the demography, clinical presentation, histopathology findings, response of treatment among patients with CTCL at the Department Of Dermatology, Hospital Raja Permaisuri Bainun, Ipoh.

RESULTS
This is a 5-year retrospective review from June 2010 to June 2015 for total of 24 patients with biopsy proven CTCL at the Department Of Dermatology, Hospital Raja Permaisuri Bainun, Ipoh. Clinical data were extracted including patient age, sex, gender, date of first diagnosis, duration of presentation before diagnosis, disease subtype and presentation, status of disease at last follow up and treatment options.

A total of 24 patients with CTCL were recruited in this study that consist of 17 males (71%) and 7 females (29%). There were 9 males (37.5%), 11 Chinese (45.8%) and 4 Indians (16.7%). The median age was 51 years old and the median duration of presentation before diagnosis was 2 years (range 1-3 years). There were 3 subtypes of CTCL being detected which were mycosis fungoides (MF), hydroa vacciniforme like CTCL (HV like CTCL) and peripheral T-cell lymphoma. MF is the commonest type of CTCL which accounted for 21 cases (87.5%) with 2 cases developing into EBER positive cases (8.3%) from HV like CTCL and CD30 positive may cause by up regulation of the expression of CD30 in neoplastic lymphocytes by Ebstein Barr virus. TCRGR ( T cell receptor gene rearrangement ) using Southern blot or PCR methods are another tool to diagnose CD30 positive cases.

The goal of treatment is to bring long term remission without compromising patient's quality of life as no curative therapy is available. Skin directed therapies such as corticosteroids, nitrogen mustard, carmustine, topical retinoids as well as ultraviolet therapy and body irradiation are the standard mainstay of therapy with CTCL.

DISCUSSION
CTCL is a rare indolent malignant proliferation of T-lymphocytes which occurs worldwide and is of clinical and pathologic relevance, the commonest subtype of CTCL and it is also shown in our study which accounted for 21 cases (87.5%) . MF usually arises in late adulthood and more commonly seen in male patient[1]. Our study also showed a male predominance (71%) with median age of 51 years old at the time of presentation. Majority of our patients were Chinese (45.8%). These findings were also consistent with another study in Hospital Sultanah Aminah, Johor Bharu by Tey et al which showed predominance of male patients (56%) and Chinese patients (44.5%) with MF being the predominant histologic subtype[2]. The patients were usually male with a median age of 50 years old [2]. However, Regina et al showed that female patients were predominant among pediatric age group (52%) [3].

The disease activity of MF is usually indolent with slow growing over years in which, most patients present with clinically asymptomatic, minimal, or mild involvement and are free of symptoms. However, multiple lesions were seen in some patients[4]. Our study, the median duration of presentation before diagnosis was 2 years compared to 3.5 years reported by Tey et al[2]. Early stage of MF may represent with clinicopathologic features mimic of eczema, psoriasiform eruptions, pustular lesions, generalized parakeratosis in many cases, lichenoid clinical appearance in others. Patients with MF usually present with lesions on the scalp, trunk, and extremities. The skin biopsy for histology and immunohistochemistry is mandatory for diagnosis and staging work-up[5]. CTCL may resemble other chronic inflammatory dermatoses with wide range of histologic spectrum[4,6]. The diagnosis of MF can be confirmed by the presence of atypical microabscesses with spongiosis, atypical hyperconvoluted lymphocytes and Pautrier's microabscesses. The lesions may have epidermotropism and Pautrier's microabscesses were seen in 33% and 42% of patients respectively.

Immunohistochemistry shows infiltrates composed of T cells with positivity of CD2, CD3, CD4 and CD8 with loss of CD5. EBER was found in approximately 75% of patients. The clinical presentation of MF varies from patch to plaque to plaque with microabscesses which may be present or not. The diagnosis of MF may be confirmed by up regulation of the expression of CD30 in neoplastic lymphocytes by Ebstein Barr virus. TCRGR ( T cell receptor gene rearrangement ) using Southern blot or PCR methods are another tool to diagnose CD30 and TCRGR positive cases.

The goal of treatment is to bring long term remission without compromising patient's quality of life as no curative therapy is available. Skin directed therapies such as corticosteroids, nitrogen mustard, carmustine, topical retinoids as well as ultraviolet therapy and body irradiation are the standard mainstay of therapy with CTCL. Chemotherapy, phototherapy, oral retinoids (bexarotene) and photodynamic therapy are the treatment options for early stage of CTCL. Systemic therapy are reserved for more severe disease.

CONCLUSION
MF is the commonest type of CTCL in our center while other spectrum of CTCL still remain a rarity. The diagnosis and therapy of CTCL remain challenging. Skin directed therapies with phototherapy, low dose interferon and low dose bexarotene are the treatment options for early stage of CTCL. Systemic therapy are reserved for more severe disease.

[1]Verrasse et al Update on Cutaneous Lymphomas, MelbournePathology April 2014 No 1033