How I manage CD4+ small/medium T cell lymphoproliferative disorder

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I. Definition of Disease
   • Clinical
     – Solitary erythematous papule or nodule
     – Lesions < 5 cm in diameter
     – Face, neck, upper trunk
   • Histopathology
     – Most of the cells small to medium-sized with less than 30% large cells
     – CD3+/CD4+
     – Rosettes of PD-1 positive

II. Principals behind management
   • Ensure correct diagnosis
   • Local therapies
     – Radiotherapy
       • Ideal for lesions with significant clinical residuum
       • Surgical excision not ideal
     – Excision
       • Ideal for lesions with significant clinical residuum
• Ideal for lesions in which excision is unlikely to cause significant deformity
• Aim for 2-3 millimeter margin

– **Clinical observation**
  • Ideal for lesions with small to no residuum
  • Consider for up to 2-3 months before additional treatment if minimal to no residual disease

– **Intralesional steroid injection**
  • Typically 10 mg/ml IL Kenalog
  • 0.5 -1 cc
  • Stronger strength in some settings
  • Ideal for tumors with small amount of residual disease
  • Consider either for definitive treatment or to shrink residuum prior to excision

### III. Need for staging

a. Controversial
  i. Staging recommended for all based on 2/23 with systemic disease. Both had multifocal lesions.
     1. Full body imaging (either CT or PET/CT)
     2. Bone marrow biopsy
     3. Peripheral blood flow cytometry

b. My approach
  i. Solitary lesion that fits classically, no staging needed
  ii. Unusual presentation, large size, multi-lesions, staging prudent

### IV. Treatment algorithm

a. Ensure correct diagnosis

b. Small amount of residual clinical disease
  i. Clinical monitoring
  ii. Intralesional steroid injection

c. Sizable amount of residual clinical disease
  i. Excision
  ii. Radiotherapy

d. No staging if all fits for diagnosis
e. Follow for many years