## 1 PATIENT INFORMATION

### 1 PATIENT DETAILS

NAME
Marcus T. Ellison

DOB
03/14/1968

AGE/SEX
58 / Male

MRN / PATIENT ID
MTE-7730514

DATE OF SERVICE
10/21/2026

PROVIDER
Priya Raman

CREDENTIALS
MD, FCAP (Dermatopathology)

VISIT TYPE
Dermatopathology Consultation — second-opinion slide review with new biopsy correlation

CARE SETTING
Dermatopathology Lab — presented at Cutaneous Lymphoma Conference

REFERRING DERMATOLOGIST / CLINICIAN
Angela Brooks, MD

PRIMARY CARE PROVIDER, IF APPLICABLE
Kevin Huang, DO

SPECIMEN ACCESSION NUMBER
DP26-18842 (A–C)

SPECIMEN DATE
10/14/2026

REPORT DATE
10/21/2026

INTERPRETER USED, IF APPLICABLE
Not applicable — slide review

## CC CHIEF COMPLAINT

### 2 PRIMARY DIAGNOSTIC QUESTION

Second-opinion review and clinicopathologic correlation: 6-year history of persistent, treatment-resistant patches on the buttocks and flanks, previously signed out twice as “spongiotic dermatitis.” Referring dermatologist asks: “Early mycosis fungoides versus chronic eczematous or drug-related dermatitis?”

## S SUBJECTIVE

### 3 CLINICAL HISTORY SUPPLIED

### 3a DIAGNOSTIC QUESTION & SPECIMEN

**Reason for Dermatopathology Review:**

Second opinion on two outside biopsies (2022, 2024) plus primary interpretation of three new punch biopsies taken off topical steroids, for malignancy classification (cutaneous T-cell lymphoma) and clinicopathologic correlation.

**Clinical Question:**

Patch-stage mycosis fungoides versus chronic spongiotic/nummular dermatitis, allergic contact dermatitis, or a lymphomatoid drug eruption (amlodipine started 2019).

**Lesion / Rash Clinical History:**

Six years of slowly enlarging, finely wrinkled, pink-brown patches with fine scale in a "bathing-trunk" distribution (buttocks, hips, flanks, inner thighs), 3–12 cm, about 12% BSA. Mildly itchy; no bleeding or ulceration. Partial fading in summer; never fully clears. Photos from 2020–2026 show slow spread.

**Specimen Site and Procedure Type:**

A: 4 mm punch, left buttock (oldest patch). B: 4 mm punch, right flank. C: 4 mm punch, left medial thigh. All taken after a 3-week washout from topical steroids.

### 3b BACKGROUND & PRIOR PATHOLOGY

**Prior Dermatologic History:**

Labeled "nummular eczema" since 2020. Two prior biopsies read as spongiotic dermatitis. No skin cancer, lymphoma, or blistering disease.

**Treatment History:**

Triamcinolone 0.1% and clobetasol 0.05% on and off for years — partial, temporary improvement. Prednisone taper ×2 (2023). No phototherapy, biologics, or dupilumab. Steroids stopped 3 weeks before the current biopsies.

**Medication and Exposure History:**

Amlodipine 10 mg (since 2019), losartan 50 mg, rosuvastatin 10 mg. No checkpoint inhibitors, antiepileptics, or immunosuppressants. Patch testing (2024) negative for relevant allergens. Retired postal carrier; no chemical exposure.

**Relevant Medical History:**

Hypertension, hyperlipidemia. HIV and HTLV-1 negative (2025). No autoimmune disease, hematologic malignancy, or radiation exposure. Not immunosuppressed.

**Family History:**

Mother — psoriasis. No family history of lymphoma or skin cancer.

**Clinical Images / Dermoscopy, if available:**

Serial clinical photos (2020, 2023, 2026) and a body map with marked biopsy sites reviewed. Dermoscopy: fine short linear vessels and orange-yellow patchy areas ("spermatozoa-like" vessels) noted by the referring dermatologist.

**Prior Pathology / Outside Slides:**

Outside SP22-04417 (L hip, 2022): "spongiotic dermatitis." Outside SP24-11903 (R buttock, 2024): "superficial perivascular dermatitis with mild spongiosis; cannot exclude early MF — correlate." Both sets of slides and blocks received and reviewed. No prior immunostains or TCR studies.

**Pertinent Negatives:**

No plaques, tumors, or ulceration. No erythroderma. No B symptoms. No palpable lymph nodes per referral. No immunosuppression. No mucosal involvement.

## ROS DERMATOPATHOLOGY REVIEW OF SYSTEMS

### 4 CLINICALLY RELEVANT INFORMATION

**Skin lesion change, bleeding, ulceration, pain, itching, or recurrence**
Positive — slow enlargement and mild itch; no bleeding or ulceration.

**Rash distribution, photosensitivity, mucosal involvement, blistering, or systemic symptoms**
Positive — sun-protected "bathing-trunk" distribution, improves with summer sun. No blistering or mucosal involvement.

**Fever, weight loss, night sweats, lymphadenopathy, fatigue, or constitutional symptoms**
Negative per referral.

**Joint pain, oral ulcers, Raynaud symptoms, sicca symptoms, muscle weakness, or autoimmune symptoms**
Negative.

**Hair loss, scalp symptoms, nail changes, or mucosal lesions**
Negative — no alopecia within patches; nails normal.

**Medication reaction symptoms, new drug exposure, infection exposure, or immunosuppression-related concerns**
Amlodipine since 2019 noted as possible trigger; no new drugs in 3 years. No immunosuppression.

**Treatment response or progression despite therapy**
Positive — persistent and slowly spreading despite potent topical steroids.

## O OBJECTIVE

### 5 SPECIMEN & MICROSCOPIC FINDINGS

#### 5a SPECIMEN INFORMATION

ACCESSION NUMBER
**DP26-18842**

SPECIMEN SITE
**A: L buttock · B: R flank · C: L medial thigh**

LATERALITY
**Left (A, C); Right (B)**

SPECIMEN TYPE
**Punch ×3 (4 mm each)**

NUMBER OF SPECIMENS
**3 new + 2 outside cases**

CLINICAL DIAGNOSIS / DIFFERENTIAL
**Early MF vs. chronic spongiotic dermatitis vs. drug eruption**

GROSS DESCRIPTION AVAILABLE
**Yes**

CLINICAL IMAGES REVIEWED
**Yes**

OUTSIDE SLIDES REVIEWED
**Yes — SP22-04417, SP24-11903**

#### 5b GROSS & MICROSCOPIC FINDINGS

**Gross Description:**

Three tan-white skin punches, each 0.4 cm diameter × 0.5–0.6 cm deep, with subcutis. Bisected and entirely submitted, one cassette each (A1, B1, C1). Adequate depth; no fragmentation.

**Microscopic Description:**

All three specimens show a band-like (lichenoid) superficial dermal lymphoid infiltrate with epidermotropism of atypical lymphocytes out of proportion to spongiosis. Findings most developed in A (buttock). Outside 2024 slide shows the same pattern, more subtle; outside 2022 slide is mostly steroid-modified and nonspecific.

**Epidermal Findings:**

Mild psoriasiform acanthosis with focal parakeratosis. Single and small clusters of lymphocytes in the basal layer ("string of pearls"), lymphocytes with perinuclear halos, and two Pautrier-like microabscesses in A. Epidermotropic cells are larger than dermal lymphocytes. Minimal spongiosis. No dyskeratosis or interface necrosis.

**Dermal Findings:**

Patchy band-like papillary dermal infiltrate of small-to-medium lymphocytes with irregular, hyperchromatic (cerebriform) nuclei, few histiocytes and rare eosinophils. Wiry papillary dermal fibrosis (coarse collagen bundles). No vasculitis, granulomas, plasma cells, or mucin. Focal folliculotropism absent.

**Subcutaneous Findings, if present:**

Superficial subcutis present in all three; uninvolved. No panniculitis or atypical infiltrate.

**Melanocytic Findings, if applicable:**

Not applicable — no melanocytic lesion. Mild basal hyperpigmentation with dermal melanophages only.

**Keratinocytic Tumor Findings, if applicable:**

Not applicable.

**Inflammatory Dermatosis Pattern:**

Lichenoid/psoriasiform pattern with disproportionate epidermotropism — the pattern of patch-stage MF rather than spongiotic dermatitis. Spongiosis is too mild to explain the intraepidermal lymphocytes.

**Infectious Findings:**

No organisms on H&E. PAS negative for fungal elements in all three specimens.

**Hair / Scalp Biopsy Findings, if applicable:**

Not applicable — truncal skin. Sampled follicles show no folliculotropism or follicular mucinosis.

**Nail Unit Findings, if applicable:**

Not applicable.

## AS ANCILLARY STUDIES

### 6 STAINS, IHC, DIF & MOLECULAR

**Special Stains:**

PAS (A–C): negative for fungi. Alcian blue (A): no follicular or dermal mucin.

**Immunohistochemistry:**

Panel performed on A and C with appropriate positive and negative controls. Supports a CD4-predominant epidermotropic T-cell infiltrate with loss of a pan-T-cell antigen (see lymphoid markers).

**Melanocytic Markers:**

Not performed — not indicated.

**Epithelial / Carcinoma Markers:**

Not performed — not indicated.

**Lymphoid Markers:**

CD3+ T cells throughout; CD20 shows only scattered B cells. CD4:CD8 ratio about 8:1 in the epidermis (about 4:1 in the dermis). CD7 lost in more than 80% of epidermotropic cells; CD2 and CD5 retained. CD30 positive in less than 5% of cells (no large-cell transformation). CD56 negative. TCR-beta F1 positive, TCR-gamma negative. Ki-67 about 15% in the intraepidermal cells.

**Direct Immunofluorescence:**

Not performed — no blistering or connective tissue disease in the differential.

**Molecular / Genetic Testing:**

TCR gamma gene rearrangement PCR (BIOMED-2): clonal peak in A and C. The identical clone was found in outside block SP24-11903. Same clone at two separate body sites strongly supports MF over a reactive process.

**Margin Assessment:**

Not applicable — diagnostic punch biopsies of a widespread process; margins not assessed.

## CPC CLINICOPATHOLOGIC CORRELATION

### 7 CLINICAL–PATHOLOGIC CONCORDANCE

WHETHER HISTOLOGY SUPPORTS THE CLINICAL DIAGNOSIS

**Yes — supports early MF raised by the referring dermatologist**

WHETHER FINDINGS ARE DIAGNOSTIC, COMPATIBLE, NONSPECIFIC, OR DISCORDANT

**Diagnostic when combined with the clinical picture, IHC, and identical clone at two sites**

KEY FEATURES SUPPORTING THE DIAGNOSIS

**Epidermotropism out of proportion to spongiosis, haloed atypical cells, Pautrier-like microabscesses, wiry fibrosis, CD4:CD8 8:1, CD7 loss, same clone at two sites, sun-protected distribution**

IMPORTANT DIFFERENTIAL DIAGNOSES

**Chronic spongiotic/nummular dermatitis; lymphomatoid (amlodipine) drug eruption; pityriasis lichenoides chronica; large plaque parapsoriasis**

LIMITATIONS OF SPECIMEN DEPTH, SAMPLING, SITE, PRIOR TREATMENT, OR ARTIFACT

**Outside 2022 biopsy was steroid-modified; current biopsies taken after a 3-week washout and adequate**

NEED FOR REPEAT BIOPSY, DEEPER BIOPSY, EXCISION, CULTURE, DIF, ADDITIONAL STAINS, MOLECULAR TESTING, OR CLINICAL FOLLOW-UP

**No repeat biopsy needed now; biopsy any future plaque or nodule (CD30, large-cell transformation)**

COMMUNICATION WITH REFERRING CLINICIAN WHEN CLINICALLY IMPORTANT

**Phoned Dr. Brooks 10/21/2026, 15:10; case presented at lymphoma conference**

## DI DIAGNOSTIC IMPRESSION

### 8 FINAL DERMATOPATHOLOGY INTERPRETATION

FINAL DIAGNOSIS FOR EACH SPECIMEN

**A–C: Atypical epidermotropic T-cell infiltrate consistent with mycosis fungoides, patch stage. Outside SP24-11903: same diagnosis on review. Outside SP22-04417: nonspecific, steroid-modified**

DIAGNOSIS CERTAINTY

**Consistent with (A–C, SP24-11903); nonspecific (SP22-04417)**

TUMOR TYPE, SUBTYPE, GRADE, DEPTH, MARGINS, AND STAGING ELEMENTS WHEN APPLICABLE

**Classic MF, patch stage; no folliculotropism or large-cell transformation; clinical T1b (about 12% BSA, patches only)**

INFLAMMATORY PATTERN AND DIFFERENTIAL DIAGNOSIS WHEN APPLICABLE

**Lichenoid/psoriasiform pattern; differential diagnosis as above**

INFECTIOUS ORGANISMS OR NEED FOR MICROBIOLOGIC CORRELATION

**None identified; PAS negative**

DIRECT IMMUNOFLUORESCENCE INTERPRETATION WHEN APPLICABLE

DIRECT IMMUNOFLUORESCENCE INTERPRETATION WHEN APPLICABLE

**Not performed**

ANCILLARY STUDY INTERPRETATION

**CD4-predominant, CD7-deficient T cells; clonal TCR-gamma, same clone at two sites**

COMMENT WITH CLINICAL RELEVANCE AND RECOMMENDED CORRELATION

**Meets ISCL early-MF algorithm (7 points). Recommend staging with exam, CBC with Sézary flow, LDH; cutaneous lymphoma clinic referral**

## L LABORATORY AND DIAGNOSTIC RESULTS REVIEWED

### 9 RESULTS INCORPORATED

PRIOR BIOPSY OR EXCISION REPORTS

**SP22-04417, SP24-11903 reports reviewed**

OUTSIDE SLIDE REVIEW

**Both outside cases — H&E and blocks**

CLINICAL PHOTOGRAPHS OR DERMOSCOPY IMAGES

**Serial photos 2020–2026; dermoscopy images**

MICROBIOLOGY CULTURES OR PCR RESULTS

**None performed**

SEROLOGIC TESTS, AUTOIMMUNE LABS, OR INFLAMMATORY MARKERS

**HIV and HTLV-1 negative (2025); ANA negative (2024)**

IMAGING FOR TUMOR STAGING, LYMPH NODE CONCERN, OR DEEP EXTENSION

**None to date — not routinely needed for T1 without adenopathy**

MEDICATION MONITORING LABS WHEN RELEVANT

**CBC normal 08/2026 (WBC 6.8, ALC 1.9); LDH not done**

PRIOR DERMATOLOGY, ONCOLOGY, RHEUMATOLOGY, INFECTIOUS DISEASE, OR PRIMARY CARE RECORDS

**Dermatology notes 2020–2026 and PCP medication list reviewed**

OPERATIVE REPORTS, MOHS MAPS, EXCISION DIAGRAMS, AND MARGIN DOCUMENTATION

**Body map with biopsy sites A–C only**

## A ASSESSMENT

### 10 DERMATOPATHOLOGIC INTERPRETATION

1) Mycosis fungoides, classic patch stage (clinical T1b) — supported by three new biopsies and revised review of the 2024 outside biopsy. Key features: disproportionate epidermotropism of haloed atypical lymphocytes, Pautrier-like microabscesses, wiry papillary fibrosis, CD4:CD8 about 8:1, CD7 loss, and identical clonal TCR-gamma rearrangement at two separate sites. 2) Differential: chronic spongiotic/nummular dermatitis is excluded by minimal spongiosis and the immunophenotype. Lymphomatoid drug eruption from amlodipine is considered less likely given the identical clone at two sites over 2 years, but stopping the drug is reasonable. Large plaque parapsoriasis is part of the same spectrum. 3) Clinicopathologic concordance: concordant with the clinical suspicion. Earlier sign-outs reflect steroid modification and lack of ancillary testing — a common cause of delayed MF diagnosis. 4) Sampling is adequate. No margins apply. 5) No large-cell transformation (CD30 below 5%), no folliculotropism — favorable features. 6) Ancillary limitation: a clone alone is not diagnostic and is interpreted with histology and phenotype. 7) No urgent findings, but a new lymphoma diagnosis — communicated directly to the referring dermatologist.

## P PLAN

### 11 RECOMMENDATIONS & COMMUNICATION

**Final pathology report completion and diagnostic wording.**
Final report signed 10/21/2026: "Atypical epidermotropic T-cell infiltrate, consistent with mycosis fungoides, patch stage (see comment)." Amended consult letter for SP24-11903 issued.

**Recommendation for clinicopathologic correlation when findings are nonspecific or discordant.**
Not needed now — concordant. Comment notes the 2022 specimen is nonspecific because of steroid effect.

**Recommendation for re-biopsy, deeper biopsy, excision, Mohs surgery, margin re-excision, or additional sampling when indicated.**
No re-biopsy now. Biopsy any new plaque, nodule, ulcer, or rapidly changing lesion to assess CD30 status and large-cell transformation.

**Recommendation for additional stains, immunohistochemistry, direct immunofluorescence, molecular testing, or outside expert consultation when needed.**
No further stains. Keep blocks for future clone comparison. Intradepartmental consensus reached with a second dermatopathologist (Dr. Liu).

**Recommendation for microbiologic culture, serologic testing, imaging, or systemic evaluation when histology suggests infection, autoimmune disease, lymphoma, vasculitis, panniculitis, or metastatic disease.**
Staging workup: full skin exam with mSWAT, lymph node exam, CBC with differential, CMP, LDH, peripheral blood flow cytometry for Sézary cells (CD4:CD8, CD26/CD7 loss), and blood TCR clone comparison. Imaging only if adenopathy or more advanced disease.

**Recommendation for dermatology, Mohs surgery, oncology, rheumatology, infectious disease, hematology/oncology, genetics, or primary care coordination when indicated.**
Referral to multidisciplinary cutaneous lymphoma clinic (dermatology + hematology/oncology). PCP to consider replacing amlodipine with another antihypertensive.

**Documentation of direct communication with referring clinician for malignant, unexpected, urgent, discordant, or clinically significant findings.**
Diagnosis phoned to Dr. Angela Brooks 10/21/2026 at 15:10; read back confirmed. Also presented at Cutaneous Lymphoma Conference 10/21/2026.

**Patient-facing explanation plan if results are discussed during a clinical visit, including diagnosis, uncertainty, next steps, and expected follow-up.**
Dr. Brooks will disclose at a visit on 10/24/2026. Suggested framing: early-stage, slow-growing skin lymphoma with an excellent long-term outlook; staging blood tests and skin-directed therapy (e.g., NB-UVB) are next.

**Pathology addendum plan for pending stains, deeper levels, outside slides, molecular testing, or amended diagnosis if needed.**
Addendum if the blood TCR clone matches the skin clone. Slides and blocks returned to the outside lab with the consult report.

## F FOLLOW-UP

### 12 PENDING ITEMS & REVIEW

Blood flow cytometry and blood TCR clone comparison expected in 7–10 days — addendum issued then. Re-present at Cutaneous Lymphoma Conference after staging (about 4 weeks). Compare any future biopsy with clone DP26-18842. Dr. Brooks to confirm patient disclosure by 10/24/2026.

## TB TIME DOCUMENTATION & BILLING

### 13 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
2 h 25 min

MICROSCOPIC REVIEW TIME
55 minutes (3 new + 2 outside cases)

CLINICAL CORRELATION TIME
25 minutes

ANCILLARY STUDY REVIEW TIME
30 minutes

OUTSIDE SLIDE REVIEW TIME, IF APPLICABLE
20 minutes

CARE COORDINATION / CLINICIAN COMMUNICATION TIME
10 minutes (call + conference)

REPORT ADDENDUM TIME, IF APPLICABLE
5 minutes (amended outside consult)

### 13a BILLING CONSIDERATIONS — DERMATOPATHOLOGY CODING

SURGICAL PATHOLOGY CODE(S)
88305 ×3 (A–C)

CONSULTATION / OUTSIDE SLIDE REVIEW CODE(S), IF APPLICABLE
88321 ×2 (SP22-04417, SP24-11903)

SPECIAL STAIN CODE(S), IF APPLICABLE
88312 ×3 (PAS); 88313 ×1 (Alcian blue)

IMMUNOHISTOCHEMISTRY CODE(S), IF APPLICABLE
88342 ×2, 88341 ×14 (CD3, CD4, CD8, CD7, CD2, CD5, CD20, CD30)

DIRECT IMMUNOFLUORESCENCE CODE(S), IF APPLICABLE
Not applicable

MOLECULAR TESTING CODE(S), IF APPLICABLE
81342 ×3 (TRG rearrangement, A, C, SP24-11903)

ADDENDUM / ANCILLARY REVIEW DOCUMENTATION, IF APPLICABLE
Addendum pending blood TCR comparison

BASIS FOR BILLING
Specimen interpretation + Consultation + Ancillary stains + Molecular testing

ICD-10 DIAGNOSIS CODES
C84.00 — Mycosis fungoides, unspecified site

[SECONDARY LESION / MALIGNANCY / INFLAMMATORY / INFECTIOUS DIAGNOSIS CODE(S), IF APPLICABLE]
L30.9 — Dermatitis, unspecified (prior working diagnosis, outside 2022 specimen)

SO

## SIGNATURE

### 14 PROVIDER SIGN-OFF

| PROVIDER NAME | CREDENTIALS | SPECIALTY |
| --- | --- | --- |
| Priya Raman | MD, FCAP | Dermatopathology |

| DATE | TIME |
| --- | --- |
| 10/21/2026 | 15:40 |

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