EA DV CONGRESS
PARIS 17-20 SEPTEMBER 2025
EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY

Abstract N°: 2901

Granulomatous Slack Skin: A Rare Variant of Mycosis Fungoides

Fernanda de Souza Barbosa*[1], tomaz vasconcelos[1], Maisa Nagao[1], Kaique Arriel[1], ARTUR ANTONIO DUARTE[1], Dimitri Luz Felipe Da Silva[1]

[1]University Santo Amaro, Dermatology, São Paulo, Brazil

Introduction & Objectives: Granulomatous slack skin (GSS) is a rare and indolent variant of mycosis fungoides, characterized by loose, erythematous plaques, primarily in flexural areas. Histologically, it features loss of elastic fibers and a granulomatous infiltrate of T cells (1). It predominantly affects men in their 30s or 40s and tends to progress slowly but may recur (2). In about one-third of cases, GSS is associated with hematologic malignancies, particularly Hodgkin's lymphoma, warranting long-term monitoring. This case aims to improve recognition of this underdiagnosed condition.

Materials & Methods: A 72-year-old man from São Paulo, with a history of hypertension, myocardial infarction, and dyslipidemia, presented with a one-year history of pruritic, violaceous plaques in the axillae and proximal thighs, progressing to areas of lax skin. Clinical examination revealed a poorly defined violaceous plaque with poikiloderma and a "cigarette paper" texture on the right upper limb, along with milder lesions on the thighs, feet, and popliteal fossae. Initial differential diagnoses included contact eczema, atopic eczema, and GSS. Biopsies from three sites revealed granulomatous dermatitis with edema. Lab work was unremarkable, except for gamma-globulinemia at the upper limit of normal (18.8 g/L). Topical clobetasol was ineffective.

Subsequent biopsies from the right axilla and popliteal fossa showed a dense, atypical lymphocytic infiltrate with melanophages, capillary proliferation, collagen thickening, and multinucleated giant cells. Verhoeff staining demonstrated a marked reduction in elastic fibers. Immunohistochemistry confirmed the presence of atypical T lymphocytes (CD3+/CD4+/CD20-/CD30-), consistent with a diagnosis of GSS. The patient was treated with 42 sessions of PUVA therapy (20 mg oxsoralen), leading to symptom relief. Maintenance therapy with topical corticosteroids and antihistamines was continued.

Results: Results: Granulomatous cutaneous T-cell lymphoma includes mycosis fungoides (GMF) and granulomatous slack skin (GSS) (2). These overlapping entities share clinical and histopathological characteristics, posing a diagnostic challenge. Both conditions may exhibit a granulomatous proliferation with T lymphocytes. However, numerous multinucleated foreign body giant cells and loss of elastic fibers are hallmark features of GSS, while elastophagocytosis is observed in only a minority of cases (3). Elastic fiber loss, although present in GMF, is more pronounced in GSS (4). Thus, the case presented here aligns with what is described in the literature, particularly the limited studies highlighting histological differences between GMF and GSS In both conditions, dermal infiltrates may be granulomatous, lacking epidermotropism and showing minimal cytological atypia—features that often mislead pathologists into favoring inflammatory conditions (5,6).

Conclusion: This case underscores the diagnostic challenges of GSS, a rare mycosis fungoides variant frequently misidentified due to histopathological overlap with other granulomatous disorders. Key diagnostic clues include atypical lymphocytic infiltrates, multinucleated giant cells, and loss of elastic fibers. Early recognition through careful histopathological evaluation is essential for appropriate management. Given its potential link to hematologic malignancies, long-term follow-up is critical.