

### Lymphomatoid Papulosis: Response to Treatment With Recombinant Interferon alfa-2b

*To the Editor:* Lymphomatoid papulosis is a rare lymphoproliferative disorder of skin that involves a clonal expansion of T lymphocytes.<sup>1</sup> These lesions are pathologically distinct from mycosis fungoides, with histologic findings more akin to non-Hodgkin's lymphoma of the skin. The lesions tend to have a self-limiting growth sequence, but individual lesions can often enlarge to a substantial size and require surgery or local radiotherapy. The literature suggests that there is a predisposition to the development of generalized non-Hodgkin's lymphoma, often of a pleomorphic T-cell type.<sup>2,3</sup>

A 42-year-old patient who had a diagnosis of lymphomatoid papulosis made in 1982 was treated by radiotherapy, surgery, and photochemotherapy (PUVA). She developed a non-Hodgkin's lymphoma of large T-cell pleomorphic type in 1990. This lymphoma was treated with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) chemotherapy for six cycles and radiotherapy to the initial area of nodal bulk disease in the right iliac fossa. During treatment with this high-grade chemotherapy, it was noted that the lymphomatoid papulosis skin lesions regressed. After discontinuing treatment there was a recurrence of the skin lesions over the trunk and limbs. After reports of the value of interferon alfa-2b ( $\alpha 2B$  IFN) in the treatment of skin lymphoma<sup>4</sup> and mycosis fungoides,<sup>5</sup>  $\alpha 2B$  IFN was started, initially with injections into three skin lesions using 1 mU per lesion, three times per week, giving a total dose of 3 mU three times per week. It was noted that the lesions smaller than 0.5 cm completely disappeared after three IFN injections. Larger lesions required three to 10 injections before regression. When all existing lesions had been thus treated, IFN was continued at a dose of 3 mU units subcutaneously three times a week in a subcutaneous site in the

abdomen. This systemic form of delivery appeared to reduce the recurrence of skin lesions, though some recurred subsequently. Intralesional IFN injections still caused regression.

There is little doubt that  $\alpha 2B$  IFN has a place in the treatment of cutaneous T-cell lymphoma. We add the rare disorder of lymphomatoid papulosis to the list of responding conditions. We have decided to continue the systemic use of  $\alpha 2B$  IFN at the above dose in our patient, hoping that it might influence this patient's predisposition to the development of further lymphoma.

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## ERRATUM

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Joseph W. Fay and C. Frederick LeMaistre should have been included in the byline of the report "Intensive Chemotherapy With Cyclophosphamide, Carmustine, and Etoposide Followed by Autologous Bone Marrow Transplantation for Relapsed Hodgkin's Disease" (*J Clin Oncol* 9:1871-1879, 1991). Following is the complete authorship of this report: Donna E. Reece, Michael J. Barnett, Joseph M. Connors, Randall N. Fairey, Joseph W. Fay, John P. Greer, Geoffrey P. Herzig, Roger H. Herzig, Hans-G. Klingemann, C. Frederick LeMaistre, Susan E. O'Reilly, John D. Shepherd, John J. Spinelli, Nicholas J. Voss, Steven N. Wolff, and Gordon L. Phillips.

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