In reply: Drs Weenig and Pittelkow raise an interesting point about the cross-reactivity of some polyclonal CD3 immunophenotyping assays with NK cells and question whether the lymphoma described in the case we reported could therefore have been a cutaneous NK-cell lymphoma rather than a CTCL, as was discussed in our article. The patient’s lymphoma was CD8 positive, which would be most compatible with cytotoxic CTCL, not cutaneous NK-cell lymphoma. The full immunophenotype was not included in the text because our article appeared in the Residents’ Clinic section of the journal, which has a general medicine focus, and extensive discussion of immunophenotyping and the various types of cutaneous lymphoma would have been inappropriate. The best answer to question 3 in our teaching case is still CTCL, given the information provided in the article.

The observation that the appearance and histological features of our patient’s lymphoma would be atypical for classic MF is correct—her lymphoma was not typical and likely belonged to the cytotoxic subset of CTCL. This distinction was not emphasized in the article because the classification of CTCL is highly complex and specialized, and decisions about the patient’s clinical management were driven by her precarious state of health and her wishes to avoid any invasive or toxic therapies. Prognostic information related to the specific subclass of CTCL was not clinically important in this case.

In sentences 1 and 2 of paragraph 2 in the Discussion section of our article, “CTCL” should have read “cutaneous lymphoma,” with no B or T designation, because both B- and T-cell lymphomas were discussed in the reports we cited. This error was introduced during the editing process in an effort to use the abbreviation “CTCL” when possible, and unfortunately it did not apply in this instance. This error was astutely recognized by Drs Weenig and Pittelkow, as evidenced by the comments in paragraph 5 of their letter.

Our patient underwent bone marrow biopsy, which revealed no evidence of lymphoma or hemophagocytosis. Bone marrow biopsy is appropriate when a diagnosis of cutaneous lymphoma is considered for the reasons mentioned in their letter, but it would not be the most appropriate answer to question 2 in our article, which appeared before the patient’s diagnosis was revealed.

We do not agree with Weenig and Pittelkow’s statement that the diagnosis of CTCL in our patient is “precarious,” inasmuch as the only feasible alternative diagnosis presented in their letter that is not a form of CTCL is cutaneous NK-cell lymphoma, which is included in the differential diagnosis because of the possibility of a false-positive CD3 immunophenotyping result. Most cutaneous NK-cell lymphomas are secondary to nasal or upper airway NK-cell lymphomas, which classically present as midline destructive facial lesions. Primary cutaneous NK-cell lymphoma has been described in case reports but is rare. We agree that CTCL is a disease with many different subtypes that influence clinical outcomes and that immunophenotyping and genetic analysis can often provide more detailed prognostic information than traditional staging methods alone. Immunophenotyping used to establish the diagnosis in our patient was discussed after question 3, and genetic methods were referenced in question 4. More detailed discussion of these methods was considered inappropriate for this type of article.

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CORRECTIONS

Misspelled last name: In the article by Samenuk et al entitled “Adverse Cardiovascular Events Temporally Associated With Ma Huang, an Herbal Source of Ephedrine,” published in the January 2002 issue of Mayo Clinic Proceedings (Mayo Clin Proc. 2002;77:12-16), on page 12, the last name of the fifth author was spelled incorrectly as “Theohardes.” The correct spelling is “Theohares.”

Incorrect term: In the Residents’ Clinic article by Niewold and Swaroop entitled “78-Year-Old Woman With Fever, Weight Loss, and Rash,” published in the May 2003 issue of Mayo Clinic Proceedings (Mayo Clin Proc. 2003;78:635-638), in the first 2 sentences of the first paragraph in the Discussion section on page 638, the abbreviation “CTCL” was used incorrectly for the phrase “cutaneous lymphoma.” The 2 sentences should read: “There are at least 4 prior reports of cutaneous lymphoma developing in patients with RA.” In 2 of these reports,10,11 patients were being treated for RA with methotrexate, and withdrawal of the methotrexate resulted in regression of the cutaneous lymphoma.”