

The young side of LYMPHOMA

gli under 40 a confronto

Reggio Emilia, Hotel Mercure Astoria
2-3 ottobre 2026

Linfomi cutanei



Gabriele Roccuzzo

*Section of Dermatology - PhD Programme Medical Pathophysiology
Department of Medical Sciences
University of Turin, Turin, Italy*

EORTC-Cutaneous Lymphoma Tumor Group Y-ECI representative

Nothing to disclose

EORTC Classification for Primary Cutaneous Lymphomas: A Proposal From the Cutaneous Lymphoma Study Group of the European Organization for Research and Treatment of Cancer

By R. Willemze, H. Kerl, W. Sterry, E. Berti, L. Cerroni, S. Chimenti, J.L. Diaz-Peréz, M.L. Geerts, M. Goos, R. Knobler, E. Ralfkiaer, M. Santucci, N. Smith, J. Wechsler, W.A. van Vloten, and C.J.L.M. Meijer

Primary cutaneous lymphomas represent a heterogeneous group of T- and B-cell lymphomas that show considerable variation in histology, phenotype, and prognosis. Recently, the European Organization for Research and Treatment of Cancer (EORTC) Cutaneous Lymphoma Project Group has reached consensus on a new classification for this group of diseases. The EORTC classification for primary cutaneous lymphomas is based on a combination of clinical, histologic, and immunophenotypic criteria, and thus contains well-defined disease entities rather than histologic subgroups. In addition, this new classification contains a number of provi-

sional entities, which may display characteristic histologic features, but are not yet well defined clinically. These provisional entities account for less than 5% of all primary cutaneous lymphomas. In this report the basic principles of this new classification, as well as the characteristic features of the different disease entities, are described. In addition, survival data of 626 patients with primary cutaneous lymphomas derived from the registry of the Dutch Cutaneous Lymphoma Working Group, illustrating the clinical validity of this new classification, are presented.

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PRIMARY CUTANEOUS lymphomas represent a heterogeneous group of T- and B-cell lymphomas, which show considerable variation in clinical presentation, histology, immunophenotype, and prognosis. They are, after the group of primary gastrointestinal lymphomas, the second

of the same histologic subtype arily.⁷⁻¹¹ In addition, difference translocations and in the expression, and adhesion receptor primary cutaneous lymphoma:

1997

Review article

WHO-EORTC classification for cutaneous lymphomas

Rein Willemze, Elaine S. Jaffe, Günter Burg, Lorenzo Cerroni, Emilio Berti, Steven H. Swerdlow, Elisabeth Ralfkiaer, Sergio Chimenti, José L. Diaz-Peréz, Lyn M. Duncan, Florent Grange, Nancy Lee Harris, Werner Kempf, Helmut Kerl, Michael Kumar, Robert Knobler, Nicola Pimpinelli, Christian Sander, Marco Santucci, Wolfram Sterry, Maarten H. Vermeer, Janine Wechsler, Sean Whittaker, and Chris J. L. M. Meijer

Primary cutaneous lymphomas are currently classified by the European Organization for Research and Treatment of Cancer (EORTC) classification or the

ogy of different types of cutaneous B-cell lymphomas have resulted in considerable debate and confusion. During recent consensus meetings representatives of classification relative frequency 1905 patients phomas deriv

2005

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Review Series

THE UPDATED WHO CLASSIFICATION OF HEMATOLOGICAL MALIGNANCIES

The 2016 revision of the World Health Organization classification of lymphoid neoplasms

Steven H. Swerdlow,¹ Elias Campo,² Stefano A. Pileri,³ Nancy Lee Harris,⁴ Harald Stein,⁵ Reiner Siebert,⁶ Ranjana Advani,⁷ Michele Ghismini,⁸ Gilles A. Salles,⁹ Andrew D. Zelenetz,¹⁰ and Elaine S. Jaffe¹¹

¹Division of Hematopathology, Department of Pathology, University of Pittsburgh School of Medicine, Pittsburgh, PA; ²Department of Pathology, Hospital Clinic, University of Barcelona, August Pi i Sunyer Biomedical Research Institute, Barcelona, Spain; ³Haematopathology Unit, European Institute of Oncology, Milan, and Department of Experimental, Diagnostic and Specialty Medicine, Bologna University Medical School, Bologna, Italy; ⁴Department of Pathology, Harvard Medical School and Massachusetts General Hospital, Boston, MA; ⁵Pathodiagnostik, Berlin, Germany; ⁶Institute of Human Genetics, Christian Albrechts University Kiel, Kiel, Germany; ⁷Division of Oncology, Department of Medicine, Stanford University, Stanford, CA; ⁸Department of Medical Oncology, Oncology Institute of Southern Switzerland, Bellinzona, Switzerland; ⁹Department of Hematology, Hospices Civils de Lyon, and Université Claude Bernard Lyon-1, Lyon, France; ¹⁰Department of Medicine, Memorial Sloan Kettering Cancer Center and Weill Cornell Medical College, New York, NY; and ¹¹Hematopathology Section, Laboratory of Pathology, National Cancer Institute, Bethesda, MD

2016

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The 2018 update of the WHO-EORTC classification for primary cutaneous lymphomas

Rein Willemze, Lorenzo Cerroni, Werner Kempf, Emilio Berti, Fabio Facchetti, Steven H. Swerdlow and Elaine S. Jaffe

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2018

B-cell 20-30%

WHO-EORTC Classification 2018	Frequency (%)#	5-year DSS (%)#
Cutaneous B-cell lymphomas		
Primary cutaneous marginal zone lymphoma	9	99
Primary cutaneous follicle center lymphoma	12	95
Primary cutaneous diffuse large B-cell lymphoma, leg type	4	56
EBV-positive mucocutaneous ulcer (provisional)	<1	100
Intravascular large B-cell lymphoma	<1	72

- Average age at diagnosis: 60 years.
- Both groups twice as common in **males** as in females.
- DLBCL higher age (75 years) and more often **female**

T-cell 70-80%

WHO-EORTC Classification 2018	Frequency (%)#	5-year DSS (%)#
Cutaneous T-cell lymphomas		
Mycosis fungoides	39	88
Mycosis fungoides variants		
• Folliculotropic MF	5	75
• Pagetoid reticulosis	<1	100
• Granulomatous slack skin	<1	100
Sézary syndrome	2	36
Adult T-cell leukemia/lymphoma	<1	NDA
Primary cutaneous CD30-positive lymphoproliferative disorders		
• Primary cutaneous anaplastic large cell lymphoma	8	95
• Lymphomatoid papulosis	12	99
Subcutaneous panniculitis-like T-cell lymphoma	1	87
Extranodal NK/T-cell lymphoma, nasal type	<1	16
Chronic active EBV infection	<1	NDA
Primary cutaneous peripheral T-cell lymphoma, rare subtypes		
• Primary cutaneous γ/δ T-cell lymphoma	<1	11
• Primary cutaneous aggressive epidermotropic CD8-positive T-cell lymphoma (provisional)	<1	31
• Primary cutaneous CD4+ small/medium T-cell LPD (provisional)	6	100
• Primary cutaneous acral CD8+ T-cell lymphoma (provisional)	<1	100
Primary cutaneous peripheral T-cell lymphoma, NOS	2	15

What do they have in common?



LINFOMI PRIMITIVI CUTANEI

Entità	Lesioni elementari	Sede	Sintomi
MF early stage	Chiazze – placche	Glutei cosce addome	Variabile
MF advanced stage	Chiazze placche Noduli ulcerati - Eritrodermia	Glutei cosce addome o diffuse	Prurito variabile - dolore
MF follicolotropa	Papule cisti comedoni	Capo	Prurito
Sindrome di Sézary	Eritrodermia	Diffuse	Prurito
Papulosi linfomatoide	Papule con regressione	Diffuse	Prurito variabile
CD30+ anaplastico	Noduli ulcerati	Capo tronco	Dolore
CD8+ epidermotropo	Noduli ulcerati	Diffuse	Dolore
Marginale	Eritemato edematose placche	Tronco arti superiori	no
Follicolare	Placche noduli	Dorso cuoio capelluto	No
Grandi cellule leg-type	Noduli ulcerati	Arti inferiori	Dolore

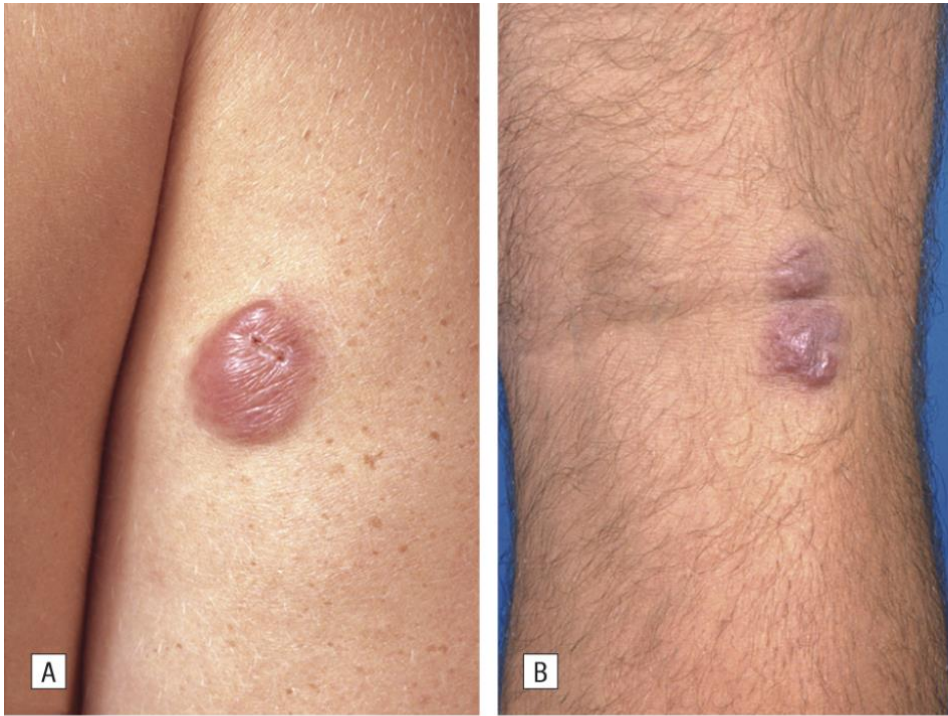


Follicle-center (PCFCL)

- Solitary purple-pink papule or multiple papules/plaques/tumors with a rim of peripheral erythema (**forehead, neck and upper back**)
- Mostly asymptomatic
- Large centrocytes and variable centroblasts derived from germinal-center B cells
- Usually no t(14;18) and no strong expression of *Bcl2* (features of extracutaneous spread)
- *CD10+/-*, *bcl6+*, MUM1/IRF4-, FOXP1-, IgM-



Marginal zone (PCMZL)



- Solitary pink papule (trunk, arm, head-neck area) or red-brown **multifocal** papules/plaques/nodules (trunk, arms)
- Mostly asymptomatic
- The 2022 International Consensus Classification redefined it as LPD due to its **benign behavior** (5y DSS >99%, dissemination 4%) though WHO still categorizes it as lymphoma.
- Small, “centrocyte-like” marginal zone B cells, often bcl2+
- CD43+/-, Bcl6-, CD10-, CD5-, CD23-.
- 90% Class-switched Ig (mainly IgG, indolent) and 10% IgM-type (recurrence).

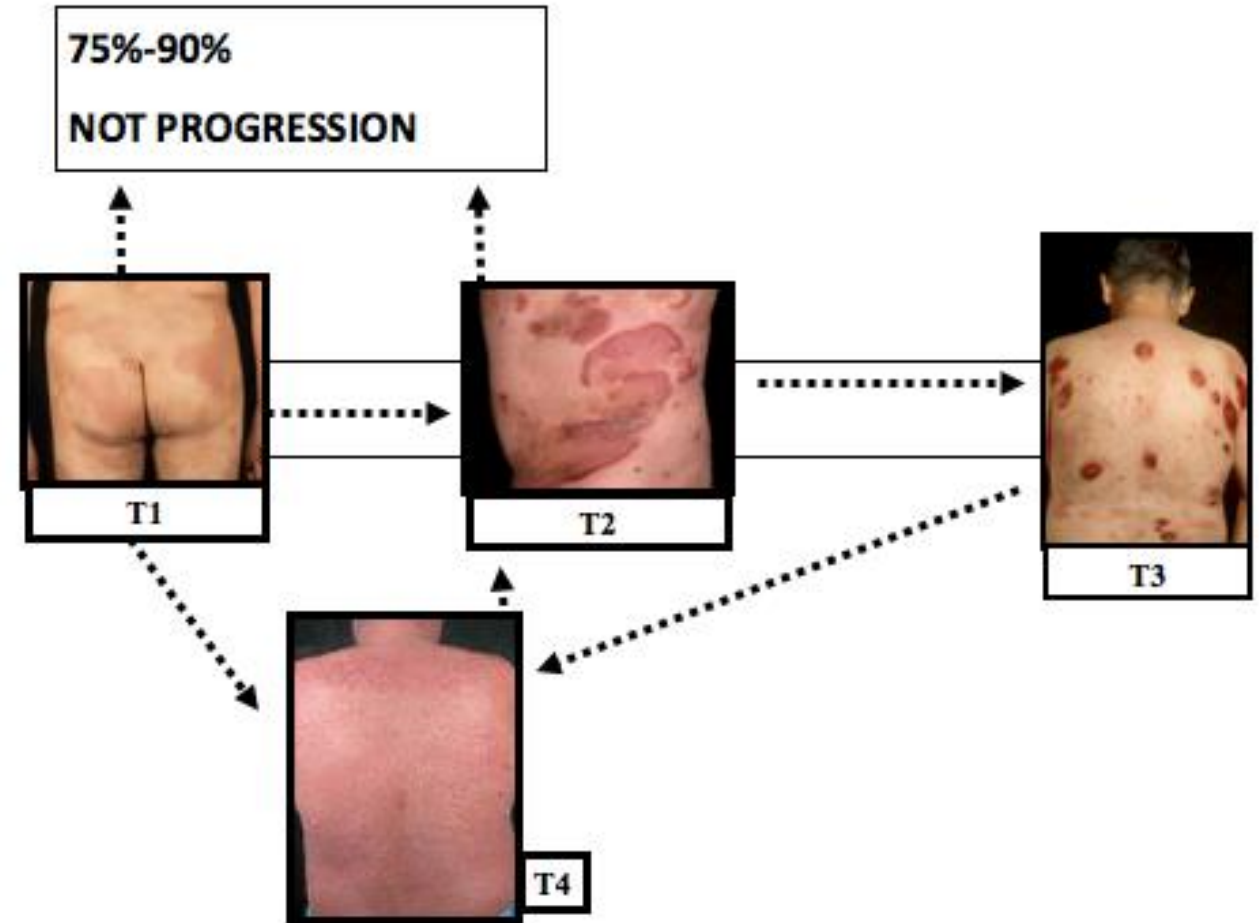
Leg type (PCDLBCL)

- Rapidly progressive red-blue tumors, often ulcerated (old XX)
- In 15% of cases areas other than **lower legs** are involved
- Pain can be found
- Epidermis-sparing centroblasts and immunoblasts that extend deep into the dermis and subcutaneous tissue, bcl2+ (gene amplification).
- MUM-1/IRF-4+, FOXP1+, IgM+, bcl6+, CD10-
- Dual expression of both bcl2 and c-myc is common and associated with inferior overall survival, as loss of CDKN2A (p16) and presence of somatic MYD88 mutation.



MYCOSIS FUNGOIDES

- Most common CTCL
- Male prevalence
- Age > 55 yrs
- Indolent clinical course
- Clinical progression from patches to plaques, tumours and erythroderma (75-90% maintain life long early-phase disease)



Current challenges in MF

- Early recognition by clinicians
- Histopathological correlation in early-stage
- Referral in case of non-responsive benign inflammatory disorders
- Symptoms
- Prognostication

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ORIGINAL ARTICLE

 JEDV Journal of
Epidemiology
and
Dermatology

Identifying unmet needs and challenges in the definition of a plaque in mycosis fungoides: An EORTC-CLTG/ISCL survey

Pietro Quaglino^{1,*}  | Julia Scarisbrick^{2,*}  | Gabriele Rocuzzo¹  | Alejandra Abeldano³ |
Maxime Battistella^{4,5} | Chris McCormack⁶ | Richard Cowan⁷  | Antonio Cozzio⁸ |
Jade Cury-Martins⁹ | Paula Enz¹⁰ | Larisa Geskin¹¹  | Emmanuella Guenova¹²  |
Youn H. Kim¹³ | Robert Knobler¹⁴  | Ivan V. Litvinov¹⁵ | Tomomitsu Miyagaki¹⁶ |
Montserrat Molgo¹⁷ | Jan Nicolay¹⁸ | Evangelina Papadavid¹⁹  | Lauren Pinter-Brown²⁰ |
Ramon Pujol Vallverdu²¹ | Christiane Querfeld²² | Pablo Ortiz-Romero²³ |
Rudolf Stadler²⁴  | Maarten H. Vermeer²⁵  | Martine Bagot^{26,*}  | Emilia Hodak^{27,*}

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HOW I APPROACH

 BJHaem
BRITISH JOURNAL OF HAEMATOLOGY

How I manage mycosis fungoides and Sézary syndrome: Current controversies and unmet needs

Rudolf Stadler¹  | Pietro Quaglino²  | Gabriele Rocuzzo² 

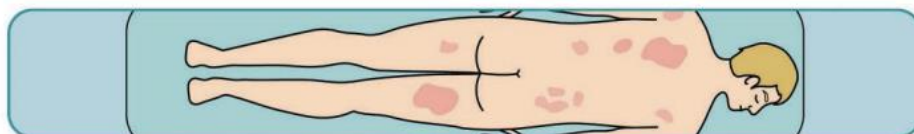
Qual è il ritardo medio dalla comparsa dei sintomi alla diagnosi di MF?

- 1 mese
- 3-6 mesi
- 1 anno
- 3 anni

A-F THINK MF!

A MEMORY AID FOR THE EARLY RECOGNITION OF CUTANEOUS
T-CELL LYMPHOMA: MYCOSIS FUNGOIDES/SÉZARY SYNDROME

A



ASYMMETRIC

Asymmetric persistent and/or progressive patches/plaques

B



BATHING TRUNK DISTRIBUTION

Sun-protected sites

C



COLOUR CHANGE IN THE SKIN

Persistent and/or progressive hypo/hyperpigmented patches/plaques or atrophic/telangiectatic patches with discolouration

D



DRUG THERAPY CAN WORSEN MF/SS

Drug therapies (e.g. ciclosporin, biologics) can be harmful in patients with undiagnosed MF/SS

E



ERYTHRODERMA

Consider MF/SS in patients with erythroderma with or without lymphocytosis

F

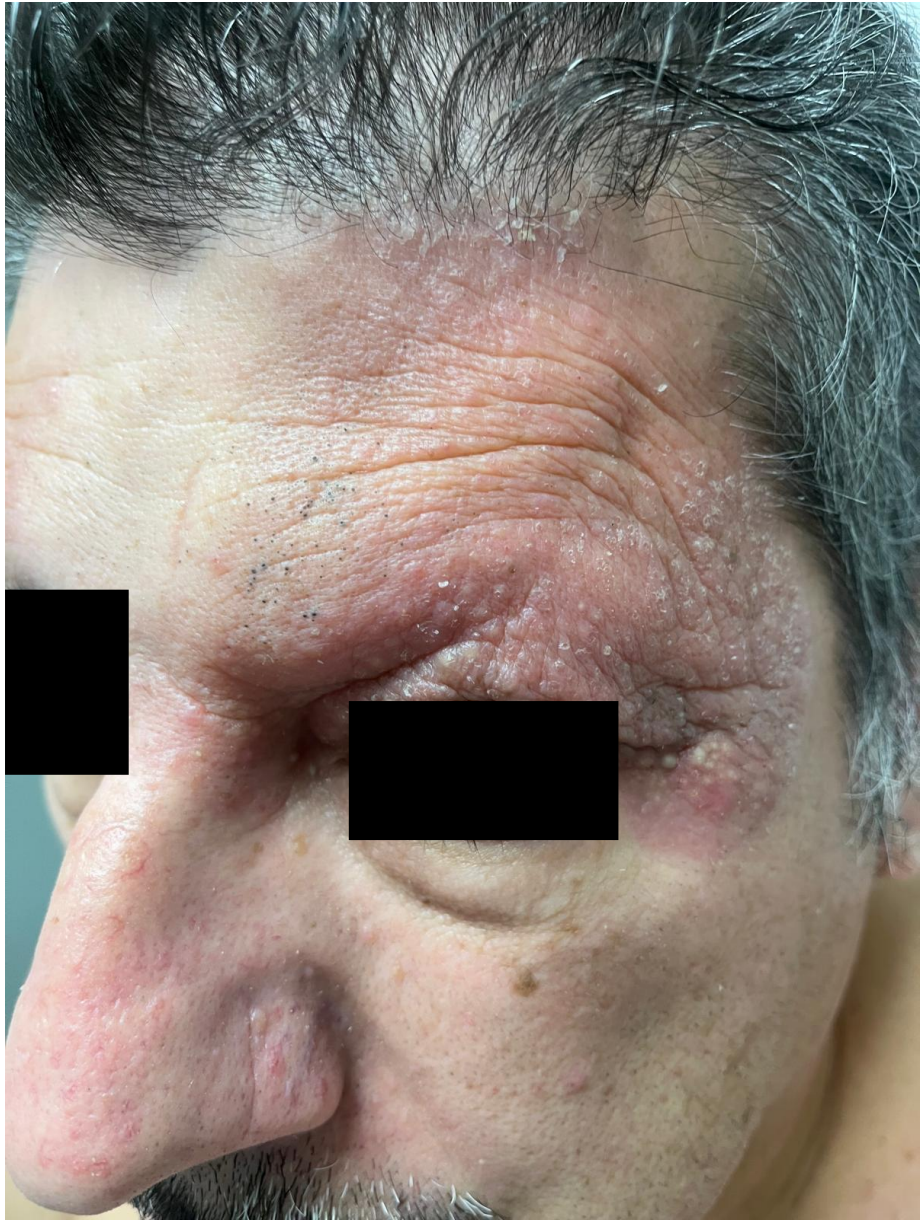


FOLLICULAR LESIONS

ATYPICAL ACNE/COMEDONES

ALOPECIA

Follicular lesions and/or atypical acne, comedones or alopecia











TNMB staging for mycosis fungoides and Sézary syndrome [1].

Skin

T1	Limited patches, papules, and/or plaques covering <10% of the skin surface. May further stratify into T1a (patch only) versus T1b (plaque +/- patch).
T2	Patches, papules, or plaques covering ≥10% of the skin surface. May further stratify into T2a (patch only) versus T2b (plaque +/- patch).
T3	One or more tumours (≥ 1-cm diameter)
T4	Confluence of erythema covering ≥80% body surface area

Node

N0	No clinically abnormal peripheral lymph nodes; biopsy not required
N1	Clinically abnormal peripheral lymph nodes; histopathology Dutch grade 1 or National Cancer Institute (NCI) LN ₀₋₂ N1a Clone negative N1b Clone positive
N2	Clinically abnormal peripheral lymph nodes; histopathology Dutch grade 2 or NCI LN ₃ N2a Clone negative N2b Clone positive
N3	Clinically abnormal peripheral lymph nodes; histopathology Dutch grades 3–4 or NCI LN ₄ ; clone positive or negative
Nx	Clinically abnormal peripheral lymph nodes; no histologic confirmation

Visceral

M0	No visceral organ involvement
M1	Visceral involvement (must have pathology confirmation and organ involved should be specified)

Blood*

B0	Absence of significant blood involvement: ≤5% of peripheral blood lymphocytes are atypical (Sézary) cells
B0a	Clone negative
B0b	Clone positive
B1	Low blood tumour burden: >5% of peripheral blood lymphocytes are atypical (Sézary) cells but does not meet the criteria of B2
B1a	Clone negative
B1b	Clone positive
B2	High blood tumour burden: ≥1000/μl Sézary cells with positive clone

SS is staged as T4 N2/3/x M0 B2.

* Blood staging for MF/SS is further defined as B0 = <250/ml of CD4⁺/CD26⁻ or CD4⁺/CD7⁻ cells, B1 = does not meet criteria for B0 or B2, and B2 = ≥1000/ml of CD4⁺/CD26⁻ or CD4⁺/CD7⁻ cells or other aberrant population of lymphocytes identified by flow cytometry [3,240].

Clinical stages (5-year disease free survival [DSS] according to Olsen et al. [1]).

Stage	T	N	M	B	5-year DSS (%)
IA	1	0	0	0,1	98
IB	2	0	0	0,1	89
IIA	1,2	1,2	0	0,1	89
IIB	3	0–2	0	0,1	56
IIIA	4	0–2	0	0	54
IIIB	4	0–2	0	1	48
IVA1	1–4	0–2	0	2	41
IVA2	1–4	3	0	0–2	23
IVB	1–4	0–3	1	0–2	18

Key Features in the Diagnosis of Early-Stage MF

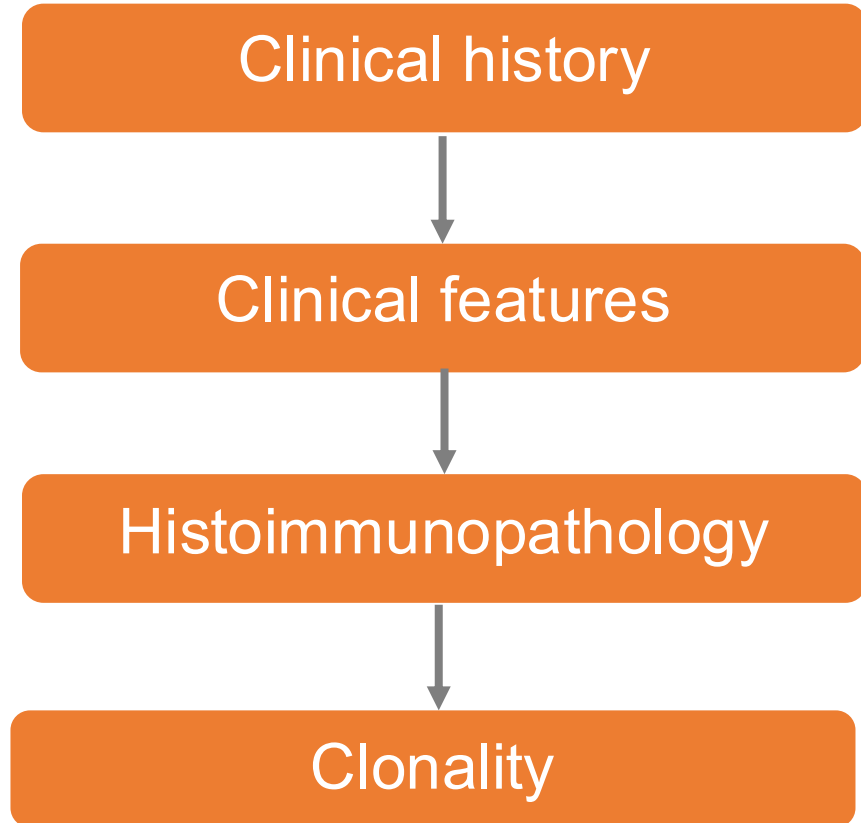
KEY FEATURES	
Clinical	Persistent and/or progressive patches and plaques with: (1) Non–sun-exposed location (2) Size/shape variation (3) Poikiloderma
Histopathologic	Superficial lymphoid infiltrate plus: (1) Epidermotropism without spongiosis (2) Lymphoid atypia*
Molecular/biologic	Clonal TCR gene rearrangement (be mindful of false-positives)
Immunopathologic	• CD2+, 3+, 5+ <50% of T-cells • CD7+ <10% of T-cells • Increased CD4/CD8 ratio

*Lymphoid atypia is defined as cells with enlarged hyperchromatic nuclei and irregular or cerebriform nuclear contours.

MF-CTCL: mycosis fungoides-type cutaneous T-cell lymphoma; TCR: T-cell receptor.

Adapted from Song SX et al. Am J Clin Pathol. 2013;139:466-490.
NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for
Non-Hodgkin's Lymphomas V.1.2016.

Diagnosing MF: ISCL algorithm



4 points to confirm diagnosis

Criteria	Major (2 points)	Minor (1 point)
Clinical		
Persistent and/or progressive plaques plus	Any 2	Any 1
1. Non-sun-exposed location		
2. Size/shape variation		
3. Poikiloderma		
Histopathological		
Superficial lymphoid infiltrate plus	Both	Either
1. Epidermotropism		
2. Atypia		
Molecular/biological		
Clonal TCR gene arrangement		Present
Immunopathological		
1. CD2, 3, 5 < 50%		Any 1
2. CD7 < 10% of T cells		
3. Epidermal discordance from expression of CD2, 3, 5, and 7 on dermal T cells		

TCR clonality

- Normal T cells exhibit **polyclonal TCR gene rearrangements**, whereas **malignant T cells** share an identical **clonal TCR rearrangement**.
- Detection of **TCR clonality** supports the diagnosis of CTLC, although clonality may also occur in some benign skin conditions.
- Available methods include:
 - **PCR (BIOMED-2)**
 - **High-throughput sequencing (HTS)**
 - **Flow cytometry**
- All methods provide **similar sensitivity**, while **HTS** and **flow cytometry** offer **higher specificity**.
- **TRBC1 flow cytometry** achieves diagnostic performance comparable to PCR, with **lower cost** and **faster turnaround time**.

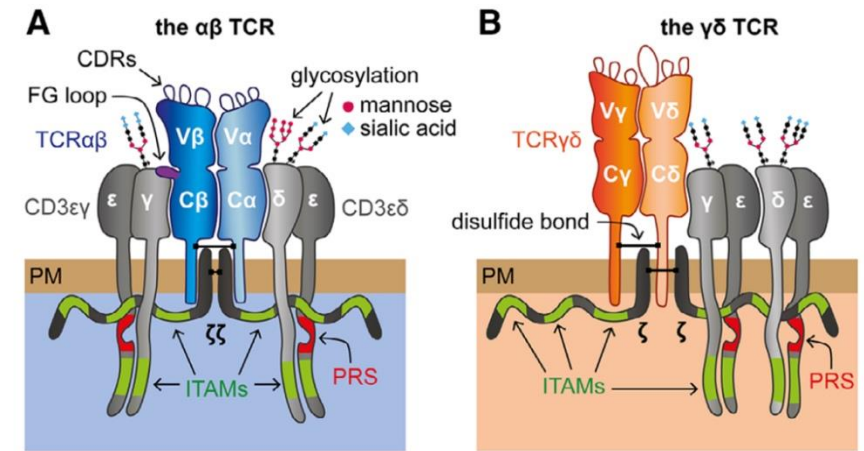


FIGURE 1 Structure of human $\alpha\beta$ and $\gamma\delta$ TCRs. (A) The $\alpha\beta$ TCR. The Ag binding heterodimer consisting of TCR- α /TCR- β (TCR $\alpha\beta$) is shown in blue and the CD3 complex in grey. TCR $\alpha\beta$ is divided into the variable (V) region with the CDRs that form the Ag binding site and the constant (C) region. The FG loop in TCR- β that communicates with CD3 is shown in violet. CD3 glycosylation patterns and intracellular motifs, such as the immunoreceptor-based activation motif (ITAMs, green) and the proline-rich sequence (PRS, red) in CD3 ϵ , are also indicated. (B) The $\gamma\delta$ TCR. The Ag binding TCR- γ /TCR- δ heterodimer (TCR $\gamma\delta$) is drawn in orange. The CD3 subunits are arranged differently, the FG loop is much shorter, the disulfide-bond between the ligand binding subunits is placed differently and CD3 glycosylation is different. PM, plasma membrane

Evaluating T-cell clonality in skin using a quantitative TRBC1 clonality score

ORIGINAL ARTICLE

Christoph Iselin¹, Pacôme Prompsy¹, Yi-Chien Tsai^{1,2}, Pauline Bernard¹, Florine André³, Maël Blanchard³, Gabriela Blanchard³, Gabriele Roccuzzo⁴, Joana Calvão⁵, Pietro Quaglino⁴, Mitchell Levesque⁶, Wolfram Hoetzenecker^{2,7}, Yun-Tsan Chang^{1,8,9} and Emmanuella Guenova^{1,2,8,9}

Journal of Investigative Dermatology (2026) ■, ■–■; doi:10.1016/j.jid.2026.03.045

Objective

- Develop an immunofluorescence-based assay to assess **T-cell clonality** in FFPE skin biopsies and distinguish CTCL from inflammatory dermatoses.

Method

- **TRBC1 Clonality Score (TRBC1-CS)**: quantifies the imbalance between **TRBC1+ and TRBC1– CD3+CD4+CD8– T cells** (0 = polyclonal, 1 = highly clonal); **cut-off ≥ 0.5**
- Validation against **BIOMED-2 PCR clonality**.

Key findings

- **TRBC1-CS ≥ 0.5** identified CTCL with **high specificity**:
 - Discovery cohort: **Specificity 96%, PPV 88%**; Validation cohort: **Specificity 89%, PPV 85%**
- Compared with PCR:
 - **Higher specificity, lower sensitivity**
 - Preserves tissue architecture and enables simultaneous immunophenotyping.

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ORIGINAL ARTICLE

**EA
DV** **JEADV** JOURNAL OF
THE EUROPEAN
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DERMATOLOGY &
VENEREOLGY

Detecting T-cell receptor clonality in patients with severe atopic dermatitis refractory to dupilumab

Hyungdon Kook¹  | Ho Eun Gwag¹ | So Yun Park¹  | Narang Hong¹  | Jung-Ho Lee² |
Hye Jung Jung¹ | Mi Youn Park¹  | Yu Sung Choi³ | Hyun Je Kim^{2,4}  |
Stephan Weidinger⁵  | Jiyoung Ahn¹ 

- 371 patients treated with dupilumab for severe AD.
- Failure to achieve an improvement of EASI of at least 50% at Week 16 and of 75% at Week 52.
- **46 (12.3%) patients** showed insufficient response to dupilumab.
- **19 (54.2% of inadequate responders)** were finally diagnosed with mycosis fungoides

Dupilumab therapy in atopic dermatitis when cutaneous lymphoma is suspected: Consensus recommendations from the EORTC Cutaneous Lymphoma Tumour Group

Joana Calvão, MD,^{a,b} Adèle de Masson, MD,^c Antonio Cozzio, MD, PhD,^d Chalid Assaf, MD, PhD,^e Constanze Jonak, MD,^f Emilia Hodak, MD,^{g,h} Evangelia Papadavid, MD, PhD,ⁱ Gabriele Roccuzzo, MD,^j Jan Peter Nicolay, MD, PhD,^k Julia Scarisbrick, MD,^l Maarten H. Vermeer, MD, PhD,^m Martine Bagot, MD, PhD,^c Maxime Battistella, MD, PhD,ⁿ Pablo Luis Ortiz-Romero, MD, PhD,^o Patrick Brunner, MD,^p Pietro Quaglino, MD,^j Richard Cowan, MD,^q Rudolf Stadler, MD,^r Werner Kempf, MD,^s Margarida Gonçalo, MD, PhD,^{a,b} and Emmanuella Guenova, MD, PhD^{t,u}
Birmingham and Manchester, United Kingdom; Chaidari, Greece; Coimbra, Portugal; Düsseldorf-Krefeld, Mannheim, and Minden, Germany; Leiden, The Netherlands; Linz and Vienna, Austria; Madrid, Spain; New York, NY; Paris, France; St Gallen and Zurich, Switzerland; Tel Aviv, Israel; and Turin, Italy



Domain	No.	Clinical consensus recommendation	Agreement	Comment/Notes
Evidence overview	1	Association between dupilumab and CTCL remains complex, controversial, and incompletely understood.	100%	—
	2	Despite concerns regarding possible association between dupilumab and CTCL, its significant clinical efficacy in AD should be acknowledged.	100%	—
Clinical scenarios warranting caution	3	Clinicians should maintain high index of suspicion for CTCL in atypical cases of AD, particularly in new-onset AD in adults aged >40 years, especially without personal or family history of atopy and/or with atypical clinical features.	100%	Clinical features suggestive of CTCL may include asymmetrical patches/plaques, predilection for bathing-trunk area, follicular lesions (particularly with alopecia), or erythroderma.
	4	Clinicians should maintain high index of suspicion in treatment-resistant AD, particularly when response to dupilumab is unexpected (eg, lack of improvement, clinical worsening, or emergence of atypical features including infiltrated plaques, tumors, erythroderma, lymphadenopathy, or B symptoms).	100%	—
Practical clinical recommendations	5	In such ambiguous presentations, skin biopsy for histopathologic and immunohistochemical analysis is warranted, with additional T-cell receptor clonality assessment when available, to exclude CTCL. In patients with erythroderma or generalized dermatitis, peripheral blood immunophenotyping by flow cytometry should also be considered, given possibility of SS.	100%	—
	6	In patients with suspected or confirmed CTCL, dupilumab should be avoided.	94%	Decisions should be individualized.

8.2025: topical steroids. Acitretin started 25 mg/die



10.2025: mild improvement. Decision to add nb-UVB



2.2026: follow up





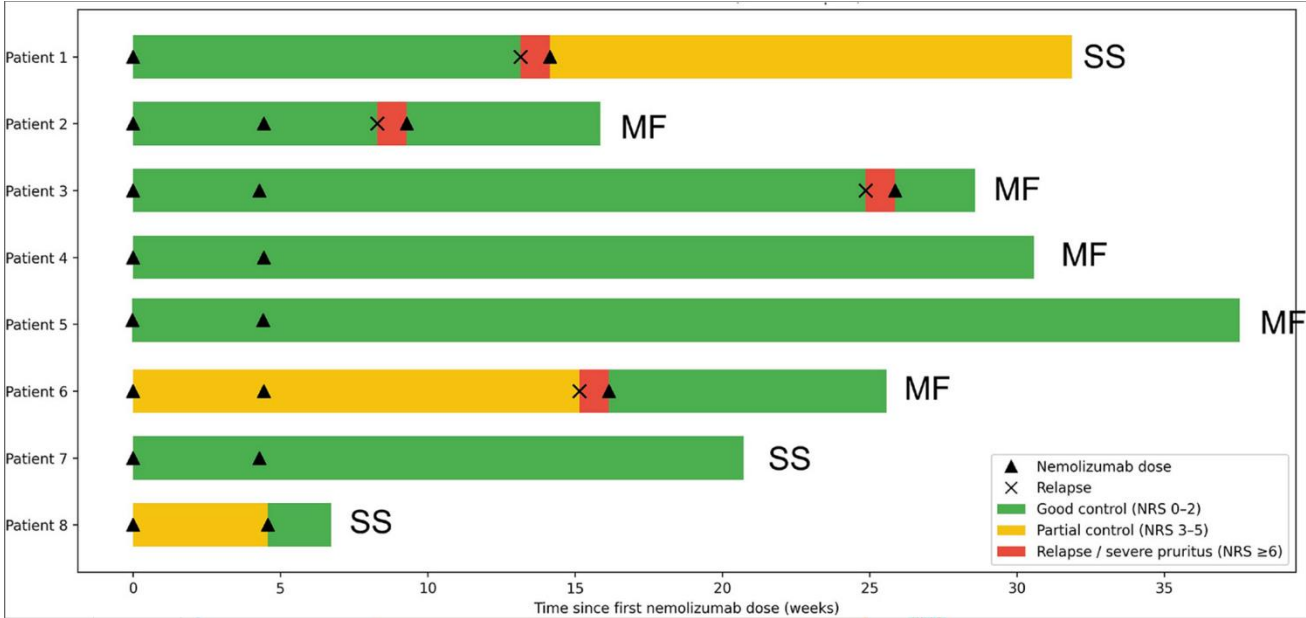
Nemolizumab for Pruritus Control in Cutaneous T-Cell Lymphoma: A Case Series

Yenny Angela, Ralf Gutzmer, Rudolf Stadler✉

First published: 24 June 2026 | <https://doi-org.bibliopass.unito.it/10.1111/ddg.70484> |

Patient	Age (years)	Sex	CTCL type	Stage	Prior systemic therapy lines (n)	Ongoing CTCL therapy	Baseline NRS	Baseline DLQI
1	65	F	SS	IVA1	1	Mogamulizumab	10	24
2	69	M	MF	IIB	3	Peg-IFN-α	10	5
3	62	M	MF	IIB	5	Peg-IFN-α	9	20
4	77	M	MF	IIB	2	Peg-IFN-α	8	18
5	51	M	SS	IIB	5	Fumaric acid esters	8	27
6	82	M	MF	IIIA	1	ECP	10	10
7	67	F	SS	IVA1	2	ECP	9	15
8	78	M	MF	IVA1	1	Mogamulizumab	9	30

Interleukin-31 receptor alpha (IL-31RA)



(Some) Prognostic factors in MF and SS

CLINICAL

Clinical factors

- Male sex
- Advanced age
- Advanced folliculotropic variant
- Advanced skin burden (based on T-score and mSWAT) (Plaque vs Patch)

BIOLOGICAL

Biological factors

- Elevated serum lactate dehydrogenase
- Blood eosinophilia (?)

PATHOLOGICAL

Pathological factors

- Large cell transformation
- High Sézary cell count (?)
- Peripheral blood T-cell clone identical to that in the skin
- CD30 negativity (?)

Quali parametri informano maggiormente sulla prognosi nei pazienti con MF avanzata (IIB-IVB)?

- La durata di malattia dalla diagnosi
- L'entità del coinvolgimento ematico (tumor burden - B)
- La presenza di eritrodermia all'esordio
- L'integrazione di parametri clinici, istologici e sierici

A New Prognostic Index (CLIPi) for Advanced Cutaneous Lymphoma Enables Precise Patient Risk Stratification

Julia J Scarisbrick ✉, Pietro Quaglino, Sean J Whittaker, Martine Bagot, Emmanuella Guenova, Evangelia Papadavid, H. Miles Prince, Jose Antonio Sanches, Denis Miyashiro, Octavio Servitje, Christiane Querfeld, Oleg E Akilov, Arvind Arumainathan, Luke Bennett, Maxime Battistella, Kim Benstead, Dr. Emilio francesco Berti, Marie Beylot-Barry, Anne-Marie Busschots, Richard Andrew Cowan, Reinhard Dummer, Giles Dunnill, Maria Teresa Estrach, Felicity Evison, Abraham Ellahi Bashir, Larisa J Geskin, Alejandro Gru, Joan Guitart, Melba C Herrera, Emilia Hodak, Steven M Horwitz, Constanze Jonak, Claus-Detlev Klemke, Robert Knobler, Pamela McKay, Marta Marschalkó, Cesare Massone, Rubeta Matin, Christina Mitteldorf, Roberto Andres Novoa, Pablo L. Ortiz-Romero, Nicola Pimpinelli, Ramon M Pujol, Annmari Ranki, Liisa Vankeva, Kerri E. Rieger, Rudolf Stadler, Franz Trautinger, Johanna Latzka, Maarten H. Vermeer, Rachel Wachsmuth, Sophie Weatherhead, Ulrike Wehkamp, Marion Wobser, Youn H Kim



Context of Research

Advanced **mycosis fungoides (MF)** and **Sézary syndrome (SS)** have a poor prognosis, with an overall survival rate of less than 5 years. Studies have found the current clinical staging (IA-IVB) to be inadequate for risk stratification.

Aim of This Study

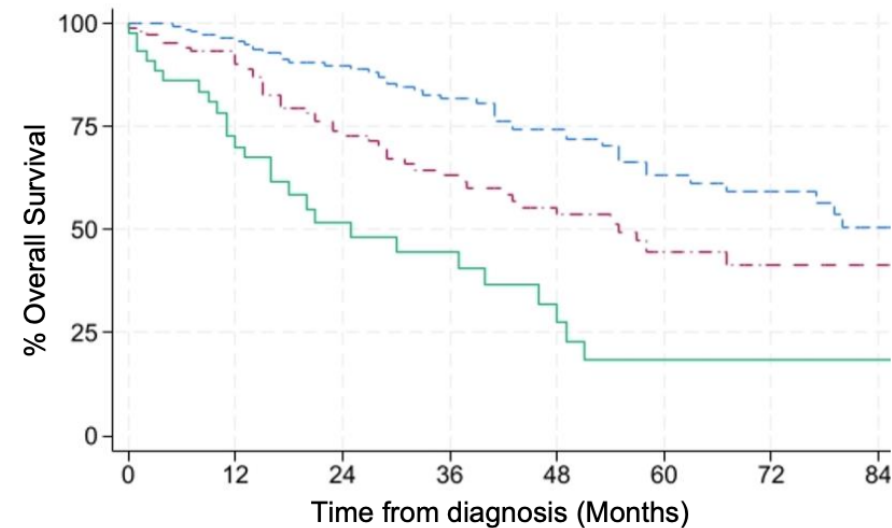
Our objective was to develop a **Cutaneous Lymphoma International Prognostic Index (CLIPi)** that could accurately identify MF/SS patients with poor outcomes, enabling better management decisions (**PROCLIPi study, NCT02848274**).

Findings

Prognostic Factors To Stratify Patients Into Risk Groups:

1. Age >60 Years
2. Raised LDH
3. N3 Node Status
4. Large Cell Transformation

- Low-risk (0-1 Risk Factors)
- - - Intermediate-risk (2 Risk Factors)
- High-risk (3-4 Risk Factors)





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Cutaneous Lymphoma International Prognostic Index and Risk Stratification in Advanced Mycosis Fungoides and Sézary Syndrome

Gabriele Rocuzzo, MD; Abraham Bashir, MD; Felicity Evison, MSc; Sean Whittaker, MBChB, MD; Martine Bagot, MD, PhD; Emmanuella Guenova, MD, PhD; Evangelia Papadavid, MD, PhD; Henry Miles Prince, MD, MBBS; Jose A. Sanches, MD, PhD; Denis R. Miyashiro, MD, PhD; Octavio Servitje, MD; Christiane Querfeld, MD, PhD; Oleg Akilov, MD, PhD; Arvind Arumainathan, MBBS, MRCP; Luke Bennett, MBBS; Maxime Battistella, MD, PhD; Mike Bayne, BSc, MD; Silvia Alberti Violetti, MD, PhD; Paolo Fava, MD; Christoph Iselin, MD; Marie Beylot-Barry, MD, PhD; Anne Marie Busschots, MD; Richard Cowan, MD; Reinhard Dummer, MD, PhD; Giles Dunnill, MBBS; Teresa Estrach, MD; Larisa Geskin, MD; Alejandro A. Gru, MD; Joan Guitart, MD; Melba C. Herrera, MD; Emilia Hodak, MD; Steve Horwitz, MD; Constanze Jonak, MD; Claus-Detlev Klemke, MD; Robert Knobler, MD; Pam McKay, MD; Marta Marschalkó, MD, PhD; Cesare Massone, MD; Rubeta N. Matin, MBBS, PhD; Christina Mitteldorf, MD; Robert Novoa, MD; Pablo Ortiz-Romero, MD, PhD; Nicola Pimpinelli, MD, PhD; Ramon M. Pujol, MD, PhD; Kerri E. Rieger, MD, PhD; Rudolf Stadler, MD, PhD; Franz Trautinger, MD; Johanna Latzka, MD; Maarten Vermeer, MD, PhD; Rachel Wachsmuth, BSc, MD; Sophie Weatherhead, MBBS, PhD; Ulrike Wehkamp, MD; Marion Wobser, MD; Pietro Quaglino, MD; Youn H. Kim, MD; Julia Scarisbrick, MBChB, MD

Figure 1. Kaplan-Meier Curves of Progression-Free Survival in the Overall Study Population With Advanced Mycosis Fungoides or Sézary Syndrome, by Baseline Disease Stage

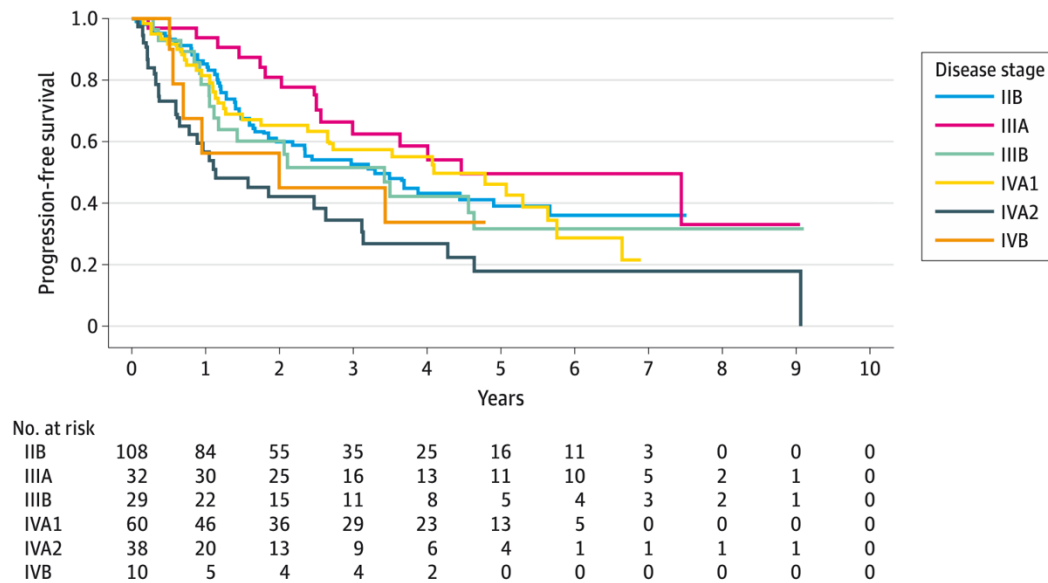
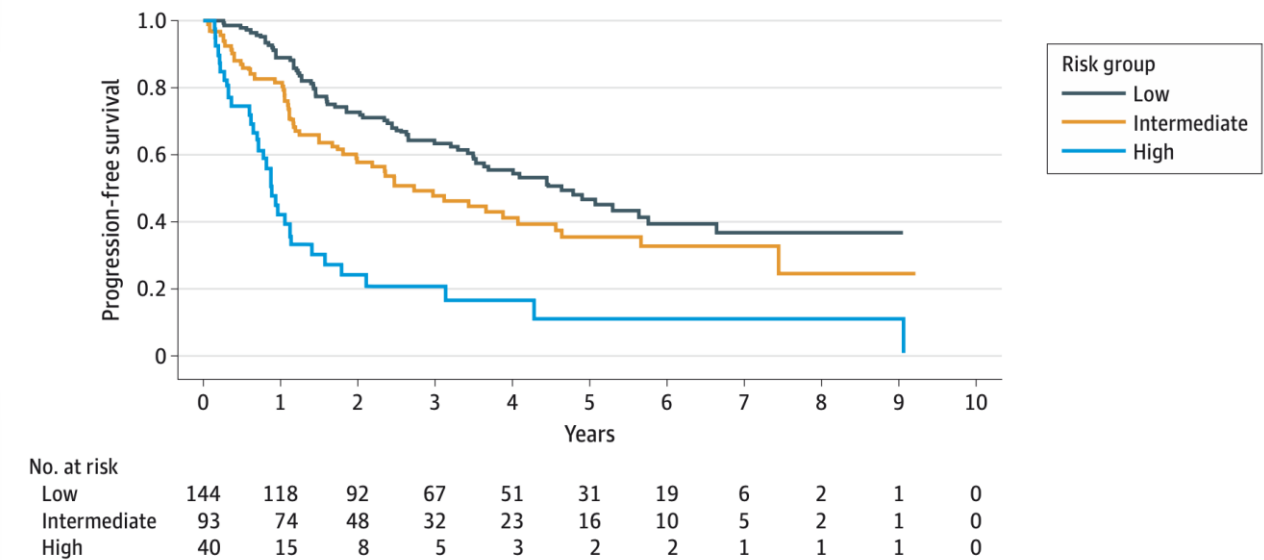


Figure 2. Kaplan-Meier Curves of Progression-Free Survival for Patients With Advanced Mycosis Fungoides or Sézary Syndrome, by Cutaneous Lymphoma International Prognostic Index Risk Group



“... Median PFS of 4.64 years (95% CI, 3.50-5.76), 2.72 years (95% CI, 1.81-4.56), and 0.89 years (95% CI, 0.65-1.14), respectively (log-rank $P < .001$). Patients in the intermediate-risk (hazard ratio [HR], 1.45; 95% CI, 1.01-2.08) and high-risk (HR, 3.84; 95% CI, 2.21-6.66) CLIP groups displayed higher hazards of progression than those at low risk...”



Table 3. Multivariate Ordered Logistic Regression on Best Objective Response (BOR) Among Patients With Advanced Mycosis Fungoides or Sézary Syndrome

BOR	OR (95% CI) ^a	SE	Z	P value
CLIP1 risk group	0.62 (0.43-0.89)	0.11	-2.60	<.01
Disease stage				
IIB	[Reference]	[Reference]	[Reference]	[Reference]
IIIA	0.38 (0.18-0.81)	0.14	-2.52	.01
IIIB	0.98 (0.44-2.19)	0.40	-0.04	.97
IVA1	0.57 (0.31-1.07)	0.18	-1.75	.08
IVA2	0.42 (0.18-0.98)	0.18	-2.00	.04
IVB	0.16 (0.05-0.65)	0.12	-2.63	<.01
Demographic characteristics				
Female	[Reference]	[Reference]	[Reference]	[Reference]
Male	0.74 (0.45-1.23)	0.19	-1.16	.25
Europe	0.89 (0.28-2.83)	0.53	-0.18	.86
US	1.89 (0.51-6.97)	1.26	0.96	.34
Race and ethnicity				
Unspecified	[Reference]	[Reference]	[Reference]	[Reference]
Asian	1.06 (0.19-6.06)	0.95	0.07	.94
Black	1.73 (0.48-6.25)	1.14	0.84	.39
Multiracial	0.44 (0.08-2.34)	0.38	-0.96	.34
White	0.92 (0.56-1.54)	0.24	-0.28	.78

Abbreviations: CLIP1, Cutaneous Lymphoma International Prognostic Index; OR, odds ratio.

^a ORs and 95% CIs are shown for CLIP1 risk group (per 1-point increase) and baseline covariates. The outcome is BOR categorized as complete response, partial response, stable disease, and progressive disease. ORs less than 1 indicate lower odds of observing a better response.

ANNUAL MEETING – 2026

EORTC Cutaneous Lymphoma Tumour Group

BERLIN
08–10 OCTOBER 2026

Thanks for your attention



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gabriele.roccuzzo@unito.it