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Skin (cutaneous) T-cell lymphoma

Skin (cutaneous) lymphomas are non-Hodgkin lymphomas that start in the skin. This page is about the most common group of skin lymphomas, T-cell skin lymphomas.

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There are lots of different types of T-cell skin lymphoma. This page contains information on all the different types. This might seem daunting. If you know what type of T-cell skin lymphoma you have, you may wish to read only the sections that apply to you.

What is T-cell skin lymphoma?

Lymphoma is a cancer that starts in white blood cells called lymphocytes, which are part of your **immune system**. There are two types of lymphocyte: **T lymphocytes (T cells)** and **B lymphocytes (B cells)**. Lymphomas can develop from either T cells or B cells.

Skin lymphomas are lymphomas that develop in the skin and have not affected any other areas of the body at the time they are diagnosed. T-cell skin lymphomas are skin lymphomas that develop from T cells.

A lymphoma that starts somewhere else in the body and then spreads to the skin is **not** a skin lymphoma. If you have a lymphoma that has spread to the skin, our information on the particular **type of lymphoma** you have will be more relevant for you.

We have separate information on **B-cell skin lymphomas** (rare skin lymphomas that develop from B cells).

Who gets T-cell skin lymphoma?

T-cell skin lymphoma (also called cutaneous T-cell lymphoma or CTCL) is rare. Fewer than 350 people are diagnosed with T-cell skin lymphoma in the UK each year.

Scientists don't know exactly what **causes** skin lymphoma but there are some factors that might increase your risk of developing it.

- **Age**: T-cell skin lymphoma is more common in older people. The average age at diagnosis is 55.
- **Sex**: Men are around twice as likely to develop T-cell skin lymphoma as women.
- **Ethnicity**: In the United States, research has found that T-cell skin lymphoma is more common in African American people than it is in white people.
- **Genetics**: Genetic factors might be involved in the development of some types of T-cell skin lymphoma. Mycosis fungoides, the most common type, can occasionally run in families but this is very rare.
- **Infections**: Adult T-cell leukaemia/lymphoma (a subtype of T-cell skin lymphoma) is linked to infection with a virus called 'human T-cell leukaemia virus type 1' (HTLV-1). This virus infects T-cells but it does not usually cause any symptoms. HTLV-1 infection is very common in some parts of the world, including Japan, West Africa, South America, the Caribbean region, Iran and the indigenous population of Australia. However, most people with HTLV-1 do **not** develop lymphoma.
- **Other conditions**: T-cell skin lymphoma is more common in people who have had a transplant (**post-transplant lymphoproliferative disorder, or PTLD**) and in people who have **HIV**.

Symptoms of T-cell skin lymphoma

Most T-cell skin lymphomas begin as patches of dry, discoloured skin (usually red), commonly on the buttocks or between the waist and shoulders (torso), but they can develop in other places. These patches may be itchy. They can look like more common skin conditions, such as dermatitis, eczema or psoriasis. Over time, other skin symptoms may develop, including:

- patches of lighter (hypopigmented) or darker (hyperpigmented) skin, particularly in people with darker skin tones
- patches of mottled skin
- harder or thicker areas of skin called plaques
- small, raised solid areas of skin called papules; these can look like a rash
- larger swellings in the skin, called nodules or tumours, which can break down (ulcerate) and scab over; you may only have one or two of these tumours, but in some skin lymphomas you might have several
- generalised reddening of the skin (erythroderma), which can be intensely itchy, dry and scaly
- thickened or cracked skin on the palms of the hands or soles of the feet.

For more information about these symptoms, including photographs, see our **overview of skin lymphomas**.

You may also have swollen **lymph nodes** in your neck, armpits or groin. They may be inflamed as a reaction to the nearby skin irritation or because they contain abnormal lymphoma cells.

If abnormal lymphoma cells (sometimes called Sézary cells) are circulating in your bloodstream, your whole body can feel very itchy. If you have large numbers of these cells, it can lower your immunity and make you more prone to **infections**.

A small number of people with T-cell skin lymphomas have more general **symptoms** such as unexplained weight loss, fevers or night sweats.

Diagnosis and staging of T-cell skin lymphoma

T-cell skin lymphomas are diagnosed using a **skin biopsy**. A skin biopsy can find out the exact type of skin lymphoma you have and whether it is slow-growing (low-grade) or fast-growing (high-grade). However, diagnosing skin lymphoma is not always straightforward, even for a specialist. You might need several skin biopsies before your doctor is able to confirm your diagnosis.

You may also have other tests to find out if any other parts of your body are affected by lymphoma – this is called '**staging**'. These may include:

- a physical examination
- **blood tests** to look at your general health and to test for bacterial or viral infections that might be linked to your lymphoma
- a **CT scan** or **PET/CT scan**
- a **bone marrow biopsy**
- a **lymph node biopsy** (if you have swollen lymph nodes).

Waiting for the results of your tests can be difficult but it is important that your specialist knows exactly what type of lymphoma you have so they can give you the most appropriate **treatment**.

Staging

The stage of the lymphoma describes how much of your body has been affected by lymphoma.

To find out the stage of your lymphoma, your doctors check:

- how your skin is affected – whether there are **patches**, **plaques** or **tumours**
- how much of your skin is affected
- whether the lymphoma is in any of your lymph nodes
- whether the lymphoma is in any of your internal organs
- for some types of T-cell skin lymphoma, whether you have abnormal lymphoma cells in your blood.

Most T-cell skin lymphomas are diagnosed at an early stage. The staging system used depends on the **type of T-cell skin lymphoma** you have.

Staging of mycosis fungoides and Sézary syndrome

Mycosis fungoides and Sézary syndrome are staged in the same way. Like most cancers, there are four main stages of these types of lymphoma.

Stage 1

The lymphoma only affects the skin (patches or plaques).

- Stage 1A means that less than a tenth of the skin is affected.
- Stage 1B means that a tenth or more of the skin is affected (roughly the size of both arms).

Stage 2

- Stage 2A means that there are patches or plaques on the skin and the lymph nodes are enlarged but they do not contain abnormal lymphoma cells.
- Stage 2B means that there are one or more raised lumps or tumours in the skin and the lymph nodes may or may not be enlarged but do not contain lymphoma cells.

Stage 3

Four-fifths or more of the skin is affected, with generalised redness, swelling, itching and sometimes pain (**erythroderma**). The lymph nodes can be enlarged, but don't contain abnormal lymphoma cells.

- Stage 3A means there are few or no lymphoma cells in the bloodstream (erythrodermic mycosis fungoides).
- Stage 3B means there are moderate numbers of lymphoma cells in the bloodstream (Sézary syndrome).

Stage 4

Stage 4 mycosis fungoides or Sézary syndrome affects the skin and has also spread to the bloodstream, lymph nodes or other organs.

- Stage 4A means there are numerous abnormal lymphoma cells in the bloodstream (Sézary syndrome) or the lymph nodes contain lymphoma cells
- Stage 4B means there is lymphoma in other organs.

'Early-stage' means anything up to 2A. Most people have this stage of skin lymphoma when they are diagnosed. A few people have more 'advanced-stage' disease (stages 2B, 3 and 4). Very rarely, the blood is affected at diagnosis (stages 3B or 4A, also called 'Sézary syndrome').

The stages are sometimes referred to as Roman numerals: I, II, III or IV. Occasionally, your doctor might also use the TNM staging system described below.

Staging of other types of T-cell skin lymphomas

Other T-cell skin lymphomas are staged using a system called 'TNM'. TNM stands for:

- **T**umour: how many papules, nodules or tumours you have, how big they are and where they are. This is shown by a 'T' and a number between 1 and 3, sometimes followed by a letter between a and c.
- **N**odes: how many lymph nodes are involved (if any) and where they are. This is shown by an 'N' and a number between 0 and 3.
- **M**etastasis: whether the lymphoma has spread (metastasised) to any part of the body apart from your skin or lymph nodes. This is shown by an 'M' followed by 0 or 1.

Your stage includes all three measures. For example:

- a person with one skin nodule smaller than 5cm, no swollen lymph nodes and no lymphoma anywhere else in their body would have a stage of T1aN0M0
- a person with several skin nodules confined to a 30cm area of skin, swollen lymph nodes in two areas of their body but no lymphoma anywhere else would have a stage of T2bN2M0.

Types of T-cell skin lymphoma

There are lots of different types of skin lymphoma, although many of them are very rare. They are often classed as either 'high-grade' or 'low-grade'.

- Low-grade lymphoma means the lymphoma cells are dividing slowly. It can develop over a long period of time. Low-grade lymphoma is sometimes called 'indolent' lymphoma.
- High-grade lymphoma means the lymphoma cells are dividing quickly. The lymphoma is likely to be relatively fast-growing. High-grade lymphoma is sometimes called 'aggressive' lymphoma.

Sometimes a lymphoma changes from a slow-growing type into a faster-growing type. Knowing how fast the lymphoma is developing is important in choosing the best treatment and in deciding how soon your treatment should start.

Most skin lymphomas are low-grade.

Skin lymphomas have complicated names based on the type of cell they develop from or the proteins they make. Below we have information on the different types, including the most common treatment options for each type. The amount of information might seem overwhelming. If you know what type of T-cell skin lymphoma you have, you can use the links to navigate straight to the sections that apply to you. If you do not know what type of T-cell skin lymphoma you have, you might find our **overview of skin lymphoma** or our page on **different treatments for skin lymphomas** more helpful.

Low-grade T-cell skin lymphomas include:

- **mycosis fungoides** and its subtypes (folliculotropic mycosis fungoides, pagetoid reticulosis and granulomatous slack skin)
- **primary cutaneous CD30-positive lymphoproliferative disorders**:
    - primary cutaneous anaplastic large cell lymphoma
    - lymphomatoid papulosis
- **subcutaneous panniculitis-like T-cell lymphoma**
- some rare types of primary cutaneous peripheral T-cell lymphoma:
    - **primary cutaneous CD4-positive small/medium T-cell lymphoproliferative disorder**
    - **primary cutaneous acral CD8-positive T-cell lymphoma**.

High-grade T-cell skin lymphomas include:

- **Sézary syndrome**
- **adult T-cell leukaemia/lymphoma**
- **extranodal NK/T-cell lymphoma, nasal type**
- some rare types of primary cutaneous peripheral T-cell lymphoma:
    - **primary cutaneous gamma/delta T-cell lymphoma**
    - **primary cutaneous aggressive epidermotropic CD8-positive T-cell lymphoma**
- primary cutaneous peripheral T-cell lymphoma, not otherwise specified (rare types of T-cell skin lymphoma that don't fit into any other category).

Mycosis fungoides

Mycosis fungoides is the most common skin lymphoma, accounting for around half of all skin lymphomas. It is a low-grade lymphoma that develops over many years or even decades. It typically affects older adults and is slightly more common in men than women. It is rarely life-threatening.

About 3 out of every 4 people have early-stage disease when they are first diagnosed. Most people have the classic type, but there are other, rarer subtypes.

Classic mycosis fungoides

Classic mycosis fungoides starts as irregularly-shaped, oval or ring-like (annular), dry or scaly **patches**. They are usually flat and either discoloured or pale. They can disappear spontaneously, stay the same size or slowly enlarge. They are most common on the chest, back or buttocks but can occur anywhere. They are often mistaken for more common skin conditions, such as eczema or psoriasis, sometimes for many years.

Sometimes similar, but thicker and slightly raised areas of skin develop, called '**plaques**'. They can be itchy and can sometimes break down (ulcerate). The most common places for them to appear are the buttocks and folds of skin. You may lose hair in affected areas.

Mycosis fungoides rarely develops beyond the early patch and plaque stage. In a small proportion of people, raised lumps appear on the skin. These are called '**tumours**'. They can ulcerate or weep and they can be painful.

In very few people the skin can become red, thickened and sore all over. This is called '**erythroderma**'. If this happens, it is possible that there are some lymphoma cells in the lymph nodes or blood too. This is called Sézary syndrome. It is rare.

Mycosis fungoides does not usually involve other internal organs or the bone marrow.

Rarer forms of mycosis fungoides

Apart from the classic form of mycosis fungoides there are three other, rarer forms that behave slightly differently and look different under a microscope.

- **Folliculotropic mycosis fungoides** is a low-grade lymphoma that accounts for around 4 in every 100 cases of skin lymphoma. It affects hair follicles in particular. It commonly affects the head and neck and can cause hair loss, particularly in the eyebrows. You may have just one patch, plaque or tumour but most people have several. You may have small cysts or blocked pores. These are sometimes called 'whiteheads' ('comedomes') or 'milk spots' ('milia') as they look like white bumps on the skin. Folliculotropic mycosis fungoides can be very itchy.
- **Pagetoid reticulosis** (also known as Woringer–Kolopp disease) is a rare low-grade subtype of mycosis fungoides. It usually shows up as a single scaly plaque, often on an arm or leg. It never spreads beyond the skin.
- **Granulomatous slack skin** (GSS) is an extremely rare low-grade form of mycosis fungoides. It is more common in people from white ethnic groups. Loose folds of skin develop in the armpits and groin. Patches and plaques might develop in skin folds.

Treatment for mycosis fungoides

Mycosis fungoides can be very well controlled with treatment, but it has a tendency to come back (relapse) when treatment is stopped. A few people need no treatment at all at first. A good skincare regime with regular use of moisturisers helps to prevent dryness and irritation. If you have stage 1 disease, this may be all you need.

If larger areas of your skin are affected, or if you have troublesome itching, you may have treatments applied directly to the skin. These are called **topical treatments**. They include **steroid creams**, **topical retinoids**, **light therapy** or **chemotherapy drugs** in a cream that you apply to your skin. You might also have **radiotherapy** to treat plaques or tumours.

If you don't respond to topical treatment or you have more advanced mycosis fungoides, you might need **whole body (systemic) treatment** as well as topical treatments. This might include:

- **total skin electron beam therapy** (a type of radiotherapy that treats all of your skin)
- **immunotherapy** (for example, **bexarotene** or **interferon-alfa**)
- **systemic chemotherapy**.

If you have erythroderma, you may have **extracorporeal photopheresis (ECP)**. This is a type of light treatment where your blood is treated with ultraviolet A light.

If your mycosis fungoides doesn't respond to these treatments (refractory) or comes back after treatment (relapses), you might have **antibody treatment** with alemtuzumab or brentuximab vedotin.

Young, fit patients who have advanced mycosis fungoides and haven't responded to other treatments might have a stem cell transplant using cells from a donor (an **allogeneic stem cell transplant**).

Some people with more advanced mycosis fungoides might be asked if they'd like to take part in a **clinical trial**.

During the course of your lymphoma, you might need several different treatments. When symptoms flare up, you don't always need 'stronger' treatment than you had before. You usually have the lowest possible treatment that controls your symptoms. This keeps your risk of side effects to a minimum.

The **Cutaneous Lymphoma Foundation** has **more information about mycosis fungoides**.

Sézary syndrome

Sézary syndrome is a rare high-grade skin lymphoma. It accounts for about 3 in every 100 cases of skin lymphoma. Sézary syndrome is similar to **mycosis fungoides** but it affects the blood as well as the skin. Most people with Sézary syndrome develop it without having had any milder form of skin lymphoma beforehand. Signs and symptoms of Sézary syndrome may include:

- large areas of bright red, thickened, swollen and sore skin (**erythroderma**) that sometimes peels
- large numbers of abnormal T cells called 'Sézary cells' in the blood
- severe itching
- swollen lymph nodes
- hair loss
- thickening of the skin of the palms of the hands and the soles of the feet
- drooping of the lower eyelid (ectropion).

A large number of Sézary cells circulating in the bloodstream also means that the immune system doesn't work as well as it should. This can make you more prone to infection.

Treatment for Sézary syndrome

Sézary syndrome affects the whole body, not just the skin. It needs to be treated with **whole body (systemic) treatment**. The first choice of treatment is usually **extracorporeal photopheresis (ECP)**. This might be combined with other treatments, such as:

- **methotrexate**
- **bexarotene**
- **interferon-alfa**.

If you have Sézary syndrome that has not responded to initial treatment or has spread to other organs, you might have:

- **radiotherapy**
- **chemotherapy**
- **antibody therapy** with alemtuzumab or brentuximab vedotin.

Young, fit patients with Sézary syndrome that hasn't responded to other treatments might have a stem cell transplant using cells from a donor (an **allogeneic stem cell transplant**). Some people might be asked if they'd like to take part in a **clinical trial**.

Primary cutaneous CD30-positive lymphoproliferative disorders

These are low-grade T-cell skin lymphomas where the abnormal lymphocytes make a protein called CD30. There are two main subtypes:

- **primary cutaneous anaplastic large-cell lymphoma**
- **lymphomatoid papulosis**.

Both of these conditions respond well to treatment and have an excellent outlook.

Primary cutaneous anaplastic large-cell lymphoma (ALCL)

Primary cutaneous ALCL usually affects adults but it can occasionally occur in children. It is more common in men than women. It usually appears as a single **tumour** on the skin, but you may have a group of tumours in one area. Tumours usually appear on the head and neck, arms or legs. They can grow to be several centimetres and they often break down (ulcerate). They can go away completely without any treatment.

If you need treatment for a single tumour, you are most likely to have surgery or **radiotherapy**. If more of your skin is affected, you might be treated with **chemotherapy** or an **antibody therapy** called brentuximab vedotin.

Lymphomatoid papulosis (LyP)

LyP comes under the umbrella of T-cell skin lymphoma but it is what is known as a 'lymphoproliferative disorder'. This is a benign condition where lymphocytes collect or grow abnormally but their overall behaviour is harmless. LyP does not spread, it does not affect life expectancy, and it often clears on its own or with very little treatment. It is very rare and it is still being studied.

LyP is very slow-growing. It is most common in adults aged 35 to 45 and affects more men than women. It tends to come and go. It usually develops as crops of red spots (**papules**) or bigger lumps (**nodules**), which appear over a period of a few days, usually on the chest, back, arms or legs. You might only have a few of these or you might have hundreds. Sometimes they break down (ulcerate) in the middle. They usually heal after a few weeks or months, but they can leave scars behind.

People with LyP have a higher risk than other people of developing some types of blood cancer, especially **primary cutaneous ALCL**, **mycosis fungoides** or **Hodgkin lymphoma**. However, most people with LyP do **not** go on to develop cancer.

Outbreaks of LyP often clear up on their own and you may not need any treatment at all. You might be put on **active monitoring** or you might have **skin-directed (topical) treatment** with ointments, creams or gels, or **phototherapy**. If you have very frequent or severe attacks, you might have treatment with a low dose **chemotherapy** drug called methotrexate, local **radiotherapy** or a drug called **interferon-alfa**.

The DermNet New Zealand Trust produces **more information on LyP**.

Rare types of cutaneous T-cell lymphoma

There are several rare types of T-cell skin lymphoma. These can be either slow-growing (low-grade) or fast-growing (high-grade).

Rare low-grade cutaneous T-cell lymphomas

Rare low-grade cutaneous T-cell lymphomas generally respond well to treatment and have an excellent outlook.

Subcutaneous panniculitis-like T-cell lymphoma (SPTCL)

SPTCL is a low-grade skin lymphoma that tends to affect young adults. It is slightly more common in women. Around 1 in 5 people with SPTCL also have an **autoimmune disease** (an illness caused by your immune system attacking your own body).

SPTCL starts in the fatty layer of the skin, just below the surface. You may have one or more **plaques** or **nodules**, often on the legs. You may also have other more general **symptoms**, such as fevers, low blood counts and weight loss. Symptoms often come and go.

This condition responds very well to **steroid tablets**, which may be the only treatment you need. If you do need more treatment, you may have local **radiotherapy** or **chemotherapy**. If your SPTCL is faster growing, you may need a **stem cell transplant**.

Primary cutaneous acral CD8-positive T-cell lymphoma

This type of lymphoma usually affects adults over 50. It is more common in men than women. It typically develops as a single slow-growing papule or nodule, usually on the ear or, sometimes, both ears. It can also affect the nose, hands or feet. It is usually treated by surgical removal or local **radiotherapy**.

Primary cutaneous CD4-positive small/medium T-cell lymphoproliferative disorder

This condition used to be considered a type of skin lymphoma but it is now classed as a 'lymphoproliferative disorder'. This is a benign condition where lymphocytes collect or grow abnormally but their overall behaviour is harmless. It tends to affect adults aged around 50 to 60. It usually appears as a single **plaque** or **nodule**, commonly on the face or neck. Treatment is usually surgery or local **radiotherapy**.

Rare high-grade T-cell skin lymphomas

High-grade T-cell skin lymphomas are faster-growing lymphomas that need stronger (more intense) treatment.

Adult T-cell leukaemia/lymphoma

Adult T-cell leukaemia/lymphoma (ATLL) is a rare lymphoma linked to infection with a virus called human T-cell lymphotropicvirus type-1 (HTLV-1). We have a detailed page on **adult T-cell leukaemia/lymphoma** in our section on **T-cell lymphomas**.

Extranodal NK/T-cell lymphoma, nasal type

Extranodal NK/T-cell lymphoma, nasal type, is a rare form of lymphoma that is linked to infection with a virus called Epstein-Barr virus (EBV). Extranodal NK/T-cell lymphoma, nasal type, is very rare in the UK. It is more common in Asia and Central and South America.

We have a detailed page on **extranodal NK/T-cell lymphoma, nasal type** in our section on **T-cell lymphomas**.

Primary cutaneous gamma/delta T-cell lymphoma

Primary cutaneous gamma/delta T-cell lymphoma usually develops in older adults. It affects men and women equally. It causes large, deep **patches** and **plaques** or ulcerated nodules, typically on the arms or legs. You may also have **B symptoms** (night sweats, fevers and weight loss). Some people develop **low blood counts** and an enlarged liver and **spleen**. Your doctor is most likely to suggest treatment with a **combination of chemotherapy drugs**, or, in some circumstances, a **stem cell transplant**. You might have **radiotherapy**, including **total skin electron beam therapy**, to help your symptoms.

Primary cutaneous aggressive epidermotropic CD8-positive T-cell lymphoma

This type of lymphoma tends to affect older adults. It appears as widespread **papules**, **plaques** and **tumours** on the skin. Affected areas may ulcerate. It can also affect the lining of the mouth. It grows quickly and can spread to other organs.

Your doctor is most likely to suggest treatment with a **combination of chemotherapy drugs**, or, in some circumstances, a **stem cell transplant**. To help your symptoms, you might have **radiotherapy**, including **total skin electron beam therapy**.

Outlook for T-cell skin lymphoma

In most cases, skin lymphomas are long-term (chronic) conditions that are not life-threatening. Treatment usually aims to control the symptoms rather than cure the lymphoma.

Your outlook (prognosis) depends on lots of factors, including your age and general health and the exact type of T-cell skin lymphoma you have. Your specialist is best placed to advise you on your outlook based on your individual circumstances.

Most low-grade skin lymphomas never develop beyond early stages. They are often diagnosed early, grow slowly and respond well to treatment. Any skin problems they cause come and go and only need treatment some of the time.

Some low-grade lymphomas do not become obvious until they are more advanced and the disease has spread to the lymph nodes, blood or internal organs. With treatment, many people with advanced disease have long periods when they are free of symptoms. However, the lymphoma may come back more quickly after treatment than earlier-stage disease. If it comes back, it can often be controlled for many years with treatment.

Some skin lymphomas are faster-growing and more aggressive in their behaviour. These develop more rapidly and need stronger (more intensive) treatment more urgently.

Occasionally, slow-growing (**low-grade**) T-cell skin lymphomas can change (**transform**) into a faster-growing type, although this is rare. Your medical team should check for this. If your lymphoma transforms, you need more intensive treatment.

Follow-up of T-cell skin lymphoma

How often you have **check-ups** depends mainly on what type of skin lymphoma you have and how it is responding to treatment. You might only see your specialist every 6 to 12 months if:

- you have a slow-growing (low-grade) skin lymphoma
- your condition is stable (unchanging) or in **remission** (no evidence of the disease) after treatment.

If your skin lymphoma is fast-growing (high-grade), or is continuing to grow, you may see your doctor as often as every 4 to 6 weeks.

At the clinic, your doctor will ask about your symptoms and examine you. Occasionally, you might have blood tests, scans or biopsies.

Tell your doctor if you have any symptoms that are troubling you, if you've noticed any changes in your skin, or you have any new swellings.

Research and clinical trials

Researchers are continually trying to find out which treatment, or combination of treatments, works best for skin lymphomas. Your doctor may ask if you would like to take part in a clinical trial. Clinical trials allow new treatments to be evaluated and compared with more established ones. Studying treatments is the only way that new and, hopefully, better treatments can become available.

Find out more about clinical trials and search for a clinical trial that might be suitable for you at **Lymphoma TrialsLink**.

We have separate information about the topics in **bold font**. Please get in touch if you'd like to request copies or if you would like further information about any aspect of lymphoma. Phone 0808 808 5555 or email **information@lymphoma-action.org.uk**.

References

The full list of references for this page is available on our website. Alternatively, email **publications@lymphoma-action.org.uk** or call 01296 619409 if you would like a copy.

Acknowledgements

- Dr Eileen Parry, Consultant Dermatologist, Tameside and Glossop Integrated Care NHS Foundation Trust. Dr Parry has been paid to take part in advisory board meetings for Actelion, Takeda and Kyowa-Kirin and has provided expert opinion on NICE submissions.
- Helen Easson, Haematology Clinical Nurse Specialist, Royal Hallamshire Hospital.
- We would like to thank the members of our Reader Panel who gave their time to review this information.
- With thanks to Kyowa Kirin for contributing towards the costs of maintaining our skin lymphomas webpages. In accordance with **how we work with healthcare and pharmaceutical companies**, Kyowa Kirin has had no involvement in the content.

Content last reviewed: April 2019
Next planned review: April 2022
LYMweb201TSkin2019v2

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