Numerous and have been generally inferred from the pedigree, giving rise to the dominant and recessive incidence values (Fine et al., 1999).

The new mutation rate for any of the forms of EB has not been calculated; however, a number of sporadic cases of DEB have been analyzed for mutations in the COL7A1 gene and are presumed to result from germline mosaicism (Rouan et al., 1998; Hashimoto et al., 1999; Lee et al. 2000). Continued elucidation of the mutations involved in all forms of EB will allow us to further understand the relative numbers of new mutations, and to correlate type of mutation and pattern of inheritance.

The carrier incidence information provided in Table I should enable genetics professionals to accurately calculate the risk of recurrence to individual family members based on the family history and provide up-to-date risk estimates that will facilitate accurate counselling of extended families at risk.

The sensitivity and specificity of the two techniques are similar, which would be expected given that both methods depend on detection of tumor-specific TCR V(D)J gene rearrangements. The reason for the authors contention that our approach is less sensitive suggests that the sensitivity of the two techniques are broadly similar. Comparative studies would be worthwhile.

A Peripheral Blood T Cell Clone is a Prognostic Marker in Mycosis Fungoides

To the Editor:

Dr Muche and colleagues (2000) have raised several criticisms of our recent article (Fraser-Andrews et al., 2000). Specifically they question our findings that a peripheral blood T cell clone is an independent prognostic feature in mycosis fungoides (p = 0.03 with a hazards ratio of 2.6 after adjusting for age, skin stage, and lymph node stage). Our results are based on multivariate analysis of 66 patients with up to 10 y follow-up and crucially includes analysis of data at diagnosis for the majority of patients. Whilst we acknowledge that further prospective studies of larger numbers with longer follow-up are required, their comment that “the survival or time to progression in stage of the reported mycosis fungoides (MF) patients with or without peripheral blood T cell clonality” is not relevant if data are analyzed from diagnosis. In other words the results at diagnosis give a measure of tumor burden that can then be entered into a multivariate analysis. The reason for the authors differing conclusions is because their study is not based on data at the time of diagnosis and predominally consists of patients with T1 and T2 MF and only four patients with T3 stage disease. In addition the follow-up in their study is much shorter than ours. They state that the presence of a peripheral blood T-cell clone fluctuated during the course of the disease in some of their patients, which would be expected and might reflect a partial response to different therapies. Once again this emphasises the importance of analysing data from diagnosis. Inevitably they cannot perform a multivariate analysis on these results and therefore cannot make any conclusions regarding the prognostic implications.

We agree that the proportion of peripheral blood T cell clones detected will reflect the sensitivity of the method and certainly the use of oligonucleotides for the tumor specific V(D)J clonal TCR gene rearrangement would be too sensitive. Intriguingly the relative proportions of their T1/T2 patients with peripheral blood T cell clones are similar to our findings in early stage disease. This suggests that the sensitivity of the two techniques are broadly similar, which would be expected given that both methods depend on distinguishing clonal rearrangements on the basis of sequence and size. In fact our method employed monoplex rather than multiplex polymerase chain reaction and radioactively labelled products which should increase the sensitivity. There is certainly no basis for the authors contention that our approach is less sensitive but comparative studies would be worthwhile.

**REFERENCES**


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The study by Laetsch et al has revealed similar findings to our study, namely that almost 75% of CTCL patients with stage III–IVb disease have peripheral blood T cell clones. The essential aspect of this study is that both the presence of a peripheral blood T cell clone and the CD4+/CD7-cell count are independently correlated with stage. They have not drawn any conclusions regarding the prognostic significance of their data as suggested by Muche et al.

Finally Muche et al speculate about physiologic recirculation of tumor cells. We agree that tumor cells will recirculate physiologically but the detection of these cells can still represent a measure of tumor burden and these two concepts are not mutually exclusive.

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