**Methods**

We selected all patients who were diagnosed with MF and presented at least 1 poikilodermatous lesion, who had been treated at our Cutaneous Lymphoma Unit since 1990. We conducted a retrospective analysis of their medical charts and interviewed each patient. Clinical stage was determined by the TNMB system [24].

We categorized patients according to the clinical presentation of their poikilodermatous lesions, determining 3 groups: (1) localized poikilodermatous MF (LpMF), with poikilodermatous patches affecting mainly the flexural areas; (2) generalized poikilodermatous MF (GpMF), with diffuse lesions affecting over 80% of the skin; (3) mixed poikilodermatous MF (mix-pMF), with poikilodermatous lesions admixed with patches and plaques of classic MF or other MF variants.

The patients’ histological and immunohistochemical slides were reviewed retrospectively by an experienced dermatopathologist and a dermatologist. The system proposed by Guitart et al. [25] (Supplement 1) was applied for the histological diagnosis of MF. The slides were stained for CD3, CD4, CD8 and CD7, and their expression was analyzed in atypical lymphocytes.

All data on T-cell receptor γ clonality in the skin, measured by polymerase chain reaction, was accessed and analyzed [26].

Continuous variables were tested for normality with the Kolmogorov-Smirnov and Shapiro-Wilk tests. The median values ranged from the 25th to 75th percentiles.

The categorical data are presented as absolute values and percentages and were checked using the Pearson χ2 and Fisher exact tests, when applicable.

Nonparametric data were compared using the Kruskal-Wallis test, followed by the Dwass-Steel-Chritchlow-Fligner post hoc test. Statistical significance was considered at *p* ≤ 0.05.