Early MF can be treated with broadband UVB, narrowband UVB, or psoralen and ultraviolet A (PUVA). The goal of treatment is to suppress the disorder to prevent possible progression to overt MF. Cases that satisfy the clinicopathologic criteria for MF should undergo a comprehensive evaluation, including a full body examination for the presence of multiple lesions. Other nonspecific histopathologic features, such as thickened epidermis, spongiosis, and hyperkeratosis, are suggestive of MF. The diagnosis of SPP because the latter disorder includes only lesions that are no more than 1 cm in diameter. Individual SPP lesions may involve any area of the body, from the head to the feet, and can be seen in any age group. These lesions are light red-brown or salmon pink, and their surface is covered with small and scanty scales. The long axis of these lesions often measures greater than 5 cm. The duration of lesions is variable, ranging from a few weeks to several months. The presence of telangiectasia defines the term poikiloderma or poikiloderma atrophicans vasculare, which also includes other dermatologic conditions such as dyskeratosis congenita, Rothmund-Thomson syndrome, and chronic radiation dermatitis. These relationships suggest that progression from LPP through the various stages of the MF disease spectrum is accompanied by an increasing gradient of dominant T-cell clonal density. The current classification of parapsoriasis includes large and small-plaque forms of the disease. Larger plaques (LPP) are typically seen in males, especially those with a history of sun-exposed skin. Small-plaque parapsoriasis (SPP) is usually seen in females, and may be associated with a number of systemic conditions such as dyskeratosis congenita, Rothmund-Thomson syndrome, and chronic radiation dermatitis. The diagnosis of parapsoriasis en plaques is based on a holistic integration of clinical, histopathologic, immunopathologic, and clonality data. This algorithm is presented in Table 25-2. This view is also supported by the presence of structural and numerical chromosomal abnormalities in patients with parapsoriasis. In this context, LPP can be regarded as the clinically benign end of the MF disease spectrum, which eventuates in transformed large cell lymphoma at its malignant extreme. To our understanding of the pathogenesis of both chronic dermatitis and mycosis fungoides (MF), it is likely that a complete understanding of the pathogenesis of parapsoriasis will develop in the future.