JBUON 2014; 19(4): 1125-1129
ISSN: 1107-0625, online ISSN: 2241-6293 • www.jbuon.com
E-mail: editorial_office@jbuon.com

LETTERS TO THE EDITOR

Anaplastic variant of diffuse large B-cell lymphoma associated with cutaneous fistulas; an unusual presentation

Dear Editor,

We present a 66-year-old female patient who developed right cervical and submandibular swelling. She had visited an Ear-Nose-Throat surgeon who performed a right cervical lymph node excision. The patient had multiple enlarged lymph nodes in the right cervical and submandibular areas. There were also 3 discharging fistulas: the first was high in the right posterior cervical area; the second, low in the right anterior cervical area; and the third was in the right submental area just left of the midline. There were red-purple, slightly painful, indurated areas surrounding the discharging tracts, which produced serohemorrhagic mucus (Figure 1). A swab of the discharge showed no bacterial growth. The histopathological examination of the lymph node biopsy revealed a necrotic and hemorrhagic lymphoid infiltrate penetrating from nasopharyngeal tissue into the subcutaneous soft tissue and skin. The neoplastic lymphoid cells were large, round, oval with pleomorphic nuclei and prominent nucleoli. They were growing in a cohesive and sinusoidal pattern. Immunohistochemically, the neoplastic cells were strongly positive for CD20 and mostly for CD30. Some of them showed intranuclear bcl6 positivity. ALK, CD3, CD5, CD138, CD10, Tdt and bcl2 were negative. The final diagnosis was diffuse large B cell lymphoma (DLBCL), anaplastic variant. Neck, chest and abdominopelvic CT were normal. The patient had Ann Arbor stage IIB disease. She was administered 6 courses of R-CHOP with complete response of the enlarghed lymph nodes and B-symptoms while the fistulas over the skin disappeared.

The presentation of anaplastic variant of DLBCL with discharging cutaneous fistulas has not been reported before. Nevertheless, tracheomediastinal [1], carotid-cavernous [2], and gastropleural fistulas [3] secondary to DLBCL have been reported. After elimination of other diagnoses, like tuberculosis, actinomycosis, oncologic malignancies, this rare presentation of anaplastic variant of DLBCL should be kept in mind in the differential diagnosis of cutaneous fistulas in the neck region.

References

1. Choudhary C, Gildea TR, Salman R, Guzman ED, Mehta AC. Management of tracheomediastinal fistula using self-expanding metallic stents. Ann Thorac Surg 2008;85:1800-1802.
2. Wong GK, Sze AM, Yu SC, Choi PC, Poon WS. Diffuse large B-cell non-Hodgkin's lymphoma associated with bilateral carotid-cavernous fistulas in an elderly woman. J Clin Neurosci 2007;14:904-907.
3. Adachi Y, Sato Y, Yasui H et al. Gastropleural fistula derived from malignant lymphoma. J Gastroenterol 2002;37:1052-1056.

Gulsum Emel Pamuk[1], Murat Tasci[2], Mehmet Sevki Uyanik[1], Mustafa Akker[2], Fulya Oz Puyan[3]

[1]*Department of Hematology,* [2]*Department of Internal Medicine,* [3]*Department of Pathology, Trakya University Medical Faculty, Edirne, Turkey*

Correspondence to: Gulsum Emel Pamuk, MD.
E-mail: gepamuk@gmail.com

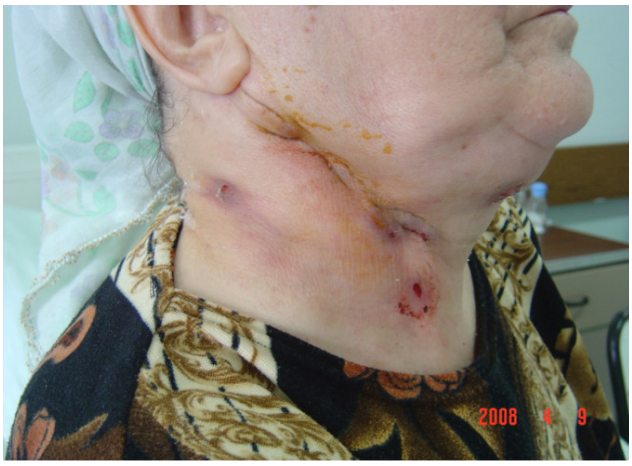

Figure 1. Photograph of the patient's neck with discharging fistulas.

Alternative oncological treatment: Psychological support for cancer patients - means for a better quality of life or better survival

Dear Editor,

For the vast majority of the people, dealing with difficult situations, such as knowledge that one is suffering from a malignant disease, inevitably leads to severe psychological reactions and emotional exhaustion [1]. This is manifested by fear, depression, anger and a sense of hopelessness. It is a state of intense emotion in which many patients regress psychologically and emotionally to infanthood, when we were all helplessly dependent on our parents, who waved a magic wand to remove our anxieties and fears. This is the reason why emotionally oversensitive people, faced with the diagnosis of a malignant disease, aspire to a fairy-tale solution, expecting the disease to disappear overnight, as if by magic. Most patients overcome this psychological barrier and face reality; however, a number remain emotionally paralyzed, unable to think and act rationally [2].

In Serbia, this psychological framework provides an ideal foundation for the operation of many miraculous healers and quacks. There are various treatments available on the market of "alternative" medicine, from ordinary spells through "bioenergy", from white magicians and herbalists to sophisticated "pharmacists", who standardize and pack their preparations in a similar way to official remedies.

I am one of the doctors who do not reject *a priori* the possibilities of alternative treatment. I was even inclined to believe that the short-term hope patients experience by reading or listening to fantastic stories of success from healers, whose sought help, represents something good and beneficial in the grey hopelessness of malignant disease. However, that hope is usually false, often very expensive, and unfortunately often replaces the right way, meaning loss of valuable time for a potentially successful treatment.

Recently, I had a patient with a story that the lump which she had felt in her breast for some time was being healed by applying tea compresses, sent to her by a herbalist from Prokuplje (a small town in southern Serbia). She found him through a newspaper advertisement. As the treatment progressed she noticed new lumps on the skin of the breast, but when she told her healer about this (by phone) he advised changing the "cure," so that she subsequently applied a marigold compress to her breast. After medical examination I noticed locally advanced breast cancer, with regional cutaneous metastases and enlarged axillary lymph nodes. In this case, the "treatment" probably caused the rapid progression of the disease by local irritation, but even if it did not, she had lost several precious months.

It is a matter of emotional maturity and stability for a patient to rely on the albeit limited but clearly defined opportunity of conventional medicine. These means can be significantly increased by the efforts and interest of both the doctor and the patient, and this is what often tips the balance to a favorable turn of events. In an atmosphere of trust and a sense that the best possible treatment offered by conventional medicine has been chosen, hope develops, not as elated and great as when a cure is offered overnight, but nevertheless stable, mature, and beneficial [3].

However, we have already said that not all patients are fit and ready for such a relationship, and we know that not all oncologists are patient enough and willing to be psychologically supportive.

Is it necessary for oncologists to act as psychotherapists?

When psychopathological reactions prevent the patient from accepting recommendations for optimal treatment, it is beyond the scope of professional activities of the oncologist. This is a field for the activity of another group of professionals - psychotherapists. If the therapist enables the patient to accept his illness and the proposed treatment, he will not only improve the patient's quality of life but also survival. I think that this is a convincing reason for a psychotherapist to become a mandatory member of the oncology team, and to be among the first to see the patient.

References

1. Cieślak K. Professional psychological support and psychotherapy methods for oncology patients. Basic concepts and issues. Rep Pract Oncol Radiother 2013;18:121-126.
2. Kash KM, Mago R, Kunkel EJ. Psychosocial oncology: supportive care for the cancer patient. Semin Oncol 2005;32:211-218.
3. Ando N, Iwamitsu Y, Kuranami M et al. Psychological characteristics and subjective symptoms as determinants of psychological distress in patients prior to breast cancer diagnosis. Support Care Cancer 2009;17:1361-1370.

Nebosja Ivanovic, Darko Zdravkovic.

Department of Surgical Oncology-University Medical Center "Bezanijska Kosa", Belgrade, and Medical Faculty of Belgrade University, Belgrade, Serbia

Correspondence to: N.Ivanovic,
E-mail: ivanovicnebojsadr@gmail.com

Acute erythroid leukemia in a patient with chronic lymphocytic leukemia

Dear Editor,

Acute erythroid leukemia (AEL) is a rare form of acute myeloid leukemia (AML) comprising < 5% of cases of adult AML [1]. In half of the cases, AEL is secondary to chemotherapy or immunosuppressive therapy and also develops as blastic crisis of myeloproliferative syndromes and final evolution of myelodysplasia [2]. Development of AEL during the course of chronic lymphocytic leukemia (CLL) is rare.

A 71-year-old female patient diagnosed with stage II CLL during examination for multiple lymphadenopathy received several courses of CHOP, chlorambucil, prednisolone and fludarabine, cyclophosphamide and rituximab (FCR) regimens in chronological order. After 5 years of disease course she developed splenomegaly and a bone marrow biopsy showed dysplastic changes in all 3 blood cell lines and no evidence of CLL. The patient was diagnosed with myelodysplastic syndrome and entered a periodic follow up schedule without medication. On the third year of follow up the patient's peripheral blood smear demonstrated a leukoerythroblastic reaction and a bone marrow biopsy was performed in an attempt to identify the underlying etiology. Biopsy and flow cytometry revealed findings consistent with erythroleukemia with prominent increase in erythroid/myeloid ratio. In aspirate specimens 86% of the cells were erythroid precursors with megaloblastic and dysplastic changes. Of the non-erythroid cells 57% were blasts .The patient started induction chemotherapy for AML with idarubicin (12 mg/m2/day, for 2 days) and cytocine-arabinoside (100 mg/m2/day, for 5 days).

Once diagnosed, the clinical course of CLL is extremely heterogeneous. Some patients will live for decades and will never require treatment, while others require immediate treatment. Patients with CLL may have disease transformation to non-Hodgkin's lymphoma or prolymphocytic leukemia; however, development of therapy-related AML (t-AML) is unusual. In a series of 521 patients 6 (1.2%) developed t-MDS (N = 3), t-AML (N = 2), or t-MDS that evolved to t-AML (N = 1) after initial therapy for CLL [3]. Development of AEL during the course of CLL was much more unusual. The first report of such a case was in 2012 [4]. This was a CLL patient with therapy-related dyplasia in bone marrow who developed pure AEL. The second case published in 2013 shared similar characteristics and final diagnosis of pure AEL [5]. Our patient is the third patient reported to date on that regard and the first patient with the diagnosis of AEL in patients with CLL. We suggest that AML development should always be kept in mind in CLL patients when clinical deterioration or changes in the patients' clinical and blood examinations occur. In transformation to AML, bone marrow changes can easily be confused with Richter's transformation and treatment of the patients can be challenging due to advanced age of the patients and possible comorbidities. Further research is needed on this topic.

References

1. Hasserjian RP, Zuo Z, Garcia C et al. Acute erythroid leukemia: a reassessment using criteria refined in the 2008 WHO classification. Blood 2010;115:1985-1992.
2. Park S1, Picard F, Dreyfus F. Erythroleukemia: a need for a new definition. Leukemia 2002;16:1399-1401.
3. Morrison VA, Rai KR, Peterson BL et al. Therapy-related myeloid leukemias are observed in patients with chronic lymphocytic leukemia after treatment with fludarabine and chlorambucil: results of an intergroup study, Cancer and Leukemia Group B 9011. J Clin Oncol 2002;20:3878-3884.
4. Sadrzadeh H, Hasserjian R, Fathi AT. Pure erythroid leukemia evolving from a therapy-related myelodysplastic syndrome secondary to treatment for chronic lymphocytic leukemia. Am J Hematol 2013;88:240-241.
5. Jain P, Chen SS. Cytoplasmic globules in erythroid blasts and CLL. Blood 2013;121:3305.

Deniz C. Guven, Taner Babacan, Furkan Sarici, Serkan Akin, Kadri Altundag, Alev Turker

Department of Medical Oncology, Hacettepe University Cancer Institute, Ankara, Turkey

Correspondence to: Kadri Altundag, MD.
E-mail: altundag66@yahoo.com

Management of primary ovarian malignant fibrous histiocytoma

Dear Editor,

Malignant fibrous histiocytoma (MFH) is the most common soft tissue sarcoma in adults [1]. In World Health Organization, four subtypes exist: storiform/pleomorphic (60%), myxoid MFH (25%), giant cell MFH (10%) and inflammatory MFH (5%) [2]. It is commonly located at the extremites, abdomen and retroperitoneum. Primary ovarian MFH is extremely rare. Herein we report on the manegement of this rare and uncommon localization of MFH.

A 46-year-old woman was admitted to our hospital with nausea, anorexia and abdominal distention on Jan-

uary 2012. Computed tomography demonstrated a tumor > 30 cm in diameter. This mass was extending from the pelvis to subdiaphragmatic space. Pre-operative CEA and Ca-125 levels were normal. Total abdominal hysterectomy, bilateral salphingo-oopherectomy and omentectomy were performed. In operation a 40 cm diameter mass originated from left ovary was remowed. Optimal debulking was not achieved.

The pathology showed myxoid MFH. Tumor cells were huge, pleomorphic , commonly shaped as spindle cells with hyperchromatic nucleus and eosinophilic cytoplasm. More than 50% were necrotic. Immunohistochemically stained myogenin and CD 68 were focally positive; S100, myoD1, inhibin, actin, desmin were negative. The proliferative index ki-67 was 90%.

Postoperative chemotherapy with ifosfamide and doxorubin was administered for 6 cyles with complete response. One year after stopping chemotherapy the disease relapsed in the abdomen. A 35 cm diameter mass was detected by abdominal computed tomography. No surgical tumor removal was attempted and second line chemotherapy with docetaxel and gemcitabine was administered. After 5 cycles, the disease progressed. Pazopanib was started as third-line treatment but the patient developed respiratory and renal problems and died 25 months after primary diagnosis.

MFH might be rarely aggresive. High rates of local recurrence and distant metastasis can occur. Poor prognostic factors have been defined, like high tumor grade, tumor size >10 cm, 19p chromosomal aberrations, and presence of tissue necrosis. Early diagnosis and effective treatment might be an effective strategy. Surgical resection with negative resection margins is the mainstay of treatment [3]. Chemotherapy and radiotherapy are also considered.

References

1. Weiss SW, Enzinger FM. Malignant fibrous histiocytoma: an analysis of 200 cases. Cancer 1978;41;2250-2266.
2. Kransdorf MJ, Murphey MD (Eds). Malignant fibrous and fibrohistiocytic tumors. Imaging of soft tissue tumors (2nd Edn). Philadelphia: Lippincott Williams & Wilkins, 2006, pp 257-297.
3. Roque DM, Jones DF, Carter G, Kelley JK. Primary giant cell malignant fibrous histiocytoma of the ovary: case report and review of the literature. Gynecol Oncol 2010;119:97-398.

Havva Yesil Cinkir, Umut Demirci, Berna Okzusoglu, Necati Alkis

Department of Medical Oncology, Dr. Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital, Ankara, Turkey.

Correspondence to: Havva Yesil Cinkir.
E-mail: doctoryesil82@yahoo.com

Gastric cancer with diffuse hepatic metastases and complete radiological response to triplet chemotherapy

Dear Editor,

A 35-year-old man with a main complaint of dysphagia was admitted to our clinic. Upper gastrointestinal endoscopic examination showed a large gastric tumor in the pylorus. Histology showed adenocarcinoma and computed tomography of the chest and abdomen revealed unilobar hepatic metastases. Docetaxel, cisplatin and 5-FU combination chemotherapy was administered as palliative treatment. After 3 courses of chemotherapy, significant tumor reduction was obtained, and radiologically complete disappearance of disease including the primary tumor was established after 6 cycles. Then, docetaxel was withdrawn because of neurotoxicity and the patient received an additional 6 cycles with the 2 drugs. At the end of treatment with doublet chemotherapy, radiologic imaging revealed no presence of disease.

The optimal management of patients with locally advanced unresectable but nonmetastatic gastric cancer is uncertain. An initial attempt at downstaging with neoadjuvant chemotherapy or chemoradiotherapy is usually administered because of the high disease control rate of neoadjuvant treatment. Several uncontrolled studies have explored the use of preoperative treatment and all have shown that some patients - initially thought to be unresectable - respond to chemotherapy sufficiently and become candidates for potentially curative resection [1]. Although these studies address the question of increased resectability, there is only scant data about their impact on survival.

On the other hand, for fit patients who initially had metastatic disease, chemotherapy is the only reasonable option. Before the era of taxanes, epirubicin and trastuzumab, the combination of 5-FU plus cisplatin was adopted by many as a safe and effective standard regimen [2]. Then, studies focused on the benefit of adding a third agent to this backbone. Triplet regimens were eventually shown to be superior to standard regimens in the treatment of gastric cancer patients with metastasis [3]. These treatment protocols also increased the possibility for superior response rates with acceptable side effect profile. Surgical exploration is occasionally done in metastatic patients who respond completely to chemotherapy and have no evidence of metastatic disease, because the role of definite surgery in patients with radiologically complete response after combination chemotherapy is largely unclear and there is no standard therapeutic approach [4]. So, there is insufficient evidence from randomized trials to support the resection of the primary tumor or the invisible

metastases after complete radiological response to triplet chemotherapy. Yet, especially in young patients with slowly progressing disease or tumors with pyloric localization tumor, resection may improve the clinical outcome of the patients or may palliate them if the disease recurs.

References

1. Yoshikawa T, Tanabe K, Nishikawa K et al. Induction of a Pathological Complete Response by Four Courses of Neoadjuvant Chemotherapy for Gastric Cancer: Early Results of the Randomized Phase II COMPASS Trial. Ann Surg Oncol 2014;21:213-219.
2. Ohtsu A, Shimada Y, Shirao K et al. Randomized phase III trial of fluorouracil alone versus fluorouracil plus cisplatin versus uracil and tegafur plus mitomycin in patients with unresectable, advanced gastric cancer: The Japan Clinical Oncology Group Study (JCOG9205). J Clin Oncol 2003; 21:54-59.
3. Cunningham D, Starling N, Rao S et al. Capecitabine and oxaliplatin for advanced esophagogastric cancer. N Engl J Med 2008; 358:36-46.
4. Ajani JA, Moiseyenko VM, Tjulandin S et al. Clinical benefit with docetaxel plus fluorouracil and cisplatin compared with cisplatin and fluorouracil in a phase III trial of advanced gastric or gastroesophageal cancer adenocarcinoma: the V-325 Study Group. J Clin Oncol 2007; 25:3205-3209.

Umut Varol[1], Ahmet Alacacioglu[1], Ibrahim Yildiz[1], Yuksel Kucukzeybek[1], Ruchan Uslu[2]

[1]Medical Oncology Clinic, Izmir Katip Celebi University Ataturk Training and Research Hospital, Izmir; [2]Division of Medical Oncology, Tulay Aktas Oncology Hospital, School of Medicine, Ege University, Izmir, Turkey

Correspondence to: Ahmet Alacacioglu, MD.
E-mail: dralaca2000@yahoo.com