ALK-positive Primary Systemic Anaplastic Large Cell Lymphoma with Extensive Cutaneous Manifestation

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Sir,

Anaplastic large cell lymphoma (ALCL) is a T-cell non-Hodgkin’s lymphoma that has a histological appearance consisting of large lymphoid cells with abundant cytoplasm and pleomorphic, often horseshoe-shaped, nuclei. The tumour cells are positive for CD30 on the cell membrane and in the Golgi body. Clinically, ALCL can be divided into three entities containing primary systemic anaplastic large cell lymphoma kinase (ALK)-positive ALCL, primary systemic ALK-negative ALCL, and primary cutaneous ALCL. ALK expression is detectable in approximately 75% of ALCL patients.

Primary systemic ALCL frequently involves both lymph nodes and extranodal sites such as skin, bone, lung and liver. On the other hand, primary cutaneous ALCL is usually ALK-negative and the disease is limited to the skin.

The usual cutaneous manifestations of primary systemic ALCL are red papules or nodules, but ALCL showing macules or plaques are quite rare. We describe here a case of ALK-positive primary systemic ALCL with a long clinical course and extensive cutaneous manifestation like that of cutaneous T-cell lymphoma.

CASE REPORT

A 37-year-old Japanese woman visited our hospital in November 2007 with an extensive cutaneous rash lasting for 3 years. Her medical history was as follows. At the age of 15 years she developed cervical lymph node swelling with fever and nasal bleeding for 2 weeks, then a solitary erosive red tumour 4 cm in diameter appeared on the right forehead (Fig. 1). She visited a local physician. Skin biopsies were performed from both the tumour and the lymph node and she was diagnosed with primary systemic ALCL (data not shown). Weekly CHOP therapy (cyclophosphamide 700 mg, doxorubicin 40 mg, vinristine 1 mg and prednisolone (PSL) 20 mg,) was given for eight cycles, (cyclophosphamide 700 mg, doxorubicin 40 mg, vincristine 1 mg and prednisolone (PSL) 10 mg. However, at the age of 25 years, she had recurring abdominal pain and diarhoea lasting for one month. Computed tomography (CT) revealed swelling of a small intestinal mesenteric lymph node. The lymph node was removed operatively and distributed over the entire body surface.

Histopathological examination from the tumour on the dorsum of the right foot revealed dense infiltration of large, polymorphic, irregular nuclei, which were CD30- and ALK-positive. With these clinical and pathological findings, the diagnosis of primary systemic ALCL with extensive cutaneous manifestation was made.

Because the patient refused systemic chemotheraphy, the cutaneous lesions were treated with intramuscular interferon-γ injection, and oral psoralen plus ultraviolet A (PUVA) therapy. Photodynamic therapy was also applied to the facial lesions. After 80 J of oral PUVA therapy, the erythematous lesions were alleviated, but the skin nodule lesions persisted.

DISCUSSION

ALCL was first described by Stein et al. in 1982 (1) and is either ALK-positive or ALK-negative. ALK expression is related to a non-random t(2; 5)(p23; q35) chromosomal translocation, which fused with the nu-

Fig. 1. Clinical features of the patient at the age of 15 years. Swelling of the cervical lymph node (dotted circle) and a solitary erosive red tumour with scaling, 4 cm in diameter, on the right forehead (arrow). The patient has approved the publication of this photo.
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cleophosmin (NPM) gene, resulting in the expression of p80 chimera proteins, i.e. NPM/ALK transcripts (2). In 1995, Shiota et al. (3) first reported that ALK expression influences the prognosis of systemic ALCL. In 1999, Gascoyne and colleagues (4) reported that the ALK-positive systemic ALCL patients have a better prognosis of 79.8% 5-year survival rate, compared with a rate of 32.9% for other ALK-negative systemic ALCL patients, although the clinical behaviour of individual patients remains unpredictable.

Primary ALK-positive systemic ALCL frequently involves both lymph nodes and extranodal sites. Extranodal lesions commonly include skin (21%), bone (17%), soft tissue (17%), lung (11%) and liver (8%), while central nervous system involvement is rare (5). Cutaneous manifestations of primary systemic ALCL are usually solitary or multiple red papules or nodules (6, 7).

In our patient, cervical lymph node enlargement and a cutaneous tumour first appeared when she was 15 years old, and approximately 10 years later ALCL lesion recurred in the mesenteric lymph node. Although our patient was treated with multiple chemotherapies, extensive skin lesions, clinically and histopathologically resembling mycosis fungoides, appeared when she was 34 years of age. To our knowledge, this is the first case report of such cutaneous manifestations of systemic ALCL. It is possible that the mycosis fungoides-like skin lesions arose as secondary lymphoma. However, although we could no longer confirm the clonality, we believe that the two lymphomas are identical because of the same positive staining pattern of CD30, ALK and EMA in the atypical cells.

Recently, systemic ALCL has been treated using multidrug chemotherapy including doxorubicin (8–10), with a complete response rate of 95%. However, recurrence has been reported in more than 40% of patients (9–11). Although a favourable prognosis is expected with ALK-positive ALCL and the extranodal lesion is currently limited to the skin, close follow-up will be needed for our patient.

The authors declare no conflict of interest.

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