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, vincristine 1 mg and prednisolone (PSL) 20 mg) was given for eight cycles, followed by a course of VEMP (vincristine 1 mg, 6-MP 100 mg, cyclophosphamide 100 mg, PSL 5 mg, daily). However, after the 25th cycle of VEMP, red papules appeared on the left thigh and the skin biopsy from the lesion revealed recurrence of ALCL. Chemotherapy with doxorubicin 40 mg, methotrexate 30 mg and procarbazine 100 mg daily was then administered, followed by maintenance chemotherapy using cyclophosphamide 200 mg and PSL 10 mg. However, at the age of 25 years, she had recurring abdominal pain and diarrhoea lasting for one month. Computed tomography (CT) revealed swelling of a small intestinal mesenteric lymph node. The lymph node was removed operatively and histopathologically diagnosed as ALCL (data not shown). At the age of 34 years, the patient had to discontinue cyclophosphamide and PSL treatment due to hemorrhagic cystitis. At the same time, scaly erythema with induration appeared and gradually increased and distributed over the entire body surface.

Physical examination revealed extensive red-brown macules and plaques, with scaling over the whole body (Fig. 2a–d). A red tumour, 2×2 cm in diameter, was also observed on the dorsum of the right foot (Fig. 2e). The clinical appearance resembled tumour stage of mycosis fungoides. She had no fever, night sweats, or weight loss. Laboratory tests revealed normal white blood counts of 8.9×10³/µl, normal liver and renal functions, but serum lactate dehydrogenase (LDH) and soluble interleukin-2 receptor (sIL-2R) levels were increased slightly to 273 IU (normal 119–229 IU) and 814 U/ml (normal 145–519 U/ml) each. Anti-HTLV-I antibody and antinuclear antibody (ANA) were negative. Southern blot analysis from the tumour on the dorsum of the foot confirmed clonal gene rearrangement of the T-cell antigen receptor (TCR) Jγ chain. Gallium-67 scintigraphy showed no abnormality. Positron emission tomography (PET)-CT revealed accumulation of fluoro-deoxyglucose (FDG) in the left cervical, bilateral axillary, and bilateral inguinal lymph nodes. No visceral lesions were detected.

Histopathological examination from the tumour on the dorsum of the right foot revealed dense infiltration of large, polymorphic, and atypical lymphoid cells from the epidermis to the deep dermis (Figs. 3a and b). Immunohistochemically, almost all tumour cells were positive for CD30 (Fig. 3b and c), ALK and EMA but, negative for CD3, CD4 CD5, CD20, CD56 and TIA-1 (data not shown). EBV gene encoding RNAs (EBER) were not detected by in situ hybridization. Histopathological examination of the left cervical lymph nodes showed atypical cells with large and 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 chemotherapy, 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-
Behavior of cutaneous ALCL after cervical lymph node enlargement and extranodal disease recurred in the mesenteric lymph node. 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.

REFERENCES


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