



Multiple Myeloma Relapse Revealed by a Solitary Skin Plasmocytoma

Filipe Martins and Gregoire Stalder*

Service and Central Laboratory of Hematology, Centre Hospitalier Universitaire Vaudois, Switzerland

Abstract

We describe an unusual case of early multiple myeloma relapse as a solitary skin plasmocytoma, in a 65-year-old woman in very good partial response (VGPR)* after induction regimen and autologous stem cell transplantation.

*International Myeloma Working Group (IMWG) 2010 Uniform Response Criteria for Multiple Myeloma.

Clinical Image

A 65-year-old woman diagnosed with an IgG Lambda multiple myeloma (MM) eight months earlier attended a follow-up hematologic consultation. She underwent a high-dose melphalan chemotherapy and autologous stem cell transplantation, after induction regimen with four cycles of bortezomib, lenalidomide and dexamethasone, five months earlier. She had recently begun a lenalidomide maintenance therapy. A bone marrow biopsy realized one month prior to consultation did not show remnant clonal plasma cells. A serum immunosubtraction revealed a slight IgG Lambda unquantifiable band, together with a normal free light chain ratio. A cytogenetic analysis revealed the persistence of a complex and hyperploid karyotype including a chromosome 1p gain. These abnormalities were already present at diagnosis.

At this follow-up consultation, a round 4 cm large mass surrounded by a dense reticular small vessel net WAS found at clinical exam (Figure 1). A biopsy of the lesion revealed highly proliferative malignant plasmocytes (MIB-1 staining >95%) with vascular plasma cell thrombi. Immunostaining for MYC was intensely strong but negative for BRAF. The later was confirmed by RT-PCR. A FISH analysis did not reveal a MYC rearrangement. PET-CT restaging revealed the described lesion (SUVmax= 4.6 g/ml) but also a centimetric subcutaneous lesion of the right thigh (SUVmax=1.9 g/ml) and a lymph node of the left external iliac region (SUVmax=4.4), together with disseminated highly metabolic bone lesions (SUVmax between 5 g/ml and 6.6 g/ml). The cutaneous lesion was treated with radiotherapy (10 Gy x 3 Gy) with a good response (Figure 2). Systemic treatment was then pursued with carfilzomib, lenalidomide and dexamethasone, until a diffuse soft-tissue, cutaneous and lymph node spread, together with a biological relapse, surged 6 months later.

Extrasosseous myeloma (EM) may surge during the disease course in almost one fifth of patients [1,2]. Its incidence is increasing, due to more extensive radiological staging, extended survival and suspected selection of more aggressive myeloma cell clones after allogenic stem cell transplant [3,4]. A shift from intact immunoglobulin towards light chain only secretion is possible [5].

OPEN ACCESS

*Correspondence:

Gregoire Stalder, Service and Central Laboratory of Hematology, Centre Hospitalier Universitaire Vaudois, CH-1011 Lausanne, Switzerland,
E-mail: gregoire.stalder@chuv.ch

Received Date: 06 Apr 2018

Accepted Date: 26 Apr 2018

Published Date: 13 May 2018

Citation:

Martins F, Stalder G. Multiple Myeloma Relapse Revealed by a Solitary Skin Plasmocytoma. *Clin Oncol*. 2018; 3: 1462.

Copyright © 2018 Gregoire Stalder.

This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



Figure 1: Plasmocytoma of the skin (left thigh). Note the dense reticular vascular bed surrounding the lesion.



Figure 2: Plasmacytoma of the skin (left thigh), 8 weeks after radiotherapy (10 Gy × 3 Gy) and pursue of systemic treatment with carfilzomib, lenalidomide and dexamethasone.

Although several breakthroughs have been made in MM treatment, this subgroup of patients still carries a poor prognosis [6]. Liver is the more frequent extraosseous site of disease spread at relapse [7]. Skin involvement is rare in the relapse setting and more prevalent at diagnosis [7]. Underlying its rarity, a recent literature review gathered 44 published cases of EM involving extremities soft tissues [8].

References

1. Blade J, Fernandez de Larrea C, Rosinol L, Cibeira MT, Jimenez R, Powles R. Soft-tissue plasmacytomas in multiple myeloma: incidence, mechanisms of extramedullary spread, and treatment approach. *J Clin Oncol.* 2011;29(28):3805-12.
2. Varga C, Xie W, Laubach J. Development of extramedullary myeloma in the era of novel agents: no evidence of increased risk with lenalidomide-bortezomib combinations. *Br J Haematol.* 2015;169(6):843-50.
3. Varettoni M, Corso A, Pica G, Mangiacavalli S, Pascutto C, Lazzarino M. Incidence, presenting features and outcome of extramedullary disease in multiple myeloma: a longitudinal study on 1003 consecutive patients. *Ann Oncol.* 2010;21(2):325-30.
4. Vincent L, Ceballos P, Plassot C. Factors influencing extramedullary relapse after allogeneic transplantation for multiple myeloma. *Blood Cancer J.* 2015;5:e341.
5. Dawson MA, Patil S, Spencer A. Extramedullary relapse of multiple myeloma associated with a shift in secretion from intact immunoglobulin to light chains. *Haematologica.* 2007;92(1):143-4.
6. Pour L, Sevcikova S, Greslikova H. Soft-tissue extramedullary multiple myeloma prognosis is significantly worse in comparison to bone-related extramedullary relapse. *Haematologica.* 2014;99(2):360-4.
7. Usmani SZ, Heuck C, Mitchell A. Extramedullary disease portends poor prognosis in multiple myeloma and is over-represented in high-risk disease even in the era of novel agents. *Haematologica.* 2012;97(11):1761-7.
8. Ames J, Al-Samarrae A, Takahashi T. Extraosseous Multiple Myeloma: Case Report of Presentation in the Lower Extremity Soft Tissues with Literature Review. *Case Rep Radiol.* 2017;2017:9159035.