Atrophic Dermatofibrosarcoma Can be Tough Call

BY BRUCE K. DIXON
Chicago Bureau

CHICAGO — Atrophic dermatofibrosarcoma protuberosan is an underrecog- nized variant that must be treated with wide local excision, Dr. Shari Clarke said at the annual meeting of the American Society for Dermatologic Surgery.

Although both wide local excision and Mohs micrographic surgery are consid- ered treatments of choice, the latter quick- ly is becoming the favored method because of its lower rate of recurrence, she said. In presenting three cases of the atroph- ic variant of dermatofibrosarcoma protu- berans (DFSP), she explained that these le- sions are slow-growing, locally aggressive fibrohistiocytic tumors that rarely metas- tase but have a marked tendency to- ward local recurrence.

“Cases of DFSP presents as indurated violaceous plaques which later develop nodules, and they’re most commonly lo- cated on the trunk,” explained Dr. Clarke, of the department of dermatology at the Milton S. Hershey Medical Center, Penn- sylvania State University, Hershey.

Histologically, DFSPs are characterized by monomorphic spindle cells in a strom- form pattern that infiltrate between adipocytes. Later, the tumor can involve the upper dermis, deeper subcutaneous fat, or striated muscle, which correlates with the development of nodules and, as we’ve demonstrated in our cases, the CD34 staining is very useful in distin- guishing DFSPs from other fibrohistio- cytus tumors,” Dr. Clarke explained.

A total of five distinct clinical vari- ants of DFSP have been described in the literature, including confluent nodules forming sclerotic plaques, keloidlike scler- otic plaques, tumor, angiomalike, and at- rrophic plaques. As exemplified in three cas- es described by Dr. Clarke, atrophic DFSP may or may not develop nodules in the lat- ter stages. In the first two cases, wide ex- cision was used because the procedures were performed by a plastic surgeon.

The third case, involving the cranial fold, was per- formed by a Mohs surgeon.

The first patient, a 43-year-old woman with a 13- year history of asymptomatic nodu- les that began as an atrophic plaque on the back of her neck, was clinically diagnosed as having multiple neurofi- bromas. She pre- sented for a second opinion as the nod- ules continued to enlarge.

A punch biopsy showed monomorphic spindle cells within a fibrous stroma infiltrating the septa between the adipose. CD34 stains were positive and she was given a diagno- sis of DFSP, but since her original clinical exam showed atrophic plaque, the diagno- sis was changed to atrophic DFSP. Dr. Clarke explained.

A wide excision with 2-cm margins was performed, producing a gross examination specimen measuring 20 by 15 cm. Intra- operative frozen sections with CD34 showed clear 2-cm margins and the wound was reconstructed with a trans- verse rectus abdominus cutaneous flap utilizing the inferoposterior epigastric artery and vein for blood supply.

The second patient was a 14-year-old girl who presented with a 7-year history of an enlarging, asymptomatic plaque on her right thigh. She was clinically diag- nosed as having a keloid and treated with- out improvement. Surveillance was stopped for a number of years because the patient thought it “just a scar,” Dr. Clarke said, but the nodules continued to enlarge.

On examination, there was an atroph- ic plaque with scattered nodules that was found on biopsy to be a DFSP.

As with the first patient, the diagnosis was changed to atrophic DFSP.


Dr. Clarke suggested using 400 mg of imatinib mesylate [Gleevec] currently approved for treating chronic myeloid leukemia, acts as a selective tyrosine kinase inhibitor of the platelet-derived growth factor receptor β and has been used successfully in isolated case reports for the presurgical treatment of locally advanced DFSPs and inoperable recurrent or metastatic disease,” she said.

Dr. Clarke suggested using 400 mg of imatinib mesylate, the dose used for gas- trointestinal stromal tumors, either daily or twice daily. “The side effects are typi- cally mild, although severe edema and liv- er toxicity have been reported in the el- derly,” she said.

MAL-PDT Reveals Cosmetic Edge Over Excision in BCC

BY NANCY WALSH
New York Bureau

VIENNA — Treatment with methyl aminolevulinate-photodynamic therapy was as effective as surgery for superfi- cial basal cell carcinoma, Dr. Roll-Marx Szeimies reported in a poster session at the 16th Congress of the European Academy of Dermatology and Venereology.

Among the methods for removal of basal cell carci- nomas are simple excision, Mohs surgery, radiotherapy, curettage/electrodesiccation, and cryosurgery, with the choice of treatment depending on type, size, depth, and location of the lesion.

Methyl aminolevulinate-photodynamic therapy (MAL- PDT) has previously been shown to be as efficacious as cryotherapy for removal of these lesions and to have su- perior cosmetic results. Now, in the first multicenter ran- domized trial comparing MAL-PDT with simple excision, similar findings have been found, according to Dr. Szeimies of the department of dermatology, Regensburg (Germany) University Hospital.

A total of 196 patients whose mean age was 63.8 years were included in the study. The mean number of lesions per patient was 1.4, and the mean diameter of the lesions was 12.4 mm.

Patients randomized to MAL-PDT underwent two treatment sessions 7 days apart, with the option of repeat treatment at 1 month if clinical response was incomplete. Those randomized to surgery underwent simple elliptical excision with 3-mm margins from the estimated edge of the lesion.

The complete response rate was 87% with MAL- PDT and 89% with excision, confirming the noninferi- ority of MAL-PDT to surgery, wrote Dr. Szeimies.

Results were similar in the two groups for lesions on the trunk and neck, with MAL-PDT and excision having complete response rates of 84% and 89%, respectively. For lesions on the face and scalp, MAL-PDT and excision showed complete response rates of 95% and 67%.

Complete response was not related to size of the lesion.

Investigator-rated cosmetic outcome, favored MAL- PDT, with 87% of lesions having good to excellent out- come, compared with 58% of those in the surgery group.

Patients also preferred the cosmetic outcome with MAL-PDT, with 83% rating the outcome as good to ex- cellent, compared with 81% of the patients in the exci- sion group.

The study was sponsored by Calderma, which makes the MAL-PDT used in the study.

In a recent review of experience with MAL-PDT for basal cell carcinoma, Dr. Szeimies noted that, while surgery remains the preferred method of treatment, patients—austromatic for those with large lesions, poor vascularization, and concomitant use of anticoagulants or immunosuppressives—may be poor candidates for surgery.

Moreover, postoperative keloid or dystrophic scarring is common, particularly on the trunk. “Because of the relatively low-risk nature of superficial [basal cell carci- noma], scarring problems should be taken into consid- eration when choosing a suitable therapy. Therefore, PDT may offer significant advantages over surgical or other destructive techniques” he wrote (Dermatol. Clin. 2007;25:89-94).

Dr. Szeimies disclosed no conflicts of interest.