An Irresectable Giant Plasmacytoma: Report of a Case

Rezeke Edilemeyen Dev Plazmasitoma: Vaka Sunumu

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ABSTRACT

A 71 year old man was admitted with left arm, shoulder and back pain. Thorax computerised tomography showed a craniocaudal 20 cm expanding tumor with invasion of the clavicle and scapula and humeral head Pathology confirmed plasmacytoma from the incisional biopsy. Primarily, chemoradiotherapy was scheduled. *(Tur Toraks Der 2008;9:188-9)*

Key words: Chest wall tumor, plasmacytoma

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ÖZET

71 yaşında erkek hasta sol kol, omuz ve sırt ağrısı ile başvurdu. Bilgisayarlı toraks tomografisinde klaviküla, skapula ve humerus başını içine alan kranyokaudal yönde 20 cm genişleyen kitle görüldü. İnsizyonel biyopsinin patolojik değerlendirmesi plazmasitoma olarak doğrulandı. Primer olarak kemoradyoterapi planlandı. *(Tur Toraks Der 2008;9:188-9)*

Anahtar sözcükler: Göğüs duvarı tümörü, plazmasitoma

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INTRODUCTION

Plasma cell malignancies are a group of related disorders characterized by the proliferation of plasma cells which are immunoglobulin-secreting B cells. The most common is multiple myeloma. Solitary plasmositomas that arise in bone account for 10% to 30% of primary chest wall malignancies [1]. Excision of a solitary extrapulmonary lesion is recommended when possible. However radiotherapy is performed to patient for reduce local recurrence.

CASE

A 71 years old man, with a solitary plasmacytoma of the chest wall is reported. He was admitted with left arm shoulder and back pain. The examination is founded mass below the scapula and clavicle. A malignant chest wall neoplasm was suspected. Thorax computerised tomography showed craniocaudal 20 cm expanding tumor with invasion of clavicle and scapula (Figure 1) and humerus head (Figure 2). A transcutaneous needle biopsy of the tumor with a Sure-Cut-Needle revealed a plasmacytoma. The tumor was an giant solitary plasmacytoma. The diagnosis is based on imaging findings and pathology. Excision of tumor is not considered because of craniocaudal 20 cm expanding tumor and invaded clavicle, scapula, humerus and chest wall in the large field. Primarily chemoradiotheraphy was sheduled to patient by the oncologist.

DISCUSSION

Localized solitary plasmacytoma of the bone (SPB) is a rare disease and is characterized by only one or two isolated bone lesions with no evidence of disease dissemination. Solitary plasmositomas that arise in bone account for 10% to 30% of primary chest wall malignancies. They are more common in male patients and usually occur mean age 60 years and later. The most common chest wall location is the ribs, clavicle and sternum [1]. Excision of a solitary extrapulmonary lesion is recommended when possible. Radiotherapy has been shown to be successful

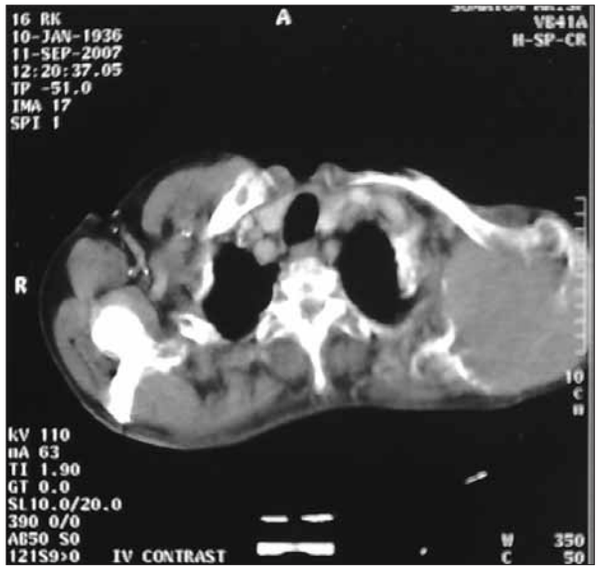

Figure 1. CT showed a huge left chest wall mass expanding and invading from clavicle and scapula

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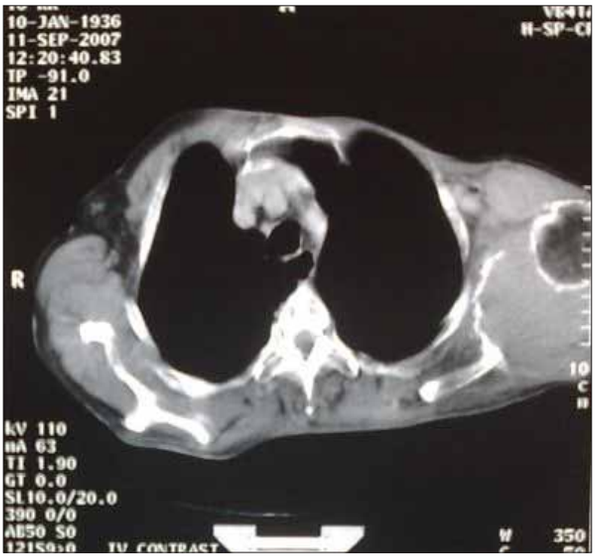

Figure 2. CT showed the same mass encircling humerus head

for the local control of solitary plasmacytomas [2]. However chemotherapy is recommended to patient with disseminated disease and evidence of disease progression. In the literature, Athanassiadi K and collegues reported five cases of chest wall plasmacytoma in 41 cases of chest wall tumor series [3]. Das-Gupta EP and collegues report three cases of massive chest wall plasmacytoma treated with a combination of VAD chemotherapy consolidated by high-dose melphalan and autologous peripheral blood stem cell transplantation and radical radiotherapy. One patient has had a durable remission. The other two patients have had disease progression but at sites other than the original tumour [4]. There was no dissemination our patient. But tumor was unresectable because of large field in the chest wall and therefore patient is referred to oncology and primarily chemoradiotheraphy was sheduled. Long term follow up is necessary because of 35% to %55 of patients, multiple myeloma develops often 10 to 12 years after inital diagnosis [5].

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