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LETTER TO THE EDITOR

Radiotherapy in indolent primary cutaneous B-cell lymphoma

Dear Editor,

Radiation therapy (RT) remains a powerful single option with curative intention in the local treatment of indolent primary cutaneous B-cell lymphoma (pcBCL). It is well known that (1) primary cutaneous marginal zone lymphoma (pcMZL) have a much higher relapse rate than primary cutaneous follicle center lymphoma (pcFCL) after RT, (2) pcFCL and pcMZL present at different skin sites, and (3) pcMZL much more often present with multifocal lesions than pcFCL. We presented an analysis of retrospective cohort investigating the role of initial RT in patients with an indolent pcBCL.[1] A radiation dose of 20 to 46 Gy was prescribed. With 131 months (range, 25-240) follow-up, we concluded that lesions at other sites than the trunk and the presence of multiple lesions were associated with an increased relapse risk on the basis of a difference in 5-year relapse-free survival (RFS) rate for patients with trunk lesion versus those with other location (89.4% versus 66.9%) and in case of single and multiple lesions (83.5% versus 57.1%, $P = .04$). Several important issues still need to be discussed. First, the multiple lesions definition could be a confounder. We classified multifocal lesions as those lesions requiring different radiation fields. Second, the substantial variation in radiation dose used (20 to 46 Gy) could potentially increase selection bias in this kind of analysis. Indolent pcBCL is a high radioresponsive disease and dose over 30 Gy is unusual, especially in radiosensitive organs such as the eye.[2] With regard to pcBCL, the high total dose up to 46 Gy was prescribed in order to control the disease on a long-term basis. We have reported excellent clinical outcomes with 10-year RFS and overall survival rates of 71.1% and 87.1%, respectively. No in-field recurrences were observed.[1] This high total dose could potentially improve severe late toxicity, including the risk of RT-induced second malignancies, although dose distribution was just limited to skin zone. We recognize that it could represent an overtreatment, based on current guidelines,[2] but the tumor size at diagnosis could justify 30 to 46 Gy as an appropriate dose, when the intent for treatment was tumor eradication. Surely, this was only one retrospective experience, but we believe it could provide an appropriate tool for a better issue's awareness. The use of low-dose involved-field RT for indolent pcBCL is generally scheduled in palliative setting.[2] Low doses of 4 Gy have been shown to be beneficial in 18 patients with low-grade malignant cBCL.[3] Results were interesting, reporting significant percentages of complete response (75%) with a median time to local progression of approximately 10 months, without side effects.

In the end, our analysis is closer to demonstrating that RT is still paramount in clinical management of patients with indolent pcBCL.

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