Significant Response to Gemcitabine Monotherapy in Primary Pleural Epithelioid Angiosarcoma

To the Editor:

Systemic chemotherapy is one treatment option for advanced epithelioid angiosarcoma, but no standard regimen has yet been established because of the rarity of the disease. We report a case of advanced epithelioid angiosarcoma showing marked response with gemcitabine monotherapy.

A 72-year-old man presented with a 1-month history of dyspnea on exertion. Computed tomography revealed a left pleural tumor measuring 6.5 cm and bilateral pleural effusions. Histopathological examination of the pleural tumor obtained by biopsy under echographic guidance revealed neoplastic proliferation characterized by nests of highly atypical, large, and round to spindle-shaped epithelioid cells with abundant eosinophilic cytoplasm and hyperchromatic nuclei containing prominent nucleoli. Atypical epithelioid cells showed focal areas of vascular formation and intracellular lumina containing erythrocytes, and positive staining for CD31, a vascular marker. Advanced epithelioid angiosarcoma with bilateral malignant pleural effusions was diagnosed, and systemic chemotherapy was initiated.

Despite treatment using four cycles of combination chemotherapy with ifosfamide and Adriamycin, new evidence suggested skin and pulmonary metastases. After two cycles of second-line chemotherapy with carboplatin and etoposide, skin lesions enlarged. Paclitaxel monotherapy (80 mg/m² on days 1, 8, and 15 every 28 days) was administered as a third-line option, but cutaneous involvement progressed. As the patient suffered from severe cancer pain and bleeding from skin metastases after paclitaxel monotherapy, he received oral S-1 with concurrent palliative radiotherapy to the skin lesions, which also proved insufficient. Skin metastases progressed rapidly (Figs. 1 and 2A), and the patient underwent fifth-line chemotherapy with gemcitabine (1000 mg/m² on days 1 and 8, every 21 days). After six cycles of gemcitabine monotherapy, computed tomography revealed excellent response with marked reduction of skin lesions (Fig. 2B). As cancer pain and bleeding were markedly improved, the patient continued gemcitabine monotherapy for nine cycles over 30 weeks, with good quality of life. The patient died 2 years after initial diagnosis because of serious hemorrhage from the tumor.

Epithelioid angiosarcomas are a subtype of soft-tissue sarcoma (STS) and are extremely rare aggressive malignancies of endothelial origin. The prognosis of unresectable angiosarcoma is typically poor. Penel et al. reported a median time to progression of 4 months, with median overall survival of 8 months. Patients with angiosarcoma display symptoms attributable to a hypocoagulable state. The present patient suffered bleeding from skin metastases. For advanced-stage disease, systemic chemotherapy is considered a treatment option. As a monotherapy, paclitaxel has shown effectiveness against advanced-stage angiosarcoma.

Gemcitabine has been reported as inactive against advanced STS, providing a response rate of only 3.23%. However, Stacchiotti et al. recently reported the overall response rate of advanced angiosarcoma to gemcitabine was 68%, with acceptable levels of toxicity. This suggests that gemcitabine could represent a good option for unresectable angiosarcoma, if not other subtypes of STS. Although paclitaxel was ineffective in our case, gemcitabine led to good response with noted reduction of the skin mass. The patient’s overall condition also improved markedly. The favorable clinical outcome in this case suggests...
Low-Dose Computed Tomography Could It be Applied for Secondary Prevention in Patients Undergoing Resection for Lung Cancer?

To the Editor:

In the January issue of Journal of Thoracic Oncology, Field et al.1 reemphasize the recently published results of the National Lung Screening Trial (NLST) regarding the role of low-dose spiral computed tomography (CT) as a screening modality in heavy smokers. The Strategic CT Screening Advisory Committee is currently engaging professional societies to focus on delivering clear guidelines and recommendations in this regard. Notably, NLST showed that primary prevention with low-dose CT in heavy smokers led to 20% fewer deaths from non–small-cell lung cancer (NSCLC) when compared with screening via old-fashioned chest radiographs.2 There is no doubt that recent technical developments have revolutionized CT capabilities and, as a result, its clinical applications. However, cost-effectiveness of this screening modality and the amount of overdiagnosis in the NLST remains to be clarified before recommending it for general practice.1,2 Confounding comorbidities and practical hurdles may further reduce this screening’s efficacy, as 89% of smokers will never develop lung cancer.

Conversely, it is known that 20% of completely resected Stage I NSCLC patients do develop recurrent lung cancer, most commonly to the thorax and usually within the first years postoperatively.3 The recurrence rate more than doubles for the

Disclosure: The authors declare no conflicts of interest.
Address for correspondence: Constantin A. Dasanu, MD, PhD, Medical Oncology and Blood Disorders Gothic Park, 43 Woodland Street, Suite G-80, Hartford, CT 06105. E-mail: c_dasanu@yahoo.com
Copyright © 2012 by the International Association for the Study of Lung Cancer
ISSN: 1556-0864/12/943-944

Kazuya Tsubouchi, MD
Hiroshige Yoshioka, MD
Tadashi Ishida, MD, PhD
Department of Respiratory Medicine
Kurashiki Central Hospital
Kurashiki, Japan

REFERENCES

Low-Dose Computed Tomography
Could It be Applied for Secondary Prevention in Patients Undergoing Resection for Lung Cancer?

To the Editor:

In the January issue of Journal of Thoracic Oncology, Field et al.1 reemphasize the recently published results of the National Lung Screening Trial (NLST) regarding the role of low-dose spiral computed tomography (CT) as a screening modality in heavy smokers. The Strategic CT Screening Advisory Committee is currently engaging professional societies to focus on delivering clear guidelines and recommendations in this regard. Notably, NLST showed that primary prevention with low-dose CT in heavy smokers led to 20% fewer deaths from non–small-cell lung cancer (NSCLC) when compared with screening via old-fashioned chest radiographs.2 There is no doubt that recent technical developments have revolutionized CT capabilities and, as a result, its clinical applications. However, cost-effectiveness of this screening modality and the amount of overdiagnosis in the NLST remains to be clarified before recommending it for general practice.1,2 Confounding comorbidities and practical hurdles may further reduce this screening’s efficacy, as 89% of smokers will never develop lung cancer.

Conversely, it is known that 20% of completely resected Stage I NSCLC patients do develop recurrent lung cancer, most commonly to the thorax and usually within the first years postoperatively.3 The recurrence rate more than doubles for the