Primary Cutaneous B-Cell Lymphomas
NCCN Guidelines Version 2.2015
Primary Cutaneous B-Cell Lymphomas

**DIAGNOSIS**

**ESSENTIAL:**
- Review of all slides with at least one paraffin block representative of the tumor should be done by a pathologist with expertise in the diagnosis of primary cutaneous B-cell lymphoma. Rebiopsy if consult material is nondiagnostic.
- Histopathology review of adequate biopsy (punch, incisional, excisional).
- Adequate immunophenotyping to establish diagnosis:
  - IHC panel: CD20, CD3, CD5, CD10, BCL2, BCL6, IRF4/MUM1
- Review of all slides with at least one paraffin block representative of the tumor should be done by a pathologist with expertise in the diagnosis of primary cutaneous B-cell lymphoma. Rebiopsy if consult material is nondiagnostic.
- Adequate immunohistochemical studies to establish lymphoma subtype:
  - IHC panel: Ki-67, CD43, CD21, CD23
  - Cyclin D1, kappa/lambda
  - Assessment of IgM and IgD expression (to further help in distinguishing PC-DLBCL, leg type from PCFCL)
- Cyto genetics or FISH: t(14;18)
- If adequate biopsy material available, flow cytometry or PCR can be useful in determining B-cell clonality.

**USEFUL IN CERTAIN CIRCUMSTANCES:**
- Additional immunohistochemical studies to establish lymphoma subtype:
  - IHC panel: CD20, CD3, CD5, CD10, BCL2, BCL6, IRF4/MUM1
- USEFUL IN CERTAIN CIRCUMSTANCES:
  - Additional immunohistochemical studies to establish lymphoma subtype:
    - IHC panel: CD20, CD3, CD5, CD10, BCL2, BCL6, IRF4/MUM1
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    - Additional immunohistochemical studies to establish lymphoma subtype:
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    - Additional immunohistochemical studies to establish lymphoma subtype:
      - IHC panel: CD20, CD3, CD5, CD10, BCL2, BCL6, IRF4/MUM1

**WORKUP**

**ESSENTIAL:**
- History and physical exam, including complete skin exam
- CBC, differential, comprehensive metabolic panel
- LDH
- Hepatitis B testing if rituximab considered
- Contrast enhanced chest/abdominal/pelvic CT and/or PET-CT scan
- Bone marrow biopsy, if PC-DLBCL, Leg type
- Pregnancy testing in women of child-bearing age (if chemotherapy planned)

**USEFUL IN SELECTED CASES:**
- Bone marrow biopsy:
  - Consider if PCFCL
  - Optional if PCMZL
- Peripheral blood flow cytometry, if CBC demonstrates lymphocytosis
- SPEP/quantitative immunoglobulins for PCMZL

**NOTE:** A germinal (or follicle) center phenotype and large cells in a skin lesion is not equivalent to DLBCL but is consistent with primary cutaneous germinal/follicle center lymphoma.

See Initial Therapy for Primary Cutaneous Marginal Zone Lymphoma (CUTB-2)

See Initial Therapy for Primary Cutaneous Follicle Center Lymphoma (CUTB-2)

See Initial Therapy for Primary Cutaneous Diffuse Large B-cell Lymphoma, Leg Type (CUTB-3)

PCMZL: Primary Cutaneous Marginal Zone Lymphoma
PCFCL: Primary Cutaneous Follicle Center Lymphoma
PC-DLBCL, Leg type: Primary Cutaneous Diffuse Large B-cell Lymphoma, Leg type

**d** Rule out drug-induced cutaneous lymphoid hyperplasia.

**e** Hepatitis B testing is indicated because of the risk of reactivation with immunotherapy + chemotherapy. Tests include hepatitis B surface antigen and core antibody for a patient with no risk factors. For patients with risk factors or previous history of hepatitis B, add e-antigen. If positive, check viral load and consult with gastroenterologist.

**Note:** All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Primary Cutaneous B-Cell Lymphomas

**INITIAL THERAPY**

- **Solitary/regional, T1-2 (Ann Arbor Stage IE)**
  - Local RT (preferred) and/or Excision
  - In selected cases: Observation or Topicals or Intralesional steroids

- **Generalized disease (skin only), T3**
  - Observation or Topicals or Local RT for symptoms or Intralesional steroids or Rituximab or Other systemic therapy

### Generalized disease (extracutaneous disease)

- **Response**
  - Relapsed or progressive disease
  - Generalized disease (skin only)
  - Generalized disease (extracutaneous disease)

- **Response**
  - Refractory disease
  - Manage as per FOLL-3

### Extracutaneous disease

- **Manage as per FOLL-3**

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PRIMARY CUTANEOUS DIFFUSE LARGE B-CELL LYMPHOMA, LEG TYPE

STAGE\(^g\) | INITIAL THERAPY | SECONDARY THERAPY
---|---|---
Solitary regional, T1-2 (Ann Arbor Stage IE) | RCHOP\(^n\) + local RT or Local RT\(^o\) or Clinical trial | CR → Observe → Relapse | RCHOP (if not previously received) or Manage as per BCEL-6 or Local RT to previously unirradiated tumor

Generalized disease (skin only), T3 | RCHOP\(^n\) ± local RT or Clinical trial | CR → Observe → Relapse | Manage as per BCEL-6 or Local RT for palliation or Radioimmunotherapy

Extracutaneous disease | Manage as per BCEL-3

\(^g\)See TNM Classification of Cutaneous Lymphoma other than MF/SS (CUTB-A).

\(^n\)For patients who cannot tolerate anthracyclines, see BCEL-C for regimens for patients with poor left ventricular function.

\(^o\)For patients not able to tolerate chemotherapy.

Consider prophylaxis for tumor lysis syndrome (See NHODG-B)

See monoclonal antibody and viral reactivation (NHODG-B)

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## TNM CLASSIFICATION OF CUTANEOUS LYMPHOMA OTHER THAN MF/SS<sup>a,b</sup>

<table>
<thead>
<tr>
<th><strong>T</strong></th>
<th><strong>T1</strong></th>
<th>Solitary skin involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1a:</td>
<td>a solitary lesion &lt;5 cm diameter</td>
</tr>
<tr>
<td></td>
<td>T1b:</td>
<td>a solitary &gt;5 cm diameter</td>
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<tr>
<td><strong>T2</strong></td>
<td>Regional skin involvement: multiple lesions limited to 1 body region or 2 contiguous body regions&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
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<tr>
<td></td>
<td>T2a:</td>
<td>all-disease-encompassing in a &lt;15-cm-diameter circular area</td>
</tr>
<tr>
<td></td>
<td>T2b:</td>
<td>all-disease-encompassing in a &gt;15- and &lt;30-cm-diameter circular area</td>
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<tr>
<td></td>
<td>T2c:</td>
<td>all-disease-encompassing in a &gt;30-cm-diameter circular area</td>
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<tr>
<td><strong>T3</strong></td>
<td>Generalized skin involvement</td>
<td></td>
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<tr>
<td></td>
<td>T3a:</td>
<td>multiple lesions involving 2 noncontiguous body regions&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>T3b:</td>
<td>multiple lesions involving ≥3 body regions&lt;sup&gt;b&lt;/sup&gt;</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>N</strong></th>
<th><strong>N0</strong></th>
<th>No clinical or pathologic lymph node involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>N1</strong></td>
<td>Involvement of 1 peripheral lymph node region&lt;sup&gt;c&lt;/sup&gt; that drains an area of current or prior skin involvement</td>
</tr>
<tr>
<td></td>
<td><strong>N2</strong></td>
<td>Involvement of 2 or more peripheral lymph node regions&lt;sup&gt;c&lt;/sup&gt; or involvement of any lymph node region that does not drain an area of current or prior skin involvement</td>
</tr>
<tr>
<td></td>
<td><strong>N3</strong></td>
<td>Involvement of central lymph nodes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>M</strong></th>
<th><strong>M0</strong></th>
<th>No evidence of extracutaneous non-lymph node disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>M1</strong></td>
<td>Extracutaneous non-lymph node disease present</td>
</tr>
</tbody>
</table>

<sup>a</sup>This work was originally published in Blood. Kim YH, Willemze R, Pimpinell Ni, et al, for the ISCL and the EORTC. TNM classification system for primary cutaneous lymphomas other than mycosis fungoides and Sézary syndrome: A proposal of the International Society for Cutaneous Lymphomas (ISCL) and the Cutaneous Lymphoma Task Force of the European Organization of Research and Treatment of Cancer (EORTC) Blood 2007;110:479-484. ©The American Society of Hematology.

<sup>b</sup>For definition of body regions, see Body Regions for the Designation of T (Skin Involvement) Category (CUTB-A 2 of 2).

<sup>c</sup>Definition of lymph node regions is consistent with the Ann Arbor system: Peripheral sites: antecubital, cervical, supraclavicular, axillary, inguinal-femoral, and popliteal. Central sites: mediastinal, pulmonary hilar, paraaortic, and iliaco.

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BODY REGIONS FOR THE DESIGNATION OF T (SKIN INVOLVEMENT) CATEGORY\textsuperscript{a,b,c}

\begin{tabular}{|l|l|}
\hline
HN & Head & Neck \\
C & Chest \\
LUA & Left Upper Arm \\
LLAH & Left Lower Arm & Hand \\
AG & Abdominal & Genital \\
LUL & Left Upper Leg \\
LLL & Left Lower Leg & Feet \\
RUA & Right Upper Arm \\
RLAH & Right Lower Arm & Hand \\
RUL & Right Upper Leg \\
RLL & Right Lower Leg & Feet \\
UB & Upper Back \\
LBB & Lower Back & Buttock \\
\hline
\end{tabular}


\textsuperscript{b}Left and right extremities are assessed as separate body regions. The designation of these body regions are based on regional lymph node drainage patterns.


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TREATMENT REFERENCES

Rituximab

Topicals
Topical/intralesional corticosteroids

Topical nitrogen mustard

Topical bexarotene

Topical imiquimod

Chemotherapy

Palliative low-dose RT

Chemoimmunotherapy

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Cutaneous B-cell Lymphomas

Cutaneous B-cell lymphomas (CBCLs) are a group of B-cell lymphomas originating in and usually confined to the skin. CBCLs are estimated to represent approximately 20% to 25% of all primary cutaneous lymphomas. In the United States, the SEER (Surveillance, Epidemiology, and End Results) data from the National Cancer Institute (NCI) indicated that the incidence of cutaneous T-cell lymphomas accounted for 71%, whereas CBCLs accounted for 29% from 2001 to 2005. The WHO-EORTC classification for cutaneous lymphomas distinguishes 3 main types of CBCL:

- Primary cutaneous marginal zone lymphoma (PC-MZL)
- Primary cutaneous follicle center cell lymphoma (PC-FCL)
- Primary cutaneous diffuse large B-cell, leg type (PC-DLBCL, leg type).

PC-FCL is the most common type of CBCL whereas PC-DLBCL leg type is less common. PC-MZL and PC-FCL are generally indolent or slow growing, whereas PC-DLBCL, leg type is usually an aggressive lymphoma associated with a generally poorer prognosis. In an analysis of 300 patients with CBCL from the Dutch cutaneous lymphoma registry, PC-FCL, PC-MZL, and PC-DLBCL comprised 57%, 24%, and 19% of cases, respectively, based on the WHO-EORTC classification. Extracutaneous relapse developed in 11%, 8.5%, and 46.5% of patients, respectively, demonstrating the higher incidence of extracutaneous progression associated with PC-DLBCL. The 5-year disease-specific OS rates in this series were 95%, 98%, and 50%, respectively. In an Italian series of 467 patients with CBCL, PC-FCL and PC-MZL accounted for 57% and 31% of cases, respectively; PC-DLBCL leg type was reported in only 11% of patients. While the various types of CBCL can occur anywhere on the skin, PC-FCL is more prevalent in the scalp and the forehead, whereas the trunk and extremities are the most common sites for PC-MZL. Leg remains the most common, but not the only, site for PC-DLBCL. As noted previously, extracutaneous involvement is more frequent with PC-DLBCL, leg type. In the same large Italian series, extracutaneous involvement eventually developed in 6% of patients with PC-MZL, 11% with PC-FCL, and 17% with PC-DLBCL, leg type. In this study, radiotherapy was given as first-line treatment in 52.5% of patients and chemotherapy was given in 25% of patients. The 5-year overall survival (OS) rate was similar between patients with PC-MZL and PC-FCL (97% vs. 96%, respectively), but was significantly inferior in patients with PC-DLBCL, leg type, compared with either of the other 2 types of CBCL (73%; P<0.0001). In patients with PC-MZL and PC-FCL, the disease-free survival (DFS) and OS rates were significantly higher for patients with single lesions compared with those with regional/disseminated lesions (5-year DFS, 62% vs. 44%; 5-year OS, 97% vs. 85%), whereas the difference in outcomes between single and regional/disseminated cutaneous involvement in patients with PC-DLBCL, leg type, was not significant (5-year DFS rate 55% vs. 44%; 5-year OS rate 79% vs. 67% for single and regional/disseminated lesions, respectively).

Diagnosis

Adequate biopsy of the lesions and the slides should be reviewed by a pathologist with expertise in the diagnosis of primary CBCLs. Incisional, excisional or punch biopsy is preferred to shave biopsy, as CBCL have primarily dermal infiltrates, often deep, which are less well sampled and can even be missed by a shave biopsy. Adequate immunophenotyping with an immunohistochemistry (IHC) panel that evaluates B- and T-cell markers is needed to establish the diagnosis of the exact subtype of CBCL. The panel should include the following markers: CD20, CD79a, CD3, CD5, CD10, BCL2, BCL6, kappa/lambda and IRF4/MUM1.
FCL is consistently BCL6-positive, whereas CD10 and BCL2 are expressed in only a few cases with a follicular growth pattern. PC-MZLs are always negative for BCL6 and CD10, but are often BCL2-positive. Under certain circumstances, additional IHC studies may be useful to further establish the lymphoma subtype. These may include evaluation of additional markers such as Ki-67, CD43, CD21, and CD23, assessment of cyclin D1 using paraffin panels, and assessment of IgM and IgD expression.

While the diagnosis of PC-MZL is generally straightforward and reproducible among pathologists, it is more difficult to distinguish between PC-FCL and PC-DLBCL, leg type. Part of the difficulty is that cell size (i.e., large vs. small), is not a defining feature as it is in nodal B-cell lymphomas. Most patients with PC-FCL have lesions with a germinal center phenotype, whereas most with PC-DLBCL, leg type have an activated B-cell phenotype. In nodal DLBCL, the germinal center phenotype is associated with a better prognosis than the activated B-cell phenotype. Both PC-FCL and PC-DLBCL are CD20 and BCL6 positive. BCL2 is usually negative in PC-FCL but highly expressed in PC-DLBCL, leg type. In addition, PC-FCL is usually MUM/IRF4-negative while PC-DLBCL, leg type is usually IRF4/MUM1-positive and show strong expression of FOXP1. IRF4/MUM1 and FOXP1 may serve as additional diagnostic markers in the differential diagnosis of PC-FCL and PC-DLBCL. Additionally, assessment of surface IgM and IgD expression may also be helpful in distinguishing PC-DLBCL, leg type from PC-FCL.

The t(14;18) translocation only rarely occurs in CBCLs. Therefore, the detection of a t(14;18) translocation in CBCL suggests the presence of systemic disease. Molecular genetic analysis to detect TCR gene rearrangements and IgH gene rearrangements, and cytogenetics or FISH to detect t(14;18) may be useful in selected circumstances. If adequate biopsy material is available, flow cytometry analysis can be useful in determining B-cell clonality. The use of cyclin D1 may be useful to differentiate PC-MZL (negative for CD5 and cyclin D1) from mantle cell lymphomas (positive for CD5 and cyclin D1). Mantle cell lymphoma is not a primary cutaneous lymphoma and finding it in the skin requires a careful search for extracutaneous disease.

Workup
The initial workup is geared toward evaluating extent of disease on the skin and seeking extracutaneous disease. The absence of extracutaneous disease at diagnosis is part of the definition of primary CBCL. The workup includes a complete physical examination, a comprehensive skin examination and CT scans of the chest, abdomen and pelvis. PET-CT may have higher sensitivity in finding otherwise occult systemic disease, but this is not validated and the higher rates of false positive findings can create confusion. Bone marrow biopsy is essential for PC-DLBCL, leg type, whereas its role is unclear for PC-FCL and PC-MZL. Senff et al evaluated 275 patients with histological features consistent with marginal zone lymphoma (MZL; n=82) or follicle center lymphoma (FCL ;n=193) first presenting in the skin. Bone marrow involvement was seen in about 11% of patients in the FCL group compared with 2% in the MZL group. FCL patients with skin lesions and a positive bone marrow had a significantly worse prognosis compared with those with PC-FCL; the 5-year OS rate was 44% and 84%, respectively.

The International Society of Cutaneous Lymphomas (ISCL) and the EORTC task force recommend that bone marrow biopsy be obtained for cutaneous lymphomas with intermediate to aggressive behaviors and should be considered for cutaneous lymphomas with indolent behavior and when there is any evidence of extracutaneous disease, as
indicated by other staging assessments (e.g., radiographic evidence or serologic clues such as elevated monoclonal or polyclonal immunoglobulins). The guidelines recommend considering bone marrow biopsy for patients with PC-FCL. It is optional for patients with PC-MZL. Peripheral blood flow cytometry will be useful in selected cases, if CBC demonstrates lymphocytosis.

**Treatment**

Primary CBCLs have a different clinical course and prognosis that distinguish them from their nodal counterparts. Treatment options for CBCLs depend on the histology and stage of the disease. Most commonly used therapies include excision, radiation therapy (RT), rituximab or systemic chemotherapy.

In a large retrospective analysis by the Italian Study Group for Cutaneous Lymphomas involving 467 patients with CBCL, the complete remission (CR) rate, 5-and 10-year OS rates for all patients with PC-FCL and PC-MZL who received first-line treatment (RT in 52.5%, with total dose of 35–45 Gy; chemotherapy in 25%, mainly with CHOP; surgery in 23%) were 92% to 95%, 96% to 97% and 89% to 90.5%, respectively. The relapse rate was 44% to 46.5% and extracutaneous spread was observed in 6% to 11% of patients. Relapse rate did not vary by type of initial therapy. In patients with PC-DLBCL, leg type, the CR rate, 5-and 10-year OS rates were 82%, 73% and 47%, respectively. PC-DLBCL, leg type was also associated with higher relapse rates (55%) and higher incidences of extracutaneous spread (17%). Among the patients with PC-DLBCL, a higher relapse rate was confirmed both for patients with single or regional lesions treated with RT and for patients with disseminated cutaneous involvement treated with chemotherapy. RT is very effective when used as initial local therapy as well as for cutaneous relapses in most patients with indolent CBCLs. In patients with indolent histologies, RT and excision were associated with higher response rates compared to chemotherapy (98%, 97% and 76-86%, respectively) but were generally used for those with more limited disease so a direct comparison cannot be made. The majority of patients with regional or disseminated disease will relapse regardless of type of initial treatment. However relapses are generally confined to the skin in which case survival does not appear to be affected.

In a retrospective study of 34 patients with CBCL treated with RT, 5-year relapse-free survival (RFS) rates ranged from 62% to 73% for PC-FCL and PC-MZL but were only 33% for patients with PC-DLBCL, leg type. The 5-year OS rate was 100% for PC-FCL and PC-MZL but was 67% for PC-DLBCL, leg type. Senff et al evaluated the outcome of 153 patients with CBCL (25 with PC-MZL; 101 with PC-FCL; and 27 with PC-DLBCL) that were initially treated with RT with a curative intent. Overall, 45% of patients had single lesions while localized or disseminated lesions were seen in 43% and 12% of patients, respectively. CR was obtained in 151 of 153 patients (99%). Relapse rates for PC-MZL, PC-FCL, and PC-DLBCL, leg type were 60%, 29%, and 64%, and the 5-year disease-specific survival rate was 95%, 97%, and 59%, respectively. The PC-FCLs presenting on the legs also had a higher relapse rate (63%) and a lower 5-year disease-specific survival (44%) compared with PC-FCLs occurring at other sites (25% and 99%, respectively).

Thus, local therapy is suitable for patients with indolent histologies, whereas patients with PC-DLBCL, leg type, which is associated with a more unfavorable clinical course, are generally treated with more aggressive treatment modalities—often with combined modality approaches as appropriate for systemic DLBCL.
NCCN Recommendations

Because there are no data from randomized clinical trials, the treatment recommendations included in the NCCN Guidelines are derived from the management practices of patients with CBCL at NCCN member institutions based on the limited data from retrospective analyses and studies involving small cohort of patients.

**PC-FCL and PC-MZL**

**Initial Treatment**

The NCCN Guidelines recommend local RT or excision as the initial treatment options for patients with solitary lesions or regional disease (T1-2). In select cases, patients may be considered for initial therapy with topical regimens (with steroids, imiquimod, or nitrogen mustard or bexarotene gel) or intralesional steroids.\(^1\) Selected patients with local disease that is not amenable to local therapy (e.g., lesions on the scalp where hair loss is a major concern) can be observed.

For patients presenting with generalized skin lesions (T3), several treatment options are available. Chlorambucil has been shown to be effective in the treatment of PC-MZL with multifocal skin lesions.\(^2\) In patients presenting with PC-FCL, multiagent chemotherapy or RT were equally effective for multifocal skin lesions.\(^1\) Rituximab has shown activity as a treatment option for patients with indolent CBCLs with multiple lesions for which local therapy is not effective.\(^1\) In a series of 16 patients with CBCL, 14 patients (87.5%) achieved a CR with rituximab monotherapy: 35% of these patients with CR eventually relapsed between 6 and 37 months.\(^1\) In another retrospective analysis of 15 patients with indolent CBCLs, the overall response rate (ORR) was 87% (60% CR); the ORR was 100% for patients with PC-FCL and 60% for PC-MZL. With a median follow-up of 36 months, the median duration of response was 24 months.\(^1\) Several case reports showed the effectiveness of topical therapy using steroids, imiquimod, and nitrogen mustard or bexarotene gel.\(^1\) Interlesional corticosteroids have also been used in the management of PC-FCL or PC-MZL, although only limited data are available.\(^1\)

For patients presenting with generalized disease, the NCCN Guidelines have included observation, rituximab, topical therapy, local RT, intralesional steroids or systemic therapy (chlorambucil or cyclophosphamide, vincristine, prednisone [CVP]) with or without rituximab, as options. In patients with very extensive or symptomatic disease, other chemotherapy regimens recommended for the treatment of follicular lymphoma may be used. Patients presenting with extracutaneous disease should be managed according to the NCCN Guidelines section for follicular lymphoma.

**Treatment for relapsed or refractory disease**

While most of the patients respond to initial therapy, relapses do commonly occur. Patients with regional or localized relapse should receive additional therapy (excision, intralesional steroids, local RT or topical therapy using steroids, imiquimod, nitrogen mustard or bexarotene gel) and those with generalized disease relapse confined to the skin should receive additional therapy with treatment options recommended for generalized disease at presentation.

Patients with a PR or persistent progressive disease following additional treatment should be treated with the other options included in the listing of initial treatment to improve response before starting treatment for refractory disease. Patients with extracutaneous relapse or those with cutaneous relapse that are not responding to any of the initial treatment options should be managed according to the NCCN Guidelines section for follicular lymphoma.
PC-DLBCL, leg type

Initial Treatment

PC-DLBCL, leg type has a poorer prognosis than other types of CBCL, particularly in patients with multiple tumors on the legs. RT alone is less often effective in patients with PC-DLBCL. While these lesions do respond to RT, remissions are often short lived and higher rates of dissemination to extracutaneous sites occur. In a retrospective multicenter study from the French Study Group on 60 patients with PC-DLBCL, leg type, patients treated with anthracycline containing chemotherapy and rituximab had a more favorable short-term outcome, although no particular therapy (RT or multiagent chemotherapy with or without rituximab) was significantly associated with improved survival outcomes. Among 12 patients treated with anthracycline-based chemotherapy with rituximab, the CR rate was 92% compared to 62% for patients who received other therapies. The 2-year OS rate for these two groups was 81% and 59%, respectively. Recent case reports have also pointed to the potential utility of employing chemotherapy combined with rituximab in the management of patients with PC-DLBCL, leg type.

For patients with localized disease, the NCCN Guidelines panel recommends local RT alone or in combination with R-CHOP. RT alone can be used in elderly patients or patients who are not able to tolerate systemic therapy. In patients with generalized disease, R-CHOP with or without RT is recommended. Extracutaneous disease should be managed according to the NCCN Guidelines section for DLBCL. The Guidelines recommend enrollment in clinical trials for all patients with PC-DLBCL, leg type, given the potentially aggressive nature of this disease.

Treatment for relapsed or refractory disease

In patients with regional relapses, R-CHOP is recommended if they have not received prior chemotherapy. Patients who have received prior chemotherapy should be treated with local RT or second-line chemotherapy regimens recommended for relapsed or refractory DLBCL. Local RT or second-line chemotherapy regimens recommended for relapsed or refractory DLBCL are the options for patients with generalized relapse. In a pilot study of 10 patients with relapsed CBCL, radioimmunotherapy (RIT) with yttrium-90 ibritumomab tiuxetan was shown to be effective with a CR rate of 100% and a median time to relapse of 12 months. The NCCN Guidelines have included RIT as one of the treatment options for patients with relapsed PC-DLBCL.
References


