

Re: Lambda light chain myeloma presenting as nodular hepatic lesion: A clinical rarity

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Website: www.cancerjournal.net	Quick Response Code: 
DOI: 10.4103/0973-1482.144555	

Sir,

I read an interesting article by Pal S *et al.*,^[1] entitled “Lambda light chain myeloma presenting as nodular hepatic lesion: A clinical rarity” in your Journal published on 2014 Jan-Mar; 10 (1) 191-3. The patient in this report had a successful outcome. Nevertheless, we want to share supportive information about

this rare disease. We treated a patient with a multiple liver extramedullary plasmocytomas.

A 64-year-old female was incidentally found to have a multiple masses in the liver. She has slightly right upper quadrant pain. Her routine physical examination was unremarkable. Her blood count and routine biochemical parameters were within normal limits.

Abdominal ultrasonography (US) showed a hepatic mass on segment 8. This lesion displayed an isoechoic pattern with a surrounding hypoechoic halo [Figure 1]. Computed tomography (CT) and magnetic resonance imaging (MRI) showed multiple masses on the right liver lobe. Pre-contrast CT showed multiple nodular hypodense lesions on the right

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liver lobe. Post-contrast CT scans (portal phase) revealed hypovascular and hypodense lesions compared with normal liver parenchyma [Figure 2]. Similarly, MRI showed multiple right liver lobe lesions. These masses showed low signal intensity on T1-weighted imaging and high signal intensity on T2-weighted imaging [Figure 3a and b]. The initial impression of the contrast-enhanced CT suggested the possibility of hypovascular hepatic metastases. Hematological indexes, liver function tests, and renal function tests were within the normal limits. A needle biopsy of the largest liver mass was performed.

Histological examination of the liver biopsy showed diffuse solid proliferation of monotonous small round cells. These cells had eccentric cytoplasm and round nuclei with peripheral condensed chromatin. The diagnosis after immunohistochemical staining was plasmacytoma of the kappa type. Leukocyte common antigen, cytokeratin, CD34, S100, synaptophysin, and desmin staining was negative [Figure 4].

Extramedullary plasmacytomas (EMPs) are uncommon, and most are found in the lungs, oronasopharynx, or paranasal

sinuses.^[2,3] These lesions represent a rare form of plasma cell proliferation in which the tumor arises outside the bone marrow. The diagnosis of EMP requires the absence of bone marrow plasmacytosis, a normal skeletal survey, and plasma cell infiltration only at the site of EMP.^[4]

Hepatic plasmacytomas are rare, and images of these lesions on US, CT, and MRI are variable, providing insufficient knowledge. US may be the first choice, but it must be supported by other radiological modalities because it is unable to detect all lesions.

Generally, including in our case, these lesions are defined as having a hypovascular pattern. Matheiu *et al.*,^[4] described a case where the dynamic CT finding of peripheral enhancement with gradual filling-in toward the center of the lesion is very similar to those encountered in

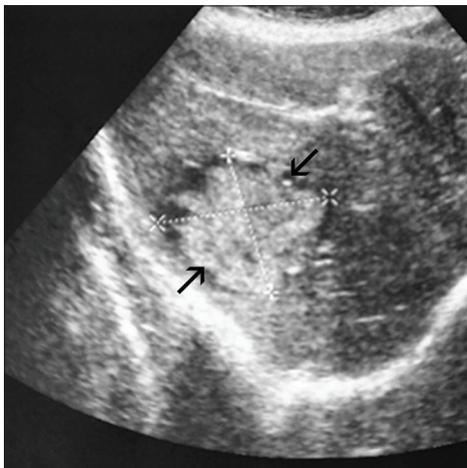


Figure 1: Abdominal ultrasonography showed a hepatic mass on segment 8. This lesion displayed an isoechoic pattern with a surrounding hypoechoic halo (arrows)

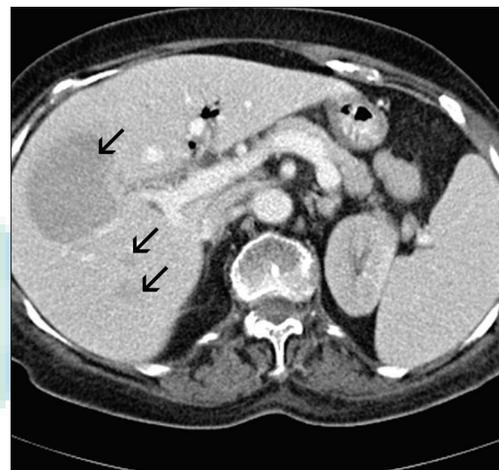
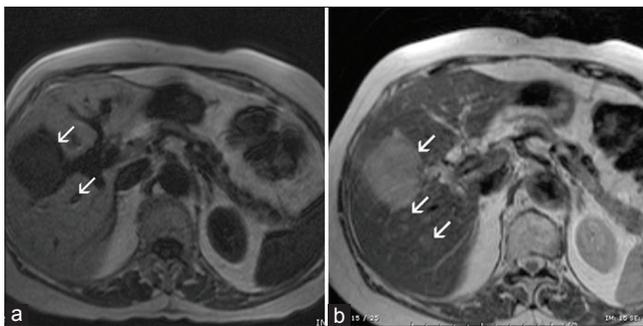


Figure 2: Post-contrast computed tomography at the level of the portal hilus scan (portal phase) demonstrated multiple hypovascular and hypodense lesions compared with normal liver parenchyma (arrows)



Figures 3: (a and b). Axial magnetic resonance imaging showed multiple right liver lobe lesions. These masses showed low signal intensity on T1-weighted imaging (a) and high signal intensity on T2-weighted imaging (b)

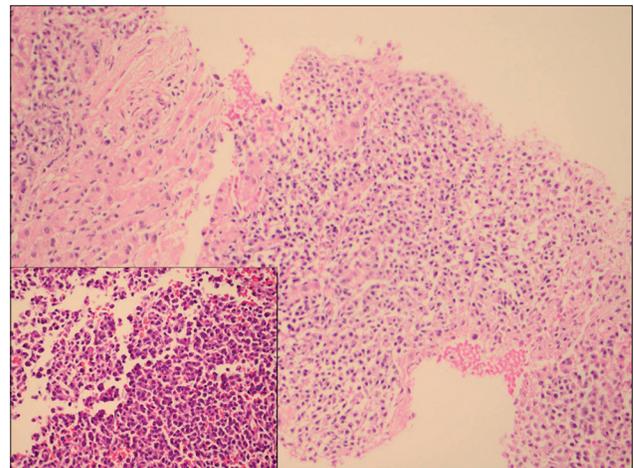


Figure 4: Photomicrograph showing atypical infiltrating plasma cells and effacing normal liver tissue [main frame: (H and E) staining, x100; inset frame: H and E x400]

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cavernous hemangiomas. However, in all cases of hepatic plasmacytomas described, including ours, the lesions were more conspicuous on US, which was also the preferred method of biopsy in most cases.

The MRI images of hepatic plasmacytomas are also variable and limited. In the English-language literature, these lesions are described as showing low signal intensity on T1-weighted imaging and high signal intensity on T2-weighted imaging.^[5]

It is important to differentiate plasmacytomas from other hepatic metastases by biopsy because they may be resectable, are radiosensitive, and show a better prognosis.

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