Correspondence

Primary malignant lymphoma of bone

Sir,

I read with interest the article "Primary malignant lymphoma of bone" by Dr. Qidwai and Dr. Khattak.[1] The authors should be complimented for successfully conveying the message to the physicians through their article to keep the possibility of this rare malignant bone tumor in the differential diagnosis of osteolytic lesion. Hereby, I would like to elaborate some important points of this tumor.

Lymphoma of bone (previously called reticulum cell sarcoma of bone) accounts for only 5% of the primary bone tumors.[2] In general, lymphoma presenting in the bone is a sign of disseminated (stage IV) disease; occasionally, it may be a true solitary lesion, defined as "involvement of single extralymphatic organ or site (stage IE)".[3] It has been emphasized that all patients with a presumed solitary lymphoma of bone should undergo a thorough evaluation for other involvement, because 50% of the so-called solitary lesions are associated with disease elsewhere.[3] The following criteria must be met to establish the diagnosis of primary lymphoma of bone: 1. Only a single bone is initially affected. 2. There is unequivocal histopathological evidence of lymphoma of the bone lesion and 3. There is metastasis to only the regional areas on presentation, or the primary tumor precedes the metastasis by at least 6 months. These criteria still hold valid since Cooley[4] developed them in 1950.

Establishment of prompt and early diagnosis is of paramount importance for treatment and prognosis point of view. Primary lymphomas are potentially curable, whereas lymphomas involving bone secondarily usually have been fatal. With treatment, a primary malignant lymphoma of bone is associated with a much better 5 year survival rate (50%) than is systemic non-Hodgkin's lymphoma (20%).[5] This emphasizes the importance of thorough evaluation of the patient and staging of the tumor.

Treatment is based on extent of disease. Stage IE lesions have traditionally been treated with radiotherapy (reported cure rate 90%).[6] Systemic chemotherapy is recommended if disseminated disease is present either initially or during follow-up of an initially primary lesion. There is no role of curettage and filling the defect with either cement or bone graft. The role of surgery is limited to obtaining adequate tissue for diagnosis and treatment of pathological fracture.[2]

Lymphoma of bone can occur at any age and in any bone. It can have nonspecific clinical and conventional radiographic features, which may mimic inflammatory, neuropathic, infectious, or other neoplastic conditions of the extremities.[7] Therefore, it is recommended that its diagnosis should be considered in the differential diagnosis of any patient with a bone lesion or persistent bone pain in spite of the rarity of this lesion.

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Reply from the Author

Authors are thankful to Dr. Suresh K. Dargan for his interest to read our article and for valuable additions to this important subject. He has rightly highlighted the need to make an early diagnosis of this rare tumor, keeping a high index of suspicion while evaluating the lytic lesions of bone. This is the real message of the article.

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