# Les sarcomes folliculaires dendritiques

### Les critères de Mulrow

Pour être qualifiée de systématique, la revue doit répondre aux critères de Mulrow:

- 1. spécification de l'objectif de la revue
- 2. source des données: éviter les biais liés à la sélection des publications
- 3. sélection des données: critères (inclusion/ exclusion) utilisés pour la revue
- 4. évaluation de la validité et de la qualité des études (critères à définir au départ)
- 5. synthèse des données: qualitative et quantitative (méta-analyse)
- 6. résumé et discussion des investigations futures à mener

### Tableau 1 Classification des histiocytoses<sup>a</sup>.

Histiocytoses langerhansiennes (HL)<sup>b</sup>

Formes localisées

Granulome éosinophile

HL pulmonaire

HL cutanée isolée

Formes systémiques

Sans atteinte d'organe à risque (syndrome de

Hand-Schüller-Christian)

Avec atteinte d'organes à risque<sup>c</sup> (syndrome de

Letterer-Siwe)

### Histiocytoses non langerhansiennes (HNL)

HNL d'origine monocytaire/macrophagique

HNL d'origine exogène

HNL métaboliques

**HNL** infectieuses

HNL hémophagocytaires

Maladie de Destombes-Rosai-Dorfman

Réticulo-histiocytose multicentrique

HNL à cellules dendritiques (dendrocyte interstitiel):

HNL de type xanthogranulome juvénile (XGJ)

HNL de type XGJ à prédominance cutanéo-muqueuse

 ${\sf HNL}$  de type  ${\sf XGJ}$  atteignant la peau avec une

prédominance extra-cutanée

HNL de type XGJ essentiellement extra-cutanée

Maladie d'Erdheim-Chesterb

Histiocytose à cellules indéterminées

### Histiocytoses malignes (HM)

HM d'origine monocytaire/macrophagique

Sarcomes histiocytaires/macrophagiques<sup>b</sup>

Leucémies myélomonocytaires

HM d'origine dendritique

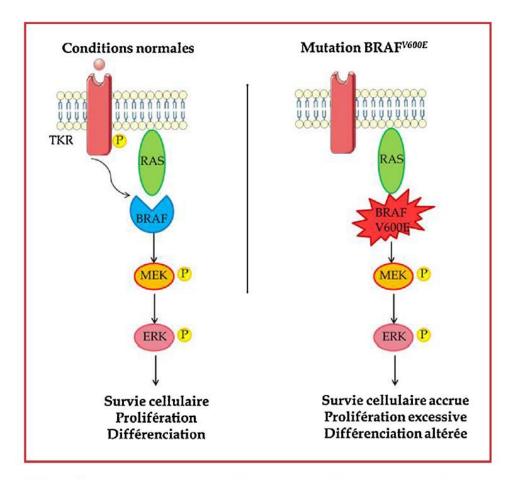
Sarcomes à cellules de Langerhans<sup>b</sup>

Sarcomes à cellules interdigitées

<sup>&</sup>lt;sup>a</sup> Adaptée de la référence [1]. Des formes de passage ou mixtes existent.

 $<sup>^{\</sup>rm b}$  Pathologies dans lesquelles la mutation  ${\rm BRAF}^{V600E}$  a été décrite.

<sup>&</sup>lt;sup>c</sup> Organes à risque: foie, rate, atteinte hématologique.



**Figure 4.** Représentation schématique de la voie de signalisation RAF-MEK-ERK en situation normale et cas de mutation BRAF $^{V600E}$ . Adaptée à partir de la référence [96].

## Deux formes de sarcomes dendritiques

- à cellules folliculaires dendritiques
- à cellules inter-digitées dendritiques

# Interdigitating and Follicular Dendritic Cell Sarcomas A SEER Analysis

Stephanie M. Perkins, MD and Eric T. Shinohara, MD, MSCI

Objectives: Follicular dendritic cell sarcoma (FDCS) and interdigitating dendritic cell sarcoma (IDCS) are rare neoplasms of dendritic cell origin. Because of the rarity of these diagnoses, optimal management is unclear.

**Methods:** In this study, we reviewed the data on FDCS and IDCS available in the Surveillance, Epidemiology, and End Results database. Fifty-four patients with FDCS and 20 with IDCSs were identified between the years 2001 and 2008.

Results: Median follow-up was 28 months. Sixty-one percent of FDCS patients and 55% of IDCS patients presented with localized disease. Of the FDCS patients with localized disease, 31/33 (94%) underwent surgical resection. Fifty-five percent (6/11) of localized IDCS patients underwent surgical resection. Radiation therapy was given to 30% of patients. Overall survival was significantly better for patient with FDCS compared to those with IDCS. Median survival was 35 months in patients with IDCS and was not reached in patients with FDCS. There was a trend toward improved overall survival in FDCS patients with localized disease. IDCS patients with localized disease had a significantly improved overall survival compared with those with distant disease with 2-year overall survival of 72% versus 33%, respectively (P=0.05).

Conclusions: These data demonstrate that most patients with localized disease are treated similar to a soft tissue sarcoma with primary surgical resection with or without radiation. No chemotherapy data were available in the Surveillance, Epidemiology, and End Results database. The role of chemotherapy and radiation therapy remains unclear.

Key Words: SEER, dendritic cell sarcoma, follicular

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reported in the literature, and the clinical course and optimal treatment for these neoplasms is unclear.

FDCS most commonly presents in the head and neck at both nodal and extranodal sites. These tumors typically occur during middle age but have been reported from childhood to late adulthood. <sup>1,4</sup> IDCS is rarer than FDCS, and previous reviews have indicated that this variant may have a poorer outcome. <sup>1</sup> Treatment for both IDCS and FDCS is often approached similar to that of sarcoma with surgical excision, followed by either observation, radiation, chemotherapy, or a combination of chemotherapy and radiation. Surgery is potentially curable in the setting of localized disease; however, these tumors have the potential to recur both locally and/or distantly. <sup>1,5</sup> The efficacy of adjuvant radiation therapy or chemotherapy is unclear. <sup>6</sup>

Because of the rarity of both IDCS and FDCS, prospective data on optimal management of these patients do not exist. The present study was designed to evaluate patient characteristics, treatment modalities, and outcome using the Surveillance, Epidemiology, and End Results (SEER) database.

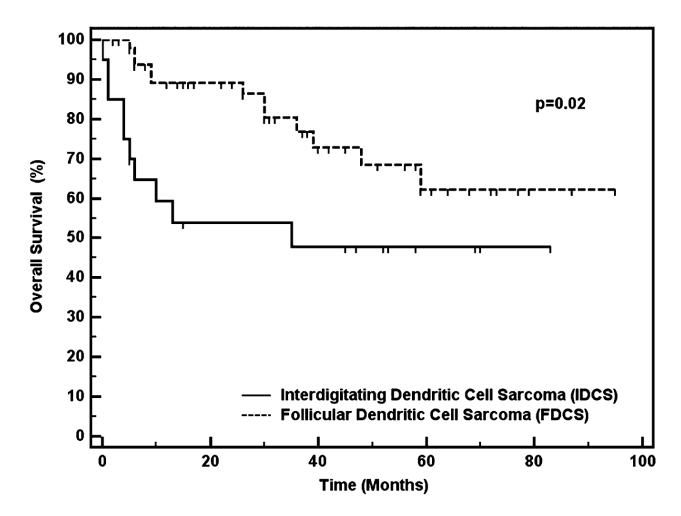
### **MATERIALS AND METHODS**

The present study is a retrospective review of data extracted from the National Cancer Institute's SEER database. Patients from 1973 to 2008 provided by 17 registries were identified (November 2010 submission).

Cases of interdigitating dendritic sarcomas were identified using the International Classification for Childhood Cancer site recode extended ICD-0-3 histology code 9757/3 (IDCS, Inter-

**TABLE 1.** Patient Demographics, Tumor Characteristics, and Treatment Information

Variables	Categories	Follicular Dendritic Cell Sarcomas, N (%)	Interdigitating Dendritic Cell Sarcomas, N (%)
Age	<40	16 (29)	2 (10)
1180	40-49	9 (17)	1 (5)
	50-59	14 (26)	3 (15)
	>60	15 (28)	14 (70)
Sex	Male	27 (50)	12 (60)
	Female	27 (50)	8 (40)
Race	White	45 (83)	16 (80)
	Black	4 (7)	3 (15)
	Other	3 (6)	1 (5)
	Unknown	2 (4)	0 (0)
Grade	П	3 (6)	2 (10)
	III	5 (9)	2 (10)
	IV	5 (9)	3 (15)
	Unknown	41 (76)	13 (65)
Stage	Local	33 (61)	11 (55)
	Distant	17 (32)	9 (45)
	Unknown	4 (7)	0 (0)
Year of diagnosis	2001-2004	22 (41)	10 (50)
or diagnosis	2005-2008	32 (59)	10 (50)
Marital status	Yes	30 (56)	15 (75)
Wairtar Status	No	20 (37)	5 (25)
	Unknown	4 (7)	0 (0)
Radiation	No	37 (68)	13 (65)
radiation	Yes	16 (30)	6 (30)
	Unknown	1 (2)	1 (5)
Surgery	Yes	44 (81)	9 (45)
burgery	No	8 (15)	9 (45)
	Unknown	2 (4)	2 (10)
Primary site	Head and neck	16 (30)	3 (15)
	Abdomen/ pelvis	19 (35)	2 (10)
	Thorax	10 (19)	6 (30)
	Other	4 (7)	5 (25)
	Extremity	5 (9)	4 (20)



**FIGURE 1.** Kaplan-Meier curve of the overall survival of patients with follicular dendritic cell sarcoma and interdigitating dendritic cell sarcoma.

### Dendritic Cell and Histiocytic Neoplasms: Biology, Diagnosis, and Treatment

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Background: Dendritic and histiocytic cell neoplasms are rare malignancies that make up less than 1% of all neoplasms arising in lymph nodes or soft tissues. These disorders have distinctive disease biology, clinical presentations, pathology, and unique treatment options. Morphology and immunohistochemistry evaluation by a hematopathologist remains key for differentiating between these neoplasms. In this review, we describe tumor biology, clinical features, pathology, and treatment of follicular dendritic cell sarcoma, interdigitating dendritic cell sarcoma, indeterminate dendritic cell sarcoma, histiocytic sarcoma, fibroblastic reticular cell tumors, and disseminated juvenile xantbogranuloma.

**Methods:** A literature search for articles published between 1990 and 2013 was undertaken. Articles are reviewed and salient findings are systematically described.

Results: Patients with dendritic cell and histiocytic neoplasms have distinct but variable clinical presentations; however, because many tumors have recently been recognized, their true incidence is uncertain. Although the clinical features can present in many organs, most occur in the lymph nodes or skin. Most cases are unifocal and solitary presentations have good prognoses with surgical resection. The role of adjuvant therapy in these disorders remains unclear. In cases with disseminated disease, prognosis is poor and data on treatment options are limited, although chemotherapy and referral to a tertiary care center should be considered. Excisional biopsy is the preferred method of specimen collection for tissue diagnosis, and immunohistochemistry is the most important diagnostic method for differentiating these disorders from other entities.

**Conclusions:** Dendritic cell and histiocytic cell neoplasms are rare hematological disorders with variable clinical presentations and prognoses. Immunohistochemistry remains important for diagnosis. Larger pooled analyses or clinical trials are needed to better understand optimal treatment options in these rare disorders. Whenever possible, patients should be referred to a tertiary care center for disease management.

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Table 1. — Differential Diagnosis of Dendritic Cell Sarcomas

FDCS and IDCS	FRCT	нѕ	INDCS	JXG
Anaplastic large cell lymphoma IDCS (for FDCS) or FDCS (for IDCS) Inflammatory pseudotumors Intranodal myofibroblastoma LCH Non-Hodgkin lymphoma Peripheral nerve sheath tumors True histiocytic lymphomas	FDCS IDCS INDCS Palisaded myofibroblastoma Sarcoma	Anaplastic large cell lymphoma Diffuse large B-cell lymphoma Hemophagocytic lymphohistiocytosis LCH Lymphoma Metastatic carcinoma or melanoma	LCH Pityriasis rosea Scabies T-cell lymphomas (cutaneous T-cell hyperplasia, mycosis fungoides)	Dermatofibroma Eruptive xanthomas LCH Mastocytoma Papular xanthoma Spitz nevus Tuberous xanthoma Xanthoma disseminatum

FDCS = follicular dendritic cell sarcoma, FRCT = fibroblastic reticular cell tumor, HS = histiocytic sarcoma, IDCS = interdigitating dendritic cell sarcoma, INDCS = indeterminate dendritic cell sarcoma, JXG = juvenile xanthogranuloma, LCH = Langerhans cell histiocytosis.

Table 2. — Clinical and Pathological Findings of Dendritic Cell Sarcomas

	FDCS	IDCS	INDCS	HS	FRCT	JXG
Clinical Findings (usual presentation)	Slow growing mass, usually a lymph node	Asymptomatic solitary lymph node mass	Papules, nodules, or plaques on the skin	Solitary mass with systemic symptoms Can have skin le- sions (rash-like)	Asymptomatic mass	Small solitary papule
Cytomorphology	Spindle to ovoid cells with whorls	Spindle to ovoid cells with whorls	Resembles Langerhans cells with irregular nuclear grooves and clefts	Large and round to oval shape with focal areas of spindling	Spindle to ovoid cells with whorls in paracortical areas	Small and oval with a bland round to oval nucleus without grooves
Immunophenotypical Markers	CD4 (+) CD21 (+) CD34 (-) CD35 (+) CD68 (+/-) Fascin (+)	CD4 (+) CD45 (+/-) CD68 (+) Fascin (+) S100 (+)	CD1a (-) CD4 (+) Fascin (+) S100 (+) CD68 (+/-) Birbeck granules (-)	CD163 (+) CD68 (+) Lysozyme (+) CD1a (-) CD21 (-) CD35 (-) CD33(-)	Vimentin (+) Desmin (+) Smooth muscle actin (+) Factor XIIIa (+) CD21 (-) CD35 (-) S100 (-) CD1a (-)	Vimentin (+) sCD14(+) CD68 (+) Stabilin-1 (+) CD163 (+) Factor XIIIa (+) CD1a (-)
Treatment for Limited Disease	Surgical resection ± adjuvant chemotherapy or RT	Surgical resection or RT	Surgical excision	Surgical resection ± RT	Surgical resection ± RT	None needed for localized asymptomatic lesion
Treatment for Disseminated Disease	Lymphoma-type chemotherapy	Lymphoma-type chemotherapy	Multimodality	Lymphoma-type chemotherapy	Participation in a clinical trial	Langerhans histiocytosis– based treatment

FDCS = follicular dendritic cell sarcoma, FRCT = fibroblastic reticular cell tumor, HS = histiocytic sarcoma, IDCS = interdigitating dendritic cell sarcoma, INDCS = indeterminate dendritic cell sarcoma, JXG = juvenile xanthogranuloma, RT = radiation therapy.





# Dendritic cell sarcoma: A pooled analysis including 462 cases with presentation of our case series

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Table 3

Demographic and clinical features of our and reported cases.

	FDCS (343 cases)	IDCS (100 cases)	FRCT (19 cases)
	[10–190]	[191–253]	[254–264]
Age			
Range	9–90 years	1.8–88 years	13-80 years
Median	50 years	56.5 years	61 years
Gender	,	•	•
Male:female	169:172 (1:1.01)	58:42 (1.38:1)	11:8 (1.38:1)
Ethnicity			
Asian	NA	16/40	4/13
USA, white	NA	11/40	6/13
USA, black	NA	2/40	_
Caucasian	NA	8/40	2/13
Hispanic	NA	2/40	1/13
Other	NA	1/40	-
Presentation	177	1140	
Nodal	105/334	45/95	16/19
Extranodal	194/334	23/95	3/19
Both	35/334	27/95	3/19
Involved sites (number of cases)	33/334	21193	_
Lymph nodes	22		
Cervical	77	41	9
Axillary	22	22	3
Mediastinal	21	9	8
Abdominal	24	18	5
Inguinal	5	10	_
Epitrochlear	-	-	1
Extranodal sites			
Liver	45	13	2
Lung	31	10	2
Tonsil	27	3	_
Spleen	25	10	2
Soft tissue	24	1	1
Mediastinum	20	_	_
GIT	18	11	_
Retroperitoneum	17	=	_
Mesentery	13	1	_
Bone	11	5	1
Nasopharynx	10	3	
Parapharyngeal space	10	_	
Oral cavity	9	1	
Breast	8	2	_
Pancreas	5	_	_
	4		_
Thyroid		-	_
Bone marrow	2	11	_
Skin	2	7	_
Chest wall	2	3	-
Kidney	2	2	1
Pleura	1	3	_
Testis	_	2	_
Bladder	_	2	_
CNS	1	2	_
Other	26 <sup>a</sup>	6 <sup>b</sup>	1 <sup>c</sup>

FDCS, follicular dendritic cell sarcoma; IDCS, interdigitating dendritic cell sarcoma; FRCT, fibroblastic reticular cell tumor; GIT, gastrointestinal tract; CNS, central nervous system; NA, not available.

<sup>&</sup>lt;sup>a</sup> Other rare extranodal sites of FDCS included omentum, peritoneum, ovary, thymus, adrenal gland, abdominal wall, diaphragm, infratemporal fossa, piriform sinus, oropharynx, hypopharynx, ethmoid/sphenoid sinus, muscle, lip and dura mater.

b Less common extranodal sites of IDCS included nose, ovary, cervix, eyelid and heart.

<sup>&</sup>lt;sup>c</sup> Adrenal gland was involved in our case 1.

Table 4
Univariate analysis of factors associated with adverse outcome (i.e. local recurrence, distant metastasis or death) (chi-square method).

	FDCS (number with positive events/total number of patients)	p value	IDCS (number with positive events/total number of patients)	p value	FRCT (number with positive events/total number of patients)	p value
Age	<u> </u>					
≤40 years	48/79		20/27		2/6	
>40 years	68/157	0.016	21/47	0.027	5/10	0.633
Gender						
Male	51/113		26/47		4/10	
Female	65/123	0.292	15/27	0.823	3/6	1.000
Tumor type						
CIRC	NR		NR		5/11	
CNRC	NR		NR		2/5	1.000
Presentation						
Nodal	33/58		10/29		5/14	
Extranodal	75/149		7/18		2/2	
Nodal and extranodal	11/30	0.198	22/24	< 0.001	-	0.175
Intraabdominal involveme	nt					
Present	40/78		18/21		3/5	
Not present	76/158	0.748	23/53	0.002	4/11	0.596
Classical morphology*						
Present	79/159		12/31		2/9	
Not present	15/25	0.457	13/22	0.235	2/3	0.236
Lymphoplasmacytic infiltr	ration					
Present	71/153		21/43		4/11	
Not present	6/6	0.011	6/13	0.883	1/1	0.416
Epithelioid cells						
Present	12/25		3/4		1/3	
Not present	87/169	0.912	24/28	0.343	4/9	1.000
Giant cells						
Present	18/42		8/13		2/4	
Not present	81/152	0.306	19/40	0.575	3/8	1.000
Tumor size						
≥6 cm	37/71		8/14		1/2	
<6 cm	27/79	0.040	12/29	0.519	4/10	1.000
Necrosis						
Present	28/62		8/14		3/6	
Absent	30/48	0.106	7/22	0.247	2/3	1.000
Mitosis						
≥5/10 HPF	35/55		6/11		3/5	
<5/10 HPF	25/61	0.024	7/14	0.859	1/5	0.524

FDCS, follicular dendritic cell sarcoma; IDCS, interdigitating dendritic cell sarcoma; FRCT, fibroblastic reticular cell tumor; CIRC, cytokeratin positive interstitial reticular cell tumor; CNRC, cytokeratin negative interstitial reticular cell tumor

NR, not relevant as this classification is only for FRCT.

<sup>\*</sup> Histological pattern common to all three subtypes includes spindled to ovoid cells forming fascicles, whorls, sheets, or nodules.

Table 5 Mulitvariate Cox regression analysis for prognostic factors.

	FDCS $(n = 50 \text{ cases})$		
	HR (95% CI)	p value	
Age ( $\leq$ 40 years)	0.907 (0.318–2.586)	0.855	
Intraabdominal involvement	0.613 (0.184–2.047)	0.426	
Absence of lymphoplasmacytic infiltration	6.330 (1.592–25.165)	0.009	
Tumor size $(\geq 6 \text{ cm})$	5.263 (1.483–18.675)	0.010	
Necrosis	0.638 (0.199–2.045)	0.450	
Mitosis (≥5/10 HPF)	1.461 (0.461–4.625)	0.519	

FDCS, follicular dendritic cell sarcoma; HR, hazard ratio; CI, confidence interval.

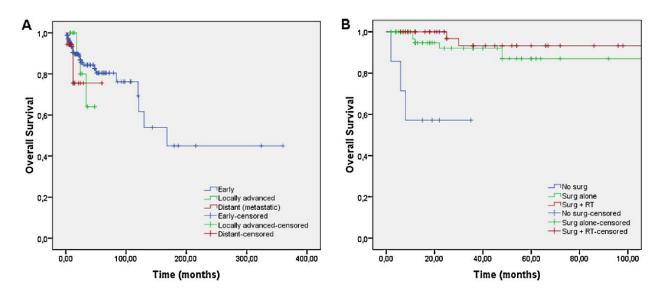


Fig. 1. Kaplan–Meier curve of overall survival (OS) of patients with follicular dendritic cell sarcoma (FDCS). (A) Stage at presentation (early, locally advanced, or with distant metastasis) had no significant influence on OS of cases (p = 0.44). (B) Localized FDCS cases who received surgery had a significantly better OS when compared to patients who had other treatment modalities (p < 0.001). There was no significant difference between OS of patients who received adjuvant radiotherapy and surgery alone (p = 0.474).

# Etiologie et associations

- Étiologie virale:
  - EBV
  - herpès virus humain 8 (HHV-8)
- Maladie de Castleman (précurseur?): pathologie lymphoproliférative atypique d'étiologie indéterminée
- Autoimmunité: pemphigus, myasthénie