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Editorial Board Member of *World Journal of Clinical Cases*, Jae Gil Lee, MD, PhD, Professor, Surgeon, Department of Surgery, Yonsei University College of Medicine, Seoul 03722, South Korea. jakii@yuhs.ac

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Myeloid sarcoma of the colon as initial presentation in acute promyelocytic leukemia: A case report and review of the literature

Lei Wang, Da-Li Cai, Na Lin

ORCID number: Lei Wang 0000-0003-1075-0086; Da-Li Cai 0000-0003-2441-223X; Na Lin 0000-0002-6725-1205.

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Lei Wang, Da-Li Cai, Na Lin, Department of Hematology, The First Affiliated Hospital of China Medical University, Shenyang 110001, Liaoning Province, China

Corresponding author: Na Lin, MD, Associate Professor, Department of Hematology, The First Affiliated Hospital of China Medical University, No. 155 Nanjing North Street, Shenyang 110001, Liaoning Province, China. salinaofcmu@163.com

Abstract

BACKGROUND

Myeloid sarcoma (MS) rarely occurs in acute promyelocytic leukemia (APL) at onset, but it can develop in relapse cases, especially after APL treated with all-trans retinoic acid (ATRA). Therefore little is known about the clinical features and suitable treatment for APL related MS due to the rarity of the disease, although this may be different from the treatment and prognosis of MS in the relapse stage. To our best knowledge, this is the second case report of APL initial presentation as colon MS.

CASE SUMMARY

A 77-year-old woman complained of intermittent right lower abdominal pain, black stool, and difficult defecation for 2 mo. Physical examination showed diffuse tenderness during deep palpation and an anemic appearance. Laboratory findings showed positivity for fecal occult blood testing; white blood cell count: $3.84 \times 10^9/L$; hemoglobin: 105 g/L; platelet count: $174 \times 10^9/L$; and negativity for tumor markers. Abdominal enhanced computed tomography showed a space occupying lesion in the colon (1.9 cm). Fibrocolonoscopy revealed a polypoid and ulcerated mass measuring 2.5 cm. The tumor was removed. To our surprise, MS was confirmed by immunohistochemistry. *PML/RAR α* fusion gene was detected in colon specimens by fluorescent *in situ* hybridization and real-time reverse transcription polymerase chain reaction, which was consistent with the bone marrow. She was diagnosed as having APL related MS. A smooth and unobstructed intestinal wall was found by fibrocolonoscopy, and continuous molecular remission was confirmed in both the bone marrow and colon after four courses of ATRA + arsenic trioxide (ATO). ATRA + ATO showed a favorable therapeutic response for both APL and MS.

CONCLUSION

Early use of ATRA can benefit APL patients, regardless of whether MS is the first or recurrent manifestation.

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Core Tip: Myeloid sarcoma (MS) rarely occurs in acute promyelocytic leukemia (APL) at onset. We report the second case of APL with colon MS as the initial presentation. *De novo* APL related MS is a very rare disease. Its clinical features and prognosis may be different from those of extramedullary disease, and the disease free survival may be shorter than MS occurring in APL relapse. To date, a total of 28 cases of APL with MS as the initial presentation have been reported worldwide. The tumor was removed. Continuous complete remission was achieved after the treatment of all-trans retinoic acid (ATRA) + arsenic trioxide (ATO). After radiotherapy or tumor resection, ATRA + ATO showed a favorable therapeutic response for both APL and MS.

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INTRODUCTION

Myeloid sarcoma (MS) may exist as an independent tumor, or as an extramedullary disease (EMD) developing in patients with acute myeloid leukemia (AML)[1], especially M2, M4, and M5 subtypes. MS is an extramedullary tumor consisting of immature myeloid cells. It can occur in any part of the body, in particular the skin, bone, lymph nodes, soft tissue, testis, and gastrointestinal tract. MS may develop *de novo* or even concurrently with 3%-8% of AML patients. It may be the only initial manifestation of relapse in AML patients regardless of the examination results of blood and bone marrow. MS rarely occurs in acute promyelocytic leukemia (APL) at onset[2-4], but it can develop in relapse cases, especially after APL treated with all trans retinoic acid (ATRA)[5]. de Botton *et al*[3] have reported the association between treatment with ATRA and extramedullary relapses. What's more, *de novo* MS as the first manifestation of APL is really a rare event, which occurs in less than 1% of EMD cases[6,7]. Therefore, little is known about the clinical features and suitable treatment for APL related MS due to the rarity of the disease, although these may be different from those of MS in the relapse stage. To our best known, this is the second case of APL with colon MS as the initial presentation.

CASE PRESENTATION

Chief complaints

A 77-year-old woman complained of intermittent right lower abdominal pain, black stool, and difficult defecation for 2 mo.

History of present illness

The patient's uncomfortable symptoms started 2 mo ago, which had worsened over the last week.

History of past illness

The patient's medical history included diabetes and hypertension for 3 years.

Personal and family history

The patient's mother had a history of hypertension.

Physical examination

The patient's body temperature was 36.9 °C, tachycardia was 101 bpm, respiratory rate was 20 breaths/min, and blood pressure was 145/75 mmHg. Physical examination showed muscle tension, Murphy's sign and voiced mobility was negative, but diffuse tenderness during deep palpation and bowel sounds were observed 3 times per minute, together with an anemic appearance.

Laboratory examinations

Laboratory findings showed positivity for fecal occult blood testing; serum amylase: 29 U/L; serum lipase: 14.8 U/L; white blood cell (WBC) count: $3.84 \times 10^9/L$; hemoglobin: 105 g/L; platelet count: $174 \times 10^9/L$; and negativity for tumor markers.

Imaging examinations

Hepatomegaly and splenomegaly were not found by Doppler ultrasound of the abdomen. Abdominal enhanced computed tomography showed a space occupying lesion in the colon (1.9 cm), with obvious enhancement. Fibrocolonoscopy revealed a polypoid and ulcerated mass measuring 2.5 cm, with hyperemia and erosion of the ileocecal mucosa, irregular ulcer, uneven bottom, annular lesions in the mucosa, and moderate to severe inflammatory cell infiltration. Part of the tumor was removed for biopsy.

FINAL DIAGNOSIS

To our surprise, MS was confirmed by immunohistochemistry using a panel of myeloid cell surface marker antibodies, which revealed CK+, CD68+, CgA+, CD117+, and MPO+. The Ki67 index was 65%, and B-cell and T cell lymphomas were excluded by negative staining for CD20 and CD3. Subsequently, bone marrow aspiration revealed 68% of blasts, and the patient was diagnosed with APL based on the morphology (Figure 1A) and immunohistochemistry (CD33+, CD117+, CD13+, CD64+, MPO+, CD9+, CD34-, CD19-, CD10-, and cCD79a-) (Figure 1B). Cytogenetics revealed a karyotype with $t(15; 17)(q22; q21)$ (Figure 1C), and a real-time reverse transcription polymerase chain reaction assay showed a typical *PML/RAR α* fusion, which further confirmed the diagnosis. Fluorescence *in situ* hybridization (FISH) using a *PML/RAR α* dual-color, dual-fusion probe showed *PML/RAR α* fusion signals (Figure 1D). *PML/RAR α* fusion gene was also detected in colon specimens by FISH and real-time reverse transcription polymerase chain reaction (PCR), which was consistent with the bone marrow (Figure 1E). The final diagnosis was APL related MS (MS/APL).

TREATMENT

After two courses of ATRA + arsenic trioxide (ATO) treatment, the patient's symptoms improved, and laboratory examination showed improvement of anemia. PCR analysis for *PML/RAR α* transcription and FISH using a *PML/RAR α* dual-color, dual-fusion probe on bone marrow cells confirmed molecular remission. Meanwhile, colon ulcerative lesions improved significantly, as revealed by fibrocolonoscopy.

OUTCOME AND FOLLOW-UP

Continuous molecular remission was confirmed in both the bone marrow and colon. A smooth and unobstructed intestinal wall was found by fibrocolonoscopy without ulcer or polypoid masses after four courses of ATRA + ATO. ATRA + ATO showed a favorable therapeutic response for both APL and MS.

DISCUSSION

MS as an initial presentation of APL is an extremely rare event, and more than 95% of cases occur at the time of relapse, especially after ATRA treatment[8]. High WBC count is suggested as a risk factor[7]. ATRA enhances the migration and adhesion of

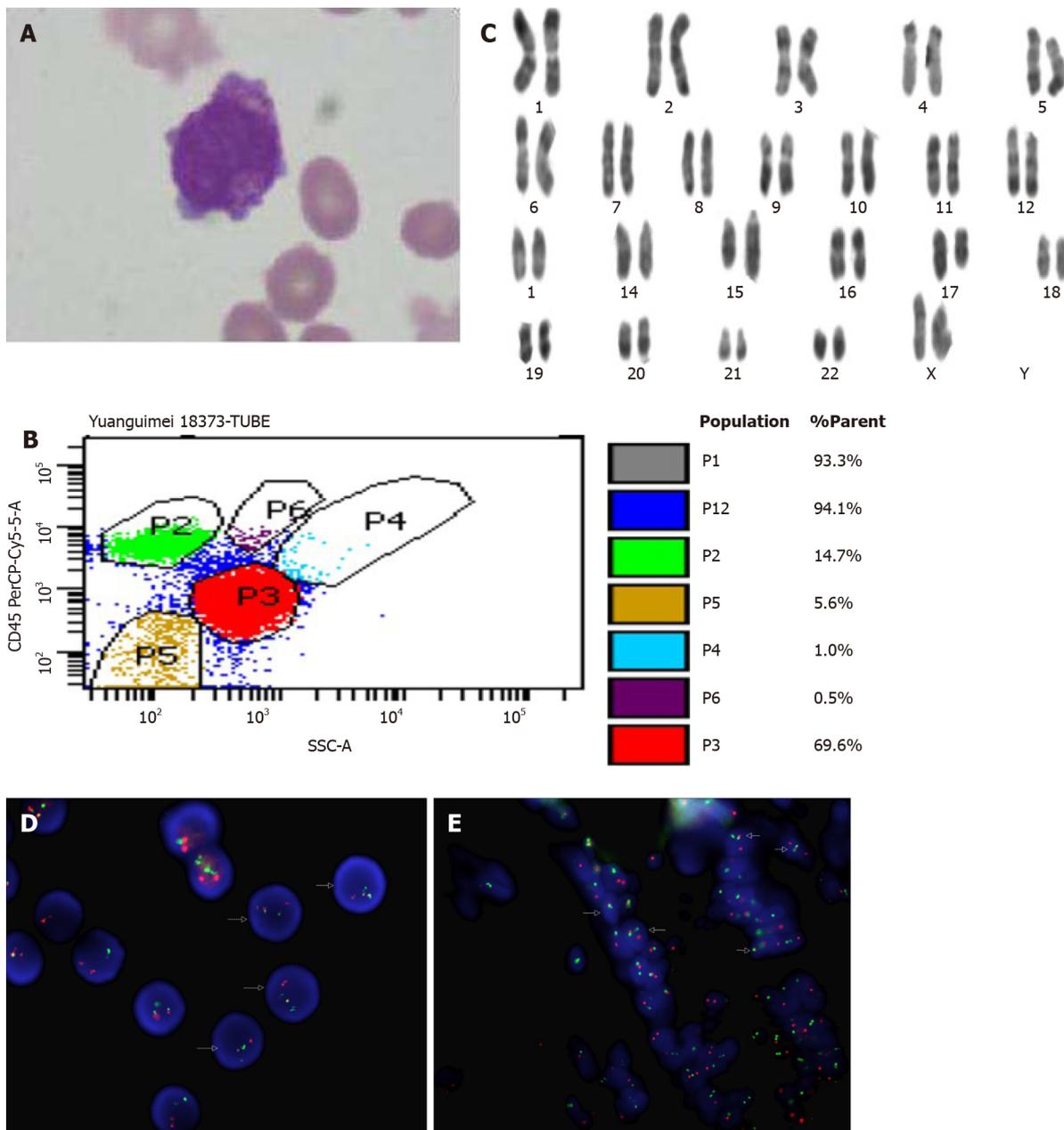


Figure 1 Laboratory examination results of this patient. A: Bone marrow morphology revealed 68% of abnormal promyelocyte cells (100 ×); B: Flow cytometric analysis of bone marrow cells showed a population of abnormal cells (P3: 69.6%); C: Karyotype of this patient: 46, XX, t(15; 17) (q22; q21); D: Fluorescence *in situ* hybridization (FISH) results in bone marrow cells at diagnosis showed *PML/RARα* fusion; E: FISH results in intestinal tissue cells at diagnosis showed *PML/RARα* fusion.

extramedullary tissues by increasing the adhesion molecules of leukemia cells *in vitro*, which explains why the number of patients with extramedullary relapse is increasing [9]. However, the risk of EMD after treatment with ATRA is not increased compared with chemotherapy alone in a large cohort study[10]. MS has the tendency to develop into AML, and most of the untreated MS cases transformed into acute leukemia within 6 mo. So comprehensive and careful examination of the bone marrow smear and biopsy is important for patients with MS in order to rule out bone marrow involvement[11,12]. However, *PML/RARα* fusion gene or characteristic chromosome translocation of MS could be detected in patients with a normal result of bone marrow smear and blood routine test. Once bone marrow is involved, it should be treated according to the workup of APL. For MS, surgical resection, radiotherapy, systemic chemotherapy, and hematopoietic stem cell transplantation are the main treatment methods [13]. For MS/APL, early use of ATRA can improve the prognosis, regardless of whether MS is the first or recurrent manifestation. A misdiagnosis of lymphoma may occur and diagnostic distinction can be difficult[14,15] in the isolated presentation of MS without any signs of leukemia. Tissue examination plays a very important role in

the diagnosis of MS, because some patients have no bone marrow involvement at the time of onset. When fresh tissue samples cannot be obtained, the cytogenetic abnormalities of fixed section and paraffin embedded section can be detected by FISH [16]. Once *PML/RAR α* fusion gene is found in *de novo* MS, it is recommended to use ATRA treatment and pay attention to monitoring the condition of peripheral blood and bone marrow.

De novo MS/APL is a very rare disease. Its clinical features and prognosis may be different from those of EMD, and the disease free survival may be shorter than MS occurring in APL relapse. To date, a total of 28 cases of APL with MS as the initial presentation have been reported worldwide (Table 1)[17-41]. The average age of onset was 35 (1-77) years, and sex-bias phenomenon (only 8 female) was difficult to explain due to the limited number of patients. The sites of *de novo* MS were widely distributed, and the most common sites were vertebra (6 cases) and extradural (6 cases), followed by the intestine, tongue, pelvis, skull, pleura, hip, mandible, spinal, humerus, tibia, femur, sternum, skin, mediastinal, thymus, cerebellum, and testicle. A single site was involved in most cases (16/28), and multiple site MS occurred in a few APL patients. Only one patient carried a complex karyotype, and *PML/RAR α* was detected in *de novo* MS/APL in 22 patients. Bone marrow involvement was found in most patients (18/28), and 6 of the remainders developed bone marrow involvement within 1-16 mo. Increased/decreased WBC count was only seen in nine cases, the remainders' (19/28) WBC count was normal at the time of onset. In addition, the coagulation dysfunction characteristic was observed in only six patients. The optimum therapy for MS/APL is also unclear. Twenty *de novo* MS/APL patients received ATRA with chemotherapy; 16 achieved complete remission (CR), two achieved PR, and the other two died of sepsis and cerebral hemorrhage, respectively. On the other hand, eight patients were treated only with chemotherapy without ATRA or ATO; two achieved CR, one achieved PR, and the remaining five died. The longest follow-up until now was 96 mo, and in this case, the patient was treated with radiotherapy + ATRA + chemotherapy, although radiotherapy or tumor resection together with ATRA and chemotherapy may improve the prognosis of MS/APL. MS/APL is a kind of disease with diverse clinical manifestations, molecular biology, and cytogenetics, is easily confused with stromal tumor, lymphoma, and carcinoma, and is therefore associated with a high misdiagnosis rate, poor prognosis, and high recurrence rate. Our patient complained of intermittent right lower abdominal pain, black stool, and difficult defecation, which reminded us of the possibility of gastrointestinal tumor. MS occurring in the gastrointestinal tract is relatively rare when MS occurs as the first presentation in acute promyelocytic leukemia, and only four cases have been described in the literature (Table 1, cases 25-27 and current case). Abdominal pain, change in bowel habit, and small bowel obstruction were the most common clinical presentation. In conclusion, gastrointestinal bleeding may result from coagulopathy disorders or serious thrombocytopenia caused by leukaemia, especially in APL patients, but the bleeding can also be the consequence of gastrointestinal MS. Therefore, gastrointestinal MS must be considered in those who present with black or bloody stool. However, prospective and large sample clinical trials are needed to determine the optimal treatment for MS/APL. Early recognition of this rare disease with timely treatment may improve the outcomes of patients.

CONCLUSION

To our knowledge, this is the second case report of APL with colon MS the initial presentation. *De novo* MS/APL is a very rare disease. Its clinical features and prognosis may be different from those of EMD in APL relapse. Once *PML/RAR α* fusion gene is found in *de novo* MS, it is recommended to use ATRA treatment and pay attention to monitoring the condition of peripheral blood and bone marrow. Early use of ATRA can benefit the APL patients, and radiotherapy or tumor resection together with ATRA and chemotherapy may improve the prognosis of MS/APL, regardless of whether MS is the first or recurrent manifestation.

Table 1 Clinical information of myeloid sarcoma as initial presentation in acute promyelocytic leukemia

Case	Age/sex	Location	Single or multiple sites	Chromosome	Gene	BM involvement	Progression to APL	Coagulation abnormality	WBC	Treatment	Prognosis	Ref.
1	55/M	Vertebra, extradural	Multiple	-	<i>PML/RARα</i>	No	No	No	Normal	ATRA, chemotherapy, radiation	CR (15 mo, ongoing)	Fiegl <i>et al</i> [17]
2	26/M	Vertebra, extradural	Multiple	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	No	Low	ATRA, chemotherapy	CR (22 wk, ongoing)	Specchia <i>et al</i> [10]
3	61/F	Vertebra	Single	-	<i>PML/RARα</i>	No	No	-	-	Radiotherapy, ATRA, chemotherapy	CR (96 mo, ongoing)	Piñán <i>et al</i> [18]
4	52/F	Vertebra	Multiple	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	No	Normal	ATRA, chemotherapy	CR (54 mo, ongoing)	Cornfield <i>et al</i> [19]
5	56/M	Vertebra	Single	<i>t</i> (15;17)	<i>PML/RARα</i>	Yes	-	No	Normal	ATRA, chemotherapy, ASCT, ATO	CR (24 mo, ongoing)	Shah <i>et al</i> [20]
6	50/F	Vertebra	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	-	Low	ATRA, ATO, chemotherapy	CR (44 d, ongoing)	Mori <i>et al</i> [21]
7	31/M	Extradural	Multiple	-	-	No	Yes (32 d)	Yes	Normal	Radiotherapy, ASCT	PR (23 mo, ongoing)	Zuible <i>et al</i> [22]
8	53/M	Extradural	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	Yes	Normal	Radiotherapy, ATRA, chemotherapy	No improvement, died of sepsis	Bittencourt <i>et al</i> [23]
9	18/M	Extradural	Multiple	<i>t</i> (15; 17)	-	No	Yes (10 mo)	No	Normal	Chemotherapy	CR (11mo, ongoing)	Savranlar <i>et al</i> [24]
10	27/M	Extradural	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	Yes	Normal	Tumor removed, ATRA, chemotherapy, radiotherapy	CR (293 d, ongoing)	Tosi <i>et al</i> [25]
11	4/M	Pelvis	Single	-	-	Yes	-	Yes	High	Chemotherapy	CR (14 mo, ongoing)	Belasco <i>et al</i> [26]
12	-/M	Skull, pleura, hip	Multiple	<i>t</i> (15; 17)	<i>PML/RARα</i>	No	No	-	Normal	ATRA, chemotherapy	CR (13 mo, ongoing)	Bobbio-Pallavicini <i>et al</i> [27]
13	16/F	Humerus, tibia, femur	Multiple	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	No	Normal	ATRA, chemotherapy	CR (ongoing)	Fiegl <i>et al</i> [17]
14	1/M	Mandible	Single	-	<i>PML/RARα</i>	Yes	-	No	-	ATRA, chemotherapy	CR (12 mo, ongoing)	Yamashita <i>et al</i> [28]
15	50/M	Spinal	Multiple	(47, XY, +8, der (11; 22) (q10; q10), add (14) (q32), der (15) <i>t</i> (15; 17) (q22; q12), ider (17) (q10) <i>t</i> (15; 17))	<i>PML/RARα</i>	No	Yes (10 mo)	No	Normal	Chemotherapy	Died of a brain hemorrhage (40 mo)	Yamashita <i>et al</i> [29]

16	19/M	Sternum	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	No	No	No	Normal	Tumor removed, ATRA, chemotherapy	CR (24 wk, ongoing)	Thomas <i>et al</i> [30]
17	45/M	Tongue	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	-	High	ATRA, chemotherapy	CR (12 mo, ongoing)	Mohamedbhai <i>et al</i> [31]
18	35/M	Tongue	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	No	High	ATRA, chemotherapy	CR (ongoing)	Ignacio-Cconchoy <i>et al</i> [32]
19	34/M	Skin	Multiple	-	-	Yes	-	Yes	High	Chemotherapy	Died (1 mo)	Uematsu <i>et al</i> [33]
20	23/M	Mediastinal	Single	-	-	No	Yes (2 mo)	No	Normal	Radiotherapy, chemotherapy	Died of heart failure (14 mo)	Kubonishi <i>et al</i> [34]
21	21/M	Thymus	Multiple	-	-	Yes	-	No	High	Chemotherapy	Died (8 mo)	Ajarim <i>et al</i> [35]
22	27/m	Testicle	Multiple	-	<i>PML/RARα</i>	No	Yes (16 mo)	No	Normal	Radiotherapy, ATRA, chemotherapy	PR (16 mo, ongoing)	Gopal <i>et al</i> [36]
23	39/F	Cerebellum	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	Yes	High	Chemotherapy	Die of cerebral hemorrhage	Fukushima <i>et al</i> [37]
24	26/F	Ovary	Single	-	<i>PML/RARα</i>	No	Yes	No	Normal	Chemotherapy, ATRA	PR (43 mo, ongoing)	Wang <i>et al</i> [38]
25	17/F	Rectum	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	-	Normal	ATRA, chemotherapy	CR (48 mo, ongoing)	Benjazia <i>et al</i> [39]
26	66/M	Small intestine	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	No	Normal	ATRA, chemotherapy	Died of cerebral hemorrhage	Takeh <i>et al</i> [40]
27	29/M	Colon	Multiple	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	No	Low	ATRA, chemotherapy	CR (2 mo, ongoing)	Damodar <i>et al</i> [41]
Current case	77/F	Colon	Single	<i>t</i> (15; 17)	<i>PML/RARα</i>	Yes	-	No	Normal	Tumor removed, ATRA, ATO	CR (6 mo, ongoing)	

ATRA: All-trans retinoic acid; ATO: Arsenic trioxide; ASCT: Autologous stem cell transplantation; CR: Complete remission; PR: Partial remission.

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