“A 49 year old man facing amputation for large left leg mass”

Tuesday, July 28, 2020

Dr Joseph Kasese

BOTSOGO

BOTSWANA ONCOLOGY
GLOBAL OUTREACH

Continuing Medical Education Announcement

Harvard Medical School

RSS 3081: Monthly BOTSOGO Tumor Board; 2020 - 2021 Academic Year

Today's Objectives:

- Describe the need for timely cancer case presentation and referral to treatment
- Formulate a multi-disciplinary plan for the care of common and complex oncologic cases
- Adopt successful, sustainable strategies to mitigate barriers to quality cancer care common in resource constrained environments

Target Audience:

Oncologists, internists, surgeons, radiation oncologists, infectious disease specialists, nurses, physicists, therapists, technicians, research staff, administrators, policy makers.

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The following planners, speakers, and content reviewers, on behalf of themselves and their spouse or partner, have reported financial relationships with an entity producing, marketing, re-selling, or distributing health care goods or services (relevant to the content of the activity) consumed by, or used on, patients:

Name	Role	Type of Financial Relationship
Jason Efstathiou, MD	Course Director	Blue Earth Diagnostics – Consultant Taris Biomedical – Consultant Janssen – Advisory Board
Bruce Chabner, MD	Course Planner	EMD Serono – Consultant Chagai - Consultant Boston Pharmaceutical – Consultant Eli Lilly – Consultant Takeda Pharmaceuticals – Consultant Bristol Myers Squibb – Lecture Honoraria Alnylam Pharmaceuticals – Equity Holding Abbott Laboratories – Equity Holding Bluebird – Equity Holding Biomarin – Equity Holding Constellation Pharmaceuticals – Equity Holding Glaxo Smith Klein – Equity Holding PharmaMar – Equity Holding Seattle Genetics – Equity Holding Springworks – Equity Holding

Financial Relationships *(continued)*

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Name	Role	Type of Financial Relationship
Peter Vuylsteke, MD	Course Planner	Novartis – Consultant Pfizer – Consultant Lilly – Consultant MSD – Consultant, Travel grants AstraZeneca – Consultant, Travel grants Roche – Consultant, Travel grants

All other individuals including course directors, planners, reviewers, faculty, staff, etc., who are in a position to control the content of this educational activity have reported no financial relationships related to the content of this activity.

Financial Relationships *(continued)*

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Statements

Accreditation Statement

The Harvard Medical School is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians

Credit Designation Statement

The Harvard Medical School designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity

This activity meets the criteria of the Massachusetts Board of Registration in Medicine for 1.0 credits of Risk Management Study

Disclosure Statement

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Claim your CME credits!

- To claim your CME credit for attendance at this session of the BOTSOGO Tumor Board, please fill out our survey following the Tumor Board.
- You can do this at your convenience on your personal or work computer by navigating to www.botsogo.org
  - Click “What We Do”
  - Click “Tumor Board”
  - Click the link under the section “Continuing Education Credits,” and complete and submit the survey
- A link to the survey is also sent to the BOTSOGO Tumor Board email list following each Tumor Board.

Core Principles of Case Review

Clinicians, pathologists, and other other members of the health care team uniformly strive to provide the best possible clinical care.

Despite these efforts, adverse outcomes still occur.

Reflection on, and re-evaluation of, our practices and outcomes are imperative to continuously improve the care we provide to patients.

Core Principles of Case Review

Discussion will focus on medical decision-making and reporting systems.

Discussion is privileged and content should not be discussed outside of this forum.

We seek to create a safe, collaborative, open and respectful atmosphere for discussion, learning, and improvement

“A Challenging Case of Kaposi’s Sarcoma”

Dr Joseph Kasese

Tuesday, July 28, 2020

Patient KL

PATIENT: KL

AGE: 49

MALE

PMH: RVD (diagnosed 2004)

KS 2004

FH: NONE

SOCIAL: NON SMOKER

NO ALCOHOL

WORK: ARMY

History:

2004:

Presented with scattered nodular lesions involving left lower limb at PMH

Biopsy done; confirmed Kaposi's Sarcoma

CD 4 WAS 450

NO COMMENT ON VL

Commenced on ART

Patient not seen for two years

History – continued

2006:

Seen again at PMH

Worsening of lesions with now more infiltrative lesions as well as woody oedema

CD4 slightly raised at 465

Commenced on chemotherapy ABV

No substantial response after 6 cycles;

Referral to GPH for radiation therapy.

****Given 30Gy in 15 fractions from April – June 2006****

History - continued

- Excellent response noted with flattening of lesions and reduction in leg swelling
- Sustained response noted in the next 3 months, with complete flattening of the nodular lesions but remained with some degree of woody feeling
- Pt followed up routinely – initially every 3 months, then every 6 months with no new developments until **late 2009** when he presented with a flareup of lesions involving **both lower limbs**

Initiated on chemotherapy using Taxol, receiving 6 cycles

Achieved complete response of the lesions in the **right leg**, with minimum residual disease in the **left leg**

Referred to GPH where he received radiation to the same leg: 30 Gy in 15 fractions from **March – April 2010**

OVERALL GOOD RESPONSE WITH JUST MILD SWELLING NOTED AT THE END OF TREATMENT.

Patient History - continued

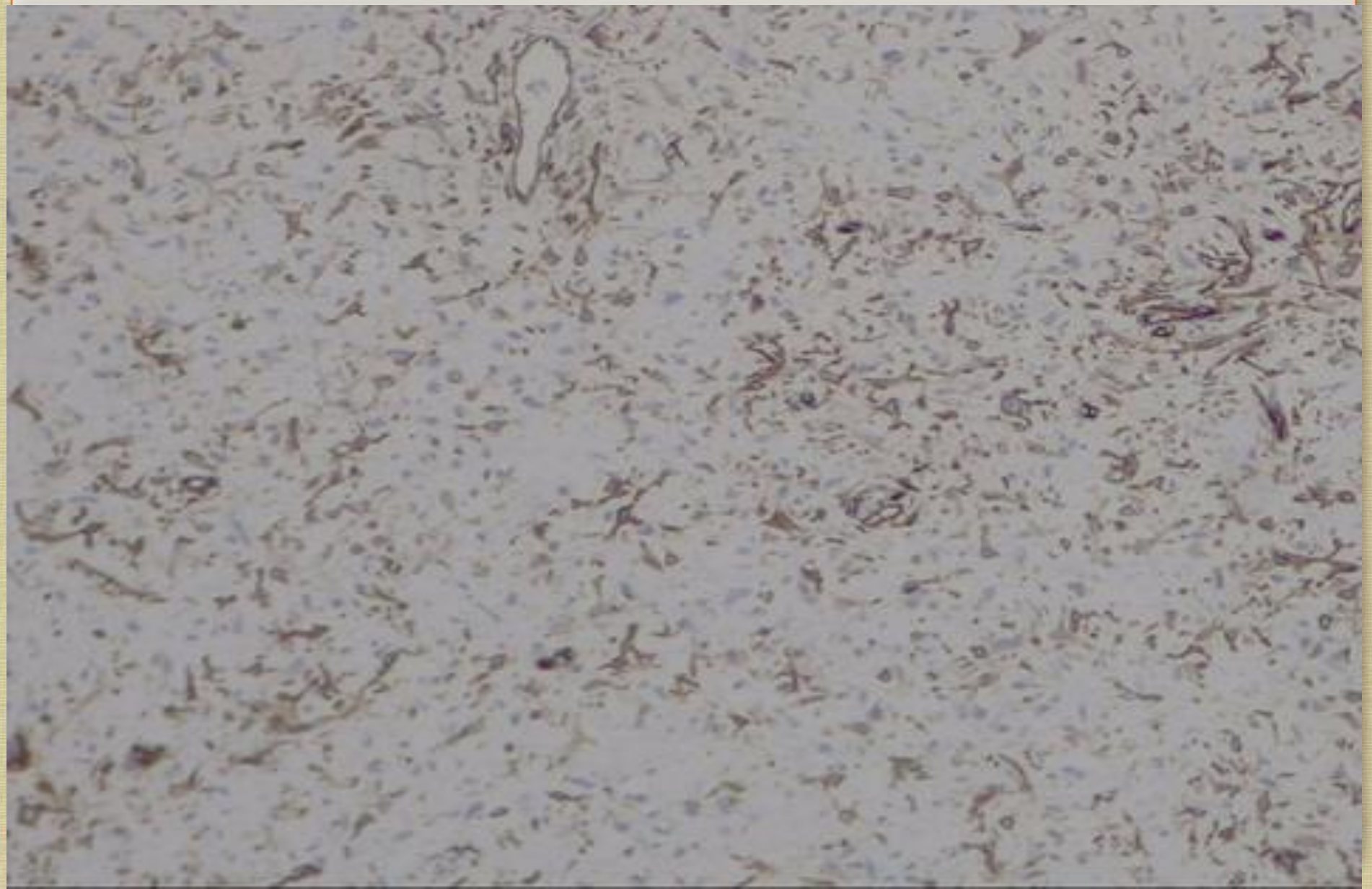
2016:

- I saw him in late 2016
- Worried about hardening of skin which had remained the same for past 6 years
- On exam: pt had this woody feeling but smooth skin with no evidence of any nodular infiltrate
- His CD in early 2016 was 460
- VL: LESS THAN 25 COPIES
- Pt reassured that it was post-radiation fibrosis.
- Booked him for follow-up after 6 months, but was lost to follow-up until late 2018 when he presented to the general surgeon.

Patient history – 2018

- Presented with a nodular lesion of about 6 cm on the left calf as well as several other smaller lesions including the popliteal fossa and thigh just above knee
- An FNA was done on the larger lesion
- **Pathology reported as KS (Kaposi's Sarcoma)**

Pathology – FNA, 2018:



History – continued (2018)

- On O/E there were several nodular lesions in the left lower limb, the largest being on the calf followed by the popliteal fossa
- On the background of woody oedema, two main lesions were fixed
- **CT scan** chest/abdomen/pelvis done – was normal

FNA – Pathology report, Oct 2018

NATURE OF SPECIMEN
FINE NEEDLE ASPIRATION
2 slides

CLINICAL HISTORY
48 year old male patient with a history of Kaposi sarcoma.
Patient has been treated but now has multiple nodules.
A FNA was done of one of these nodules.

MICROSCOPIC EXAMINATION
Scattered groups of spindle cells present
Mild acute inflammatory infiltrate.
Large amount of blood.

CONCLUSION
Spindled cells are present.
In this clinical context, this is most likely in keeping with recurrence of this patient's known Kaposi's sarcoma.

RECOMMENDATION
Histopathological confirmation advised.

FNA – Pathology report, Oct 2018

MACROSCOPY

A soft tissue mass with overlying ellipse of skin, measuring 110 x 80 x 55mm. On sectioning a firm white solid mass with small cystic areas in the central parts are seen. The mass bulges onto the skin surface. The specimen is not orientated.

MICROSCOPIC EXAMINATION

Multiple sections were examined showing skin with large portion of tissue.

A poorly cellular nodular non-circumscribed tumour is visible involving the deep dermis and deeper tissue showing central cystic degeneration with haemorrhage.
The tumour is composed of short plump spindled cells in a fibrous stroma which show small capillary sized blood vessels some of which are ectatic. The tumour cells are arranged in a patternless pattern mostly focally having a storiform growth pattern. Mitoses and pleomorphism is not identified.

The tumour can be seen extending into the deep surgical margins.

Immunohistochemical stains have been requested.

HHV 8	–	negative.
CD34	–	focally positive.

The histological appearance is that of a low grade fibrohistiocytic lesion with morphology and immunohistochemistry consistent with a dermatofibrosarcoma protuberans.

Clinical follow-up is indicated.

FNA – Pathology report, Oct 2018

DIAGNOSIS

SKIN (LOCATION SITE UNKNOWN)

- SPINDLE CELL TUMOUR WITH FEATURES THAT ARE CONSISTENT WITH DERMATOFIBROSARCOMA PROTUBERANS (DFSP).

- THE LESION IS INCOMPLETELY EXCISED AT MOST SURGICAL MARGINS.

History – continued (2019)

Commenced on chemotherapy (CAELYX/TAXOL)

Very slow response, although lesions noted to be getting softer

By 8th cycle, April 2019:

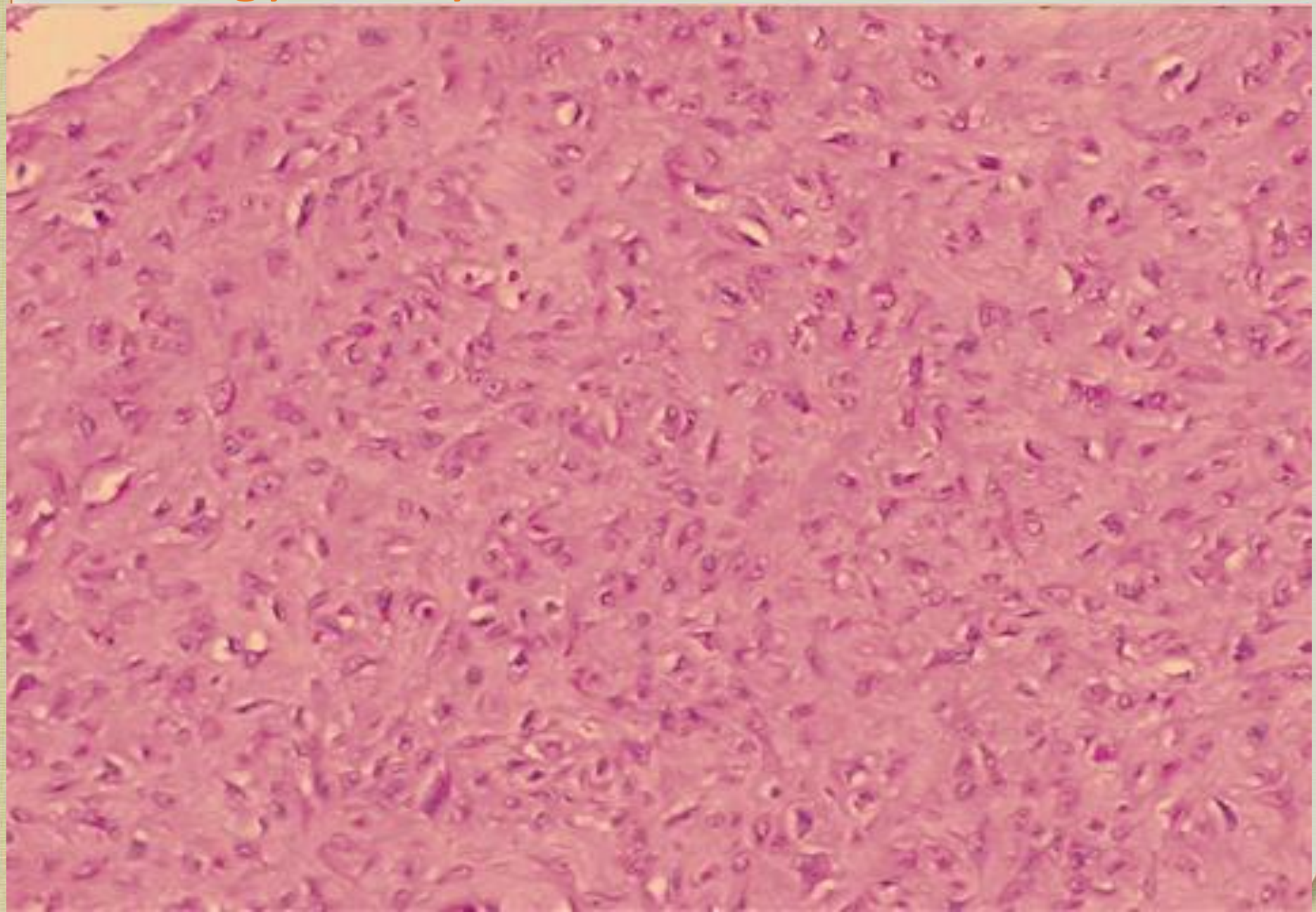
The bigger mass was down to 50% and the rest of the lesions were not palpable

Discussed with surgeon who agreed to excise the residual mass

History – continued (May 2019)

- Excision done May 2019
- Final pathology confirmed **DERMATOFIBROSARCOMA PROTUBERANCE**
- Positive resection margins
- Patient recommended for amputation but strongly refused
- Referral to Sarcoma Centre for specialist visit (outside of country)
- Patient was not seen until end of 2019.

Pathology – May 2020



History – 2019-2020

- Did not go for specialist sarcoma consult.
- Presenting with progression of disease
- Lesion on the calf ulcerated and bleeding
- Worsening of previously known lesions in the popliteal fossa and thigh
- Options for radiation discussed but ruled out
- Commenced on Gleevec, 800 MG daily, December 2019
- Bleeding stopped in early 2020

History – 2020 - continued

Severe bleeding, March 2020

Given 800 cGY single fraction which controlled the bleeding

No significant response to Imatinib

CT Chest/Abd/Pelvis

CT Chest/Abdomen/Pelvis was normal

CT lower limb

- CT LOWER LIMB CONFIRMED: large 10 cm soft tissue swelling w/ areas of skin discontinuity in the L calf containing multiple vascular nodules.
- Early feeling of the L femoral vein indicating arterio-venous fistulations demonstrated to arise from multiple subcutaneous nodules.
- Diffuse infiltrate process in & around the muscles, tendons, vessels and fascial plains w/ loss of interfaces.

Features consistent w/ nodular Kaposi's Sarcoma.


A
GPH MIB
SOMATOM Definition AS
R
10cm
SL 3/ p0.8/ FpR 15.3
mAs 88
kV 120
SP -320.5
W: 1400
C: 300


A
GPH MIB
SOMATOM Definition AS
R
10cm
SL 5/ p0.85/ FpR 16.3
mAs 105
kV 80
C APPLIED
SP -334.5
W: 450
C: 80

2020 – continued:

Eventually agreed to above near amputation clearing the proximal thigh lesion by 10 cm, April 2020

Post-amputation:

CHALLENGES:

- KS not responsive to initial chemoRx
- Radiation therapy may have contributed to development of sarcoma
- FNA role in KS
- At what point should we have insisted on the amputation?
- OPTIONS IF HE COMES BACK WITH NEW LESIONS

THANK YOU