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EDİTÖRE MEKTUP/LETTER TO THE EDITOR

Granulocytic sarcoma of finger

Parmakta granülositik sarkom

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Dear Editor,

I have read with a great interest the case report presented by Purbager et al. published in the journal in the first issue of 2016, titled "Granulocytic sarcoma of finger: a case report"[1]. The authors described a thirty-year-old woman with acute myeloid leukemia (AML) presented with progressive swelling and onychoptosis at her right fourth finger. The distal phalanx of the fourth finger was surgically resected. Histopathological evaluation revealed a neoplastic mass of atypical myeloid cells, morphologically immature hematopoietic cells indicative of relapsed acute myeloblastic leukemia, infiltrating the bone trabeculae, subcutaneous tissue, and epidermis.

Granulocytic sarcoma (GS) was originally named "chloroma" by King in 1853 due to the occasional greenish color of freshly cut tumor tissue. It is a solid tumor of immature granulocytes that most commonly occurs in a patient with leukemia or some other myeloproliferative disorder, but may occasionally occur in an otherwise healthy individual[2].

Peak incidence occurs in the third and fourth decades of life. Skin, soft tissue, and lymph nodes are the most common locations of GS. Lesions of the eye, omentum, breast, testis, intestine, peritoneum, pericardium, gingiva and uterus have also been reported[3]. Bone is a well described location for GS. Osseous lesions are most common in the skull and the orbit. Lesions have been described in the vertebrae, sacrum, rib, pelvis, sternum, clavicle, scapula, humerus, femur, and tibia[4,5]. As stated by the authors, distal phalanx localization is atypical.

Although the localization of the GS in the patient was an unexpected site tumoral masses in soft tissues or bones can precede an AML relapse. Before excision of the distal phalanx, I would like to see complete blood count, peripheral blood smear, bone marrow aspiration and bone marrow biopsy since the patient had been followed with a diagnosis of AML and in remission for 4 years. If bone marrow is not involved, biopsy from the tumoral mass should have been the second intervention in the diagnostic algorythm. And after the diagnosis of GS I would start the treatment with chemotherapy and local radiation if necessary, because radiotherapy can be used to treat symptomatic bone lesions and with radiation therapy excellent local disease control and palliation of symptoms without significant toxicity was reported[6]. With such an approach to save the phalanx could have been possible.

Although the authors did not give information about the bone marrow relapse, chemotherapy or the last status of the patient, the prognosis for the patients who present with isolated granulocytic sarcoma can be good. Apart from chemotherapy and local therapies bone marrow transplantation has been described as a therapeutic option with good, early results[7].

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