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LETTER TO THE EDITOR

Retrospective analysis of seven patients with adult-onset langerhans cell histiocytosis syndromes: A single center experience

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I read with great interest the report by Şahin F, et al. analyzing seven patients with adult-onset Langerhans cell histiocytosis (LCH)[1].

Firstly, in the title, "Langerhans" should have been written with a capital letter as "Langerhans". As it is known, Langerhans cells (LC) were firstly defined by Dr. Paul Langerhans in 1865 as aureophilic cells present within the epidermis, and as many following studies revealed, LC as important immunological cells are one of the most potent antigen–presenting cells in the body[2].

To begin, I think the article needs a classification of the patients in order to have a better understanding of the disease[3-5]. In most pediatric centers, LCHs are classified according to Raney, et al. as follows[4]:

Group IA: Localized disease. Those with a single bone lesion with or without associated soft tissue mass or regional lymph node involvement.

Group IB: Multifocal disease. Patients with two or more bone or soft tissue lesions with or without skin rash, diabetes insipidus or both.

Group II: Patients with organ dysfunction.

Since there is a high incidence of lung involvement in adults, possibly associated with smoking[6], it should be clarified in the study if the patient with lung involvement has a smoking history. Furthermore, another point not mentioned in the article is the long-term permanent sequelae in these patients.

Survival has improved over time, but widely varies by age and systems affected at diagnosis in children[7]. Additionally, systemic LCH could be associated with cellular immune deficiency in the presence of zinc deficiency in Turkish children[8-10].

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