
Letter to the Editor

CLL and Squamous Cell Cancer of the Auricle

To the Editor,

Dr. Fen's article in the recent issue of the Journal (2003;20(2):111) demonstrates an important haematological pattern with oncological implications. The scenario described requires comments.

The appearance of squamous cell carcinoma (SCC) in patients with CLL is not uncommon but frequently is a life taking circumstance for affected patients. SCC of skin arising in the presence of immunosuppression, whether by association with CLL or NHL, or associated with treatment for malignancy or transplantation, have a deserved reputation for being especially aggressive^[1-4].

SCC in this setting frequently recur locoregionally with dermal lymphatic seeding, perineural infiltration and regional nodal involvement^[5]. The SCC itself seems to be as sensitive to radiation as normal SCC of the skin, but recur around the periphery of inadequately sized fields.

In addition, there is the impression that once SCC start to appear, there is a reducing interval between new and recurrent cancers in the same patient.

In this case "amputation of the ear" alone is inadequate locoregional treatment. The lesion is at least 5 cm in size and has a high probability of lymph node metastases in the ipsilateral neck. An opinion from a multidisciplinary Head & Neck Clinic would be expected to recommend high dose radical radiation therapy irrespective of the extent of the surgery, or whether clear margins were achieved.

From an oncological stance, the difference in the natural histories of the two malignancies indicates that the management of CLL has secondary importance to the locoregional management of the SCC of the auricle cancer^[6,7].

If a reply is provided, I would be grateful if Dr. Fen could give an update of the patient's outcome.

REFERENCES

1. Levi F, Randimbison L, Te VC, La Vecchia C. Non-Hodgkin's lymphomas, chronic lymphocytic leukaemias and skin cancers. *Br J Cancer* 1996;74:1847-50 [PMID: 8956805].
2. Larsen CR, Hansen PB, Clausen NT. Aggressive growth of epithelial carcinomas following treatment with nucleoside analogues. *Am J Hematol* 2002;70:48-50 [PMID: 11994981].
3. Davidovitz Y, Ballin A, Meytes D. Flare-up of squamous cell carcinoma of the skin following fludarabine therapy for chronic lymphocytic leukemia. *Acta Haematol* 1997;98:44-6 [PMID:9210914].
4. Bridges N, Steinberg JJ. Aggressive squamous cell carcinoma of the skin after chronic lymphocytic leukemia. *J Surg Oncol* 1986;33:27-30 [PMID: 3762169].
5. Hartley BE, Searle AE, Breach NM, Rhys-Evans PH, Henk JM. Aggressive cutaneous squamous cell carcinoma of the head and neck in patients with chronic lymphocytic leukemia. *J Laryngol Otol* 1996;110:694-5 [PMID: 8759553].
6. Frierson HF Jr, Deutsch BD, Levine PA. Clinicopathologic features of cutaneous squamous cell carcinomas of the head and neck in patients with chronic lymphocytic leukemia/small lymphocytic lymphoma. *Hum Pathol* 1988; 19:1397-402 [PMID: 3056829].
7. Veness MJ, Quinn DI, Ong CS, Keogh AM, Macdonald PS, Cooper SG, Morgan GW. Aggressive cutaneous malignancies following cardiothoracic transplantation: The Australian experience. *Cancer* 1999;85:1758-64 [PMID: 10223570].

Andrew MILLER, MD

Department of Radiation Oncology
Palmerston North Hospital
NEW ZEALAND

Response

We would like to thank to Dr. Andrew Miller for his valuable contribution to our case. I would like to emphasise that the patient was scheduled to receive radiation therapy after amputation but he was lost to follow-up and even could not receive the chemotherapy for chronic lymphocytic leukemia.

Turgay FEN, MD

Department of Hematology,
Ankara Oncology Research
and Education Hospital
Ankara, TURKEY