

Letter to the Editor

Isolated regional nodal metastasis in giant cell tumor of the bone: Case report and review of literature

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Dear Editor,

Giant cell tumors (GCTs) of the bone are benign osteolytic tumor commonly occurring in the third to fourth decades with distal femur being the most common site.^[1] They form 5% of the primary skeletal tumors.^[2] Metastasis though uncommon is usually seen with recurrences. Curettage with intralesional adjuvant therapy with polymethylmethacrylate, liquid nitrogen, and bone graft has been successfully used to reduce recurrences while preserving function.^[3] The management of metastasis is still debatable due to the scarcity of literature.

A 47-year-old female who was diagnosed to have GCT of the left radius for which she underwent left distal radius curettage with bone grafting. After 1 year of disease-free interval (DFI), she developed local recurrence and underwent *en bloc* resection of radius with reconstruction using nonvascularized fibula graft with plating. She developed local recurrence in the soft tissue in the next 2 years which was managed by wide local excisions. After a DFI of 1 year, she presented with an enlarged mobile epitrochlear node, fine-needle aspiration cytology of which was suggestive of GCT. Computed tomography of the chest showed no pulmonary metastasis. The patient was discussed in multispecialty board and she underwent epitrochlear nodal dissection. The final histopathology showed five nodes, with one node showing metastatic GCT. There was no perinodal spread. Figures 1 and 2 show the presence of tumor within the lymph nodes. She is on regular follow-up for 1 year and has shown no sign of recurrence.

GCT is characterized by scattered multinucleate giant cells among mononuclear stromal cells, together imparting a syncytium-like appearance causing a typical radiolucent lytic shadow on X-ray.^[4] The tumor is known for its propensity for local recurrences which are generally amenable to wide excisions. The potential for metastatic spread was first reported by Jaffe *et al.* in 1940.^[5] Distant metastasis is seen in 2%–3% of cases with the lungs

being the most common site of distant metastasis and the incidence of pulmonary metastasis varies from 4% to 11% in the literature.^[6] Other uncommon sites being the bone, skin, soft tissue, breast, and endobronchial tree have also been reported.^[7]

Lymph nodal involvement is very rare in GCT and only 13 cases have been reported in the English literature.^[7-19] Table 1 lists the cases of GCT with lymph node involvement. Dyke, in 1931, reported the presence of GCT in lymph nodes in a case with extensive metastatic disease.^[8] Since then, majority have reported mediastinal and para-aortic nodal involvement. Only five have reported regional lymph node involvement, of which two were associated with pulmonary metastasis.^[7,9-12] Isolated regional node involvement as seen in our case has been reported previously only in three cases.^[9-11] Budzilovich *et al.* reported the first regional nodal involvement in 1963.^[9] Present *et al.*, in 1986, reported a GCT metastasizing to regional lymph node; however, it spread to lungs after a year.^[10] In another case reported by Aftab and Umar, there was axillary nodal spread from GCT of the distal humerus without pulmonary involvement.^[11]

In one of the largest reviews from a tertiary care center, Viswanathan and Jambhekar retrospectively evaluated 470 patients of GCTs, of which 24 had distant metastasis and only one patient had regional lymph node metastasis to inguinal lymph node. In their patient, the primary site was femur and there were multiple lung metastasis along with lymph node metastasis. The authors concluded that there was no association between clinicopathological variables and the development of metastasis.^[12]

The mechanism of pulmonary metastasis has been speculated to be tumor emboli either upfront or during the time of curettage. Lymphatic spread can also be explained similarly by the multiple surgeries performed previously for our patient.

Metastatic GCT has been successfully treated with complete resection of primary and the metastasis. Pulmonary metastatectomy has been routinely performed in resectable patients, with similar principle applied for lymph node metastasis also. All four cases with regional lymph node metastasis have been managed with surgical resection. Connell *et al.* successfully managed a patient with excision of primary patellar GCT along with excision of posterior mediastinal

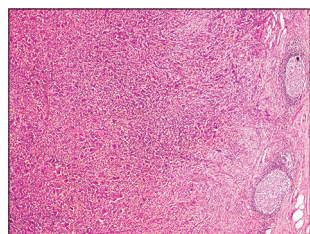
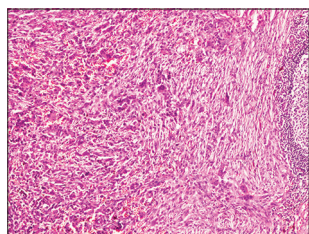
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Table 1: Cases of giant cell tumor of bone with lymph node metastasis

Study	Site of primary	Primary procedure	Setting	Lymph node involved	Other site of metastasis	Treatment
Qureshi <i>et al.</i> ^[7]	Patella	Wide excision (patellectomy)	Recurrent	Regional (inguinal nodes)	Lungs	Surgical resection
Dyke ^[8]	Patella	Amputation	Recurrent	Distant (mediastinal and peritoneal nodes)	Lungs, spine	None
Budzilovich <i>et al.</i> ^[9]	Femur	Curettage with bone grafting	Recurrent	Regional (popliteal nodes)	None	Surgical resection
Present <i>et al.</i> ^[10]	Femur	Wide excision	Recurrent	Regional	None	Surgical resection
Aftab and Umar ^[11]	Distal humerus and proximal ulna	Wide excision	Primary	Regional (axillary nodes)	None	Surgical resection
Viswanathan and Jambhekar ^[12]	Femur	Amputation	Recurrent	Regional (inguinal)	Lung	Surgical resection
Connell <i>et al.</i> ^[13]	Patella	Wide excision (patellectomy)	Recurrent	Distant (mediastinal nodes)	None	Chemotherapy f/b surgical resection
Rock <i>et al.</i> ^[15]	Tibia	Curettage and bone grafting	Recurrent	Distant (mediastinal nodes)	Lungs	Chemotherapy
Kay <i>et al.</i> ^[16]	Tibia	Curettage, phenol application and bone grafting	Recurrent	Distant (mediastinal nodes)	Lungs	None
Lewis <i>et al.</i> ^[14]	Radius	Curettage with bone grafting	Recurrent	Distant (mediastinal nodes)	None	Steroid f/b surgical resection
Goldenberg <i>et al.</i> ^[17]	NA	NA	Recurrent	Distant (mediastinal nodes)	Lungs	NA
Vanel <i>et al.</i> ^[18]	Fibula	Not treated	Primary	Distant (mediastinal node)	None	Radiotherapy
Sung <i>et al.</i> ^[19]	NA	NA	Recurrent	Distant (mediastinal nodes)	None	NA
Present case	Radius	Curettage with bone grafting	Recurrent	Regional (epitrochlear)	None	Surgical resection

NA=Not available, f/b : followed by

**Figure 1: Lymph node replaced by metastatic tumor composed of spatially arranged multinucleate giant cells in a background of mononuclear stromal cells (H and E, x40)****Figure 2: Higher magnification shows uniformly arranged multinucleate giant cells admixed with mononuclear stromal cells with residual lymphoid follicle (right extreme) (H and E, x100)**

nodal mass.^[13] Another similar case of GCT of the patella with pulmonary and nodal metastasis treated with metastasectomy.^[7] Alternate treatments for unresectable disease have also been attempted with limited success. Lewis *et al.*, in 1996, reported a case of distal radius GCT with mediastinal node metastasis. They used high dose steroids to downsize the tumor followed by resection of the mediastinal mass.^[14] There are isolated cases where chemotherapy and radiotherapy have been utilized with varied success rates.^[18] In the absence of literature, no definitive recommendation can be made.

In the present case, an upfront incomplete surgery followed by multiple recurrences with repeated surgeries would have led to tumor emboli spreading through the lymphatics. The patient was successfully managed by lymph node dissection. The implication of lymph node and distant spread in malignant GCT is not as worse compared to other malignancies and hence should be treated with curative intent if completely resectable.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

Kanuj Malik, Anand Raja, Sundersingh Shirley¹

Departments of Surgical Oncology and ¹Pathology, Cancer Institute (WIA), Chennai, Tamil Nadu, India

Correspondence to: Dr. Anand Raja,

E-mail: dr_anand@yahoo.com

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