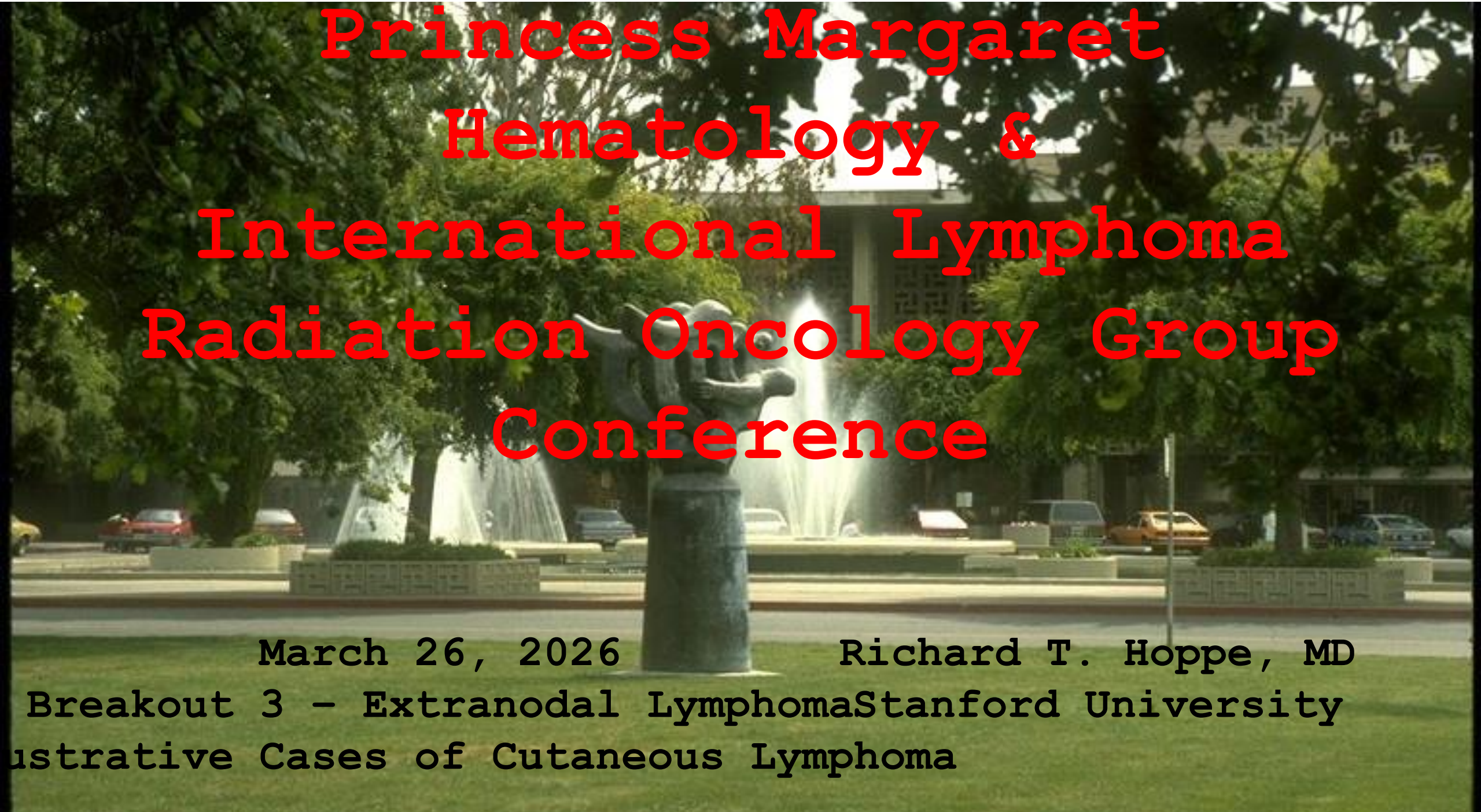


Princess Margaret Hematology & International Lymphoma Radiation Oncology Group Conference

March 26, 2026

Breakout 3 - Extranodal Lymphoma

ustrative Cases of Cutaneous Lymphoma

Richard T. Hoppe, MD
Stanford University

Conflicts of Interest

- No Conflicts
  - Member of the Executive Committee of ILROG

Cases to be discussed

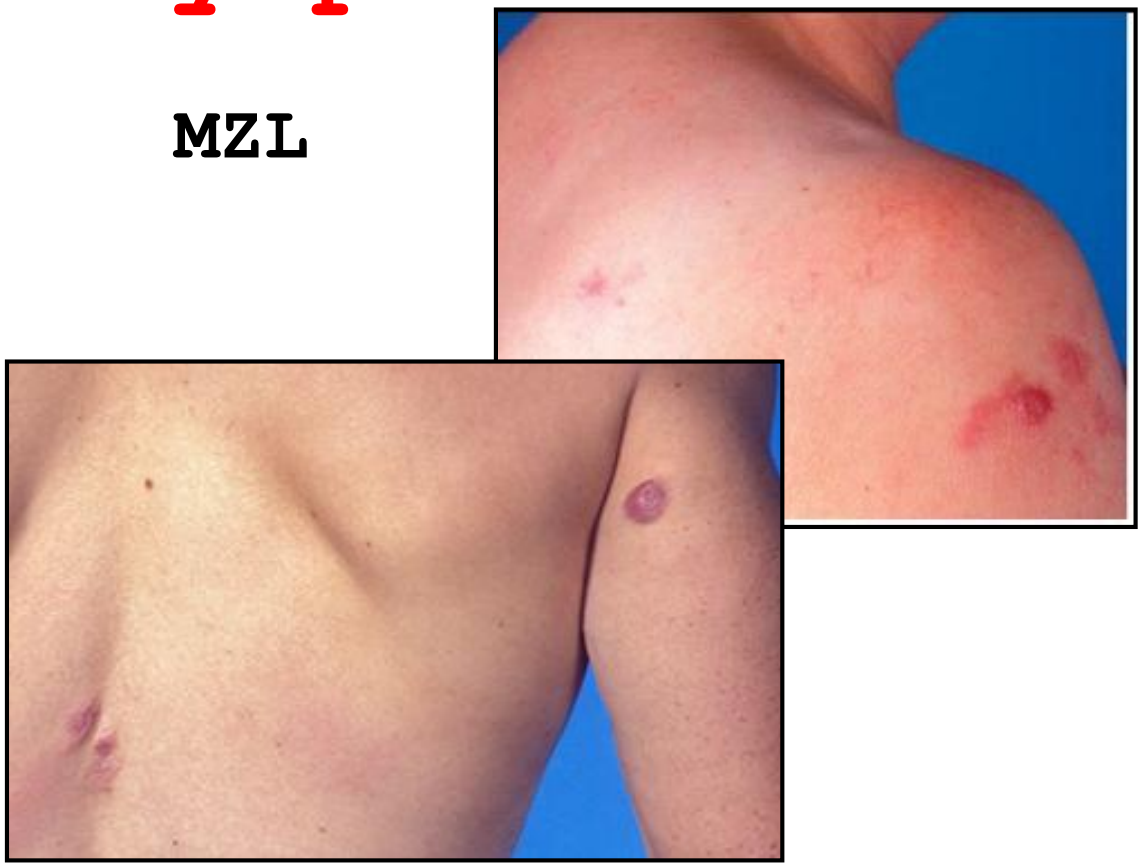
- Indolent cutaneous B-cell lymphoma
- Diffuse large B-cell lymphoma, leg type
- Primary cutaneous anaplastic large cell lymphoma

Indolent Cutaneous B-cell Lymphoma

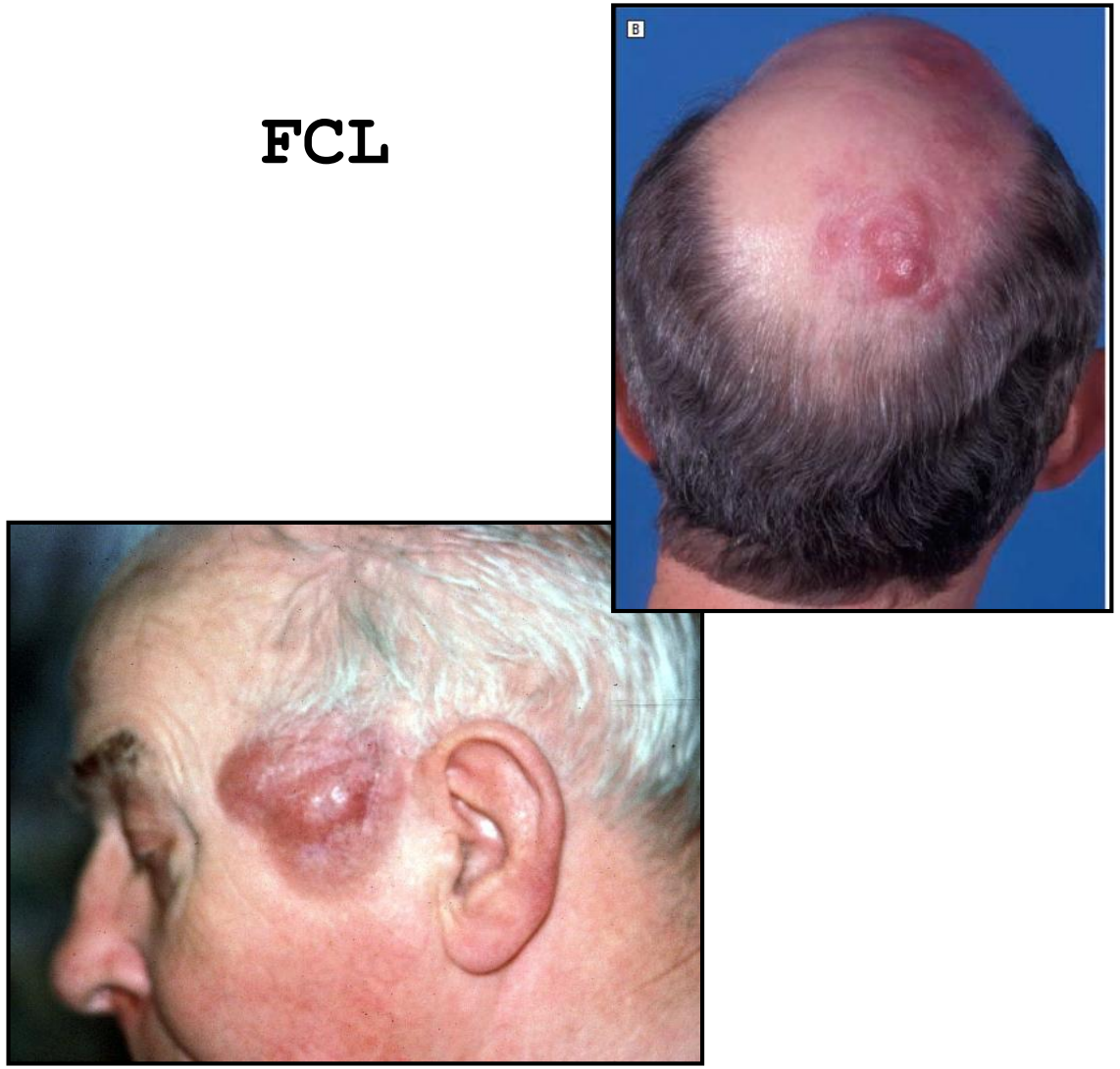
- **Marginal zone lymphoma**
  - Primary cutaneous marginal zone lymphoma (5th WHO) (previously included in extranodal marginal zone lymphoma)
  - Primary cutaneous marginal zone lymphoproliferative disorder (CAC)
    - 2 potential subtypes
      - Class-switched usually IgG+ (75% of cases)
      - Non-class-switched, usually IgM+(behave more like ENMZL, ?more likely associated with extracutaneous disease)
  - Typically, CD20+, CD5-, CD10-, Bcl6-
- **Follicle center[-re] lymphoma** (WHO and CAC)
  - CD20+, Bcl-6 +

Indolent Cutaneous B-cell Lymphoma

MZL

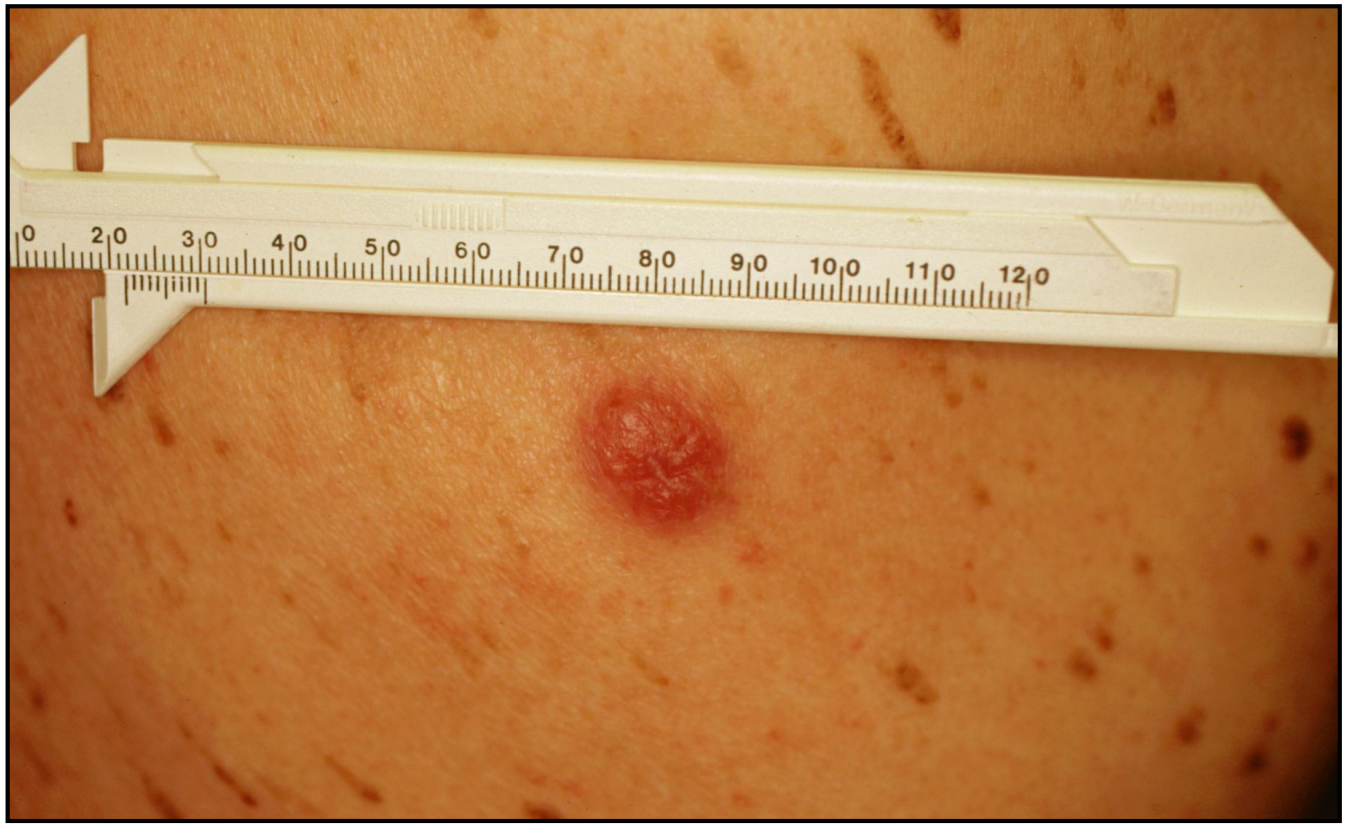


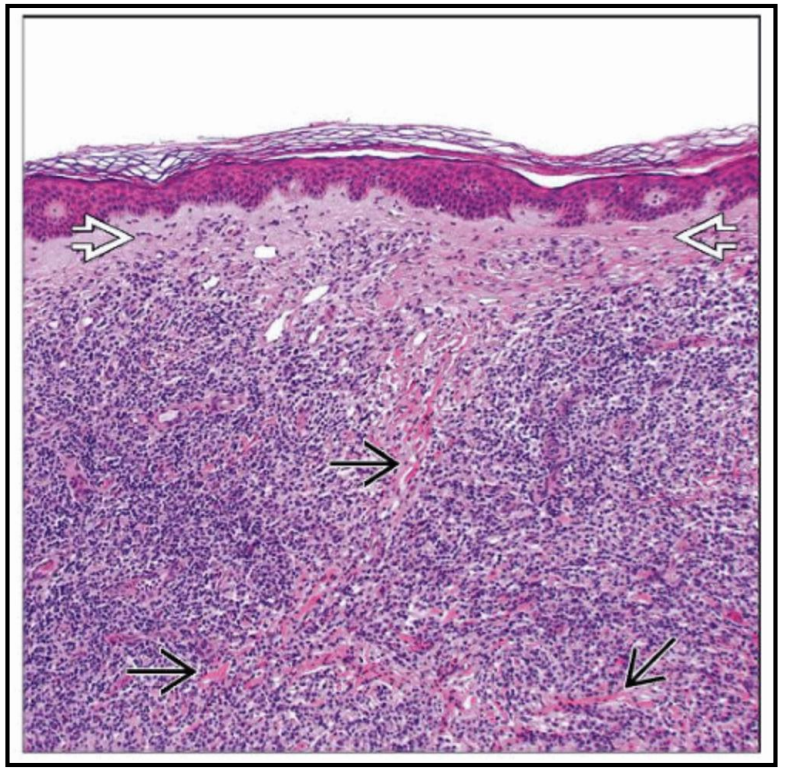
FCL



68 year old male

2 mo hx enlarging nodule on shoulder





PE – no other suspicious skin lesions, no adenopathy or hepatosplenomegaly

CBC, LFTs, LDH all normal
PET-CT negative

Bx=follicle center lymphoma

What management would you recommend?

1. Excision
2. Local radiation – 24 Gy equivalent
3. Local radiation – lower dose
4. Rituximab
5. Combined modality therapy

Follow up

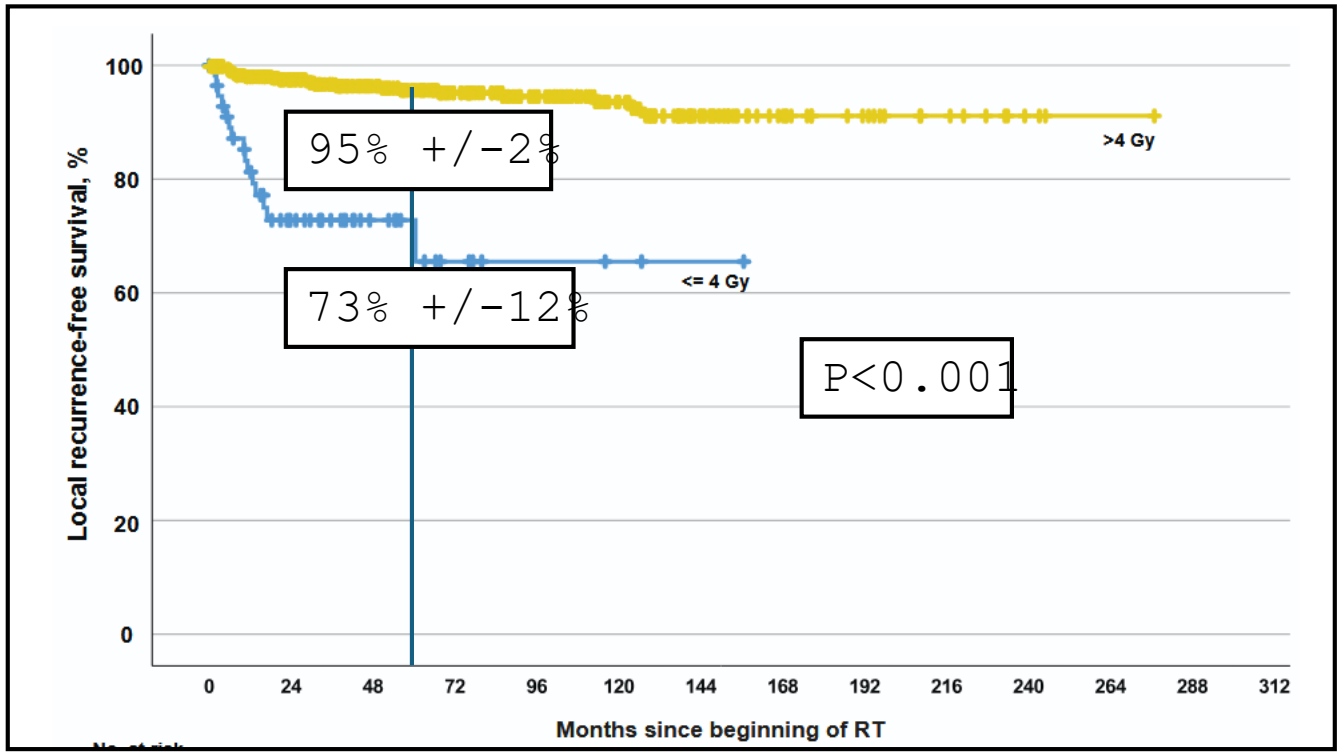
- Patient was treated to 24 Gy with 6 MeV electrons (1 cm bolus, 1.5 cm margins)
- He had a complete response
- 9 months later, he presented with two new nodules on his back, biopsy showed recurrent follicle center lymphoma
- Thorough re-staging negative

Follow up

- Two new lesions were treated with local irradiation alone (2 Gy x 2)
- Patient was followed for 7+ years, NED

RT for indolent B-cell Lymphoma

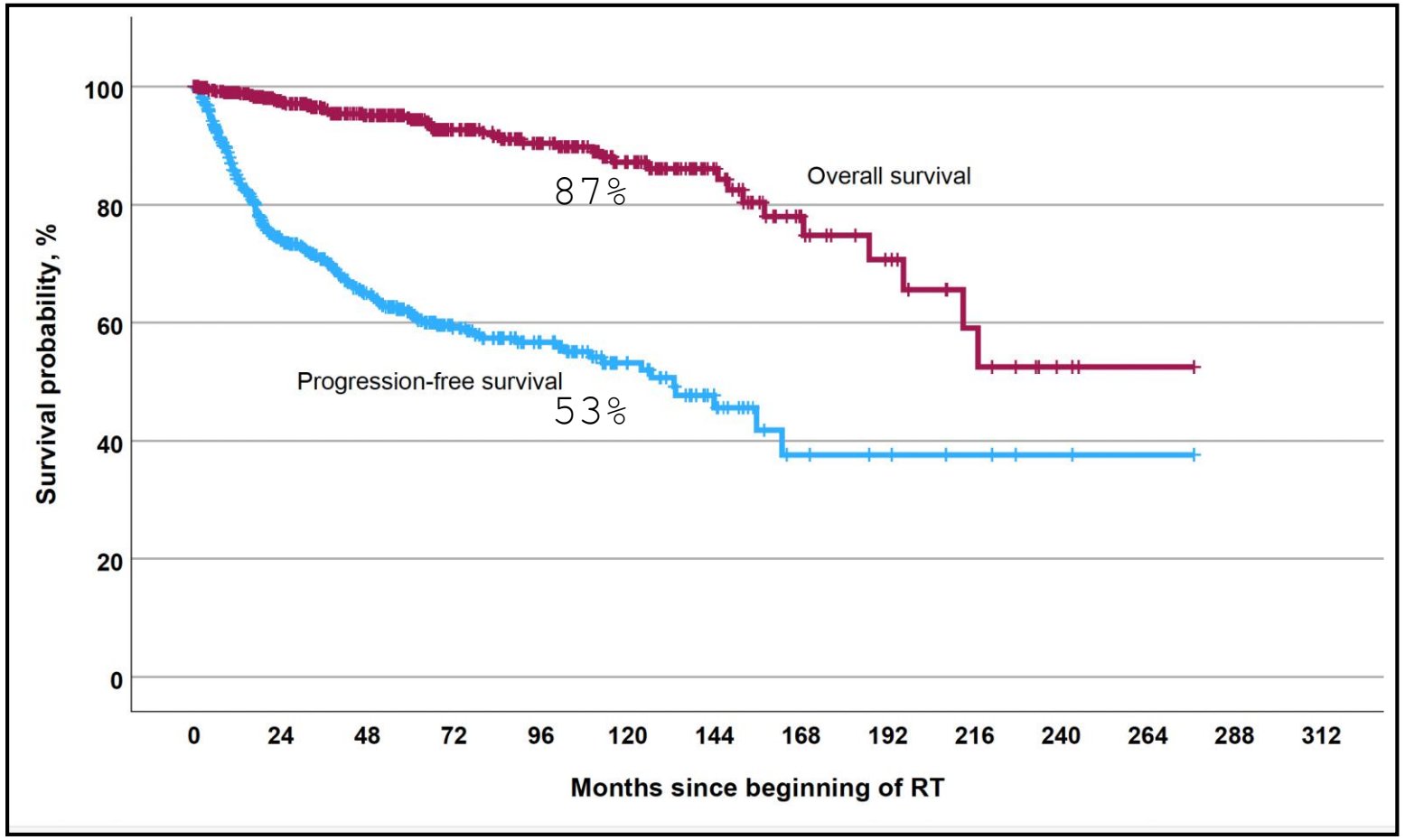
- ILROG multi-institutional analysis, 535 patients
- 52% PCFCL; 41% PMZL
- Median age = 58
- ≤4 Gy, N=57
- Higher dose, N=478



from Oertel M *et al.*, accepted for publication in *BLOOD*, 2026.

RT for indolent B-cell Lymphoma

- Relapses tended to occur in distant skin sites
- 44 deaths. Only 1 attributable to lymphoma



from Oertel M *et al.*, accepted for publication in *BLOOD*, 2026.

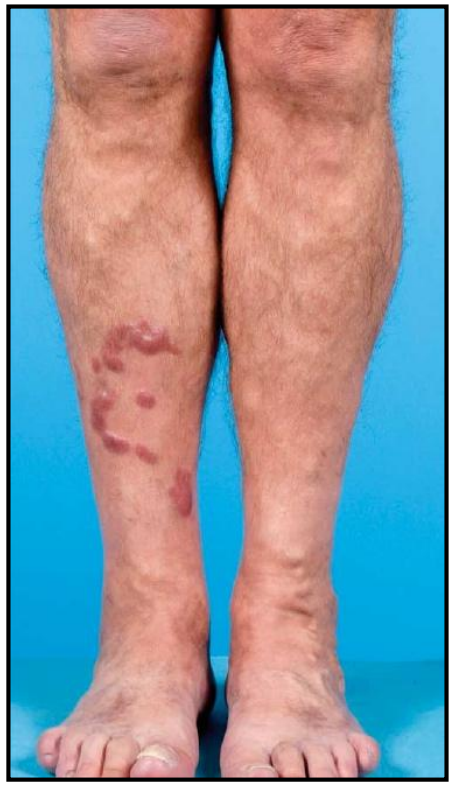
PRIMARY CUTANEOUS MARGINAL ZONE LYMPHOMA OR FOLLICLE CENTER LYMPHOMA[j]

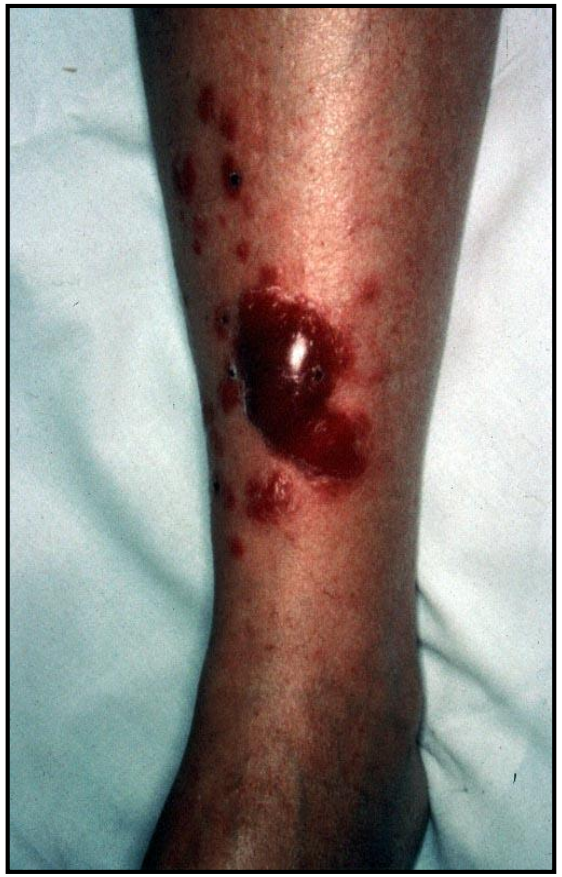
STAGE[k]	INITIAL THERAPY[l]
Solitary/regional, T1–2	Local ISRT (preferred)[m] In selected cases: Observation[n] or Excision[o] or Skin-directed therapies[p] or Intralesional steroids

Dose Guidelines:
Optimal initial management for solitary/regional disease is with 24 Gy EBRT. Alternatively. Lower doses (e.g. 4 Gy) may be used initially, with supplemental RT (4-20 Gy) for inadequate response or subsequent local relapse.

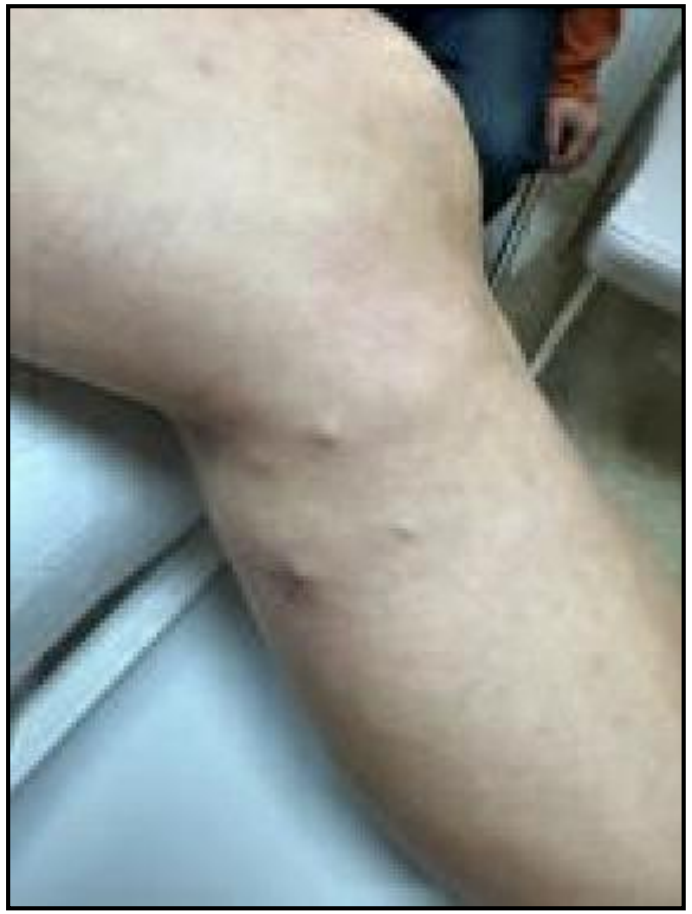
Primary cutaneous diffuse large B-cell lymphoma, leg type (WHO, CAC)

- Usually non-GCB type
- frequent *MYD88* and *CD79B* mutations.
- *CD20+; Bcl-2+*, CD10-
- Often elderly females.





66 year old female



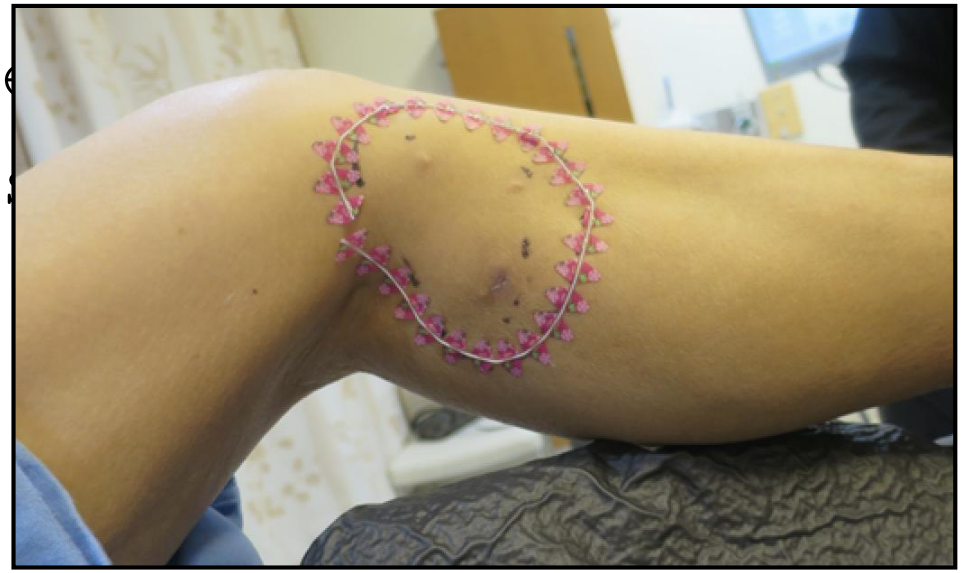
- 3 nodules progressing over the pas
- Bx shows DLBCL, leg type.
- CD20+, BCL2+; Ki67=70%
- PE – no adenopathy
- Labs – nl.
- PET-CT – intense uptake in 3 nodul

What management would you recommend?

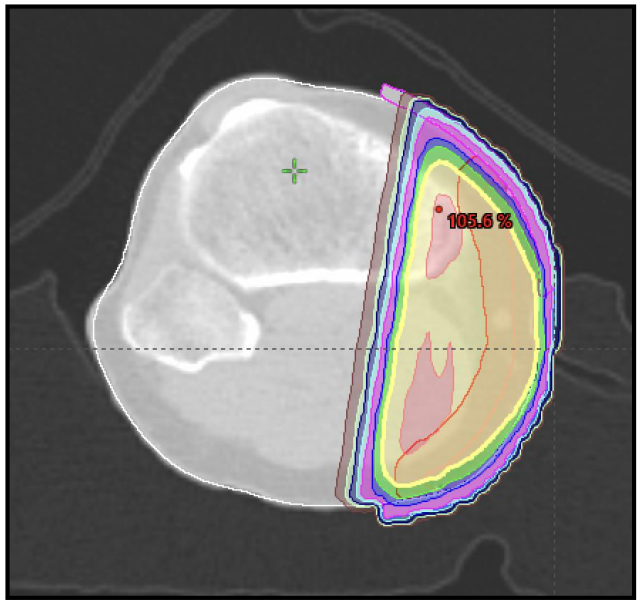
1. Excision
2. Local radiation – 24 Gy equivalent
3. Local radiation – lower dose
4. Rituximab or R-CHOP alone
5. Combined modality therapy
   (R-CHOP+RT)

Follow up

- Decision to treat with combined modality therapy – R-CHOP + RT
- Given limited disease burden, R-CHOP x 3 + ISRT 30 Gy
- PET CR afte
- NED @ 3 yr



Pre-chemo simulation



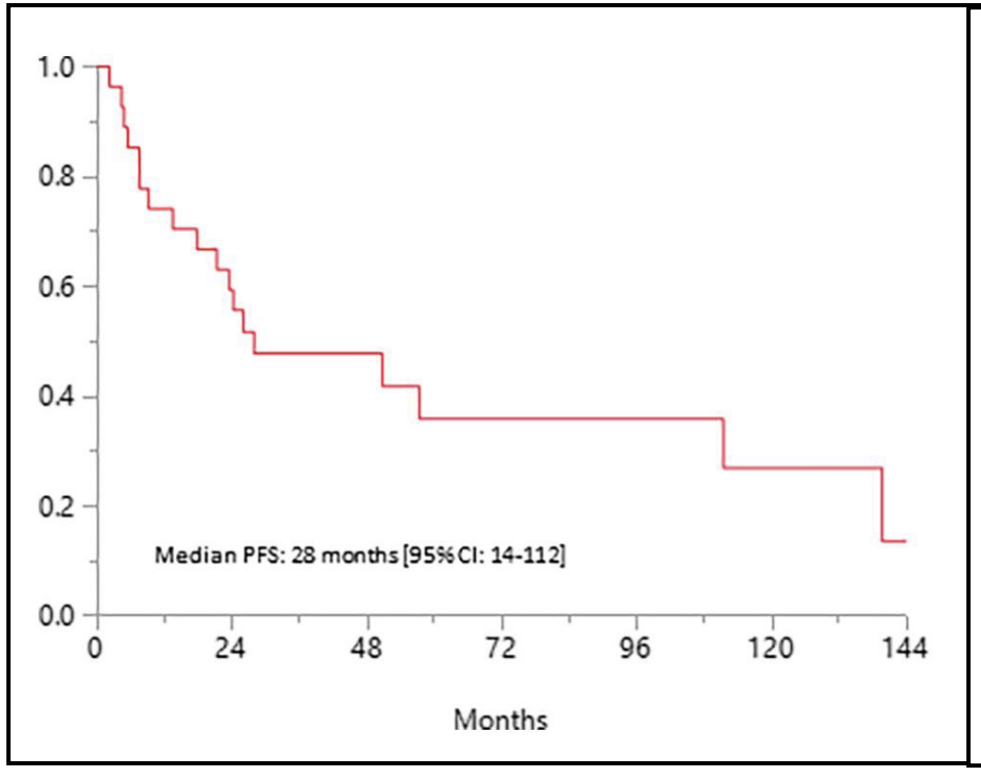
6 MeV photons with 3 mm bolus

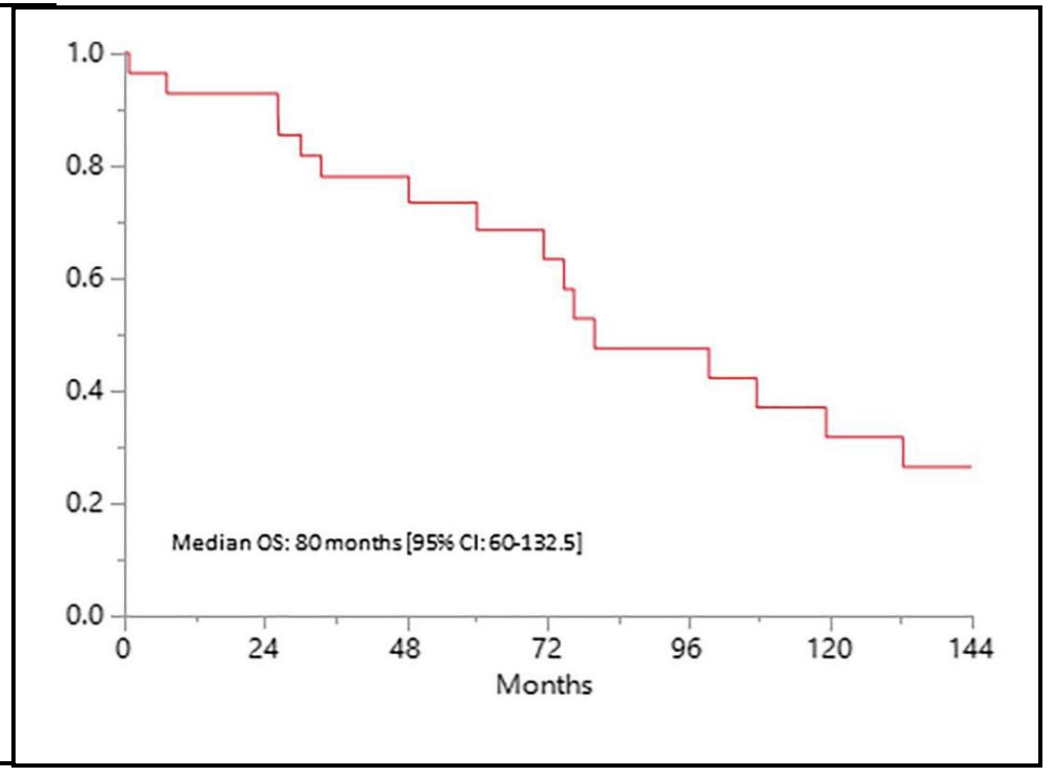
PC-DLBCL-LT – Retrospective Studies

Institution/ Group	Accrual period	N	Treatments	5-yr survival	Notes
Graz[1]	1960-2004	40	various	53%	10/31 followed pts DoD, median 12.5 mo. FOX-P1+ and MUM-1+ adverse.
Italian[2]	1980-2003	51	various	45%	17% developed EC disease
French[3]	1988-2006	60	various R-chemo=12	41% (DSS)	15% nodal and 28% visceral progression. 52% died from lymphoma
Dutch[4]	1985-2005	58	Various RT=32; CT=14	37%	47% developed extracutaneous disease 45% dead from lymphoma
French[5]	1988-2010	59	various R-chemo=34	52%	57% cutaneous and 36% EC progression 19/58 dead from lymphoma
Mayo[6]	2000-2020	28	various R-CHOP=9	59%	CPIs appear beneficial in relapse

1. Kodama et al., *BLOOD 2005*;106:2491-
2. Zinzani et al., *JCO 2006*;24:1376-
3. Grange et al., *Arch Derm 2007*;143:1144-
4. Senff et al., *JCO 2007*;25:1581-
5. Pham-Ledard et al., *JAMA Derm 2014*;150:1173-
6. Kurz et al., *Hematol Oncol 2021*;39:165-

DLBCL - Leg Type





From Kraft et al., *Hematol Oncol 2021*;39:658-

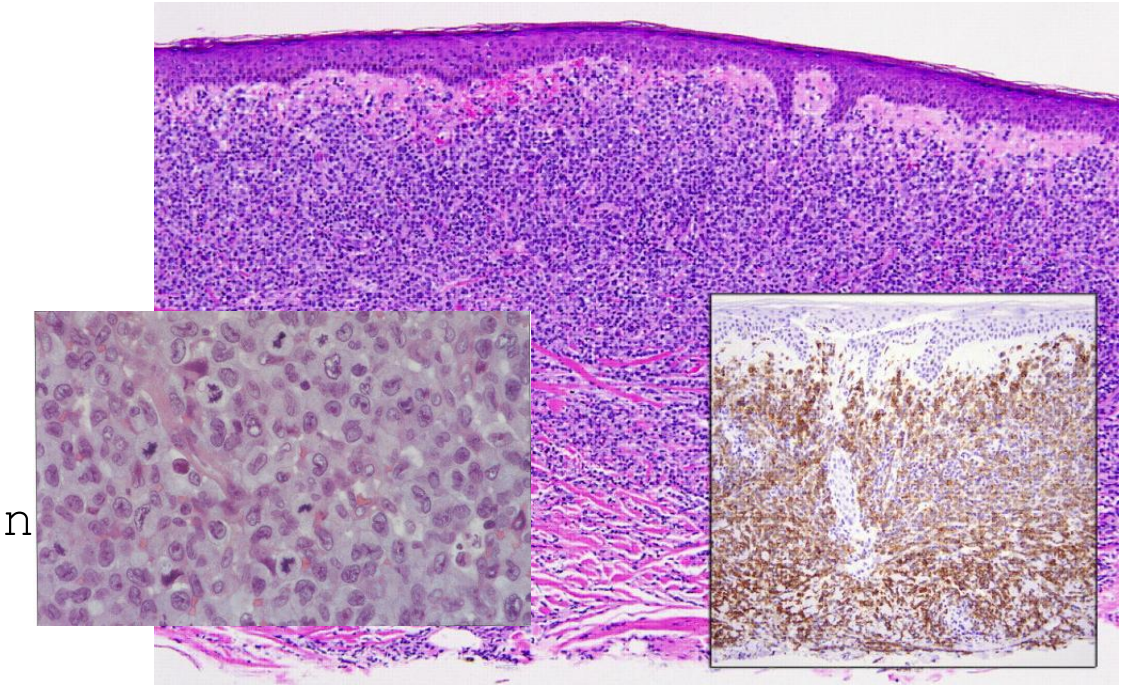
PRIMARY CUTANEOUS DIFFUSE LARGE B-CELL LYMPHOMA, LEG TYPE[oo]

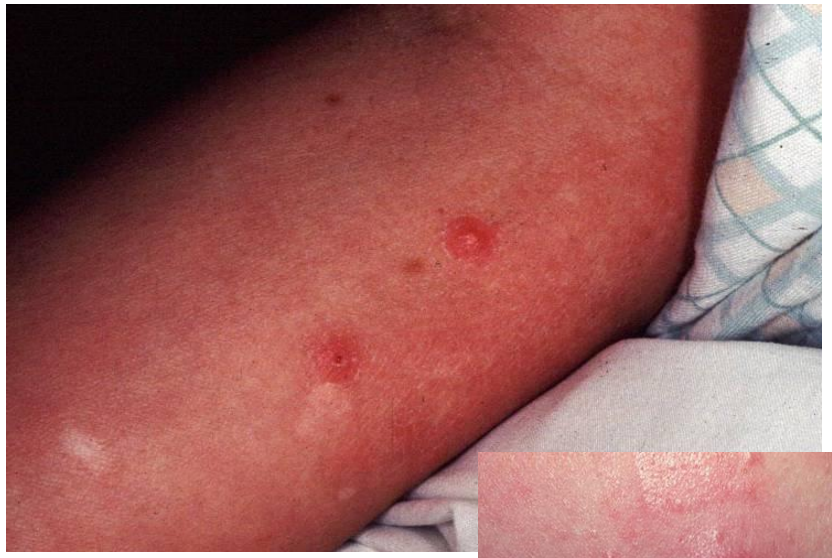
STAGE[pp]	INITIAL THERAPY[qq,rr,s]
Solitary regional, T1–2 (Ann Arbor Stage IE)	Pola-R-CHP[tt] + local ISRT[t] or Local ISRT[t,uu] or Clinical trial
Generalized disease (skin only), T3	Pola-R-CHP[tt] ± local ISRT[t] or Clinical trial
Extracutaneous disease	Manage as DLBCL (BCEL-3)

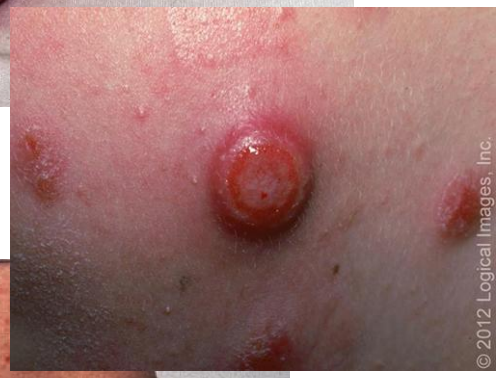
T1 = Solitary
T2 = 1-2 body regions
T3 = Generalized skin

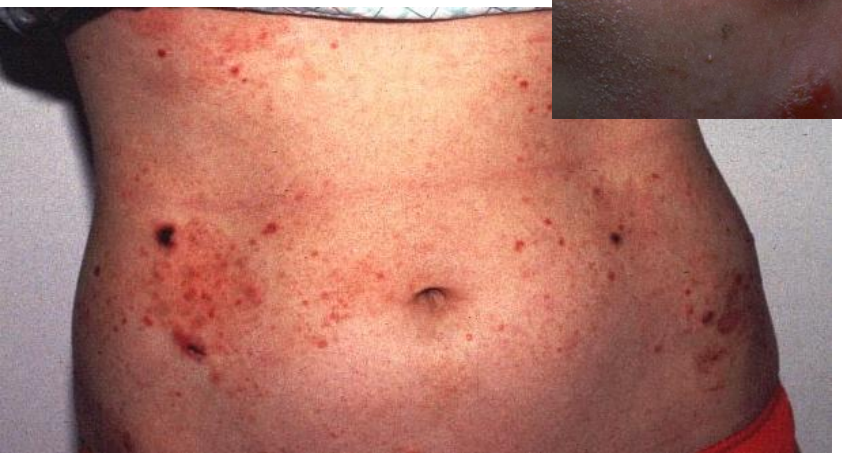
Primary cutaneous anaplastic large cell lymphoma

- **Part of the spectrum of primary cutaneous CD30+ T-cell lymphoproliferative disorders (WHO, CAC)**
  - Lymphomatoid papulosis
  - Primary cutaneous anaplastic large cell lymphoma
- CD30+; ALK-
- **LyP vs. PCALCL**
  - Histology indistinguishable
  - Multifocal vs. loco-regional
  - Spontaneous regression
  - Chronicity
- **PCALCL**
  - Middle-age – older males
  - 80% localized
  - 10% have lymph node involvemen

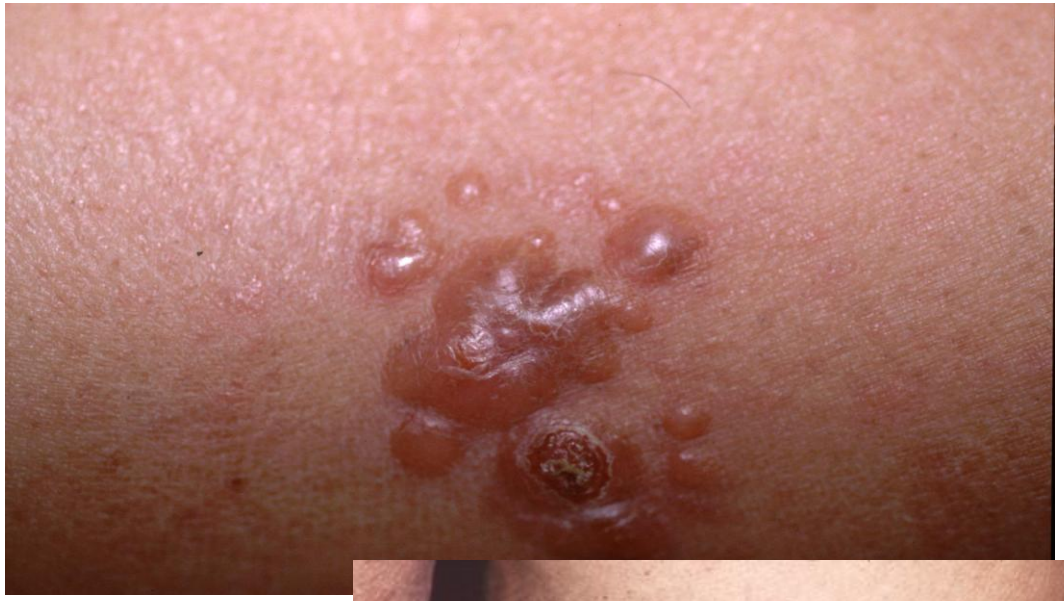


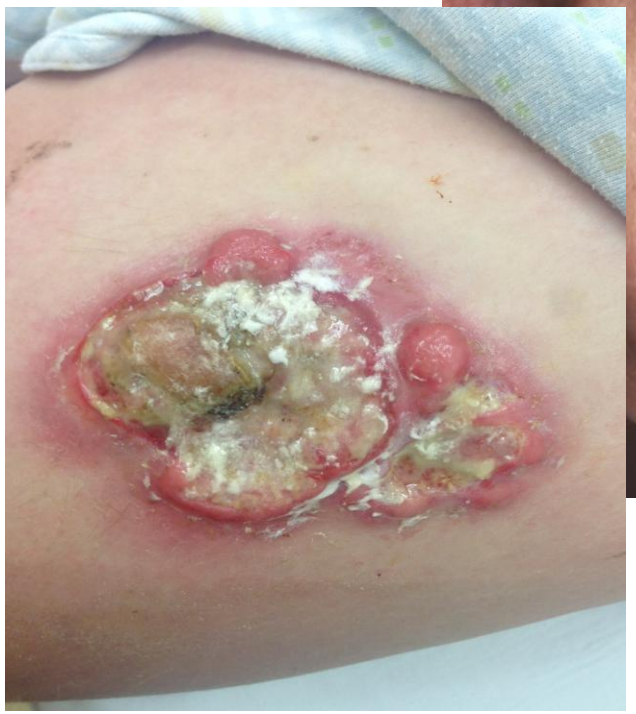


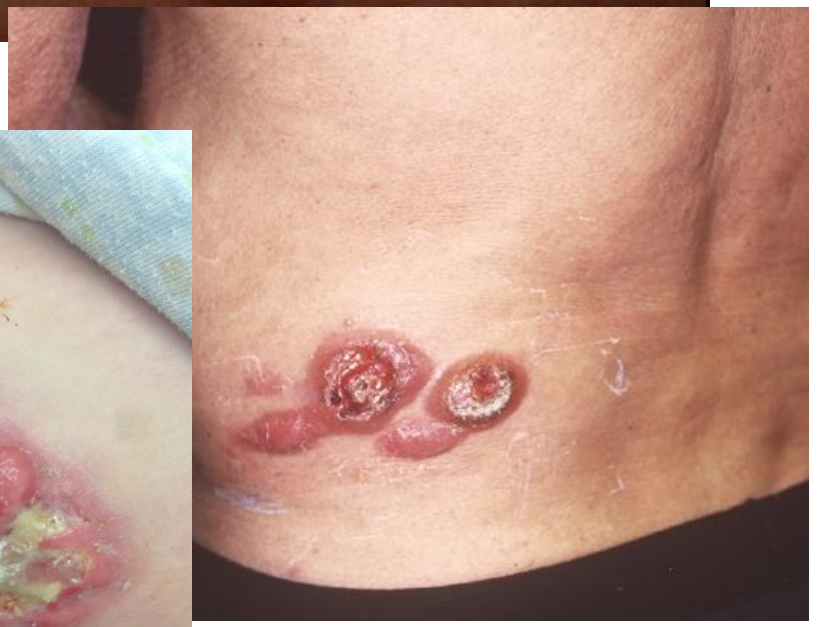




LyP



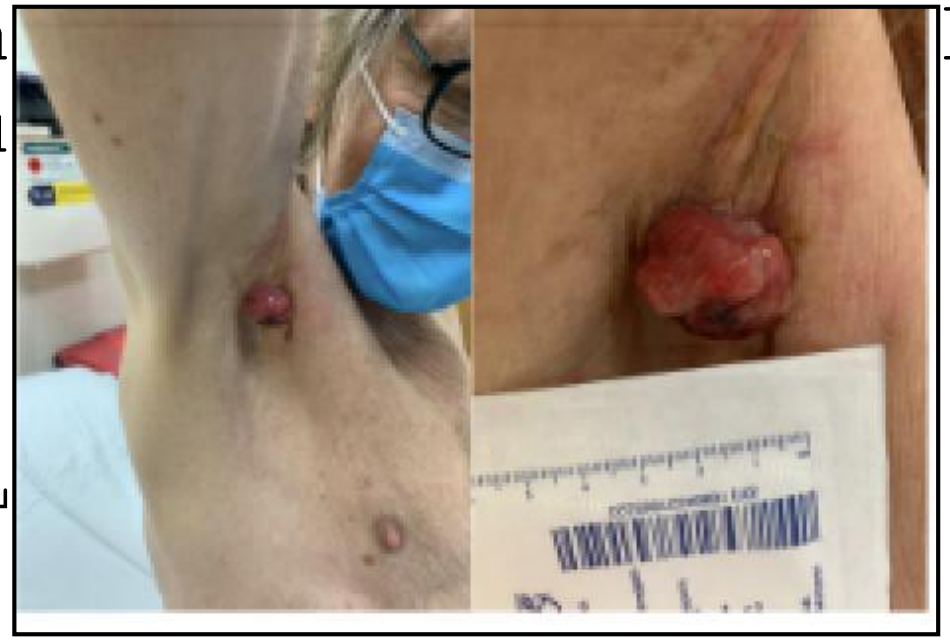


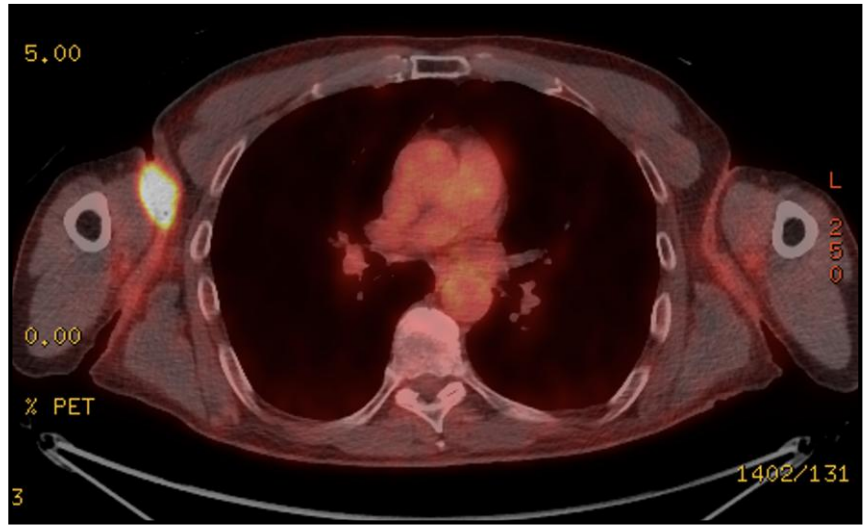


pcALCL

74 year old male

- 3 month history of enlarging mass in the R axilla
- Bx = CD30+ LPD
- PE 3 cm n kin lesions suspiciou
- Lab wnl
- PET-CT:
- Dx = ALCL



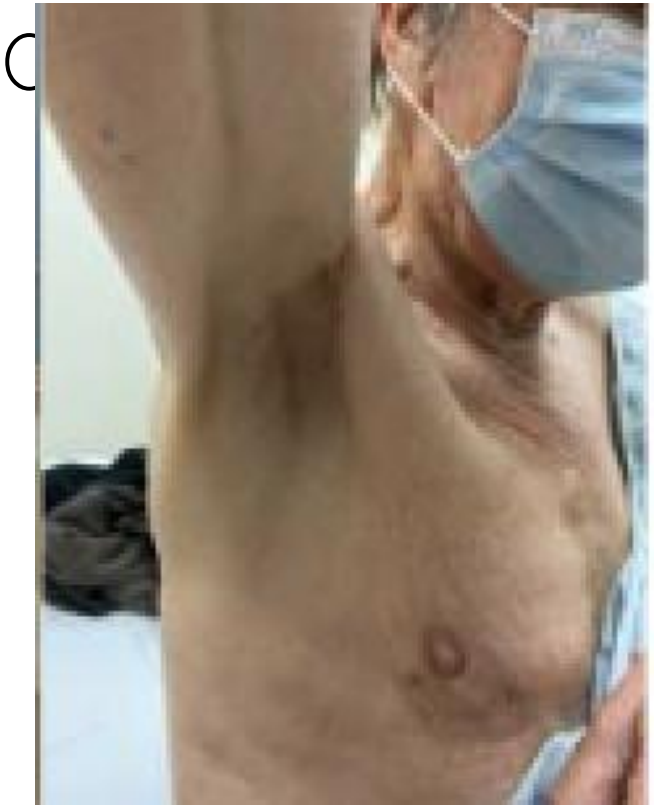


What management would you recommend?

1. Excision
2. Local radiation – 24 Gy equivalent
3. Local radiation – lower dose
4. Brentuximab vedotin
5. Combined modality therapy

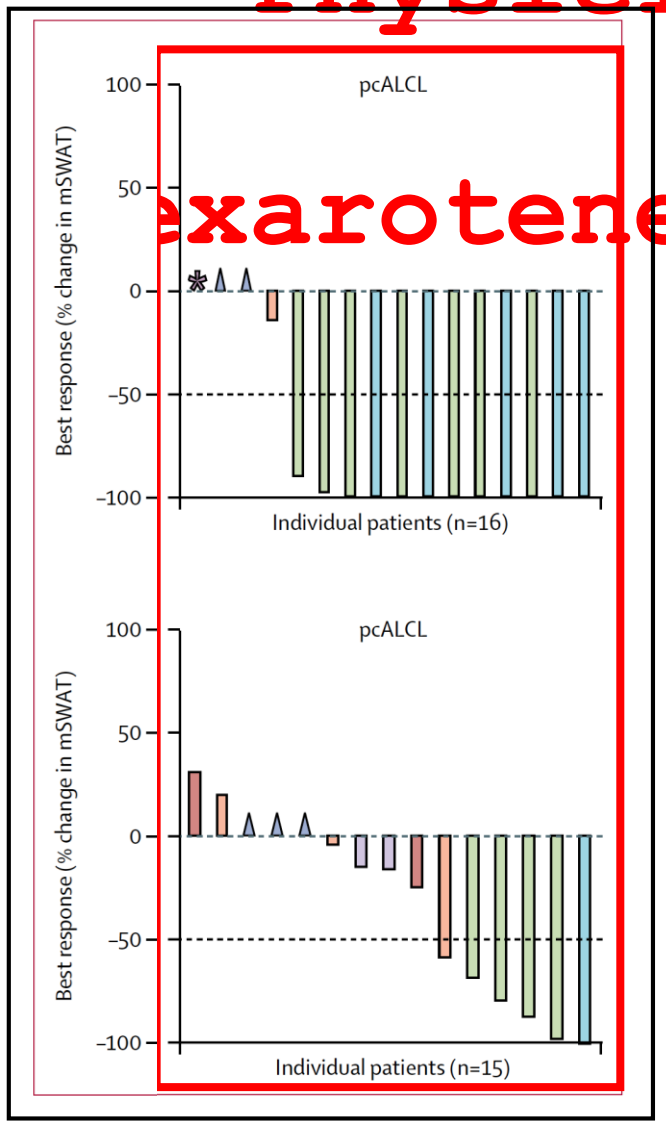
74 year old male

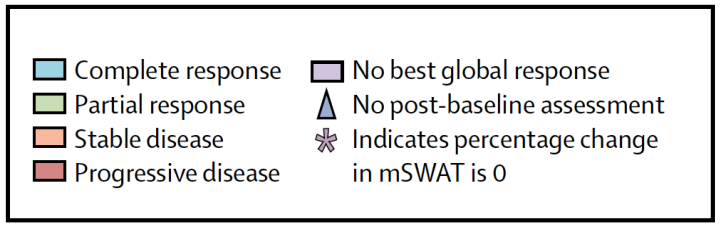
- ISRT 20 Gy/5 fractions (CC
- NED (skin) @ 5 years
- stage IV colon cancer



3 years after RT

ALCANZA Trial – Brentuximab vedotin vs. Physician Choice (methotrexate or bexarotene)





from Prince HM *et al.*, *Lancet* 2017; 390:555-566

NCCN Guidelines Version 2.2026
Primary Cutaneous CD30+ T-Cell Lymphoproliferative Disorders

SUBTYPE	EXTENT OF DISEASE	PRIMARY TREATMENT[s]
PC-ALCL[q]	Solitary or grouped lesions	ISRT[t] or Surgical excision[u] ± ISRT[t]
	Multifocal lesions	Preferred • Brentuximab vedotin[v] Other recommended ± skin-directed therapies (MFSS-A) • Methotrexate (≤50 mg weekly) • Systemic retinoids[w] • Pralatrexate • Observation, if asymptomatic • Interferon[x] (category 3)

Dose Guidelines:
- RT for curative treatment:
- Palliative RT: 2 Gy x 2 or


Thank you!