Managing Aggressive CD30-Positive Lymphoproliferative Disorder and Toward Early Palliative Care Inclusion

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INTRODUCTION

- Cutaneous T-Cell Lymphomas (CTCL) are rarely seen clinically, with a global annual incidence of <10 per 100,000, and only 11% are CD30+ Lymphoproliferative disorders (LPD).
- Their heterogenous clinical and pathologic presentation result in significant diagnostic challenges.
- Diagnosis of potentially aggressive CTCL warrants prompt clinical, histopathological, and immunohistochemical evaluation.
- Management of the patient with suspected CTCL, as with other life-limiting disease, should include quality of life and goals of care assessment, as well as early inclusion of palliative care in medical management.

CASE PRESENTATION

HPI: An 85-year-old female with PMH of dementia and major depressive disorder was brought to the ED by her daughter on recommendation of dermatology following two months of rapidly progressive cellulitis. She had complained of itching, swelling, and painful raised lesions on her left foot and ankle. Empiric treatment with oral antibiotics and topical steroid therapy had not improved symptoms or findings. Shave biopsy had been performed on 5/10, results pending. Patient reported being dependent on her adult daughter for activities of daily living, as well as medical management. The patient expressed significant anxiety related to her leg.

Physical Exam:

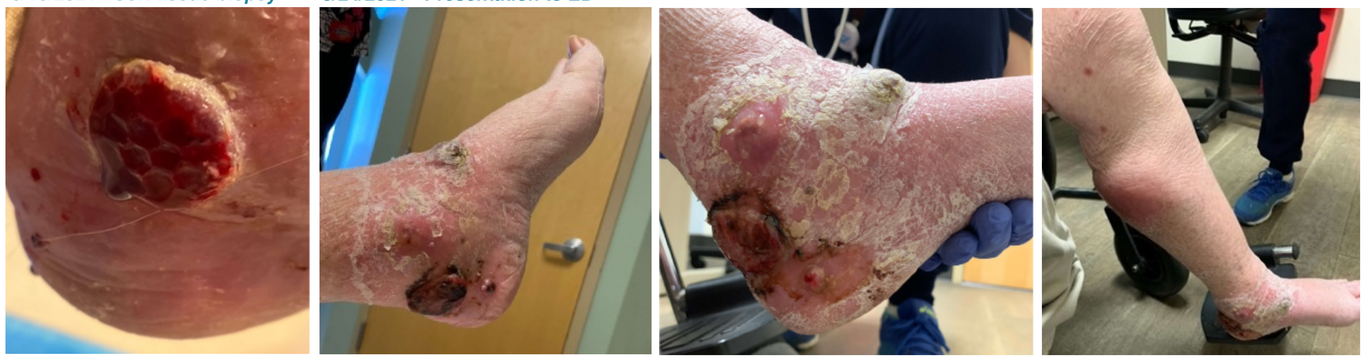
- Left lower extremity edema with multiple, ulcerated as well as raised, erythematous and weeping lesions over the foot, ankle, and posterior lower leg.
- Alert, oriented to self only.

Further Studies, Significant Findings:

- WBC 24.3 K/μL
- Neutrophils 87%
- Lymphocytes 5%
- ANC 20.9 K/μL
- C-reactive protein 12.8 mg/dL
- ALK-1 Negative
- HTLV-1+2 Ab Negative
- Beta-2-Microglobulin of 2,989 g/dL
- US and CT showed subcutaneous soft tissue edema and innumerable, enhancing, necrotic masses
- Shave biopsy showed enlarged, atypical lymphoid cells positive for CD30, MUM1, CD4, and CD25

CLINICAL IMAGES

5/10/2021 - Soft tissue biopsy ***5/24/2021 - Presentation to ED***

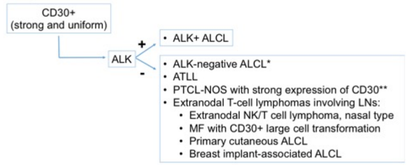


FINAL DIAGNOSIS + CLINICAL COURSE

Findings were consistent with CD30+ T-cell LPD of poor prognosis. Differential diagnosis provided in algorithm, to the right.

Further workup was not pursued due to patient clinical course, preferences, and passing.

DIFFERENTIAL DIAGNOSIS FOR LYMPHOMAS POSITIVE FOR CD30



- Additional considerations regarding patient condition included both her dementia and depressive disorder with risk for recurrence.
- Treatment prioritized quality of life due to poor prognosis and overall clinical condition, as well as patient and family preference.
- Patient was referred to palliative care and hospice.
- The patient died 35 days after hospital discharge, only 13 weeks from the onset of symptoms.

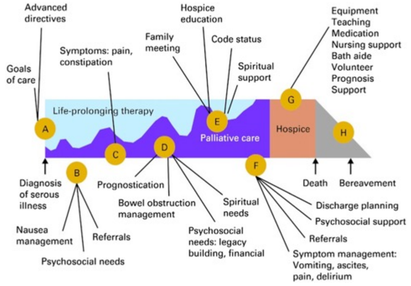
INDICATIONS FOR PALLIATIVE CONSULT

Palliative care consult is warranted upon admission of any patient with acute or chronic life-limiting illness with adverse symptom and psychosocial management needs, even in the absence of final diagnosis or known end-of-life status.

Common triggers for palliative consult eligibility seen in this case include:

- Complex comorbidities
- Symptom management
- Failed treatment
- Impacts to mental health
- Family caregiver dependence
- Potential for poor outcomes
- Request of spiritual support
- Benefit from holistic approach

COMMON PALLIATIVE CARE COMPONENTS



TIMELINE

Initial Presentation — 3/28/21
Contacted PCP due to appearance of raised lesion on foot.
Referral provided for outpatient dermatology.

Dermatology Referral — 4/11/21
Seen by outpatient dermatology for evaluation of suspected cellulitis.
Prescribed oral antibiotics and topical steroids.

Shave Biopsy — 5/10/21
Shave biopsy performed for histopathologic + immunohistochemical evaluation.
No changes to treatment plan at that time.

ED Presentation — 5/24/21
Presented with lesion expansion and proliferation, unresolved with prior protocol.
Empiric treatment discontinued and further studies obtained.

Hospital Discharge — 5/27/21
Discharged home with preliminary diagnosis of lymphoma.
Referral to oncology and palliative care, with follow-up on final diagnosis.

Final Diagnosis — 6/01/21
Patient informed of diagnosis and treatment options.
Patient elected for hospice and palliative care.

Patient Passing — 7/01/21
Patient passed at home on hospice, aligned with patient and family preferences.

DISCUSSION

- CTCL and CD30+ LPD typically have a high five-year disease specific survival. However, they can present in highly aggressive fashion with variable clinical course.
- Prompt clinicopathological evaluation is essential for accurate diagnosis and adequate counseling of the patient and family members.
- Early inclusion of palliative care is warranted for patients with life-limiting illness and observed impacts to quality of life across physical, mental, behavioral, social, and spiritual components of health.
- Inclusion of palliative care within 24 hours of admission minimizes disruption and maximizes benefit to patient, family, and medical team in the context of life-limiting disease requiring complex management.

DOMAINS OF PALLIATIVE CARE

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