Primary Non-Hodgkin's Lymphoma of the Larynx Treated Only by Chemotherapy

To the Editor:

Non-Hodgkin's lymphoma isolated to the larynx (stage IE), is a rare extranodal localization of the disease, with only 25 cases previously reported in the literature. Although the unfavorable histologic condition of many of these lymphomas, radiotherapy appears to be the treatment of choice, with excellent response and prognosis. Only one patient was treated by combination radiotherapy and chemotherapy.

An additional case of primary non-Hodgkin's lymphoma of the larynx is reported here, treated successfully by chemotherapy alone. Chemotherapy reflects the current approach to treating localized aggressive lymphomas.

A 54-year-old man presented in 1983 for evaluation of a left subglottic mass, 0.5 cm in diameter. There was a six-month history of sore throat-like symptoms and hoarseness, gradually becoming worse. Histologically, it was found to be a diffuse, small, cleaved lymphoma. Staging investigations (including CT scan of the thorax and upper and lower abdomen, and a bone marrow biopsy) showed no evidence of disease outside of the larynx. The patient denied radiotherapy. He was treated with six cycles of combination chemotherapy with cyclophosphamide, doxorubicin, vincristine and prednisone. The patient at follow up remains alive and disease-free so far.

We suggest that combination chemotherapy is an efficient alternative to radiotherapy for isolated lymphoma of the larynx in cases where the latter is not feasible.

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Regression of Primary Pulmonary Hypertension

To the Editor:

Primary (unexplained) pulmonary hypertension has generally been regarded as a progressive disease which is rapidly fatal. As a result, these patients may be managed in a highly aggressive way. Nevertheless, a significant subgroup of cases has been indicated to have a substantially better prognosis; in some cases, like the following one, there may be complete regression of pulmonary hypertension.

A 36-year-old woman was admitted to the hospital because of increasing dyspnea and syncopal attacks on effort. Symptoms had begun after her first delivery six months before admission. Past clinical history was uneventful; she was normotensive, there was no evidence of primary lung disease, valvular heart disease or connective tissue disease; she did not smoke, nor had taken any drugs before. Pregnancy and delivery had been completely normal. Physical examination revealed only a loud second sound in the pulmonary area. Brachial pressure was 130/80 mm Hg. ECG was normal and there was a moderate bulging of the pulmonary artery visible on chest roentgenogram. Right heart catheterization showed the following pressures (mm Hg): right atrium 2 (mean), right ventricle 65/0/10; pulmonary artery 63/25 (mean 38), capillary wedge 8 (mean). Cardiac index was 3.2 l/min/m²; pulmonary vascular resistance 753 din/mlcm⁻². Angiopneumograph showed no filling defect in the pulmonary circulation, either on the arterial or venous side, left atrium and left ventricles were normal. After angiography pulmonary arterial pressure raised to 85/44 mm Hg (mean 60).

The patient was discharged on drug therapy consisting of xantinol nicotinate (150 mg × 3) and a mixture of mesergylons isolated from veal aorta (Prisma, Medicolanum Co, Italy, 12.5 mg × 2) for four months. Symptoms gradually disappeared within the following year. At the age of 40 years she was well and the right heart pressures (mm Hg) were: right atrium 4/0, right ventricle 32/0, pulmonary artery 32/11, capillary 6 (mean). At the age of 48 years she was in a perfect health.

Pulmonary hypertension may be considered unexplained in our case, although microemboli from the pelvic veins after pregnancy cannot be excluded. Whatever the underlying mechanism, this case stresses once again the difficulties in evaluating the clinical course and treatment of patients with primary (unexplained) pulmonary hypertension.

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