International Society of Cutaneous Lymphoma (ISCL) and the European Organization of Research and Treatment of Cancer (EORTC) revisions to the staging and classification of mycosis fungoides and Sézary syndrome.

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Abstract
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She is certified in Internal Medicine and Dermatology. She has been a principal and co-principal investigator on numerous clinical trials studying the immunology of T-cell mediated disorders and skin cancers, as well as clinical drug development and translational research in T-cell lymphomas, melanoma, and various skin cancers. A prolific author, she has written manuscripts, book chapters, abstracts, and over 300 peer-reviewed journal articles. She is co-author on a recent book on Retinoids and Carotenoids in Dermatology.

Dr. Olsen is Professor of Dermatology and Oncology at Duke University Medical Center and the founder and Director of the Duke Cutaneous Lymphoma Research and Treatment Center. She is a Past President, Secretary-Treasurer and member of the Board of Directors of the International Society for Cutaneous Lymphomas (ISCL) and has chaired the ISCL initiatives on the revisions to 1) the staging and classification of Mycosis Fungoides (MF) and Sézary Syndrome (SS) (published in Blood 2007) and 2) standardized response criteria and endpoints for MF and SS (in progress). She is a founder and current President of the United States Consortium for Cutaneous Lymphomas (USCCL), a multidisciplinary group whose mission is to enhance patient care through a national registry of patients with cutaneous lymphoma and collaborative clinical trials. She has authored over 90 original articles and is the editor of two textbooks. Dr. Olsen is currently on the Board of Directors of the American Academy of Dermatology (AAD) and Deputy Chair of the AAD Patient Advocacy Task Force.

As background to the following educational activity, this brief review will discuss the International Society of Cutaneous Lymphoma (ISCL) and the European Organization of Research and Treatment of Cancer (EORTC) revisions to the staging and classification of mycosis fungoides and Sézary syndrome.

PURPOSE OF REVISION
The Mycosis Fungoides Cooperative Group (MFCG) developed a staging system for CTCL, designed for the particular clinical findings in the mycosis fungoides (MF)/Sézary syndrome (SS) subtypes and based on the TNM (tumor-node-metastasis) classification advocated by the International Union Against Cancer (UICC) and American Joint Committee on Cancer. This classification and staging system was modified in conjunction with the National Cancer Institute (NCI) and the Veteran's Administration (VA) Hospital and published in 1979.
The updated International Society of Cutaneous Lymphoma (ISCL)/European Organization of Research and Treatment of Cancer (EORTC) staging and classification applies to MF and SS and has maintained the major components of the MFCG system to allow for continued comparison of patient outcomes within both systems. WHO/EORTC considers SS to be a separate entity from cases that otherwise meet the criteria for SS but has been preceded by clinically typical MF.

PURPOSED CHANGES TO T CLASSIFICATION

In both the original MFCG and the revised staging system, the T1 skin rating is defined as papules, patches, and/or plaques covering less than 10% body surface area (BSA) and T2 skin rating is defined as patches and/or plaques covering 10% or more BSA (Table 1).

Figure 1

TNMB STAGES

* For skin, patch indicates any size skin lesion without significant elevation or induration. Presence/absence of hypo- or hyperpigmentation, scale, crusting, and/or poikiloderma should be noted.

† For skin, plaque indicates any size skin lesion that is elevated or indurated. Presence or absence of scale, crusting, and/or poikiloderma should be noted. Histologic features such as folliculotropism or large-cell transformation (> 25% large cells), CD30+ or CD30−, and clinical features such as ulceration are important to document.

‡ For skin, tumor indicates at least one 1-cm diameter solid or nodular lesion with evidence of depth and/or vertical growth. Note total number of lesions, total volume of lesions, largest size lesion, and region of body involved. Also note if histologic evidence of large-cell transformation has occurred. Phenotyping for CD30 is encouraged.

§ For node, abnormal peripheral lymph node(s) indicates any palpable peripheral node that on physical examination is firm, irregular, clustered, fixed or 1.5 cm or larger in diameter. Minimal nodal groups examined on physical examination should include cervical, supraclavicular, epitrochlear, axillary, and inguinal. Central nodes, which are not generally amenable to pathologic assessment, are not currently considered in the nodal classification unless used to establish N3 histopathologically.

¶ For viscera, spleen and liver may be diagnosed by imaging criteria.

| For blood, Sézary cells are defined as lymphocytes with hyperconvoluted cerebriform nuclei. If Sézary cells are not able to be used to determine tumor burden for B2, then one of the following modified ISCL criteria along with a positive clonal rearrangement of the TCR may be used instead: (1) expanded CD4+ or CD3+ cells with CD4/CD8 ratio of 10 or more, (2) expanded CD4+ cells with abnormal immunophenotype including loss of CD7 or CD26.

# A T-cell clone is defined by PCR or Southern blot analysis of the T-cell receptor gene.

In the classification published by the MFCG, 1% BSA was defined as equal to the “palmar surface of the hand,” but it has since been determined that the palm and fingers of the patient’s hand is a better approximation of 1% BSA.

Another method of determining BSA is to estimate the percentage of skin involvement in each of 12 regions of the body (each with a relative assigned percent BSA), multiplying this number by the percentage of the BSA for that particular region and adding up the regional percentages to obtain the total BSA involved with MF/SS.
The MFCG originally required that a diagnosis of tumor-stage disease include at least 3 tumors, but this was changed to one or more tumors in the final MFCG staging system. The proposed ISCL/EORTC classification revision retains the requirement of at least one tumor (1.5 cm in diameter) for the definition of T3. Whether there should be a minimum histologic depth of infiltrate to distinguish plaque from tumor in order to corroborate this important assignment of T stage based on a single lesion has not been yet been determined. There is currently no distinction in the updated staging system for subclassifying T4 based on varying degrees of induration, erythema, or scale.

The ISCL/EORTC recommends tracking folliculotropic MF and large-cell transformation to determine if either warrants an advance in stage. Folliculotropic MF has been shown to be associated with a worse prognosis than expected for clinical stage and is considered equivalent to T3 tumors.

**REVISIONS TO THE N (NODE) CLASSIFICATION**

The ISCL/EORTC revision defines clinically abnormal peripheral nodes as 1.5 cm or larger in the longest transverse diameter or any palpable peripheral node, regardless of size, that on physical examination is firm, irregular, clustered, or fixed. These clinically enlarged or abnormal nodes should be corroborated by an imaging study (computed tomography [CT] ± 18 F-fluorodeoxyglucose positron emission tomography [FDG-PET]) or by magnetic resonance imaging (MRI) (in cases where patients may be allergic to contrast dye) or ultrasound prior to biopsy.

Because a biopsy of a clinically abnormal node is not always done at initial staging, the revised ISCL/EORTC classification has added a new category, the Nx node rating, to facilitate capture of at least this clinical information.

**PATHOLOGY OF LYMPH NODES**

The two main histopathologic grading systems for lymph nodes in MF/SS are the NCI/VA classification system, first proposed by Matthews and Gazdar, and the Dutch System. The major difference between these classification systems resides in the criteria used to define “abnormal” lymphocytes. Specifically, the NCI/VA system, although it defines abnormal (neoplastic) cells as small (6-10 µm) or large (> 11.5 µm) cells with cerebriform, irregularly folded, hyperconvoluted nuclei (ie, Sézary cells), does not use the size of cells but instead uses the relative numbers of such cells in the paracortex of the lymph node for the LN0-2 definition. The Dutch system uses the diameter of the cerebriform cells (> 7.5 µm) to define abnormal (neoplastic) cells, and if present, this constitutes early involvement (grade 2).

N1 and N2 ratings can be further classified into 2 subgroups: N1a and N2a (clone negative) and N1b and N2b (clone positive). It is hoped that by capturing this information longitudinally, it can be determined if there is a similar prognosis of patients with and without clonal involvement and between N1b and N2b. Prognosis in MF/SS is clearly related to partially or completely effaced nodal architecture as defined by either the NCI-VA (LN4) or Dutch (grade 3/4) grading system, and continues to define the N3 node rating in the updated ISCL/EORTC staging system.
REVISION TO M CLASSIFICATION
To be considered as having visceral disease (stage IVb), documentation of involvement by only one organ outside the skin, nodes, or blood is needed. The ISCL/EORTC considers splenomegaly as visceral disease, even without biopsy confirmation, when it is (a) unequivocally present on physical exam and (b) documented radiographically by either enlargement. Liver disease may be suspected by physical examination, abnormal liver function tests, or radiologic tests (CT, FDG-PET, liver/spleen scan) but should be confirmed by liver biopsy.

The ISCL/EORTC recommends performance of a bone marrow biopsy in patients who have B<sub>2</sub> blood involvement or unexplained hematologic abnormalities. If lung abnormalities or other suggestions of extracutaneous lymphomatous involvement, besides splenomegaly, are found on radiographic examination, pathological assessment is recommended before ascribing this to visceral involvement with MF/SS.

REVISIONS TO THE B (BLOOD) RATING
The ISCL/EORTC has simplified and clarified the definitions of B to B<sub>2</sub>. B remains 5% or less Sézary cells. B<sub>2</sub> is now defined as a clonal rearrangement of the TCR in the blood and either 1.0 K/µL or more Sézary cells or one of the 2 criteria outlined by the ISCL, that is, (1) increased CD4<sup>+</sup> or CD3<sup>+</sup> cells with CD4/CD8 of 10 or more or (2) increase in CD4<sup>+</sup> cells with an abnormal phenotype (≥40% CD4<sup>+</sup>/CD7<sup>-</sup> or ≥30% CD4<sup>+</sup>/CD26<sup>-</sup>) has been suggested. B<sub>1</sub> is defined as more than 5% Sézary cells and either less than 1.0 K/µL absolute Sézary cells, absence of a clonal rearrangement of the TCR, or both.

The assessment of blood tumor burden in MF/SS in the current staging assessment is based on morphologic features of the neoplastic cells alone (eg, Sézary cell counts). Blood flow cytometry offers an alternate objective means of identifying and quantifying these neoplastic lymphocytes in the blood. The populations of CD4+CD26- or CD4+CD7- cells or V beta subtype measured by flow can be used to identify the population of SS cells.

EVALUATION AND STAGING OF THE PATIENT WITH MF/SS
The staging of MF/SS according to the TNMB system implies that an appropriate evaluation of the 4 TNMB systems has been performed. The recommended workup is detailed in Table 3 below.

CONCLUSIONS
Although the ISCL/EORTC revisions to the staging and classification of MF and SS further narrows and defines the variables involved, it does not provide a finite staging
system that inherently incorporates all potential prognostic factors.

References

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