

Using real-time PCR analysis of tissue from tissue blocks that were subsequently cored to construct the tissue microarray, we found that MCV DNA was present in 44 of these tumors and absent in 5 (data not shown). Wnt5A staining was low or absent in virtually all samples analyzed (**Figure 2A**), and no difference between virus-positive and virus-negative samples was observed. Staining of a primary melanoma was used as a positive control for Wnt5A staining, where Wnt5A positive cells stained brown (Figure 2B).

Comment. These data suggest that Wnt5A is not involved in the onset or progression of MCC and support other data that indicate that Wnt signaling is inactive in this cancer⁴ despite its neuroendocrine origins.

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Accepted for Publication: July 14, 2009.

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Author Contributions: Drs Weeraratna and Becker had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. *Study concept and design:* Weeraratna and Becker. *Acquisition of data:* Weeraratna, Houben, O'Connell, and Becker. *Analysis and interpretation of data:* Weeraratna, Houben, O'Connell, and Becker. *Drafting of the manuscript:* Weeraratna and Becker. *Critical revision of the manuscript for important intellectual content:* Weeraratna, Houben, O'Connell, and Becker. *Administrative, technical, and material support:* Weeraratna, Houben, O'Connell, and Becker. *Study supervision:* Weeraratna and Becker.

Financial Disclosure: None reported.

Funding/Support: This work was supported in part by funds from the Intramural Research Program of the NIA (O'Connell and Weeraratna) and from Wilhelm Sander-Stiftung grant 2007.057.1 (Drs Houben and Becker).

Role of the Sponsors: Wilhelm Sander-Stiftung had no role in the design or conduct of the study; in the collection, analysis, or interpretation of data; or in the preparation, review, or approval of the manuscript. The Intramural Research Program of the NIA had no role in the design or conduct of the study; in the collection, analysis, or interpretation of data; or the preparation of the manuscript; however, the manuscript passed through an internal NIA process that required review and approval.

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Combined Treatment With Rituximab and Anthracycline-Containing Chemotherapy for Primary Cutaneous Large B-Cell Lymphomas, Leg Type, in Elderly Patients

P rimary cutaneous large B-cell lymphoma, leg type (PCLBCL,LT), mainly affects the elderly population. Nevertheless, to our knowledge, no specific studies are available on the outcomes in patients 80 years or older. Herein, we aim to evaluate the efficacy and tolerance of a modified R-CHOP regimen (rituximab with cyclophosphamide, doxorubicin, vincristine, and prednisone) in this particular population.

Methods. Four patients aged 81 to 96 years (mean age, 91 years) were treated and followed up for PCLBCL,LT. Their general condition in all cases was good prior to treatment, and pretherapeutic echocardiography showed no severe ventricular dysfunction, thus allowing anthracycline therapy. All patients had multiple lesions; the lesions were confined to 1 inferior limb in 3 patients and were disseminated in the fourth case. Whole-body computed tomographic scans showed extracutaneous involvement in only 1 patient, who had a laterotracheal lymphadenopathy. An osteomedullary biopsy was performed in 1 patient, and no medullary involvement was found.

All patients received a modified R-CHOP treatment with reduced doses of the following drugs: doxorubicin, 25 mg/m²; vincristine, 1 mg/m²; and cyclophosphamide, 400 mg/m². Rituximab and prednisone were given at standard doses (ie, 375 mg/m² and 40 mg/m² for 5 days, respectively). A prophylactic injection of pegfilgrastim was administered the day after chemotherapy. Cycles were administered every 3 or 4 weeks.

Results. All patients achieved a partial or complete remission. Three patients experienced severe infections requiring hospitalization. Two patients had congestive heart failure: one had decreased ventricular function and myocardial infarction, and the other experienced worsening of a preexisting chronic atrial fibrillation. None of our patients experienced severe cytopenias, mucitis, or renal or neurologic toxic effects. In 2 cases, the treatment had to be discontinued, and these patients died of adverse effects. The other 2 completed 6 cycles of treatment and at last follow-up (15 and 21 months) remained alive and in complete remission. Clinical data and outcomes are summarized in the **Table**.

Comment. In the overall population, the outcome of PCLBCL,LT is improved by R-CHOP, which is now con-

Table. Clinical Data and Treatment Outcomes

Characteristic	Patient			
	1	2	3	4
Age at diagnosis, y	93	96	81	95
Sex	M	F	F	M
History	Renal insufficiency; chronic atrial fibrillation	Unremarkable	Unremarkable	Intermittent atrial fibrillation
ECOG performance status	2	1	0	1
Lesions, No.	Multiple	Multiple	Multiple	Multiple
Localization of the lesions	Right leg and thigh	Both legs and arms	Right thigh and buttock	Right leg
Osteomedullar biopsy findings	ND	ND	Normal	ND
Extracutaneous involvement on CT scan	None	None	Laterotracheal lymphadenopathy	None
Cycles before remission, No.	2	1	1	1
Total cycles, No.	3	5	6	6
Adverse effects	Necrotizing cellulitis of the leg; worsening of atrial fibrillation; bronchopneumopathy; bed-ridden state	Extravasation of chemotherapy; myocardial infarction; bacterial parotiditis; bed-ridden state; inhalation pneumopathy	None	Bacterial maxillary sinusitis
Outcome	Death	Death	Alive, in complete remission	Alive, in complete remission
Duration of follow-up, mo	8	4	15	21

Abbreviations: CT, computed tomography; ECOG, Eastern Cooperative Oncology Group; ND, not done.

sidered the standard first-line treatment.^{1,2} Alternative treatments such as radiotherapy or rituximab as single-agent therapy are proposed only if the condition of the patient does not allow R-CHOP treatment because these regimens have a lower complete response rate and a higher relapse rate.² Furthermore, radiotherapy is possible only for localized lesions.

Nevertheless, doxorubicin use is limited by cardiac toxic effects, which are known to be more frequent in elderly patients at lower cumulative doses.³ Moreover, elderly patients can have a lower tolerance of other chemotherapy toxic effects such as cytopenias, mucitis, and digestive adverse effects. In clinical practice, a reduction in doses can be made in consideration of the age of the patient, the presence of cardiopathy, and/or a poor general condition. Nevertheless, there is no consensus on the precise indications or amounts for this dose reduction.

In our patients, the doses were reduced based only on the age criterion. While we observed serious infectious and/or cardiac adverse effects in our 3 oldest patients, and 2 patients died of these complications, the other 2 achieved prolonged complete remission.

In our geriatric series, the expected efficacy of the treatment was counterbalanced by a poor tolerance of adverse effects, emphasizing the need for a pretherapeutic comprehensive geriatric assessment, which includes an evaluation of physiologic age, function, comorbidities, and nutritional, social, and economic needs.⁴ If this assessment shows that the patient is too fragile to receive standard treatment, less aggressive treatments should be discussed, such as radiotherapy or rituximab as single-agent therapy. Liposomal doxorubicin must also be evaluated in this indication.

Further clinical studies are needed to evaluate more precisely the outcomes of dose-reduced anthracycline-containing chemotherapy plus rituximab in elderly patients treated for PCLBCL,LT and to determine

accurately its indications with regard to less aggressive treatments in this particular population.

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Accepted for Publication: June 10, 2009.

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Financial Disclosure: None reported.

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Comparing the Efficacy of an In-Person Intervention With a Skin Self-examination Workbook

From 1992 to 2004, melanoma incidence for all categories of tumor thickness increased 3.1% annually, and there was a 3.8% annual increase in the thickest cancers (Breslow depth, >4 mm), which have the least favorable prognosis.¹⁻³ Since most melanomas are discovered by the patient or a partner, skin self-examination (SSE) with the assistance of a partner has the potential to improve long-term survival.⁴⁻⁶ Given the challenge of examining difficult-to-see body areas (eg, the back), partner assistance is important.⁷

By creating a workbook from our experience with 130 in-person interventions that increased SSE and partner-assisted skin examination (PASE),⁷⁻⁹ we extend our group's previous research. The workbook codifies the dialog of the in-person intervention with exercises that amplify skills and provide a framework for the patient and partner to understand the significance of melanoma by "story telling" about other people with melanoma in a way that is a call to action. Herein, we compare the efficacy of the workbook with that of in-person training.

Methods. Participants. We included in our study people aged 21 to 80 years with a history of stage I or IIA melanoma who had (1) treatment at least 6 weeks prior to participation, (2) sufficient vision to read a newspaper in English, and (3) a cohabitating partner. Subjects were offered nominal payment. The institutional review board of Northwestern University approved the study.

Interventions. IN-PERSON INTERVENTION. Partners jointly assessed border irregularity and color variation and measured the diameter of images of melanomas presented in the skills quiz. After the quiz, the research assistant reviewed with the partners the ABCDE criteria of melanoma (asymmetry, border irregularity, color variegation, diameter ≥ 6 mm, and evolution). During the previously described 15-minute intervention,⁷ use of a millimeter ruler and a handheld lighted magnifying lens was demonstrated. Participants received an enabling kit that contained a ruler, a magnifying lens, a laminated card with color examples of the ABCDE rule, and body maps.

WORKBOOK. We gave participants a 39-page illustrated workbook (with 72 color figures) that was designed to prompt reflection about the personal risk of developing a melanoma and to explain the biology of melanoma. It also instructed on the use of enabling kit tools. In addition, the workbook included stories about people with melanoma and 12 confidence-building exercises. The skills training exercises were designed to build participants' confidence in their ability to identify border irregularity and color variation and to measure the diameter of moles (**Figure**). Inspiring stories of people who found their melanoma in the early stage were recounted. The experiences of well-known people who died of melanoma detected late in the course of the disease,

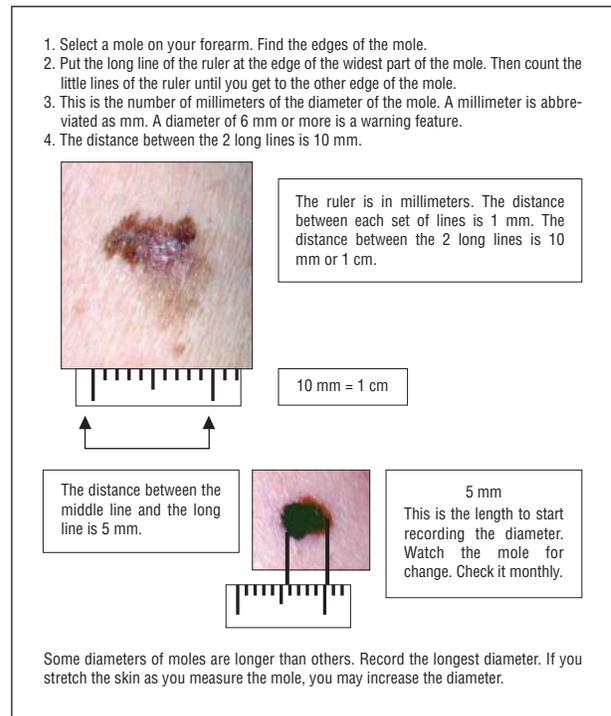


Figure. Ruler exercise. Skills training exercise designed to build patient confidence in ability to measure the diameter of moles.

such as Maureen Reagan and Bob Marley, were presented as cautionary tales of ignoring symptoms and failing to take action by seeing a physician. Patients and partners read the workbook together and wrote questions and comments on the pages of the manuals. The extensive written comments in all of the workbooks by the end of the study provided evidence that all participants had used the workbooks actively.

Measures. Baseline surveys and 1-month and 4-month follow-up assessments were separately completed by patients and partners, as previously described⁷⁻⁹ (**Table 1**). Scores from 5 questions were averaged to create a single index measure of self-efficacy in performing SSE ($\alpha = .92$); the average score from 4 questions was used to measure attitudes toward SSE ($\alpha = .85$); and the average score from 6 questions was used to measure knowledge of SSE ($\alpha = .81$).

Statistical Analysis. A series of 2 (intervention: in-person or workbook) \times 3 (measurement time: baseline, 1-month, and 4-month follow-up) repeated measures analysis of covariance tests were used to assess changes in the outcomes. Sex and age were added to the analyses as covariates. Significant main effects of intervention (F values associated with $P < .05$) reflect differences between the in-person and workbook interventions, whereas significant main effects of measurement time reflect changes from baseline to follow-up periods. Finally, significant intervention \times time interactions reflect differences between the interventions in the magnitude of change from baseline to follow-up periods.

Results. Forty participants were randomly assigned to either the in-person training ($n = 19$) or workbook intervention ($n = 21$) (**Figure**). No differences existed be-