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Secondary Cutaneous Plasmacytoma

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To the Editor,

We wish to report on a case of cutaneous plasmacytoma extending directly from an underlying solitary myeloma of the sternum. Contrary to the findings previously reported in similar cases [2], no signs of widespread disease were evident; following local radiotherapy, a good response and a long disease-free follow-up were observed. A man aged 60 presented in November 1980 with a 2 years' history of a pruriginous, red-colored, episternal skin patch which progressively enlarged from 3 to 20 cm in diameter. On examination, a firm, dusky red-colored, 3-cm nodule was found in the middle of this area. Laboratory features were normal, apart from a monoclonal serum immunoglobulin of IgG/A-type. Bone marrow aspirate and biopsy from the ileum were quantitatively and qualitatively normal. Skeletal X-ray survey revealed a large osteolytic lesion of the sternum and a marked thickening of surrounding soft tissues; other bones were negative for lytic lesions. A biopsy of the skin nodule evidenced a massive infiltration of the deep derma by atypical plasma cells and plasmoblasts, which extended up to the epidermis; the neoplastic cells, studied by immunoperoxidase, showed a definite positivity for γ - and λ -type chains. A diagnosis of solitary myeloma of the sternum with involvement of the overlying skin was made. The patient received cobalt-60 radiotherapy (4,600 rads) to the sternum; following treatment, complete regression of the skin nodule and disappearance of the serum M component were observed. Until now neither recurrence nor progression of the primary disease have developed. Primary extramedullary cutaneous tumors, solitary or multiple, were seldom reported. Their courses were variable: Sometimes the disease remained stable for a long period, more often it spread out of the skin to other organs and soft tissues [3, 5]. Cutaneous extramedullary plasmacytomas secondary to multiple myeloma or plasma cell leukemia occur more frequently and should be considered as a sign of poor prognosis: Following their appearance, 8 out of 19 reported patients died within 6 months, and 5 within 2 years [1].

A relationship between cutaneous tumors and a high tumor cell burden was postulated [1]; postmortem findings evidenced, in the majority of the cases, a widespread involvement of the bones, internal organs and soft tissues [4, 6].

The occurrence of cutaneous plasmacytomas extending directly from underlying myelomatous bone lesions, as observed in our case, seems to be as uncommon as that of primary extramedullary tumors [1]. In Bluefarb's [2] series, the largest so far reported, skin changes were associated with multiple osseous lesions, large amounts of M component, and massive bone marrow replacement by plasma cells.

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Standardization in the Laboratory Control of Oral Anticoagulant Therapy

In collaboration with the International Committee for Standardization in Haematology (ICSH), the European Community Bureau of Reference (BCR) has produced three certified reference materials for the standardization of commercial or laboratory-made human, bovine and rabbit thromboplastins, respectively. These reference materials have been calibrated against the WHO international reference preparation (IRP 67/40). By using the appropriate BCR reference material (human, bovine or rabbit) a sensitivity index can be assigned to any thromboplastin working preparation which will thus be directly related to the WHO primary reference preparation.

In clinical practice a prothrombin ratio obtained by means of a thromboplastin reagent with an assigned sensitivity index can then be converted to an international normalised ratio (INR) by a simple equation: $INR = \text{antilog of } (\log \text{ prothrombin ratio} \times \text{sensitivity index})$.

Manufacturers are being encouraged to establish the sensitivity indices of their thromboplastin reagents and to provide appropriate tables of INRs. A therapeutic range for INR of 2.0-4.0 has been recommended.

Details of the scheme have recently been described by E.A. Loeliger and S.M. Lewis (Progress in laboratory control of oral anticoagulants. *Lancet*, August 7, 1982).

Information of the availability of BCR certified reference materials, a report of the certification protocol and recommended methodology for calibration of working

preparations are available from the European Community Bureau of Reference, Rue de la Loi 200, Brussels B-1049, Belgium.