Administration of Vincristine in a Patient with Machado-Joseph Disease

Anna Colpo a Frederick H. Wilson b Valentina Nardi c Ephraim Hochberg b

a Department of Medicine, Haematology and Clinical Immunology, University of Padua School of Medicine, Padua, Italy; b Division of Haematology/Oncology, and c Department of Pathology, Massachusetts General Hospital, Boston, Mass., USA

Key Words
Machado-Joseph disease · Spinocerebellar ataxia type 3 · Vinca alkaloid · Vincristine

Abstract
Chemotherapy-induced peripheral neurotoxicity is a major problem because it represents the dose-limiting side effect of a significant number of antineoplastic drugs, such as vinca alkaloids. Hereditary neuropathies usually predispose to severe vincristine neurotoxicity. Here, we report the case of a 56-year-old man with Machado-Joseph disease, also known as spinocerebellar ataxia type 3, treated with a vinca alkaloid without exacerbation of neurological symptoms.

In December 2010, a 56-year-old man with a 14-year history of Machado-Joseph disease (MJD) noted a non-tender, painless mass in his right axilla. He denied any associated symptoms, in particular fever, night sweats or weight loss over the preceding 6 months. An ultrasound of the right axilla showed a 3.0 × 3.3 × 2.7-cm lymph node along with several other enlarged nodes nearby. One month later, an excisional lymph node biopsy was consistent with diffuse large B-cell lymphoma, anaplastic variant.

He had a baseline Eastern Cooperative Oncology Group (ECOG) performance status of 2–3. His MJD symptoms included: clumsiness, bilateral sensory paresthesias in the upper and lower extremities and progressive gait instability, which had eventually limited him to a wheelchair. The complete blood count was normal, the lactate dehydrogenase (LDH) level was elevated at 303 U/l. Examination was remarkable for a 2-cm right supraclavicular node, mild weakness and decreased grip strength in his right upper extremity, prominent muscular fasciculations, significant atrophy and hyporeflexia throughout his lower extremities.

A combined positron emission tomography/computed tomography (PET/CT) and a bone marrow biopsy revealed limited stage (IIA) disease with a revised International Prognostic Index (R-IPI) of 2. He was treated with 4 cycles of cyclophosphamide, doxorubicin, vincristine and prednisone (CHOP), with the addition of the monoclonal anti-CD20 antibody rituximab, followed by involved field radiation therapy. Due to concern for exacerbation of the patient's pre-existing neurologic symptoms, vincristine was dose-reduced to 0.35 mg/m² for cycle 1 and to 0.7 mg/m² for cycles 2–4. The patient reported...
temporary exacerbation of his sensory paresthesias never worsening beyond common toxicity criteria grade 1 in the week following each chemotherapy cycle with prompt resolution. He reported no cumulative changes in his neurological status following 4 cycles of chemotherapy, and his neurological exam was stable. A complete response by PET criteria was achieved after 4 cycles of chemotherapy.

MJD, also known as spinocerebellar ataxia type 3, is the most common of the autosomal dominant spinocerebellar ataxias [1]. MJD is caused by expanded CAG trinucleotide repeats in the ATXN3 locus in chromosome 14q32.1, resulting in the expression of polyglutamine tracts in the deubiquitinating ataxin 3 enzyme [1]. Trinucleotide repeat length is inversely correlated with the age of onset of symptoms, most commonly in the second to fifth decade, and is the most important prognostic factor in predicting the severity of the disease. The clinical findings are extremely heterogeneous and include gait ataxia, cerebellar dysarthria, dysphagia, clumsiness, oculomotor disturbances such as diplopia and nystagmus. Extrapyramidal signs comprise dystonic movements, chorea and parkinsonian features. Later, evidence of progressive symptomatic peripheral polyneuropathy with impairment in sensory nerve action potentials can occur [2]. Late in the disease course, patients are confined to a wheelchair, and later become bedridden. Currently, only symptomatic therapies are available.

Diffuse large B-cell lymphoma is the most common non-Hodgkin lymphoma in adults, comprising approximately 30% of all lymphomas and 90% of aggressive lymphomas [3]. Treatment options differ between patients with limited stage (Ann Arbor stage I–II) or advanced stage (Ann Arbor stage III–IV) disease. The presence of risk factors (namely high LDH, advanced stage, age >60 years, more than one extranodal site, ECOG performance

<table>
<thead>
<tr>
<th>Reference</th>
<th>Diagnosis</th>
<th>Oncologic diagnosis</th>
<th>Age years</th>
<th>Gender</th>
<th>Chemotherapy</th>
<th>Dose of vincristine mg</th>
<th>Symptoms after VCR</th>
<th>Later VCR treatment</th>
<th>Neurological outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weiden and Wright [11], 1972</td>
<td>CMT</td>
<td>embryonal cell carcinoma of the testis</td>
<td>46</td>
<td>M</td>
<td>VCR, B</td>
<td>4</td>
<td>severe weakness rapidly progressed to paraplegia, respiratory failure</td>
<td>withheld VCR</td>
<td>death</td>
</tr>
<tr>
<td>Griffiths et al. [12], 1985</td>
<td>CMT</td>
<td>NHL</td>
<td>57</td>
<td>F</td>
<td>VCR, CTX, P</td>
<td>2</td>
<td>severe weakness</td>
<td>withheld VCR</td>
<td>improved</td>
</tr>
<tr>
<td>Graf et al. [13], 1996</td>
<td>CMT</td>
<td>NHL</td>
<td>18</td>
<td>F</td>
<td>modified CHOP with IT MTX/ HDMTX</td>
<td>2</td>
<td>severe weakness, feet anesthesia with finger dysesthesia, absence of light touch, vibration and position sense, absence of tendon reflexes, hand tremors, restless leg movements</td>
<td>withheld VCR</td>
<td>regained ambulation at 1 year</td>
</tr>
<tr>
<td>Graf et al. [13], 1996</td>
<td>CMT</td>
<td>embryonal cell carcinoma of the testis</td>
<td>46</td>
<td>M</td>
<td>VCR</td>
<td>2</td>
<td>quadriplegia, involvement of the bulbar musculature, pneumonia, respiratory failure</td>
<td>not reported</td>
<td>death</td>
</tr>
<tr>
<td>Hildebrandt et al. [14], 2000</td>
<td>CMT</td>
<td>NHL</td>
<td>52</td>
<td>F</td>
<td>CHOP</td>
<td>4</td>
<td>severe weakness, paresthesia of the fingertips, bilateral sensory impairment of feet and lower legs and slight dysphagia</td>
<td>withheld VCR</td>
<td>improving at 6 months</td>
</tr>
<tr>
<td>Naumann et al, [15], 2001</td>
<td>CMT</td>
<td>NHL</td>
<td>31</td>
<td>F</td>
<td>BEACOPP</td>
<td>2</td>
<td>severe weakness</td>
<td>withheld VCR</td>
<td>improving at 6 months</td>
</tr>
<tr>
<td>Kalfakis et al. [16], 2002</td>
<td>CMT</td>
<td>NHL</td>
<td>37</td>
<td>F</td>
<td>CHOP</td>
<td>4</td>
<td>severe weakness leading to tetraparesis, absence of tendon reflex</td>
<td>withheld VCR</td>
<td>improving at 4 months</td>
</tr>
<tr>
<td>Gil et al. [17], 2009</td>
<td>CMT</td>
<td>NHL</td>
<td>17</td>
<td>F</td>
<td>ABVD (VCR)</td>
<td>2</td>
<td>severe weakness, hypesthesia, absence of deep tendon reflexes</td>
<td>withheld VCR, gabapentin</td>
<td>improving at 12 months</td>
</tr>
</tbody>
</table>

VCR = Vincristine; CMT = Charcot-Marie-Tooth disease; B = Bleomycin; NHL = non-Hodgkin lymphoma; CTX = cyclophosphamide; P = prednisone; IT = intrathecal; MTX = methotrexate; HDMTX = high dose methotrexate; CHOP = cyclophosphamide, doxorubicin, vincristine, prednisone; HL = Hodgkin lymphoma; BEACOPP = bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, prednisone; HNPP = hereditary neuropathy with liability to pressure palsies; ABVD (VCR) = doxorubicin, bleomycin, vincristine, dacarbazine.


