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<th><strong>Title</strong></th>
<th>Treatment outcome of rhabdomyosarcoma in Hong Kong Chinese children</th>
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Introduction

Rhabdomyosarcoma (RMS) is the most common paediatric soft-tissue sarcoma and accounts for approximately 4 to 5% of all childhood malignancies. The disease may appear in any organ or tissue, and can metastasise to lung, bone marrow, bone, and lymph nodes. Current treatment regimens incorporate surgery, chemotherapy, and radiotherapy (RT). Using this multimodality approach, the cure rates for RMS have steadily increased from only 25% in the 1970s to 70% in the 1990s.1-3 The prognostic factors include: the primary site, the histology, the age at diagnosis, the clinical stage and grouping.3-6 The Intergroup Rhabdomyosarcoma Study Group (IRSG) has conducted four consecutive clinical trials (IRS-I, 1972-78; IRS-II, 1978-84; IRS-III, 1984-91; IRS-IV, 1991-97),3-9 with treatment outcomes that compared favourably with other large international studies.3-10-12 In Hong Kong, we had largely adopted the IRSG treatment regimens. The aim of this study was to review corresponding treatment outcomes of children with RMS diagnosed at Queen Mary Hospital over the past 16 years.
Methods

Patients

Consecutive patients younger than the age of 18 years, with RMS diagnosed and treated at Queen Mary Hospital between 1989 and 2005, were identified from our clinical database. Charts were reviewed to extract demographic data, clinical features, treatment protocols, toxicity, and outcomes. Twenty-two patients with RMS presented to our hospital. Three patients were excluded because they subsequently received treatment in other medical centres; the remaining 19 formed the subjects of this study. Seventeen children were treated with the IRS-IV protocol, one patient with the IRS-V protocol and one with the International Society of Paediatric Oncology Malignant Mesenchymal Tumour (SIOP MMT)–89 protocol.

Definitions

Overall survival (OS) was defined as the time from the start of treatment to death from any cause. Events were defined as disease relapse or second neoplasm after complete remission or death from any cause. The censor date was 31 March 2006. Patients were assigned presurgical staging based on the primary tumour site, size, presence or absence of clinically evident lymph node involvement and/or metastatic disease, according to the IRSG presurgical staging classification. Patients were also assigned clinical grouping according to the surgical-pathological system of the IRSG postsurgical grouping classification. Toxicities were evaluated by the National Cancer Institute–Common Toxicity Criteria (NCI-CTC) version 2.0. Histological diagnoses of all 19 RMS cases were validated by two pathologists (SKC, TWHS), who retrieved and reviewed the original diagnostic slides, according to the International Classification of Rhabdomyosarcoma.

Statistical methods

Overall survival and event-free survival (EFS) rates were calculated using the Kaplan-Meier method. Since our study involved a relatively small number of patients in a single institution, subgroup analysis of known prognostic factors was not performed.

Results

Patient characteristics

Fourteen (74%) of the 19 patients were less than 10 years old; their median age at diagnosis was 6 (range, 0.5–17) years, eight were male and 11 female. One child had neurofibromatosis. Our patients had diverse clinical presentations, depending on the site of the primary tumour, ranging from an indolent painlessly enlarging mass to an acute onset with cranial nerve palsy, spinal cord compression, bleeding, and gastrointestinal or urinary tract obstruction. The most common primary site was the head and neck (8 cases); six of the latter sites were classified as cranial parameningeal (Table). Other primary sites were genitourinary (n=3), extremity (n=3), pelvis (n=3), and trunk (n=2). Tumour size was greater than 5 cm in diameter in 47% of cohort, and over two thirds had evidence of local tissue invasion (T2) at diagnosis. Thirty-two percent did not manifest regional lymph nodes, 47% had manifested regional lymph node involvement and in 21% the lymph node status was unknown (Table). Thirteen (68%) of 19 patients had embryonal and also had alveolar histology. Four, 3, 6, and 6 patients were classified as belonging to IRS stage I, II, III, and IV groups, respectively. The distant metastatic sites of the six stage IV cases were the lung.
TABLE Demographic and clinical features, treatment regimens, and outcomes of the rhabdomyosarcoma patients

<table>
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<tr>
<th>Patient No.</th>
<th>Age (yrs)</th>
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<th>Site</th>
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* Primary sites: GU=genitourinary (non-bladder/prostate); H&N=head and neck, non-parameningeal; PM=parameningeal
† Histology: 1=embryonal; 2=alveolar
¶ IRS denotes Intergroup Rhabdomyosarcoma Study
‖ Radiotherapy (RT) type: 1=conventional RT; 2=intensity-modulated RT; 3=3D-conformal RT; *=including right thigh 50.4 Gy, boost local 32 Gy, right lung 18 Gy; ND=not done; NA=information not available; D0=at diagnosis
§ Chemotherapy protocol: 1=IRS-IV; 2=IRS-V; 3=International Society of Paediatric Oncology Malignant Mesenchymal Tumour (SIOP MMT)-89 protocol
*† Histology: 1=embryonal; 2=alveolar
*‡ Primary sites: GU=genitourinary (non-bladder/prostate); H&N=head and neck, non-parameningeal; PM=parameningeal
** All patients had autologous bone marrow transplantation
†† Status: DOD=died of disease, NED=no evidence of disease, DOI=died of infection, AWD=alive with disease

(50%), bone (33%), and lymph nodes (33%). Median follow-up duration was 3.4 (range, 0.2-16.7) years.

**Treatment**

Multimodality treatment comprising chemotherapy, surgery, and RT was used for our RMS patients; the majority of whom received full-dose chemotherapy as specified by the corresponding chemotherapy protocol (mainly IRS-IV regimen, Table), except that the dose was reduced (to 50-75%) in two infants. According to the IRS-IV protocol, we adopted the standard treatment arm—VA (vincristine and actinomycin D) for stage I group 1, stage I group 2 or orbit, stage I group 1 or 2 paratesticular tumour; and VAC (vincristine, actinomycin D, and cyclophosphamide) for all other categories of non-metastatic RMS. Granulocyte-colony stimulating factor was not given prophylactically following each cycle of VAC, but was added as rescue therapy (5 μg/kg/day) when the patient developed neutropenic fever. Significant toxicity such as severe oral mucositis was encountered, particularly during concurrent RT and chemotherapy. Interruption and delay to the scheduled chemotherapy with subsequent reduction of the dose of actinomycin D was deemed necessary in three (16%) of the patients with persistent mucositis (NCI-CTC grade 4). Vincristine was discontinued in two patients who developed severe peripheral neuropathy (NCI-CTC grade 4).

Only five of 19 patients had surgical resection of the primary tumour at diagnosis; two (11%) achieved complete resection (IRS group 1) whilst two (11%) had microscopic residual disease (IRS group 2). The majority had a biopsy only at diagnosis; nine (47%) were in group 3, and six (32%) in group 4. Overall, 10 (53%) patients underwent surgical resection of the primary tumour, and complete resection was achieved in seven, whereas gross residual disease remained in three (Table). Surgical resection was not feasible in five of the six children with cranial parameningeal disease (Table).
Sixteen (84%) of the 19 patients received RT; the exceptions being two with stage I group 1 disease and an infant who had delayed complete resection of a right nasal ala tumour (Table). Over the entire study period, three types of RT were administered—9 (56%) of 16 patients received conventional RT, two received intensity-modulated RT, and five were given three-dimensional conformal RT. Most patients received total RT dosages of between 41.4 and 50.4 Gy. Radiotherapy was usually administered after the induction phase of chemotherapy, at about 9 and 16 weeks of treatment. Cranial parameningeal cases that showed evidence of either skull base erosion, intracranial extension or cranial nerve palsy commenced RT within the first few weeks of treatment concurrent with chemotherapy (Fig 1). Four patients, including one with metastases and three relapsed patients, underwent autologous bone marrow transplantation; only one of whom remains alive.

### Survival and outcome

Five-year OS and EFS rates of the whole cohort of patients were 49% (95% confidence interval [CI], 26-73%) and 32% (95% CI, 10-55%), respectively (Fig 2). Patients with non-metastatic tumours (IRS group 1-3) had much better outcomes than the others (IRS group 4). The 5-year OS rate was 66% (95% CI, 39-93%) in non-metastatic cases, compared to 17% (95% CI, 0-46%) in metastatic cases (Fig 3a). Five-year OS rate for patients less than 10 years old was 60% (95% CI, 33-87%) compared to 20% (95% CI, 0-55%) for those who were older (Fig 3b). There was no difference in survival between those with embryonal and alveolar histology tumours. The series of patients was too small to allow meaningful analysis of the impact of potential prognostic factors, such as primary tumour site, IRS staging and grouping.

There were 11 treatment failures in 19 patients—disease relapse (n=7), death due to severe infection (n=2), second malignant neoplasm (n=2).
Relapse was local in one (14%) patient, regional in two (29%) and combined local and distant relapse in four (57%). The median time interval from diagnosis to relapse was 25 months. The five relapsed patients died. One patient was alive with progressive disease, and another who underwent an autologous bone marrow transplant survived, with no evidence of disease.
Toxicity data

Significant toxicity was encountered with the VAC treatment regimen. According to the NCI-CTC version 2.0, 16 (86%) patients experienced myelosuppression with five (26%) reaching grade 4 severity. Infections such as neutropenic fever occurred in almost every patient; multiple episodes were frequently encountered by individual patients. Severe sepsis associated with profound neutropenia developed in two patients resulting in their death; one during the IRS-IV treatment regimen and one after the last cycle of VAC cycle.

FIG 3. (a) Survival of non-metastatic and metastatic rhabdomyosarcoma. (b) Impact of age on survival of rhabdomyosarcoma
before recovery from myelosuppression, three (16%) had severe (CTC grade 4) mucositis, four (21%) had moderate-to-severe vincristine-induced neuropathy (CTC grade 3 or 4), and four (21%) had renal toxicity. Two (11%) patients developed second neoplasms (both undifferentiated sarcomas) at 44 and 49 months after initial diagnosis of RMS.

Discussion

The primary aims of this study were to review the Hong Kong experience of treating RMS, a rare group of childhood tumours, and identify potential areas for improved management. The 5-year OS and EFS rates in this RMS cohort in Chinese children treated in a single institution were 49% and 32%, respectively. The Kaplan-Meier curve for EFS indicated that most relapses occurred within 2.5 years of diagnosis. The late events were second malignant neoplasms occurring 3.7 and 4.1 years post-diagnosis. Survival outcome appeared inferior to those reported by IRSG and in other international studies; the outcomes of our patients belonging to different IRS groups were examined to identify possible reasons.

The higher percentage (32%) of patients with metastatic RMS (IRS group 4) in our cohort compared to the average of 15% reported in international studies was the most likely factor accounting for our inferior OS. A marked difference in survival was observed when the patients were separated according to the IRS-IV protocol. Intensified chemotherapy, while also preserving form and function, should always be explored rigorously in individual patients.

Among the nine IRS group 3 patients (unresectable tumours or those with incomplete resection), all except two were in the head and neck region, of which five were cranial parameningeal. Among the five patients with parameningeal tumours, two died of the disease whilst three achieved complete remission. However, only one remained in continuous complete remission; the other two developed a second cancer at or near the radiation field. One patient was salvaged with chemotherapy and complete resection of the second tumour, whilst the other had progressive disease. Importantly, non-metastatic parameningeal tumours can be treated successfully by combined chemotherapy and radiation to the initial tumour volume, without the need for aggressive surgical resection. Again, our results were inferior to the 5-year OS rate of 73% (95% CI, 70-77%) for 611 patients with localised parameningeal tumours treated in the IRS II-IV studies. Improvement in supportive care as well as advances in RT techniques (accurately defining the tumour target volume with fusion of magnetic resonance images) are important in the treatment of this group of patients.

Most treatment failures in our patients were in disease relapses at local, regional, or distant sites. In both IRS-III and IRS-IV trials, local failure risk exceeded the risk of distant metastases as a first failure event. The IRS-A study explored the role of surgery in reducing local failures after induction chemotherapy (12 weeks for most group 3 patients). Postoperative RT is required but the dose is determined by resection margin status. In our series, complete surgical resection was mainly achieved in IRS group 1 and 2 patients, who enjoyed excellent survival. The feasibility of surgical resection of tumours after induction chemotherapy, while also preserving form and function, should always be explored rigorously in individual patients.

Age has been shown to be an important prognostic factor for certain subgroups of RMS. A significant difference in survival between patients aged less than 10 years and those who were older (Fig 3b) was noted. However, arguably older patients in our series had more advanced and invasive disease. Histological subtype has been consistently shown to be one of the most important prognostic factors for RMS; alveolar tumours generally have worse survival outcomes. There was no survival difference between patients with embryonal and alveolar RMS in our cohort of patients, very likely due to the small numbers and the advanced clinical grouping (3 or 4) of the majority (75%) with embryonal histology.

Significant treatment-related toxicities were observed in the 19 patients of our series, treated mainly according to the IRS-IV protocol. Intensified therapy used in IRS-IV resulted in myelosuppression
(>90%) with subsequent episodes of severe infections (55%) and death (1%), severe renal toxicity (2%) and second cancers in 10 (1.1%) of 883 patients. We observed frequent occurrence of myelosuppression (86%), severe mucositis (16%), renal toxicity (21%), and severe vincristine-induced neuropathy (21%). Two patients died of severe septicaemia. In two patients with parameningeal tumours, following relatively short latency periods, second malignant neoplasms (both undifferentiated sarcomas) developed within or near the radiation field. The latter were possibly due to the use of alkylating agents and RT. Development of appropriate supportive care is essential to minimise complications of this treatment regimen.

In conclusion, this retrospective review of a series of childhood RMS patients and experience in treating this cancer in Hong Kong identified potential aspects of management deserving improvement. These included post-chemotherapy supportive care, surgical resection of residual tumours, and usage of contemporary RT strategies, all of which should be targeted for continual development in the management of RMS.

Acknowledgement
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References