Surgical Management of an Inoperable Giant Pleomorphic Rhabdomyosarcoma of the Chest Wall

To the Editor:

A 65-year-old men was referred to our hospital with a complaint of giant mass on the chest wall, which reached its present size to 3 cm in 5 months. On physical examination, the mass was firm, fixed, necrotized, and nontender (Figure 1). Metastatic lesions were detected in the lung. An incisional biopsy of the tumor confirmed the diagnosis of pleomorphic rhabdomyosarcoma, 2 months ago in another clinic. The patient was considered as inoperable because the lung was metastatic, and the mass excision was not performed. Serous leakage, observed in the incision area, was irritating for the patient. The patient brought to our clinic for the mass excision. The mass was totally excised. The size of the tumor was 16 × 16 × 15 cm, and the weight was 1750 g. The chest wall and the axillary skin defect were reconstructed with a latissimus dorsi muscle flap. The skin was primarily closed. After the operation, the patient has received chemotherapy in an oncological center. The postoperative course was uneventful, and no recurrence was found. The patient is still alive after 6 months follow-up and was satisfied from the operation. Surgical excision has not seemed to contribute to the improvement in survival after the mainstay of local disease control on chest wall rhabdomyosarcoma.[1] The excision of giant tumors is usually not preferred because of its hardness, and it is useless for survival. Still, resection of giant mass can improve the patient's condition and may provide a good quality of life.[2]

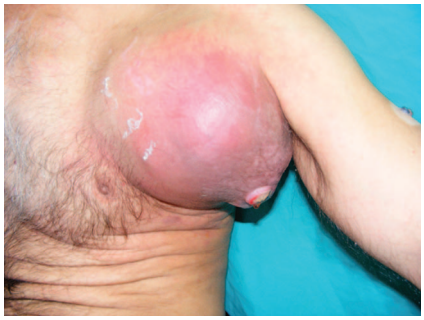

FIGURE 1. Giant mass on the left axillary and thorax wall.

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Disclosure: The authors declare no conflicts of interest.

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Acute Renal Failure in a Patient Receiving Anti-VEGF Therapy for Advanced Non-small Cell Lung Cancer

To the Editor:

Bevacizumab, a monoclonal hybrid antibody that binds to and neutralizes vascular endothelial growth factor, has shown promising efficacy in the adjunctive treatment of patients with several cancers. However, significant side effects are associated with bevacizumab, especially hypertention and proteinuria, but rarely acute renal failure. Here, we report a 67-year-old man, habitted smoker, who developed new-onset acute renal failure after receiving bevacizumab for stage IV non-small cell lung cancer. On January 16, 2008, treatment with paclitaxel 300 mg (175 mg/m^2), carboplatin 580 mg (AUC = 6) plus bevacizumab 900 mg (15 mg/kg) intravenously every 3 weeks was initiated. During the first two cycles, the patient's serum creatinine was stable at approximately 76 μmol/liter and urinalysis was unremarkable. On March 2, 2008, his serum creatinine level was 461 μmol/liter. Then he had a progressive increase in creatinine levels and became oliguric requiring intermittent hemodialysis. Dysmorphic red blood cells and a few coarse granular casts were presented in the urine sediment. Twenty-four hour urine total protein was 9.47 g. So, the scheduled third cycle was withheld. Other laboratory tests including liver function, coagulation status, autoimmune antibodies, etc. showed normal. Kidney ultrasound showed enhanced echo signal in cortex area and normal sized kidneys with no hydronephrosis. Renal vessels were normal. Fortunately, the patient's renal function continued to improve and dialysis was no longer required. And the treatment for non-small cell lung cancer was changed to Gefitinib 250 mg once per day because of PD proven by computed tomography. An ultrasound-guided renal biopsy was delayed until the patient became more clinically stable. In kidney biopsy, glomeruli were characterized by intense glomerular hypercellularity. Much of this hypercellularity was mesangial and segmental endothelial proliferation, giving the glomerular tuft a 'lobular' appearance (Figure 1*A*). The glomerular basement membrane thickening with the appearance of double contours was caused by mesangial cell and mesangial matrix interposition into the subendothelial zone of the capillary loops, which caused capillary loops narrow and occluded (Figure 1*B*). Immuno-fluorescence microscopy showed bright dif-

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