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Radiotherapy for MALT Lymphoma

To the Editor: We read with interest the case presented by Jones and Swaroop[1] in the Residents' Clinic section of the September 2003 issue of the *Mayo Clinic Proceedings*. The authors presented and discussed a rare and interesting case of MALT (mucosa-associated lymphoid tissue) lymphoma in a patient with Sjögren syndrome. We concur with the authors' conclusion that radiotherapy (RT) after superficial parotidectomy would be the most appropriate treatment. However, we disagree with the dose of 0.40 Gy recommended in the text. Although this was probably a typographical error, further discussion of appropriate doses for MALT lymphomas seems appropriate.

The authors accurately point out that lymphoma arising from the parotid gland is exceptionally rare. Indeed, primary parotid lymphoma accounts for only 0.3% of all cancer diagnoses.[2] Minimal data specific to parotid lymphoma and no data specific to MALT lymphoma of the parotid gland are available. Therefore, oncologists must extrapolate appropriate RT doses from other datasets specific to MALT lymphoma. In this regard, 2 prominent examples are noteworthy.

The first is the accumulated experience with MALT lymphomas of the stomach treated at Memorial Sloan-Kettering Cancer Center. Schechter et al[3] reported 31 cases of MALT lymphoma of the stomach treated with primary RT at a median dose of 30 Gy. The 30-month disease-free survival of these patients was 94%. No improvement in disease-free survival was seen with increasing doses (range, 28.5-43.0 Gy). The authors concluded that 30 Gy was an appropriate dose for MALT lymphoma of the stomach.

The second dataset comes from the Princess Margaret Hospital in Canada. Tsang et al[4] published their experience with RT in 62 patients with stage I and II MALT lymphomas. The median RT dose was 30 Gy (range, 17.5-35.0 Gy), and local control was achieved in 96% of the patients. Again, no major improvement in local control was seen with higher doses, and the authors concluded that 25 to 30 Gy was appropriate for the treatment of stage I and II MALT lymphomas.

The recommendation of 25 to 30 Gy is also in accordance with the doses recommended for other indolent non-Hodgkin lymphomas.[5-7] Doses of 35 to 40 Gy would be recommended if the residual tumor volume exceeded 3 cm.[6,7] This would rarely be the case for patients with primary parotid lymphoma after superficial parotidectomy.

Additionally, we recently reviewed the Mayo Clinic experience in the treatment of primary parotid lymphoma (K.R.O., S.L.S., unpublished data, 2003). Twenty-three patients with stage I and II non-Hodgkin lymphoma arising from the parotid gland were identified. The median RT dose was 36.1 Gy (range, 27-50 Gy). None of the patients had local recurrence of their lymphoma. Eight of the 23 patients had MALT lymphoma and received a median dose of 32 Gy. We found no evidence that higher doses provided greater benefit.

On the basis of our own experience and that of others, we would recommend a dose of 25 to 30 Gy for the patient described by Jones and Swaroop. In the even rarer instance of intermediate- or high-grade histology, the current standard of treatment would likely be combined chemotherapy and radiation therapy.

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In reply: We thank Drs Olivier and Stafford for bringing to our attention the incorrect dose of radiation (0.40 Gy) published in our article. We had intended for it to read "40 Gy," as this was the dose reported in some of our references. For example, Balm et al[1] (reference 5 in our article) described a few cases in which a dose of 40 Gy was used in patients similar to ours. After