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Paediatric Inflammatory Myofibroblastic Tumour

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Commentary

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An Inflammatory Myofibroblastic Tumour (IMT), also known as an inflammatory pseudo tumours, can recur and behave aggressively. The cancer is also known as pseudosarcomatous myofibroblastic proliferation or inflammatory myofibro histolytic proliferation, and it involves myofibroblastic spindle cells as well as the infiltration of inflammatory lymph plasma cells and eosinophil's. IMT can occur in a variety of extra pulmonary sites, including the colon, genital tract, spleen, and orbital region, in addition to the lungs. Around 30% of IMT patients may have clinical manifestations of inflammation symptoms.

The World Health Organization classifies IMT as an intermediate soft tissue tumour because it can be locally invasive and reoccur. In IMT, multifocal disease and distant metastases are uncommon. Nonetheless, epithelioid inflammatory myofibroblastic sarcoma (EIMS), a rare subtype of IMT, has a high rate of local recurrence and distant metastases. Surgery is still the mainstay of treatment for localised IMT, whereas systemic therapy is used in advanced disease or tumour sites that are inoperable. High-dose corticosteroids, non-steroidal anti-inflammatory drugs, cyclosporine A, vinblastine/methotrexate or doxorubicin-based chemotherapy, and local radiotherapy are all common treatments. Because activating rearrangements of the anaplastic lymphoma kinase (ALK) gene were found in 50% of cases, targeting ALK is a promising treatment option for IMT. Other actionable genomic alterations, such as ROS1, RET, NTRK, and PDGFR infusion, could be therapeutic targets as well. Despite significant progress in the treatment of IMT using various approaches, the development of standardised systemic therapy and effective clinical management approaches is urgently needed. The first risk stratification for IMT was performed at China Children's Medical Centre (CCMC).

Treatment response and toxicity

To evaluate treatment response, a modified Response Evaluation Criteria in Solid Tumors (RECIST) was used. The absence of all lesions for more than 4 weeks was defined as complete remission (CR). Partial remission (PR) was defined as a decrease in primary tumour size of more than 64% and a decrease in metastatic lesions of more than 30%, with no new metastatic lesions. Progressive disease (PD) was defined as an increase in the size of the primary tumour of more than 40% or the appearance of new lesions. Between PR and PD, there was stable disease.

Before each cycle of chemotherapy, the necessary examination, which included haematological, and biochemistry tests, an electrocardiogram, and an electrocardiograph, was completed. The National Cancer Institute Common Terminology Criteria for Adverse Effects were used to grade treatment-related side effects [1-5].

Surgery was still the most commonly used treatment. For patients in Group I, a "wait and watch" strategy was used. The need for adjuvant treatment after surgery for patients in Group II should be determined on an individual basis. Patients in Group III should receive systemic chemotherapy following surgical resection or biopsy alone. Although systemic chemotherapy was the primary treatment for patients in Group IV, ALK inhibitors may be an alternative option for ALK positive patients. Nonetheless, larger-scale studies with a larger patient population are required to assess treatment efficacy.

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