Letter to the Editor

In correspondence to "Solitary extramedullary plasmacytoma presenting as an adrenal tumor: case report and literature review"

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We have published this interesting and rare case report in *Gland Surgery* in 2021 entitled "*Solitary extramedullary plasmacytoma presenting as an adrenal tumor: case report and literature review*" (1). As we had claimed that the case was extremely rare and the published article was the number 10th case of solitary extramedullary plasmacytoma (SEMP) in the adrenal gland; the same was claimed by some other authors too at that time (2,3). The reason of this confusion was because these cases published nearly at the same period of time. But interestingly we found few extra cases published close to our publication's period (3,4), as well as we had missed a case published in 2016 by Cao *et al.* because of the same author's name who had published two different cases of SEMP in nearly two years of time (5).

So, this correspondence is for the sake of completion of the data on SEMP in the adrenal gland. A case report published by of Cao *et al.* which was the first case of SEMP of the adrenal gland associated with human immunodeficiency virus (HIV). They underwent laparoscopic adrenalectomy and there was no recurrence at 2 years follow-up (5). Another case published by Gasz *et al.* in 2020 where an 81 years old male with multiple co morbidities was presented with left adrenal mass. The mass was diagnosed to be plasmablastic plasmacytoma after immunohistopathology, other laboratory, and radiological investigations. They performed laparoscopic partial resection (80% of the tumor) because they believe the patient was not fit for such an aggressive approach which in their opinion would be a nephrectomy, splenectomy, and adrenalectomy at least. The patient received radiotherapy and tolerated it well. At 14 months follow-up; they did not notice any progression of the residual tumor (4). Elbaset *et al.* also published a case report in 2020 in a 61 years old male which was diagnosed as right adrenal EMP associated with venous thrombus extended until the infra hepatic portion of inferior vena cava. They believe their case was the first case of adrenal EMP associated with venous thrombus. Chest CT with contrast showed multiple lymph node enlargement (but diagnosis of adrenal EMP was confirmed), and the case was associated with inferior vena cava (IVC) thrombus, therefore the multidisciplinary team decided to put the patient on chemotherapy (2). One more study by Chennoufi *et al.* in 2021 revealed a plasmacytoma in the left adrenal gland associated with HIV. The tumor was large enough and invaded the nearby tissues as well as the perilesional, inferior lobar parenchymal, and supraclavicular lymphadenopathy was detected on the left side. This was the second documented case of adrenal EMP associated with HIV according to them. The patient was referred to oncology for chemotherapy and radiotherapy but unfortunately she died 3 months later (3). We would like to update the table published in our last study to the present *Table 1* which include all 14 cases of SEMP of adrenal gland until writing this article. As we have discussed in the previous paper, and after adding the new cases to the table of the current article; surgery is the treatment of choice used by most of these published articles when possible. So, we still believe radical surgery is not only a

Table 1 All the published cases of solitary extramedullary plasmacytoma of adrenal gland

No.	Authors' name	Year of publication	Country	Gender	Age (years)	Tumor side	Tumor size (cm)	Treatment	Follow-up (months)	Recurrence	Ref.
1	Kahara *et al.*	2001	Japan	Male	52	Right	4*4*2	LS+R+C	12	No	(6)
2	Asahi *et al.*	2001	Japan	Male	52	Right	4	LS+R+C	NA	NA	(7)
3	Fujikata *et al.*	2002	Japan	Male	77	Right	10*8*4	OS+R	12	No	(8)
4	Rogers *et al.*	2004	America	Female	75	Right	3.5	LS+R	NA	NA	(9)
5	Li *et al.*	2007	China	Female	64	Bilateral	R: 5*6*7; L: 3*4*4	OS	NA	NA	(10)
6	Ahmed *et al.*	2009	Saudi Arabia	Male	47	Bilateral	R: 11*8; L: 13*8	C+AHSCT	47	Regress R: 5.2*4*5.7; L: 4.5*5*3.5	(11)
7	Blanco Antona *et al.*	2011	Spain	Female	76	Left	6	S+R	40	No	(12)
8	Cao *et al.*	2014	China	Male	26	Right	2.8*3.1*4.5	LS	72	No	(13)
9	Cao *et al.*	2016	China	Male	35	Right	3.5	LS	24	No	(5)
10	Townend *et al.*	2017	Australia	Male	57	Bilateral	R: 5.5; L: 9	OS	NA	NA	(14)
11	Gasz *et al.*	2020	Austria	Male	81	Left	9.7*7.5*10	LS+R (partial resection)	14	No progression	(4)
12	Elbaset *et al.*	2020	Egypt	Male	61	Right	11*9.5*12	C	NA	NA	(2)
13	Khan *et al.*	2021	China	Female	19	Left	8*6*5	OS	60	No	(1)
14	Chennoufi *et al.*	2021	Morocco	Female	50	Left	13.5*11*12.9	C+R	3	Died	(3)

LS, laparoscopic surgery; OS, open surgery; R, radiotherapy; C, chemotherapy; AHSCT, autologous hematopoietic stem cell transplant; NA, not available.

diagnostic method but a definitive treatment option which can be combined with other available treatment options if necessary.

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Footnote

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Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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