

## Case Report

# Images in Immunotherapy and Precision Oncology: Angiosarcoma of the Spleen and Liver

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## ABSTRACT

Primary splenic or hepatic angiosarcomas are ultra-rare and aggressive malignancies associated with poor prognosis. The mainstay treatments are surgical resection and chemotherapy. We report a case of angiosarcoma in a 50-year-old woman who presented with bruising, fatigue, ecchymosis, and hepatosplenomegaly. She was treated with the multi-kinase inhibitor sunitinib for 4 weeks before developing a splenic hemorrhage and succumbing. Recent studies have demonstrated the clinical benefit of immunotherapies in angiosarcomas. Additionally, sequencing techniques have showcased the diverse molecular aberrations involved in angiosarcomas, which offer opportunities for precision-matched targeted therapies such as inhibitors of the VEGF/VEGFR axis and PI3K/Akt/mTOR pathway.

**Keywords:** splenic angiosarcoma, hepatic angiosarcoma, nivolumab, ipilimumab

## Case Summary

A 50-year-old woman presented with bruising, early satiety, fatigue, and dizziness. On physical examination, she had upper extremity ecchymosis and hepatosplenomegaly. She was hospitalized for severe hypochromic microcytic anemia (hemoglobin of 5.8 g/dL; normal  $\geq$  12 g/dL) and disseminated intravascular coagulation. Her initial laboratory profile consisted of a platelet count of 121,000/ $\mu$ L, partial thromboplastin time of 43 seconds,

prothrombin time of 21.1 seconds, international normalized ratio of 1.79, fibrinogen of 104 mg/dL, and D-dimer  $>$  20,000 ng/dL. Upper endoscopy and colonoscopy showed no significant bleeding source. A computed tomography (CT) scan revealed multiple small, low-attenuating lesions throughout the enlarged liver and spleen (Fig. 1). Abdominal laparoscopy showed multiple hemangioma-like lesions of the liver and spleen (Fig. 2). Liver biopsy demonstrated blood-filled cavities with infiltrative tumor cells; the tumor cells had abundant,



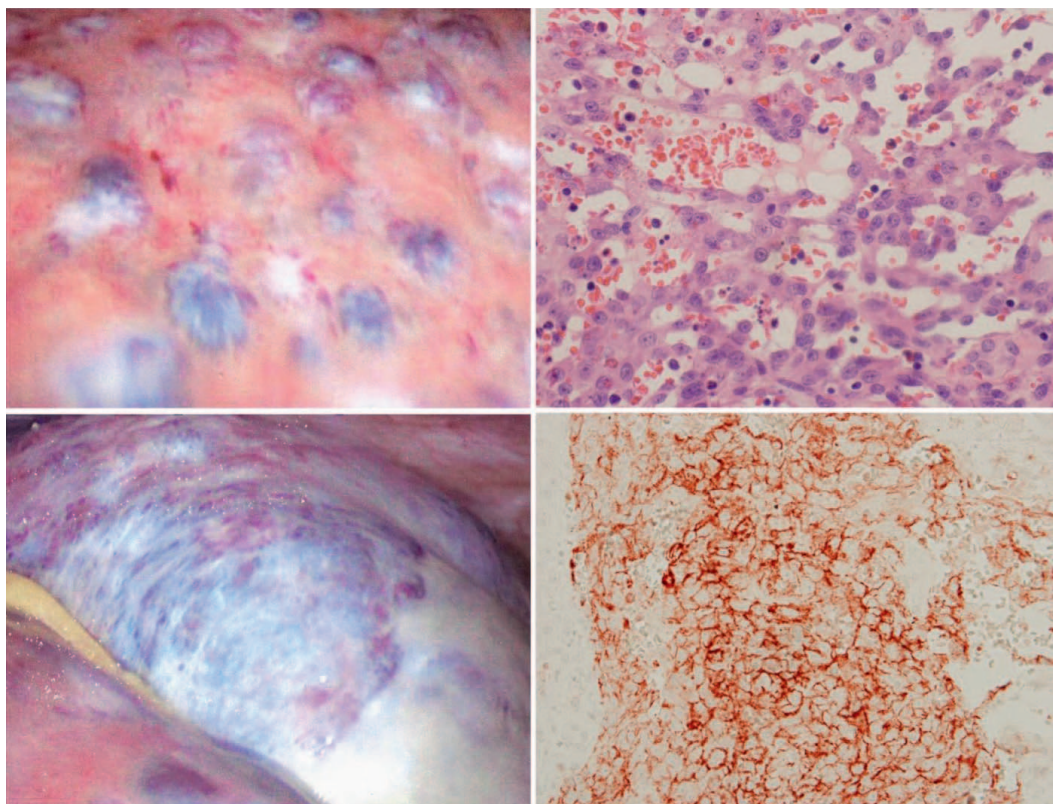
**Figure 1.** Computed tomography images revealed multiple small, low-attenuating lesions throughout the enlarged liver and spleen.

pale eosinophilic cytoplasm with poorly defined cell borders, pleomorphism, hyperchromatic nuclei, and increased mitotic activity. Immunohistochemical stains were positive for factor VIII-related antigen and cluster of differentiation 31 (CD31). The pathologic diagnosis

was angiosarcoma, but it was uncertain whether it was primary liver versus metastatic from the spleen. She was treated with the multikinase inhibitor sunitinib for 4 weeks, but she developed a splenic hemorrhage and succumbed. Informed consent was provided by the patient.

## DISCUSSION

Primary splenic or hepatic angiosarcomas are ultra-rare aggressive malignancies, associated with poor prognosis, especially after splenic rupture.<sup>[1,2]</sup> Clinically, primary splenic angiosarcoma presents with anemia and splenomegaly. Primary hepatic angiosarcoma, on the other hand, presents with right upper quadrant pain, weight loss, jaundice, and abdominal distension. Both can be diagnosed via ultrasound showing nodules or solitary masses with varying echogenicity secondary to the necrosis and hemorrhage within the lesions and later confirmed with a computed tomography scan and biopsy. For the minority of patients with localized disease, surgical resection, including splenectomy, is an option. Splenectomy can also be offered as a palliative measure for primary splenic angiosarcomas.<sup>[3]</sup> Chemotherapy (taxanes, doxorubicin, liposome doxorubicin, and ifosfamide) has been a mainstay treatment for



**Figure 2.** Angiosarcoma of the spleen and liver. The left panels represent a visualization of the liver (top) and the spleen (bottom). The right panels represent immunohistochemistry stains for CD31 (top) and hematoxylin and eosin (bottom). These stains revealed numerous blood-filled cavities with a diffusely infiltrative tumor composed of anastomosing epithelioid and spindled malignant-appearing cells protruding into the lumen of vascular channels. The tumor cells had abundant, pale, eosinophilic cytoplasm, poorly defined cell borders with increased pleomorphism, and hyperchromatic and variably prominent nucleoli with increased mitotic activity. CD31, cluster of differentiation 31.

advanced angiosarcoma. Paclitaxel is an active monotherapy.<sup>[4]</sup>

Recently, immune checkpoint blockade was reported to have activity in some angiosarcomas.<sup>[5,6]</sup> Florou et al<sup>[5]</sup> treated seven patients with immunotherapy (five had cutaneous angiosarcoma, one primary breast angiosarcoma, and one radiation-associated breast angiosarcoma); five (71%) attained partial responses. Similarly, in a phase 2 study (DART [Dual Anti-CTLA4 and Anti-PD1 in Rare Tumors]; ClinicalTrials.gov Identifier: NCT02834013 conducted by the National Cancer Institute–Southwest Oncology Group (NCI-SWOG),<sup>[6]</sup> the objective response rate to nivolumab combined with ipilimumab was 25%, with responses in breast angiosarcoma (postradiation type) and three of five patients (60%) with cutaneous scalp or face disease; some responses were ongoing at > 1 year. For treating primary hepatic angiosarcoma specifically, recent reports have shown the efficacy of pembrolizumab monotherapy, an immunotherapy targeting programmed cell death ligand 1 (PD-L1).<sup>[7,8]</sup> Immunotherapies targeting PD-L1 or the programmed cell death protein 1 PD-1 receptor have also demonstrated efficacy in treating primary splenic angiosarcomas, as recent case reports have shown significant clinical benefit with pembrolizumab monotherapy as well as with the anti-PD-1 toripalimab combined with the multikinase inhibitor anlotinib.<sup>[9,10]</sup> In addition to these novel therapies, other tyrosine kinase inhibitors that also inhibit the vascular endothelial growth factor (VEGF)/VEGF receptor (VEGFR) signaling pathway, such as sunitinib or sorafenib, have demonstrated clinical benefit in treating recurrent metastatic angiosarcomas.<sup>[11,12]</sup>

At the molecular level, angiosarcomas are heterogeneous. Those found on the scalp and face harbor high tumor mutation burden, hydrophobic (and therefore more immunogenic) amino acid variations, and ultraviolet mutational signature, all of which may predispose to immune checkpoint blockade response.<sup>[13,14]</sup> Whole-exome sequencing revealed a variety of pathogenic alterations, including *VEGFR2*, *TP53*, and *PIK3CA* alterations. *PIK3CA*-activating mutations were discerned mostly in primary breast angiosarcoma, which suggests a therapeutic rationale for phosphoinositide 3-kinase (PI3K) inhibitors. Breast angiosarcomas are also enriched for *MYC* amplification.<sup>[15]</sup> Next-generation sequencing has also revealed *FOS*-, *MCL1*-, and *PIK3CA*-activating mutations in primary splenic angiosarcomas, suggesting a rationale for using PI3K inhibitors as well as mammalian target of rapamycin (mTOR) inhibitors for therapeutic benefit.<sup>[16]</sup> In primary hepatic angiosarcomas, next-generation sequencing has shown high-level amplification of the 4q11-q13.1 region, which contains the *KIT*, *PDGFRA*, and *VEGFR2* genes.<sup>[17]</sup> Of note, whole-exome sequencing showed *PLCG1* mutations that allowed for VEGF-R independent signaling, providing a

plausible mechanism of resistance to VEGFR-directed therapies.<sup>[17]</sup>

In summary, angiosarcomas have diverse molecular abnormalities, and some of these genomic aberrations may be pharmacologically tractable. Furthermore, a subset of angiosarcomas, including but perhaps not limited to breast post-radiation and those of the face and scalp have high tumor mutational burden and are responsive to immune checkpoint blockade.

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