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Clinical case discussions

Extranodal lymphomas

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Extranodal or primary CNS DLBC lymphoma?

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A previously fit 58 year old male presented with a 6 month history of progressive sensory disturbance followed by motor weakness affecting both lower limbs such that he had lost the ability to walk. Upper limb and sphincter function was intact. There was no peripheral lymphadenopathy or hepatosplenomegaly. Neurological examination revealed mixed upper and lower motor neurone signs in keeping with a conus medullaris lesion. There was no apparent sensory level. Full blood count, biochemistry and LDH were normal. Imaging (CT and MRI) revealed a soft tissue mass filling the spinal canal from T11–L4, encasing the spinal cord, the conus and the cauda equine (image available). There was no evidence of disease elsewhere. A diagnosis of diffuse large B cell lymphoma was obtained following L3/4 laminectomy and biopsy. The tumour had a high proliferation index and immunohistochemistry revealed positivity for CD20, BCL6, BCL2 (weak), MUM1 and PAX5. The tumour was negative for CD138, CD5, CD10 and CD30. A lumbar puncture with CSF flow cytometry was not possible because of the location of the tumour mass. Bone marrow trephine showed no evidence of infiltration, in particular, no evidence of intravascular lymphoma. Our departmental clinical discussion focused around the optimal regimen to ensure adequate tumour penetration by chemotherapy. The consensus was to treat with R-CODOX-M/IVAC. Treatment is ongoing but the patient is showing prompt resolution of the neurological deficit and is now walking with assistance. Potential points for discussion: 1. Is this a primary CNS lymphoma? 2. What is the optimal management of a conus medullaris lymphoma? 3. Is there an association with intravascular B cell lymphoma? 4. Is there a role for consolidation radiotherapy?

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Intestinal T cell lymphoma

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A 59 year old female presented in June 2006 with sudden onset left iliac fossa pain on a background of chronic abdominal pain and weight loss. Clinical examination revealed features of an acute peritonitis. There was no palpable abdominal mass and no peripheral lymphadenopathy. She had a past medical history of coeliac disease. Full blood count and biochemistry including LDH were normal. CT scan showed free intraperitoneal gas, segmental small bowel thickening. She underwent laparotomy with jejunal resection and re-anastomosis. On histological examination there was extensive ulceration, necrosis and subtotal villous atrophy. The bowel wall was infiltrated with a dense, pleomorphic blast cell population which by immunohistochemistry was positive for CD2, CD3, CD7, CD30 and granzyme B. CD4, CD5 and CD8 were negative. Proliferation fraction was 60%. A diagnosis of enteropathy associated T cell lymphoma was made. CT post surgery was normal. Following 3 courses of CHOP, she had persistent abdominal pain and failed to gain weight and LDH was rising. CT scan did not show any small bowel abnormality. In view of the clinical suspicion regarding residual disease she proceeded to an MRI enteroclysis which showed diffuse thickening of the small bowel wall (image available). In view of the suboptimal response, treatment was changed to ESHAP, 3 courses, with stem cells harvested after course 2. Repeat MRI enteroclysis post ESHAP showed minimal residual nodular changes related to background coeliac disease but no residual mass (image available). She underwent a BEAM stem cell autograft in January 2007. She is currently well and in sustained remission three years post procedure. Potential points for discussion: 1. What is the optimal induction therapy for enteropathy associated T cell lymphoma? 2. Should all fit patients be considered for autologous transplant in first CR? 3. Should MRI be preferred to CT in assessing response to treatment?

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Primary hepatic low-grade B-cell lymphoma: A case report

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Introduction: Primary hepatic lymphoma is a rare disorder representing less than 1% of all extranodal lymphomas and there is no consensus on the best approach for management. Histological examination of a primary hepatic lymphoma usually reveals a diffuse large B-cell lymphoma; there have been few reports of primary hepatic mucosa-associated lymphoid tissue (MALT) lymphomas. We describe the case of low-grade B-cell lymphoma occurring in the liver.
Case report A: 74-year-old man with a history of a little pain on his right abdomen was presented in our hospital. He had no other complaints, no weight loss, fever or night sweats. Abdominal ultrasound showed a liver mass. A computed tomography (ct) scan of the abdomen was performed and it revealed a solitary mass (55×25×60 mm) in medial segment of the left lobe of the liver. Ultrasound-guided biopsy of the liver tumor suggested low-grade B-cell lymphoma Immunohistochemically, lymphoma cells were positive for CD20 and negative for CD5, CD10, CD3, CD43, Bcl-2. Staging procedures showed no lymphoma lesion other than the liver tumor, and all the biochemical blood tests were normal. Thus, the patient was diagnosed with low-grade hepatic marginal zone B-cell lymphoma. Considering that it was low-grade