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Profile of T-cell Lymphomas in Ibadan, Nigeria

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MALIGNANT LYMPHOMA (ML) is one of the commonest malignancies in Ibadan, Nigeria. Generally, B-cell lymphomas are more frequent, except in HTLV-1 endemic zones of South East Asia, where T-cell lymphomas make up 40–80% of the non-Hodgkin's lymphomas (NHLs) [1–2]. Cutaneous T-cell lymphomas and *Mycosis fungoides* constitute the majority of the post-thymic T-cell neoplasms in Western countries, whereas node-based peripheral T-cell lymphomas are predominant in other regions of the world [3, 4]. Post-thymic T-cell malignancies, in contrast to T-lymphoblastic lymphomas, show significant geographical, clinicopathological and prognostic diversity [5, 6]. Recently, previously ill-defined lymphoproliferative disorders, such as lymphomatoid granulomatosis, lymphomatoid papulosis, polymorphic reticulosis and mid-line malignant reticulosis, have been established as clonal expansions of post-thymic T-cells. The spectrum of post-thymic T-cell neoplasms has, therefore, widened. In view of this, the clinicopathological features and geographical distribution of T-cell neoplasms must be thoroughly investigated.

In Ibadan, Nigeria, although NHLs are common, very few data are available on the histopathological profile of T-cell

Table 1. Characteristics of 12 cases of T-cell lymphomas seen within a 3 year period in Ibadan, Nigeria

Case no.	Age	Sex	Presentation	Histological type Updated Kiel's classification
1	10	M	Mediastinal mass with pleural infiltration and pleural effusion	Lymphoblastic
2	62	M	Generalised lymphadenopathy, marrow failure and wasting	Small cell, lymphocytic
3	40	M	Generalised lymphadenopathy	Small cell, lymphocytic
4	19	M	Multiple skin nodules involving face, limbs and trunk	*Mycosis fungoides*
5	32	F	Breast subcutaneous, ulcerative, nodule associated, right axillary lymphadenopathy	Angiocentric pleomorphic, small cell type
6	Adult†	M	Lymph node	Pleomorphic mixed medium/large cell type
7	20	M	Cervical lymph node enlargement	Pleomorphic large cell type
8	32	M	Cervical lymph-adenopathy	Pleomorphic, small cell type
9	30	F	Extradural cord compression; nodules on the scalp. Right axillary lymph-adenopathy	Lymphoblastic type
10	68	M	Right axillary lymphadenopathy. Right submandibular mass extending to right posterior triangle of the neck. Severe generalised pruritic papular rash	AILD type*
11	50	M	Large cervical, preclavicular and axillary nodes	Pleomorphic medium and large cell type
12	60	M	Multiple discrete cervical axillary and lymphadenopathy	Small cell, lymphocytic

*AILD, angio-immunoblastic lymphadenopathy-like; † Age unknown.

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tumours in this environment. In contrast, the clinicopathological spectrum of the more common B-cell neoplasms has been well-documented. In an immunophenotyping study of 100 consecutive cases of NHLs seen in the Pathology Department of the University College Hospital, Ibadan within a 3 year period, 12 T-cell neoplasms stained positively with the T-cell markers, anti-CD3 and UCHLI, but were negative with the B-cell markers (L26, 4KB5). Table 1 shows the characteristics of the cases. The patients' ages ranged from 10 to 68 years with a mean age of 42 years, and a male to female ratio of 5:1. Of the 12 cases, 10 were post-thymic T-cell neoplasms, and 9 of these were node-based. Only one case each of T-lymphoblastic lymphoma with mediastinal tumour and *Mycosis fungoides* were identified. The two cutaneous T-cell tumours included the cases of *Mycosis fungoides* with multiple skin nodules, and subcutaneous breast nodule with angio-invasive T-cell proliferation. In Western countries, approximately 2% of chronic lymphocytic leukaemias are of T-cell origin [7] and T-cell small lymphocytic lymphoma is considered to be rarer still. However, 3 cases of T-cell lymphocytic lymphomas were identified in this series. The other morphological types of T-cell malignancies seen are listed in Table 1.

Although the number of cases seen are few, some conclusions can still be inferred. T-cell malignancies occur in Ibadan, Nigeria and post-thymic neoplasms appear to be more common than thymic neoplasms, the majority of which are node-based. It would seem that cutaneous T-cell lymphomas are not as prevalent as reported in the Western literature, nor are the post-thymic T-cell malignancies in Ibadan, Nigeria as common as in the HTLV-1 endemic areas of South East Asia.

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Splenic Metastases in Patients with Portal Hypertension

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Involvement of the spleen in the course of solid tumours usually occurs in patients with widespread disease and multiple organ involvement [1]. We describe 2 cases in which splenic metastases were the first evidence of distant disease. Both patients had liver cirrhosis, and a possible haemodynamic mechanism favouring spleen colonisation is discussed.

In a 64-year-old woman (patient 1) with a 7 year history of chronic active hepatitis progressing to cirrhosis, a large irregular pelvic mass (10 cm) and a focal lesion of the spleen were diagnosed by computed tomography (CT) scan. Serum CA125 antigen was greatly increased, and fine needle biopsies under ultrasound guidance disclosed the diagnosis of ovarian adenocarcinoma with splenic metastasis. Six cycles of chemotherapy (PEC (cisplatin, epirubicin and cyclophosphamide) regimen) were administered. Due to a very good partial response to chemotherapy, the patient underwent cytoreductive surgery (hysterectomy plus bilateral salpingo-oophorectomy, omentectomy, splenectomy, sigmoid colon resection) which confirmed the presence of left ovarian carcinoma infiltrating the sigmoid colon and a solitary splenic metastasis. No further chemotherapy was given, and the patient was well until 7 months later when pelvic wall recurrence was diagnosed.

A 65-year-old man (patient 2) underwent surgical resection for adenocarcinoma of the descending colon. The patient was HCV (hepatitis C virus) positive and a liver biopsy performed during intervention disclosed cirrhosis. Adjuvant chemotherapy was given (5-fluorouracil plus leucovorin for eight cycles). The patient was well until 18 months after surgery when a large spleen lesion (7 cm) was documented by ultrasonography. The patient was referred for surgery. Splenectomy was performed confirming the presence of a secondary lesion from adenocarcinoma of the gastrointestinal (GI) tract with no other abdominal organ involvement. No further treatment was given and the patient is alive and well with no signs of recurrence at 20 months from surgery.

Metastasis to the spleen from various neoplasms is very rare. In autopsy studies [2], splenic involvement is found in approximately 7% of patients, breast cancer, lung cancer and melanoma being the most common sources. Splenic metastases are usually part of widespread abdominal disease with lymph node involvement, and it has been suggested that they arise from

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