

PICTURES IN DIGESTIVE PATHOLOGY

Abdominal mass, multiple lymphadenopathies, and polyposis

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CASE REPORT

An 83-year-old male presented with anorexia, asthenia, weight loss, and profuse sweating. A 2-cm axillary lymphadenopathy and an abdominal mass in the right lower quadrant were palpable. Thoracic and abdominal CT scans were performed (Fig. 1). Colonoscopy revealed numerous sessile, erythematous polyps up to 1 cm in size with a white apex, and also pale, non-adenomatous polyps in the sigmoid and descending colon. Polyps in the transverse and right colon were less frequent. Polypoid masses prolapsed through the ileocecal valve. Figure 2 corresponds to an ileoscopy. Biopsy demonstrated colonic mucosal infiltration with proliferating monotonous small and medium-sized atypical lymphoid cells with irregular and cleaved nuclei, consistent with mantle lymphoma (Fig. 3). Immunohistochemistry was positive for CD20, CD43, bcl-2, CD79a, and CD5 stains. There was moderate expression of cyclin d1, but bcl-6, CD 10, kappa or lambda chains were not expressed. The patient received systemic R-CHOP chemotherapy.

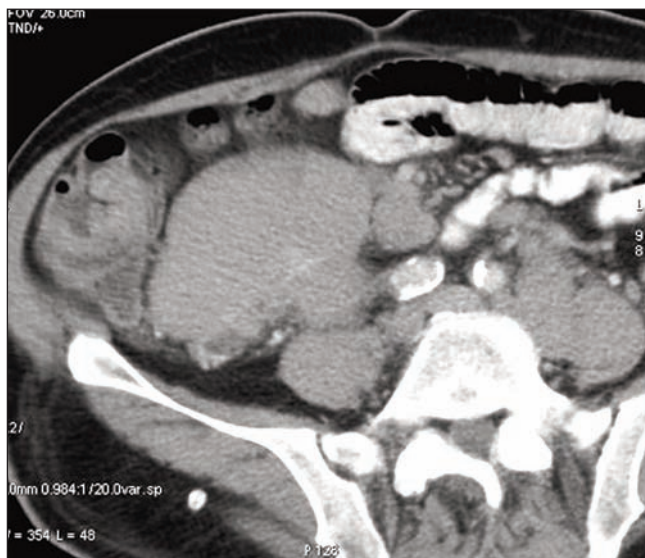


Fig. 1. 12 x 8 x 9-cm mass in the right iliac quadrant, and irregular thickened cecal mucosa. In higher CT sections lymphadenopathies are identified in the peritoneal and retroperitoneal celiac, and peri-renal areas.

Masa en fosa iliaca derecha de 12 x 8 x 9 cm y engrosamiento irregular de la mucosa de ciego. En cortes más altos se identifican adenopatías intra- y retroperitoneales a la altura del tronco celiaco y de los hilos renales.

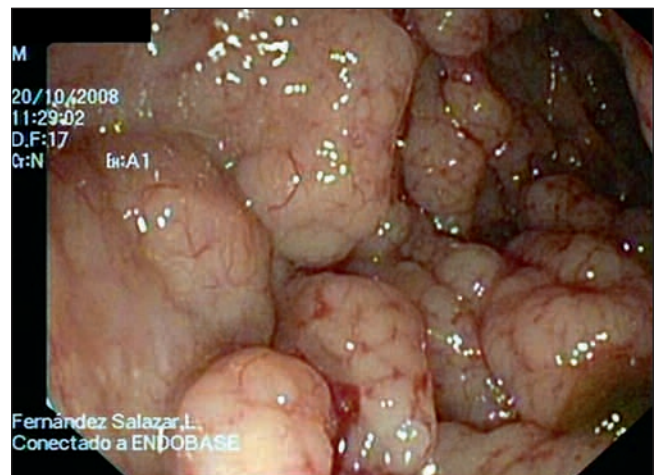


Fig. 2. Ileum: giant sessile polyps with cerebriform shape and increased vascular pattern.

Íleon: grandes formaciones polipoides de aspecto cerebroides y sésiles con aumento de la trama vascular capilar.

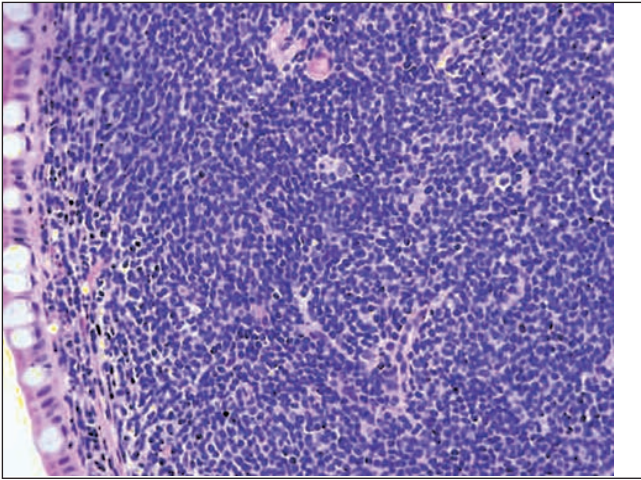


Fig. 3. Endoscopic colonic biopsy. HE40x. Mononuclear infiltrate beneath the colonic mucosa.

Biopsia de colon. HE40x. Infiltrado mononuclear por debajo de la mucosa colónica.

DISCUSSION

Most mantle lymphomas (ML) are diagnosed at advanced III or IV Ann Arbour stages, and are usually extranodal with bone marrow, liver or gastrointestinal extension. Lymphomatous polyposis is the endoscopic expression of ML and can extend from the esophagus to the rectum (1). Duodenal and colonic involvement is described as multiple sessile, flat, small, sometimes umbilicated polyps that can be enhanced with indigo carmine dye (1-3). Ileal involvement of ML can be similar to colonic disease (3) or consist of large or giant folds (2). Biopsies demonstrate atypical cleaved lymphoid cells expressing CD5 (lymphoid cell marker), CD10, CD 20, CD 22 (B-cell marker) and cyclin d1 (cell-cycle regulating protein) (1-4). Immunohistochemistry differentiates ML and follicular lymphoma, which can also manifest as lymphomatous polyposis (5). ML has the poorest prognosis. Treatment is systemic chemotherapy (CHOP) combined with rituximab (anti-CD20). Radiotherapy can be used in some cases. Allogeneic bone marrow transplant may be the only long-term curative treatment (4).

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