

## PICTURES IN DIGESTIVE PATHOLOGY

# Giant splenomegaly and non-Hodking's lymphoma

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### CASE REPORT

A 35-year-old male presented to our clinic with asthenia, hyporexia, and weight loss (3 kg in two months) of one month duration. Physical examination was positive for an abdominal mass that occupied left side of abdomen, right iliac fossa and flank consistent with splenomegaly. Blood tests showed moderated anemia (Hb: 10 g/dL) and hypercalcemia (Ca: 13.1 mg/dL). Chest/abdominal CT scan revealed splenomegaly of 27 cm major axis with multiple hypodense areas and hilar splenic adenopathies about 17-28 cm size (Fig. 1). Presumptive diagnosis of lymphoma was established and diagnostic/therapeutic splenectomy was scheduled.

Splenic resection was performed without complication via a subcostal laparotomy using an "in situ" technique (Fig. 2). Pathology returned as a diffuse large B-cell lymphoma and the patient was started on combined chemotherapy treatment (CHOP and rituximab).

### DISCUSSION

Diffuse large B-cell lymphoma is the most frequent variety of non-Hodgkin's lymphoma, representing approximately 33% of all cases (1). Presumptive diagnosis of lymphoma is based on clinical presentation, blood tests, and imaging. Splenectomy is necessary for a definitive anatomopathological diagnosis (1,2) in addition to being therapeutic (solves problems related with splenomegaly and hypersplenism) (3,4). After splenectomy blood counts return to normal values, transfusional requirements are reduced, and subsequent chemotherapy tolerance is improved (1,3,4).

Surgical approach using "in situ" technique is recommended for this kind of surgery (giant spleen and programmed surgery) (5).



Fig. 1. Abdominal CT scan: Giant splenomegaly.



Fig. 2. Operatory piece, 31 cm of major axis spleen and 2,635 kg weight.

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