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Detecting a rare composite small bowel lymphoma by Magnetic Resonance Imaging coincidentally: A case report with radiological, surgical and histopathological features

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ABSTRACT

INTRODUCTION: Diagnosing lymphoma continues to prove challenging in the clinical practice. Composite lymphoma (CL) is defined by the coexistence of different lymphoma subtypes in the same anatomical location. This condition has seldom been witnessed in the gastrointestinal (GI) tract. We weren't able to find previous cases in the literature about small bowel CL with follicular lymphoma (FL) and classical Hodgkin lymphoma (CHL). Surgery is the treatment of choice to obtain accurate histology, to manage and prevent acute complications. We state that this work has been reported in line with the SCARE criteria. **CASE PRESENTATION:** We describe an extremely rare case of small bowel CL, presenting as an intestinal bulky mass with circumferential infiltration of bowel loops. The small bowel tumor was incidentally detected by abdominal Magnetic Resonance Imaging (MRI) in a 64-year-old man who suffered from rectal discomfort and non-specific clinical symptoms. After this radiological finding, the patient underwent multiphase contrast computed tomography (MDCT) for initial staging and to study vascular involvement. Surgery was recommended to obtain an accurate diagnosis both due to initial symptoms of the intestinal obstruction and to avoid small bowel complications. The histopathological examination revealed a small bowel CL composed mainly of B cells FL with also CHL components.

CONCLUSION: It is important to note that involvement of the proximal ileal loops is very rare in small bowel lymphoma. MRI represents a precious diagnostic tool to evaluate the intra and extramural extent of the tumor.

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1. Introduction

Small bowel (SM) tumors are relatively rare and can represent a diagnostic conundrum for both clinicians and radiologists. This is mainly due to vague symptoms and the overlapping of imaging features which may present as ghost tumors. Tardy diagnosis with poor prognosis is common [1–3]. Gastrointestinal (GI) lymphoma accounts for about 1–4% of GI malignancies [2]. Almost all the primary GI lymphomas are of B cell lineage with very few T-cell lymphomas and classical Hodgkin lymphoma (CHL). Its most

frequent sites of occurrence are the stomach followed by the small bowel and the ileocecal region [2,4,5]. The coexistence of classical (CHL) and non-Hodgkin lymphoma (NH-L) in the same anatomic location is a very unusual condition known as composite lymphoma (CL). Local coexistence of a HL and NH-L in the GI tract has been reported very rarely [6–8]. We present an extremely rare case of small bowel lymphoma composed by follicular lymphoma (FL) and CHL. This case sheds light the heterogeneous variety in terms of clinical presentation, radiological features and histological subsets of GI lymphoma. We state that this work has been reported in line with the SCARE criteria [9].

2. Case presentation

A Caucasian 64-year-old man was admitted to the Gastroenterology Department of our Institution for rectal discomfort and a mild epigastric pain, which started two months earlier. He also reported a stabbing perianal pain. He had only graduated from primary school and suffered from clinical depression.

Abbreviations: ADC, apparent diffusion coefficient; CL, composite lymphoma; CHL, classical Hodgkin lymphoma; CT, computed tomography; DWI, diffusion weighted imaging; FL, follicular lymphoma; FSE, fast spin echo; GI, gastrointestinal; HB, haemoglobin; MALT, mucosa-associated lymphoid tissue; MCV, mean cells volume; MRI, Magnetic Resonance Imaging; NH-L, Non-Hodgkin Lymphoma; True-Fisp, true fast imaging steady state precession; w, weighted.

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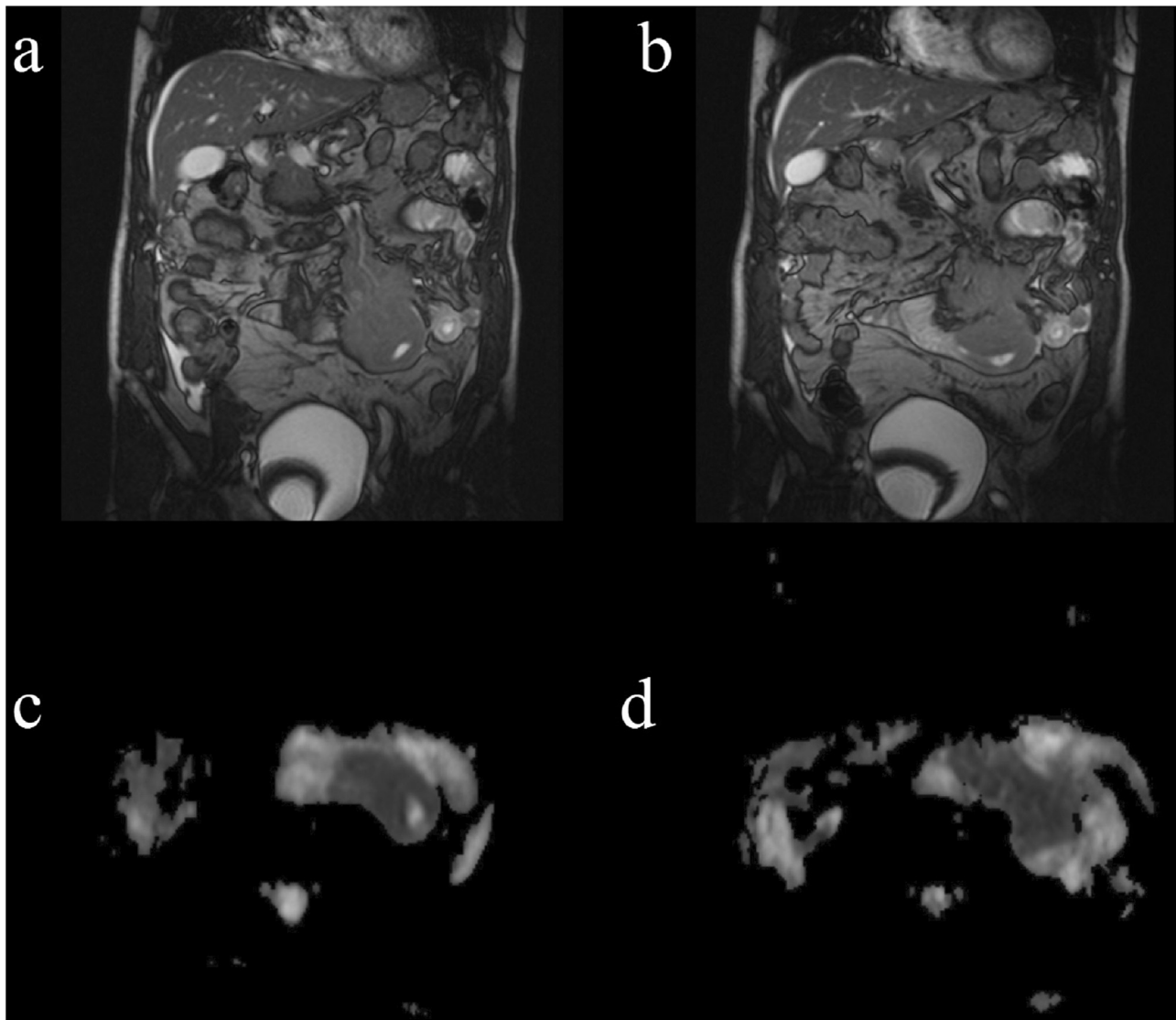


Fig. 1. The bulky mass on True-FISP characterized by mesenteric pattern (a) with circumferential extension of small bowel loop (b). Diffuse low apparent diffusion coefficients (d,c).

He had been operated two years before for haemorrhoids by means of a Longo hemorrhoidopexy. An esophagogastroduodenoscopy and colonoscopy had already been performed at another Institution, which could not find any tumor. The esophagogastroduodenoscopy described only a mild gastritis. Routine blood examination showed normal laboratory values with hemoglobin (Hb) 12.8 g/dL, mean cell volume (MCV) 85.8FL, normal white blood cell counts $6400/\text{mm}^3$ with normal platelet counts $172,000/\text{mm}^3$. The lactate dehydrogenase level was 130 IU/L in the normal range, β 2-microglobulin was mildly elevated. Other laboratory values, including electrolytes, creatinine, and liver enzymes, were normal. Serological testing showed negativity for hepatitis B virus and human immunodeficiency viral infections. Carcinoembryonic antigen, α -fetoprotein and carbohydrate antigen were in the normal range. An upper abdominal ultrasound showed only liver steatosis and a double renal district on the left side.

Therefore, clinicians requested an MRI due to the patient complaining about rectal discomfort and perianal pain and in order to rule out with certainty any perianal pathologies and also to exclude a pudendal nerve entrapment. The study was performed by oblique axial T1-weighted (w)Fast-Spin-eco (FSE), oblique axial T2w FSE, oblique axial and oblique coronal fat-suppressed T1w FSE, com-

pleted by gadolinium-based contrast material. This study did not show perianal pathologies but found a consistent amount of peritoneal ascites. Therefore, as the non-specific clinical symptoms, it was decided to extend the study to all abdomen. Coronal and axial True fast imaging steady state precession (True-FISP), axial Diffusion weighted imaging (DWI), axial and coronal fat suppressed T1w images after gadolinium-based contrast material were also carried out. These latter sequences revealed a large bulky mass in the mesenteric region, with thickening and mild dilatation of the involved small bowel walls. It displayed hypointense signal on T2w, with low apparent diffusion coefficient (ADC) (mean ADC value $0.6591 \times 10^{-3} \text{ mm}^2/\text{s}$) (Fig. 1) and homogeneous enhancement (Fig. 2). Small bowel lymphoma was given as first diagnosis, adenocarcinoma and carcinoid tumors as other differential diagnosis. A total body computed tomography (CT) was required for initial staging, which confirmed the abnormal mass with a medium size of $9.71 \times 8.64.12.62 \text{ cm}$ involving also superior mesenteric artery (Fig. 3), thought still patent. No lung, brain and bone metastasis were observed.

Twelve days after the staging CT, the patient showed symptoms of intestinal obstruction, which led to the patient's hospitalization for supportive care without the need of surgery at first because the

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