

Massive intestinal infiltration in a patient with bone t-cell rich diffuse large b cell lymphoma

Haematologica 2007; 88;(4)e56

A 49-year-old male patient presented with bone pain and a right costal mass in September 1997. The X-ray images showed osteolytic lesions in the ribs and right pelvis. He was diagnosed of stage IV A (isolated bone and bone marrow infiltration) T-cell rich diffuse large B cell lymphoma (DLBCL), IPI 1. The patient achieved first complete remission after treatment with six cycles of CHOP and subsequent involved field radiotherapy (RT). In May 2000 he experienced a nodal relapse (supra and infra-diaphragmatic, with a 6x6 cm retroperitoneal mass). Treatment with two cycles of Ifosfamide-VP16 disclosed a partial chemosensitive disease. In October 2000, the patient was conditioned with BEAM and transplanted with 2.9×10^9 CD34+ G-CSF mobilized cells/kg, achieving a second complete remission. He also received pos-transplant radiotherapy to bulky sites. Five months later the patient noticed a left supraclavicular node. Immunohistological and image studies confirmed a CD20+ DLBCL isolated nodal relapse. He was treated with local RT and CHOP-Rituximab (2 cycles). Afterwards four additional doses of Rituximab and Prednisone alone, due to protracted cytopenias. In October 2001 the patient complained of abdominal pain. CT scan showed splenic and liver hilar lymph nodes with partial involvement of small intestine. Bone marrow was hypocellular and dysplastic without lymphoma; the cytogenetic study was normal. The patient received local radiotherapy and Rituximab-Prednisone (3 cycles). In January 2002 the patient was admitted with persistent fever, abdominal pain and weight loss. The CT scan showed a 1cm nodule in the spleen, a 4x5cm mass in the splenic hilum and another mass of 12x10 cm infiltrating the wall of the small intestine (Figures 1 and 2). A percutaneous fine needle aspiration and immunocytochemistry disclosed again DLBCL. After a brief response to a fourth line of chemotherapy with high-dose Methotrexate, Vincristine, Etoposide and prednisolone, with previously cryopreserved CD34 selected stem cell rescue, the patient died of disease progression four months later.



Figure 1.

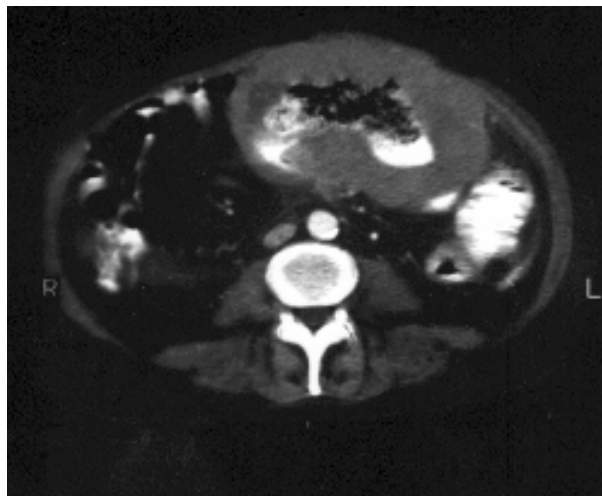


Figure 2.

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