

# A Small Bowel Stricture Revealing Intestinal Lymphoma, a Rare Presentation

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## BACKGROUND

- Primary non-Hodgkin's lymphoma (PNHL) of the gastrointestinal tract is rare.
- The most involved areas are the stomach, small intestine and ileocecal region.
- Diffuse large B-cell lymphoma (DLBCL) is the most common histological subtype of PNHL.
- Clinical presentation is non-specific and includes hematochezia, melena, abdominal pain, weight loss, nausea, vomiting, and symptoms of bowel obstruction.

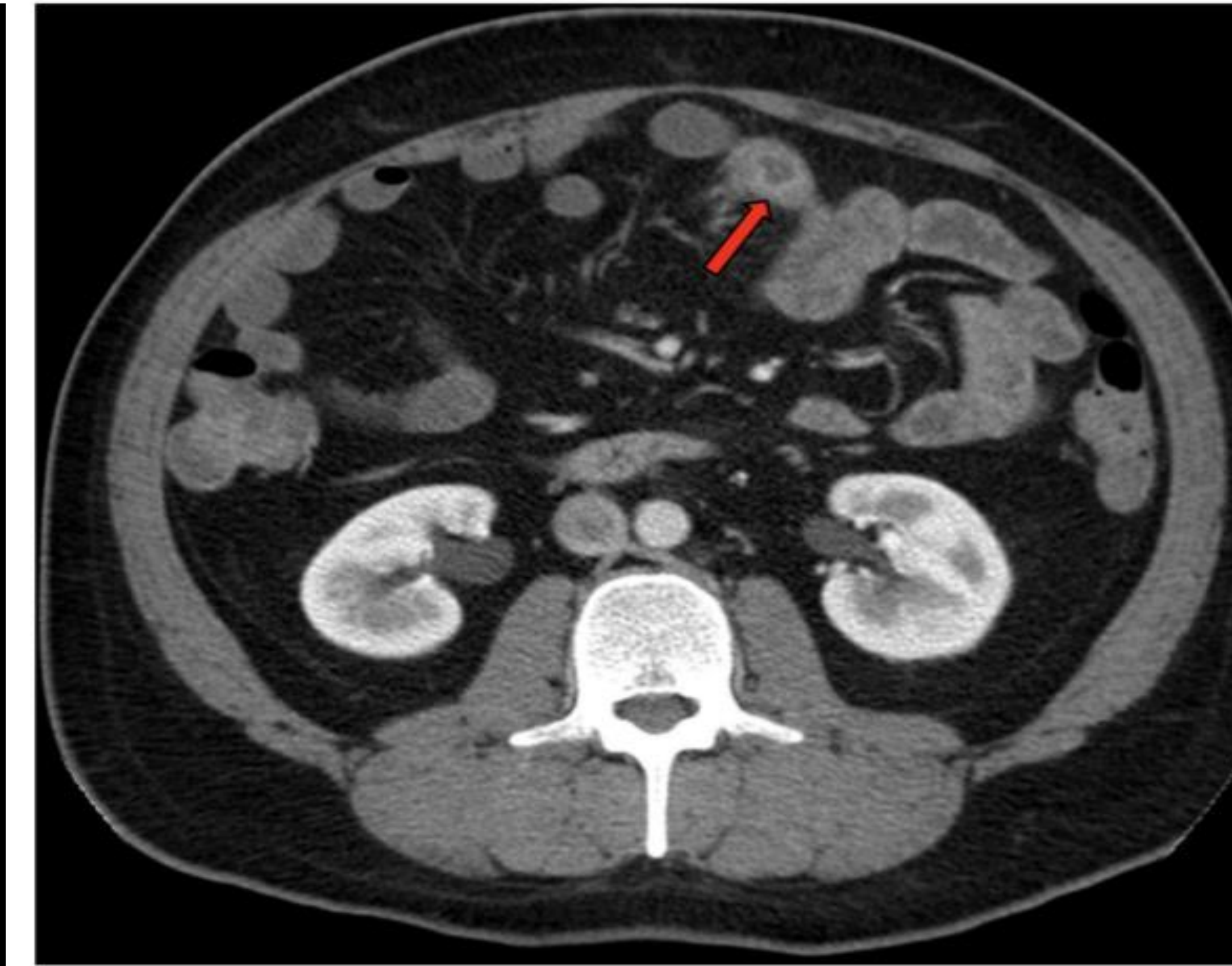
## CASE PRESENTATION

- 43-year-old male with a history of GERD, sarcoidosis (in remission), and hypertension presented with three months of periumbilical pain, a 30-pound weight loss and emesis.
- Prior outpatient workup including inflammatory bowel disease (IBD) serology, esophago-gastroduodenoscopy, and colonoscopy were unrevealing. Video capsule endoscopy (VCE) demonstrated localized inflammation in the ileum. The capsule was unable to pass beyond this point.
- Physical exam was notable for tenderness in the periumbilical area.
- Routine labs and chest radiograph were normal.
- CT abdomen/pelvis revealed a partial small bowel obstruction (image 1,3).
- SBE demonstrated congested mucosa in the proximal ileum, jejunal inflammation and gastritis. Biopsies showed nonspecific chronic inflammation of the ileum and jejunum.
- CT enterography showed a stricture in the mid-ileum (image 2,4). The capsule was lodged at the stricture (image 5) but later passed without intervention.
- ACE levels, calprotectin, and CEA were normal. Stool ova, parasites, and culture for enteric bacteria were negative.
- Small bowel resection with side-to-side anastomosis was performed. Pathology revealed DLBCL of the small bowel and the patient was started on chemotherapy.

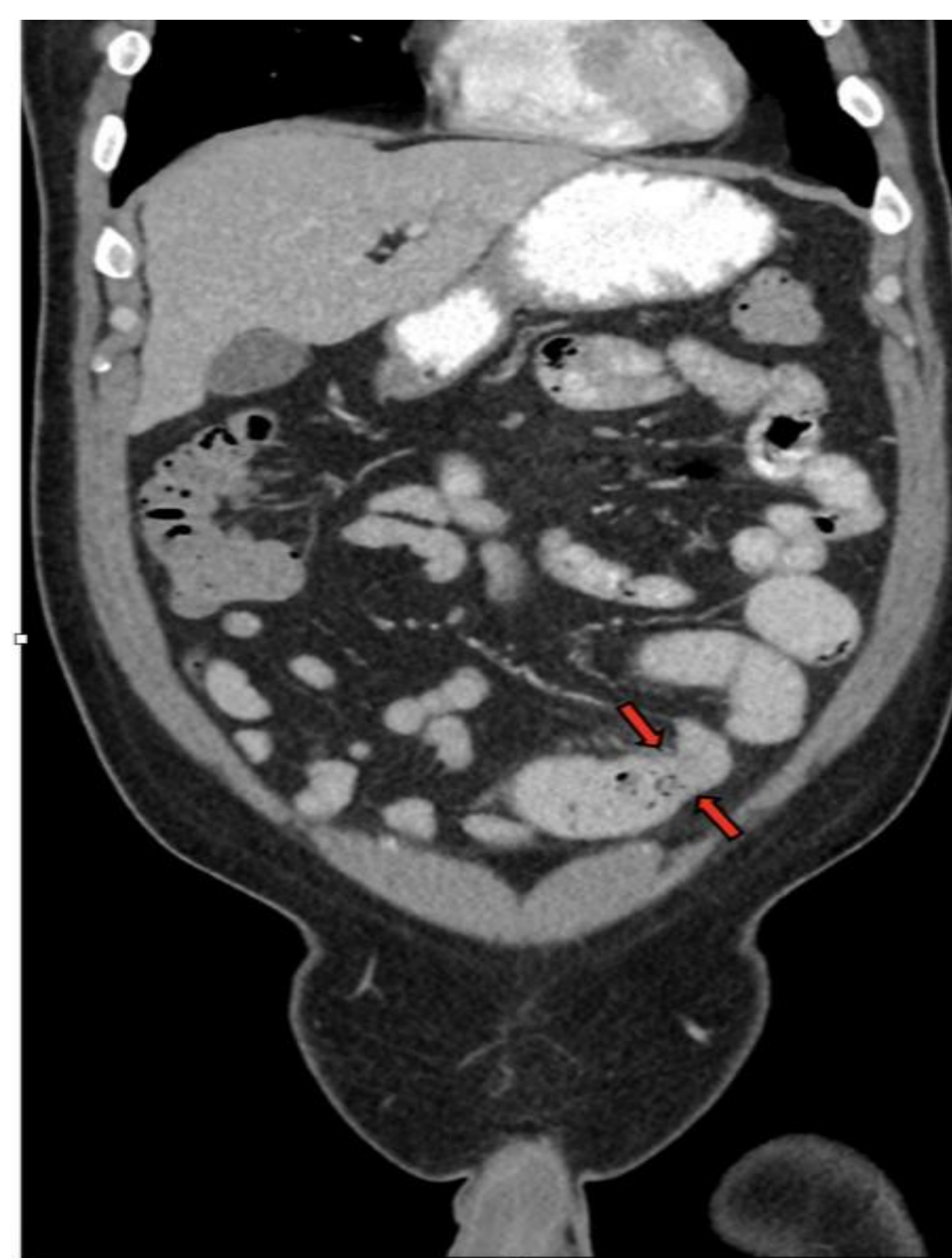
## RESULTS



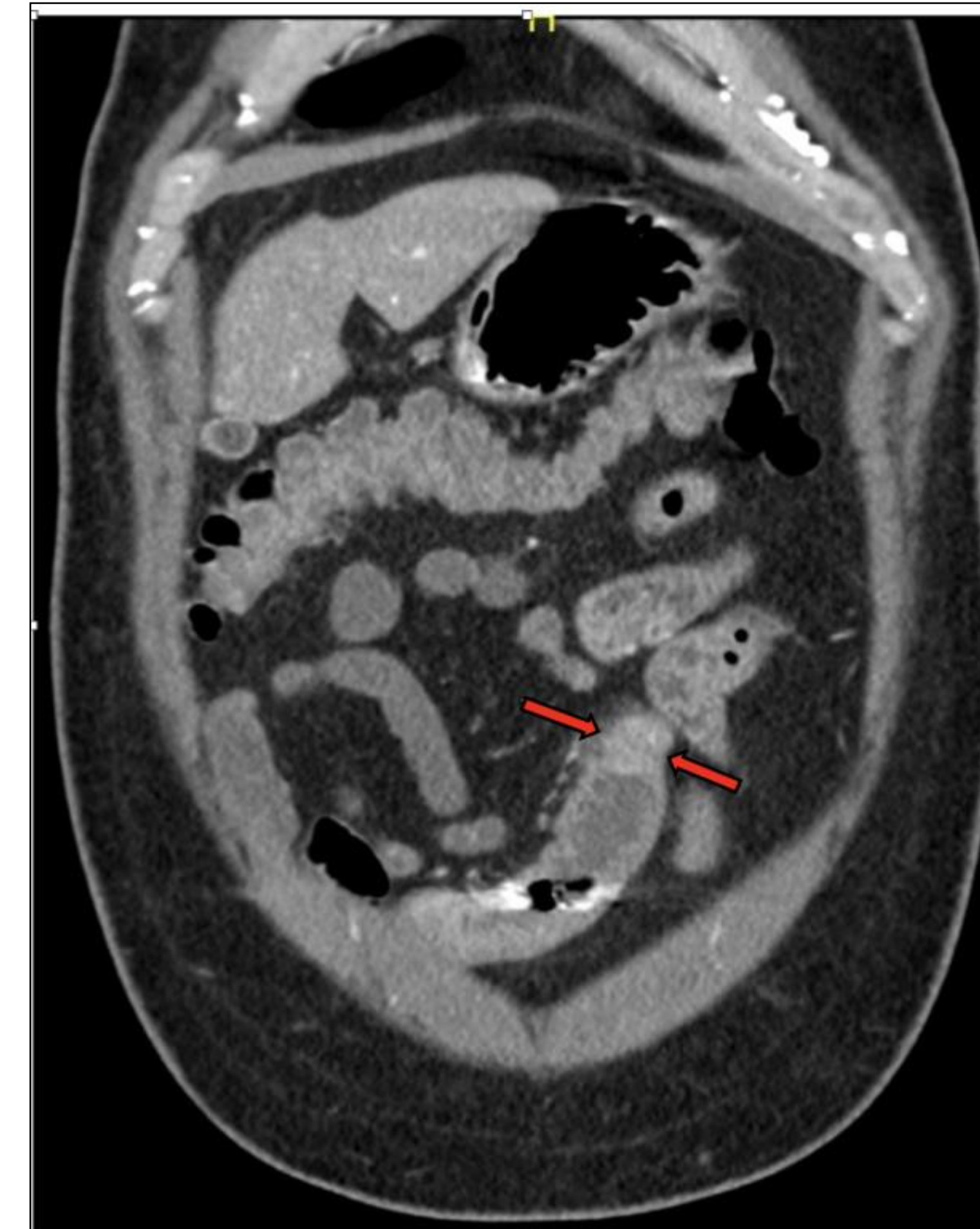
**Image 1: CT with positive oral contrast showing obstruction as indicated by the dilated loops of small bowel followed by collapsed bowel. Contrast material advanced past this point indicating the presence of partial obstruction.**



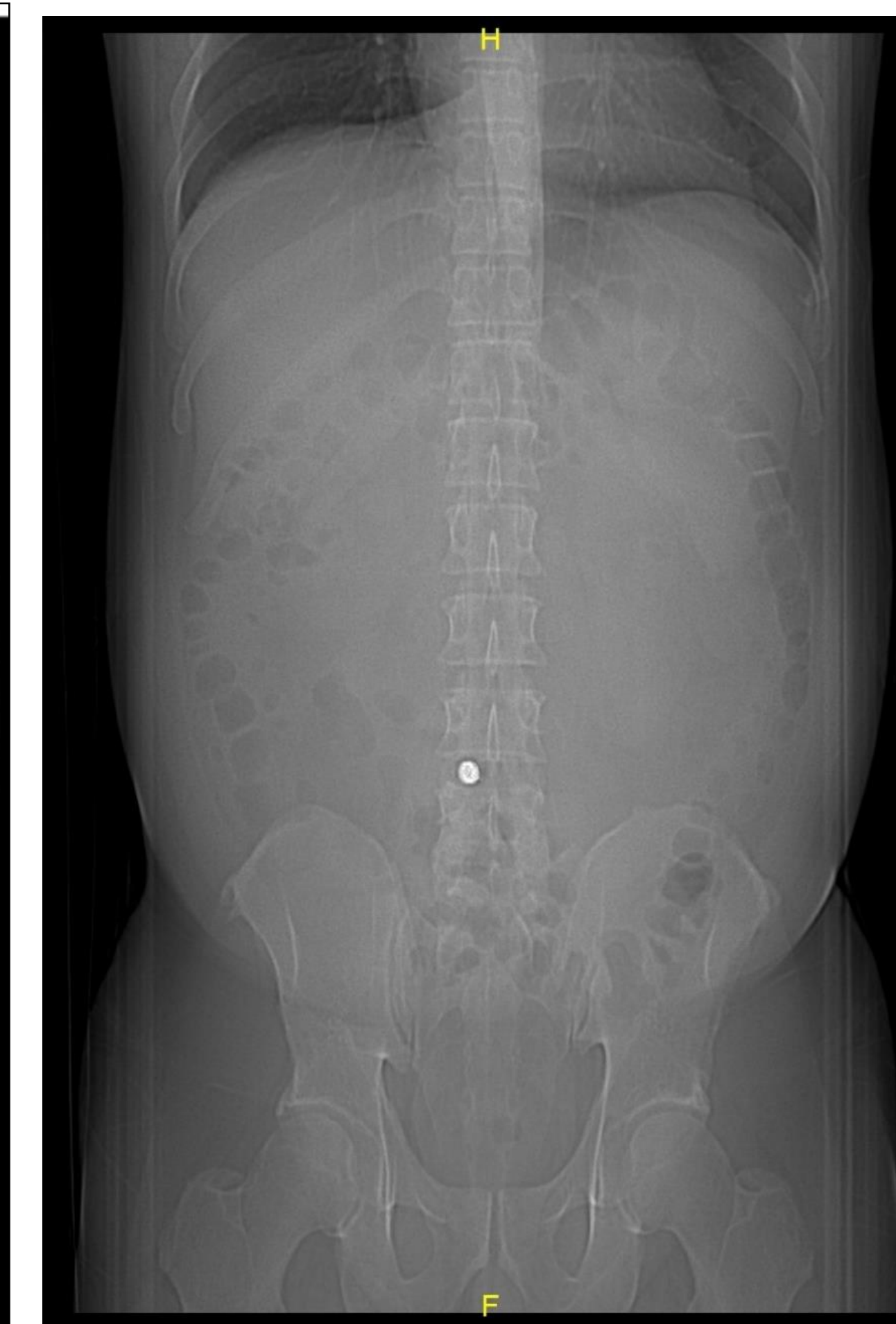
**Image 2: CT enterography showing mild hyperenhancement in the narrowed region (red arrow) with slight residual caliber change from prior CT study.**



**Image 3: CT with positive oral contrast showing wasting in the small bowel (red arrows).**



**Image 4: CT enterography showing mild hyperenhancement in the narrowed region (red arrows).**



**Image 5: CT in scout view showing lodged endoscopic capsule.**

## DISCUSSION

- A small bowel stricture raises suspicion of IBD.
- The stricture, in this case, was thought to be inflammatory given the lack of a bulky mass or lymphadenopathy and chronic inflammation on biopsies. However, the inflammatory workup for IBD was negative and sarcoidosis was stable, thus further evaluation was required.
- VCE and SBE with biopsies have improved the evaluation of small intestinal pathologies but were nondiagnostic in this case.
- CT enterography has a high spatial resolution for visualizing the small intestinal wall and surrounding structures, however, no enlarged suspicious lymph nodes or masses were identified in our case.
- Due to the patient's worsening clinical condition and lack of etiology of pathology, more invasive exploration and surgical intervention provided the definitive diagnosis.

## CONCLUSION

- Advanced imaging and endoscopic techniques are crucial in the workup of primary intestinal lymphoma.
- Lack of findings on imaging does not rule out primary intestinal lymphoma and persistent evaluation is necessary for this challenging diagnosis.

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