Primary Hepatic Diffuse Large B Cell Lymphoma Presenting As A Picture Of Acute Alcoholic Hepatitis

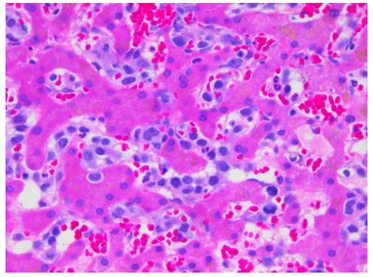
Dr. Nidhi Chintalapani, MD; Dr. Bryce Chavez, MD; Dr. John Grider, DO

EASTERN IDAHO REGIONAL MEDICAL CENTER

Introduction

- Diffuse large B cell lymphoma (DLBCL) is a prevalent subcategory of Non-Hodgkin lymphoma (NHL) comprising around 25% of all NHL occurrences. Generally, 60% of cases will present with Stage III/IV advanced disease vs 40% with localized disease. While DLBCL can arise from any tissue, 40% of cases will come from extranodal extramedullary tissue; most commonly the stomach or GI tract.
- Interestingly, primary hepatic lymphoma is exceedingly rare with a reported incidence of 0.4% of all extranodal NHL and 0.016% for all NHL. The presentation can be vague and a mimicker of other disease with symptoms such as abdominal pain, bloating, nausea, vomiting, and B symptoms.

Pathology



- A: Markedly atypical lymphoid infiltrate involving both the hepatic sinusoids and portal tracts. The lymphocytes are large with vesicular chromatin, prominent nucleoli, and fairly abundant mitotic activity

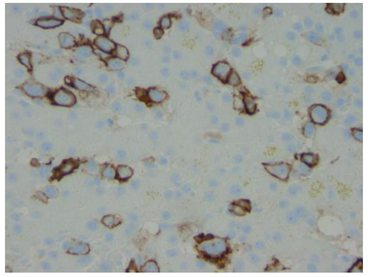
Case Description

- A 59-year-old female with no significant medical history presented for dizziness, fatigue, fever, shortness of breath, weight loss, night sweats, chills x1 month. She drinks 18 beers/week and is employed at a bar.
- Initially found to have thrombocytopenia, transaminitis (AST >ALT), hepatosplenomegaly, hypotension, normocytic anemia, latent hepatitis B, and a pulmonary embolism. Her hepatitis was thought to be secondary to alcoholic hepatitis. Her MELD was 12 and Maddrey discriminant function of -0.6.
- GI was consulted, further workup showed a past EBV and CMV infection. Quantiferon GOLD, HIV, mono, autoimmune and rheumatologic workup were negative.
- Ultimately a liver biopsy was positive for DLBCL. She was vaccinated for encapsulated organisms, treated for her Hepatitis B, and given R-EPOCH induction. She was transitioned to R-CHOP for consolidation, and ultimately had no evidence of FDG-avidity on PET scan with complete radiographic response to therapy. She was advised to have routine surveillance per NCCN guidelines.

Discussion

- Primary hepatic DLBCL is rare and not often diagnosed when a patient presents with acute hepatitis and known history of alcohol abuse. However, our patient had multiple B-symptoms concerning for lymphoma. The only way to definitively diagnose DLBCL is by liver biopsy with the prevailing management of EPOCH chemotherapy.
- Early diagnosis and initiation of treatment is crucial due to its poor prognosis and frequently advanced stage presentation. For this reason, a broad differential diagnosis must be considered when evaluating patients with alcoholic hepatitis.

Pathology



- Immunohistochemical stains are performed . The atypical lymphocytes react with CD20, PAX5, and coexpress BCL-2 (90%) and C-MYC (60%)

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