Hiding Mantle Cell Lymphoma

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BACKGROUND

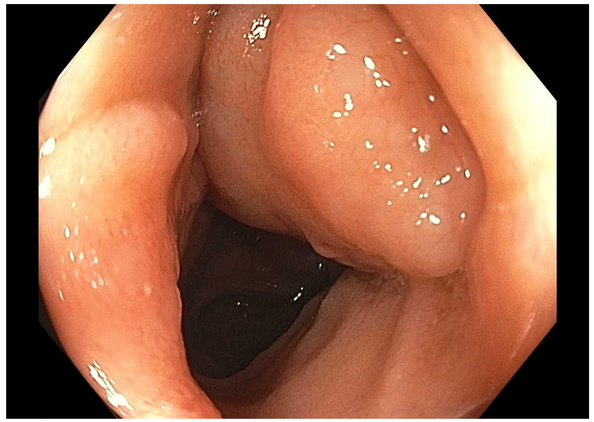
- Mantle cell lymphoma (MCL) is a subtype of mature B-cell Non-Hodgkin lymphoma.
- It comprises approximately 3-10% of non-Hodgkin Lymphomas and conventionally falls into a more aggressive nodal type and a more rare and indolent type with primarily splenic and leukemic involvement.
- Secondary involvement of the gastrointestinal tract is not uncommon, with 15-30% prevalence.
- Primary gastrointestinal MCL (without additional nodal or extranodal involvement) is rare and represents only 4-9% of all primary GI non-Hodgkin Lymphomas.

CASE REPORT

- 74 year old male with hypothyroidism and treated prostate cancer, was referred for unintentional 20 lb weight loss over 2 months as well as fatigue and dyspepsia.
- Complete blood count demonstrated peripheral eosinophilia with an absolute eosinophil count of 18,000 cells/mcL.
- Computed tomography (CT) showed a soft tissue lesion in the region of the cecum.
- Colonoscopy was performed and revealed a normal appearing cecum and ascending colon.
- Positron emission tomography (PET) was obtained to rule out malignancy-associated eosinophilia, which showed hypermetabolic activity at the ileocecal valve.
- The patient underwent a diagnostic laparoscopy which found no extraluminal masses in the colon, mesentery or omentum.
- Subsequent magnetic resonance enteroclysis (MRE) demonstrated a 2.7 cm pedunculated mass with regional adenopathy located at the lateral wall of the mid-ascending colon.
- Repeat colonoscopy was performed with ileal intubation and a 20mm subepithelial lesion was noted 2 cm proximal to the ileocecal valve (ICV).
- Biopsies were obtained, showing monomorphic lymphoid proliferation and destruction of the ileal architecture.
- Immunostains demonstrated CD20, bcl-2, cyclin D1 and SOX11 positivity. CD5, CD10 and bcl-6 were negative.
- Fluorescence in situ hybridization (FISH) was performed confirming t(11;14)(q13:q32) translocation consistent with MCL.
- Due to repeated imaging modalities showing stable disease for over a year, observation was recommended rather than radiation therapy (RT) which would not be curative and is usually reserved for symptomatic cases.
- Patient has been undergoing surveillance with CT every 6 months for his stage 2E CD-5 MCL since the time of diagnosis
- There has been no nodal progression, new extranodal disease or any new symptoms to suggest spread.

DISCUSSION

- Primary gastrointestinal MCL is a rare disease with a heterogeneous clinical presentation.
- Some symptoms may include anorexia, bloating or abdominal pain.
- Gastrointestinal MCL can be variable in appearance radiographically.
- Endoscopically, MCL can appear as normal mucosa, polypoid lesions or even ulcerated masses.
- In our patient, the assumption is that the mass, due to proximity to the ICV, periodically prolapsed into the cecum and ascending colon, resulting in the disparity between the radiographic and endoscopic findings.
- Repeat colonoscopy with ileal intubation was required to establish the diagnosis.



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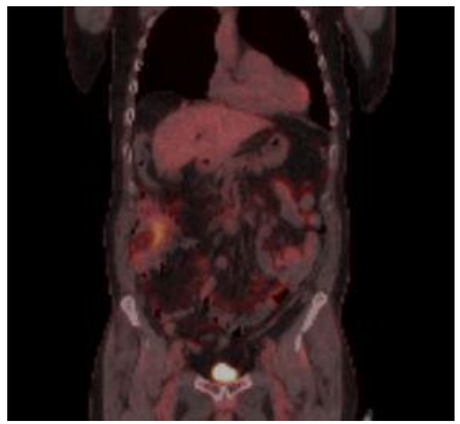

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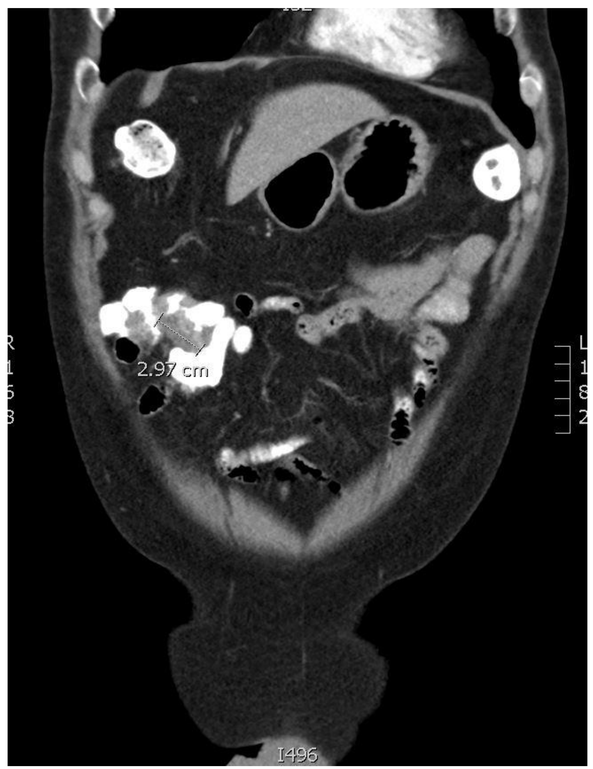

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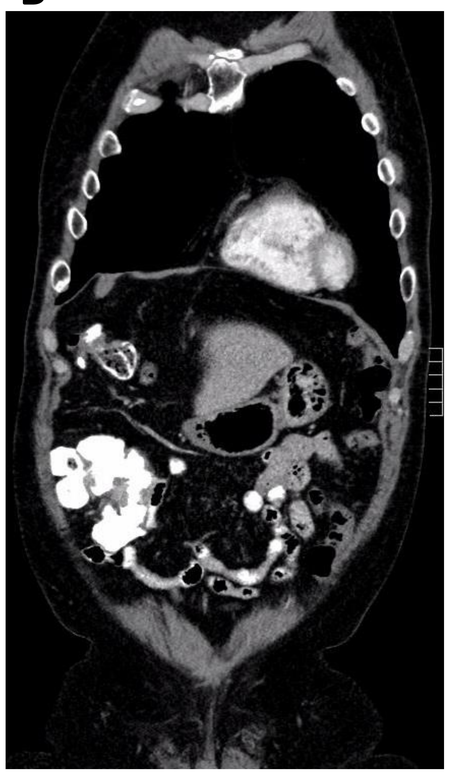

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A) Endoscopic image of terminal ileum mass. B) PET scan showing hypermetabolic activity at the ileocecal valve. C) and D) CT images showing pedunculated mass in mid-ascending colon.

References available upon request.