Extramedullary Plasmacytoma in the Stomach Presenting with Massive GI bleed

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Introduction

Multiple myeloma can rarely spread beyond the bone marrow and form an isolated plasmacytoma, which is a localized growth of plasma cells. We present a case of massive GI bleeding from a gastric plasmacytoma, a seldomly reported presentation for a plasmacytoma.

CASE

A 63 year old female with COPD, presented with shortness of breath, weakness, and melena for 3-5 days. She presented ill-appearing and was hypotensive with initial labs revealing hemoglobin of 5 and an elevated BUN/Cr of 40/0.77. She was resuscitated with massive transfusions, given proton pump inhibitors and after she was stable, she had an EGD which revealed a large ulcerative mass with stigmata of recent bleeding in the fundus. She later had CT which also demonstrated a mass lesion with wall thickening of the fundus. After her bleeding subsided, a repeat EGD with biopsies revealed a CD20+ and CD138+ kappa restricted extramedullary plasmacytoma negative for H.pylori. She later was referred to oncology, where she had a bone marrow biopsy, which demonstrated 80-90% with diffuse plasma cells infiltration, consistent with a diagnosis of multiple myeloma. She was to start chemotherapy, however, she elected to obtain a second opinion at a tertiary care center.

Endoscopy & Histopathology

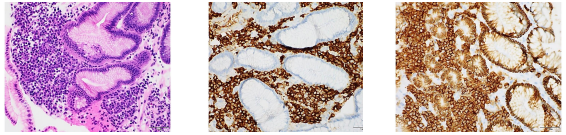

Fig 1: Gastric body H&E. Plasmacytoid infiltration. Fig 2. CD20+ FIg 3. CD138, Plasma Cell marker

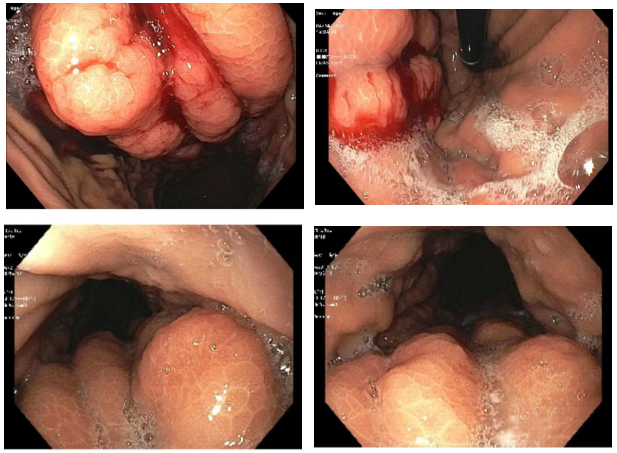

Fig 3. Endoscopic view, Gastric Body showing mass with friable hemorrhagic mucosa

DISCUSSION

Multiple Myeloma is the production of malignant plasma cells in the bone marrow. Extramedullary spread has a reported incidence of 6-20%, and it can happen either through direct skeletal invasion (more commonly) or hematogenous spread. Hematogenously, it can involve any organ but more commonly the liver, kidney, or brain, and very rarely the GI tract. Symptoms depend on the GI organ involved but usually include nausea, vomiting, early satiety, and weight loss. As in our patient, GI bleeding is extremely rare and has only been reported as case reports. Endoscopically, gastric plasmacytomas have been reported to appear as ulcerated or polypoid masses. For diagnosis, histopathology needs to reveal a plasma cell clonal population by staining for CD138, the hallmark marker for plasma cells. For primary gastric plasmacytomas that do not involve other organs or the bone marrow, surgical and radiotherapy should be attempted, and few case reports have demonstrated good 5-year mortality. However, as in our patient, who has multiple myeloma with the presence of bone marrow involvement, chemotherapy is the treatment of choice. We hope this case provides insight on GI bleeding from plasmacytomas and improves management for patients to come.

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