PRIMARY PANCREATIC DIFFUSE LARGE B CELL LYMPHOMA: A RARE AND TREATABLE MALIGNANCY

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Introduction

- Pancreatic lymphoma comprise less than 1 % of pancreatic malignancies.
- Most common location of diffuse large B cell lymphoma (DLBCL) are lymph nodes.
- In course of workup for pancreatic lesions clinical symptoms and imaging studies have significant similarity resulting in delayed diagnosis or early initiation of comfort care measures.
- It is important to determine the histology of pancreatic tumor given the differences in management and prognosis.
- Here we report a rare case of primary DLBCL arising from pancreas.

Case Description

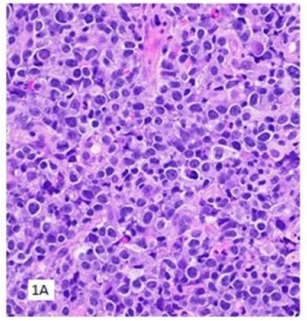
- 62-year-old female with history of HTN and DM presented with 30 lbs unintentional weight loss, epigastric abdominal pain and early satiety.

Clinical Course

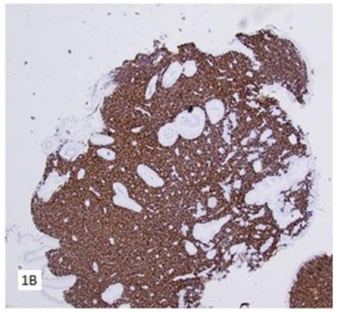
- CT abdomen with IV and oral contrast demonstrated pancreatic mass.
- Core biopsy of pancreatic head mass demonstrated infiltration by large atypical lymphoid cells with high N/C ratio, round nuclear contour, fine chromatin and variably prominent nucleoli (figure 1A).
- Atypical mitosis and apoptosis seen in background.
- Lymphoma cells positive for CD 19, CD 20 (figure 1B).
- Final diagnosis is diffuse large B cell lymphoma, germinal center type.
- FISH for BCL 2, C MYC were normal ruling out possibility of double or triple hit lymphoma.

Clinical Course

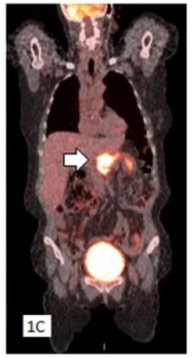
- Cancer antigen 19-9 at the time of diagnosis was within normal limits.
- FDG PET/CT prior to initiation of treatment showed main foci of increased tracer activity appears to be in the proximal body of the pancreas just medial to the stomach, measures greater than 4 cm in diameter, and has a maximum SUV of 11.86 (figure 1C).
- Rituximab- Cyclophosphamide HydrOxyadriamycin Prednisone (R-CHOP) every 3 weeks initiated.
- After one cycle of R-CHOP reported significant improvement in epigastric pain and started gaining weight.
- She completed 6 cycles of R-CHOP.
- Post treatment FDG PET/CT demonstracted complete resolution of upper abdominal lymph node mass (figure 1D).
- She remains in remission for the past 1 year.



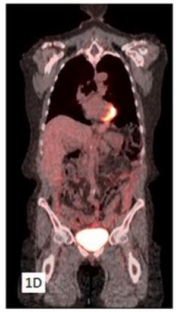
- Figure 1A: Core biopsy of pancreatic head mass demonstrated infiltration by large atypical lymphoid
- cells with high N/C ratio, round nuclear contour, fine chromatin and variably prominent nucleoli.



- Figure 1B: Lymphoma cells positive for CD 19, CD 20.



- Figure 1C: FDG PET/CT prior to initiation of treatment showed main foci of increased tracer activity appears to be in the proximal body of the pancreas just medial to the stomach, measures greater than 4 cm in diameter, and has a maximum SUV of 11.86.



- Figure 1D: Post treatment FDG PET/CT complete resolution of upper abdominal lymph node mass.

Discussion

- Our case is an example of successful biopsy and treatment with aim to cure pancreatic malignancy.
- Despite radiological differences between pancreas adenocarcinoma and lymphoma, it is crucial to obtain adequate tissue sampling from pancreas to establish histological diagnosis prior to discussion of prognosis and treatment plan.
- In general, DLBCL germinal center type has a 5-year survival of 70% with RCHOP.
- Differential diagnosis of pancreatic mass that confer better prognosis than adenocarcinoma include neuroendocrine tumor, solid pseudo papillary tumor and lymphoma.
- Therefore, it is important to obtain biopsy and direct therapy based on histology.