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A Rare Case Report of Primary Ileocecal Lymphoma

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ABSTRACT

Primary gastrointestinal lymphoma accounts for approximately 4% of all gastrointestinal malignancies, and colon involvement is extremely rare. Although imaging features are relatively characteristic, differential diagnosis can sometimes be difficult. Differential diagnosis is extremely important since its prognosis and treatment options are quite different from adenocarcinoma. Our case was followed up with a previous malignant melanoma and was admitted to our clinic with intra-abdominal lymphadenopathy. The images showed wall thickening in the ileocecal region that did not cause obstruction in the lumen, and the histopathological diagnosis was compatible with diffuse large B-cell lymphoma. First of all, a chemotherapeutic treatment protocol was applied to the patient, and rituximab was added due to progression during follow-up. However, the patient died due to lung infection. In this article, we aim to emphasize that lymphomas should be kept in mind as an important differential diagnosis from metastasis to bowel wall thickening seen in known primary cancer patients.

Keywords: Lymphoma, Malignant, Cecum, Tomography, Case Report.

INTRODUCTION

Lymphomas are split into as Hodgkin lymphoma and Non-Hodgkin lymphoma. Gastrointestinal tract is where the extranodal lymphoma is most widely seen [1]. Differential diagnosis of colorectal lymphoma is important because it is very rare among gastrointestinal lymphomas (GIL) and differs from other GILs in terms of clinical presentation, management and prognosis [2]. It presents with clinically nonspecific symptoms and imaging findings can be in very different spectrums.

Many of the GIL cases previously reported in the literature occurred as known lymphoma metastases. Isolated ileocecal lymphoma has been rarely reported in the literature, and our case is special because of the previous history of cancer and its primary appearance on follow-up imaging years later. This article allows us to demonstrate a case of primary ileocecal lymphoma who applied to our clinic as an example of the imaging findings of lymphoma.

CASE

A 72-year-old male patient, who was followed up for malignant melanoma in 2019, was referred to our clinic with a preliminary diagnosis of intra-

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abdominal lymphadenopathy (LAP). Abdominal CT showed 97x52 mm soft tissue mass in the cecum and iliocecal region (Figure 1). No narrowing of the lumen was detected in the ileocecal region (Figure 2). Asymmetric wall thickness was observed in the short segment of the ileal and right colon in the continuity of the lesion. Linear density increases and lymph nodes with a diameter of 9 mm were observed in the mesentery around the lesion. Between the lesion and adjacent bowel segments, the mid-fat plane could not be distinguished . Since its appearance is a full-thickness long bowel segment, it was first evaluated as ileocecal lymphoma and histopathological diagnosis was suggested. Diffuse large B-cell lymphoma was detected as a result of trucut biopsy of the cecum under the guidance of the ultrasonography. The patient was applied an appropriate lymphoma treatment protocol and was followed up regularly for intra-abdominal LAP. But the patient died after a while due to infectious reasons.

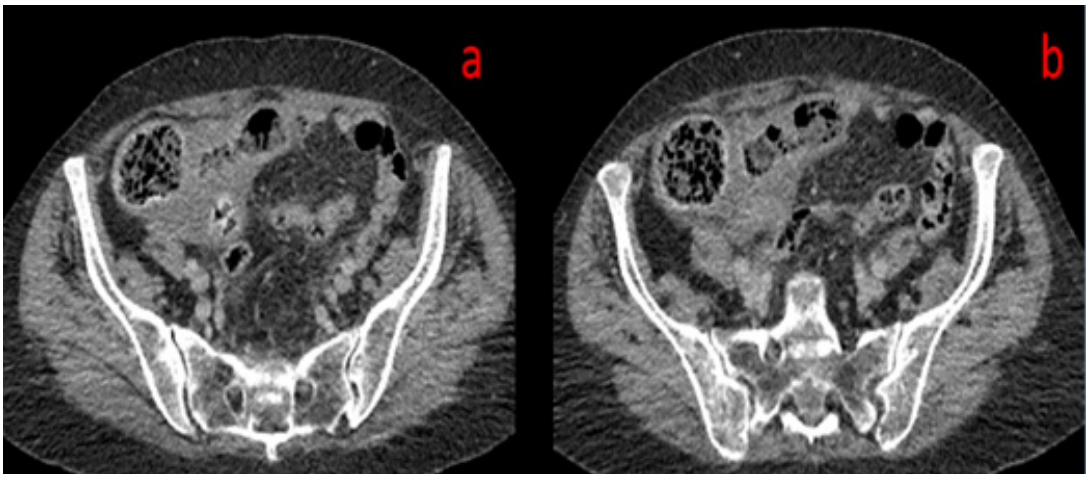

Figure 1. Tissue edema and tumoral formations at the level of ileocecal valve on axial abdominal CT images.

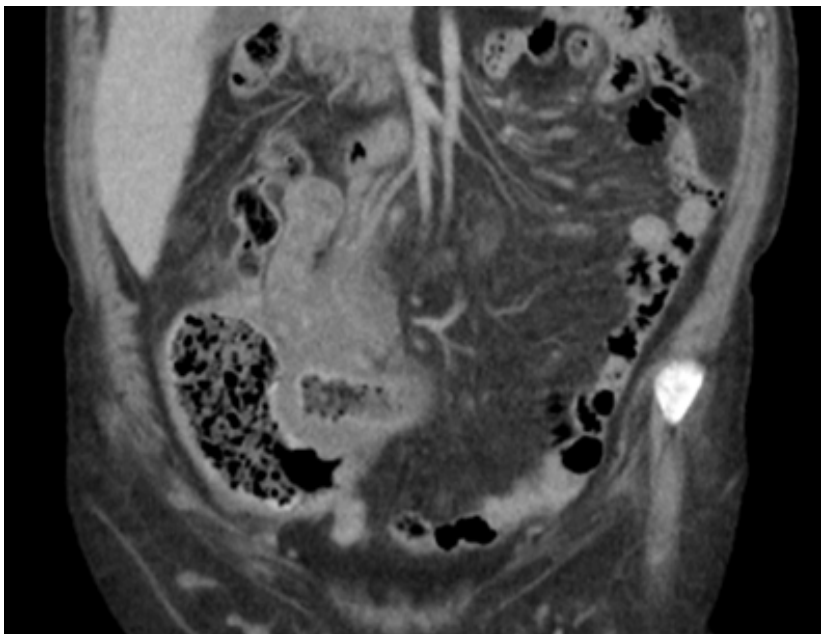

Figure 2. Long segment tumor involvement of the ileocecal valve that does not narrow the lumen in coronal abdominal CT sections.

DISCUSSION

Gastrointestinal tract is where the extranodal lymphoma is most widely seen (5-20%). Primary GIL is very rare and accounting for only 1-4% of all gastrointestinal malignancies [3]. The most common site of GIL is the stomach, and after that the small intestine (ileum (60-65%), jejunum (20%-25%), and duodenum (6-8%)), and then colorectal lymphomas (6-12%) [4]. Colorectal lymphoma is a very rare malignancy and constitutes <0.5% of primary colorectal malignancies, 1.5% of all lymphomas. The most commonly affected parts of the large intestine are the cecum and rectum [5].

The incidence of GIL increases with age and is most common in 40-60 years of age [6].

Diffuse large B-cell lymphoma is the most common subtype of colorectal lymphoma (~65%). Other rare subtypes include mucosa-associated lymphoid tissue (MALT) lymphoma and mantle cell lymphoma (MCL) [7].

The radiological imaging features of colorectal lymphoma are variable and may present in different radiological patterns that are quite similar to other tumors or inflammatory diseases of the colorectal region. These patterns include pseudoaneurysmal, polypoid, endoexoenteric, stenotic, and mesenteric forms. The pseudoaneurysmal form is the most common form of intestinal lymphoma. In this case, the tumor involves the submucosa and muscularis layers. There is mass-like wall thickening that can be extensive. Despite significant wall thickening, the lumen is preserved; in fact, there may be lumen enlargement (aneurysm enlargement) typically without obstruction [8,9]. Jasti et al. reported that lymphoma should be the primary considered diagnosis in the presence of invaded colonic segments those were characterized by peripheral thickening of the wall, including the thickness at the intestinal wall, with the absence of associated desmoplastic reaction on CT, as seen in our patient [8]. Meng Li et al. reported that diffuse wall thickening in a long segment was the most common pattern in a study conducted in 19 patients diagnosed with colorectal lymphoma in 2019, and lumen narrowing was not accompanied in the majority of these patients [10]. Similarly, our patient had long segment wall thickening that did not cause lumen narrowing. The role of CT is to evaluate the complications of the disease such as obstruction, fistulization and perforation, to detect local and/or distant organ metastases and lymph node invasion [9]. In our patient, there were no such complications and probably it was due to early diagnosis.

Although characteristic tumor morphology and imaging are beneficial for diagnosis, histopathological analysis persist in being the gold standard for diagnosis of GIL.

Proliferating aggressive lymphomas in our patient, the primary treatment was chemotherapy, not surgery. As stated in the study by Stanojevic et al., the CHOP chemotherapeutic regimen (cyclophosphamide, doxorubicin, vincristine and prednisone), which is the classical treatment protocol, was started [2]. As the patient progressed in follow-up, rituximab was added to his treatment. However, a year later, the patient died due to kidney failure following additional diseases and lung infection.

The strength of this case is that the patient has old abdominal images and primary ileocecal lymphoma was confirmed both by images and histopathology. The biggest limitation of this study is that the patient cannot be operated on due to his stage and therefore genetic and laboratory diagnostic studies cannot be performed.

The rarity of primary colorectal lymphomas causes the lack of a comprehensive study in this field in the literature. However, making a differential diagnosis is very important in determining the treatment protocol and follow-up methods. As in our case, it is very important for the treatment of the patient to carefully review and keep in mind the findings of gastrointestinal lymphoma before diagnosing metastasis in patients with known cancer. More comprehensive multicentric and multi patient studies are needed to guide differential diagnosis in this field.

CONCLUSION

Colorectal lymphomas are extremely rare malignant tumors with various clinical symptoms and imaging features. It should be kept in mind in the differential diagnosis of colonic masses with wall thickening.

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