Bilharzial Colitis Post-Autologous Stem Cell Transplantation in Non-Hodgkin Lymphoma Patient: A Case Report

Shaimaa El-Ashwah[1], Noreen Elbayoumi[1], May Denewer[1], Mohamed ELboghdady[1], Emad Azmy[1], Mohamed Mabed[1], Gehad Saleh[2], M. A. ElBaiomy[3], Maha Elzaafarany[3], Mohamed A. Ebrahim[3], Manal A. Salah-Eldin[3], Tawfik ElKhodary[3], Hayam Ghazy[3], Sameh Shamaa[3]

[1] Clinical Hematology Unit, [2] Radiology department, [3] Medical oncology unit, Faculty of Medicine, Mansoura University, Mansoura, Egypt

Background

Autologous hematopoietic stem cell transplantation (ASCT) is considered the standard of care in relapsed/refractory lymphoid malignancies. One major complication is the occurrence of infection, which is directly related to high doses of chemotherapy and the consequent major immunosuppression, breach of the mucous membrane barrier in the gastrointestinal tract, and line-related infections. The most common infection in post-transplant is bacterial, fungal or viral in nature [1].

Objective

This study is to present a case of bilharzial colitis post-ASCT for R/R Diffuse large B cell Lymphoma (DLBCL).

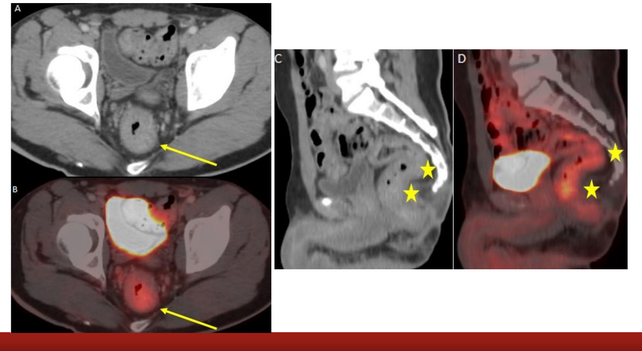
Patient

A case report which took place at Hematology and transplant unit /Oncology Center Mansoura University, Egypt, from May 2018 to till now.

Patient & Result

The patient was in overall good condition (ECOG performance status 0) and HCT-CI: 0 points. He received high-dose bendamustine/etoposide/cytarabine/melphalan chemotherapy and ASCT, a total of $8x10^6$/kg bodyweight CD34+ stem cells were administered on Day 0. ASCT procedure was complicated by left lower limb DVT treated by anticoagulant. Full engraftment on D+18. Follow-up FDG PET/CT on D+380 showed metabolically active circumferential mural thickening of the distal rectum (SUV 4) and multiple low metabolically active peri-rectal and presacral suspicious lymph node. The patient was referred for colonoscopic assessment for these newly developed lesions which revealed suspicious malignant rectosigmoid masses with multiple small sessile polyps, and abnormal mucosal patterns all over the colon. Colonic biopsy revealed snips of colonic mucosa, the lamina propria is widened by dead and living bilharzial ova and surrounding dense inflammatory cellular infiltrate formed of eosinophils and lymphoplasmacytic cells, this picture consistent with bilharzial colitis, no atypia or malignancy was detected. The patient started anti-bilharzial therapy and on follow up.

Axial post contrast CT and fused FDG-PET/CT images (A&B) revealed metabolically active asymmetrical circumferential mural thickening of the distal rectum(arrows) of maximum standardized uptake value [SUVmax] 4 with multiple mesorectal LNs of SUV max 3.3. Sagittal post contrast CT and fused FDG-PET/CT images (C & D) revealed similar metabolically active mural thickening along the rectum and recto-sigmoid region (asterisks)



Summary

Despite FDG PET/CT having a significant role in the hematological patients' management, positive lymph nodes and metabolically active masses require histologic assessment to avoid incorrect diagnosis.

Conclusion

ASCT plays a central role in the treatment of diverse diseases. Infection is one of the major causes of morbidity and costs of the procedure, representing the 2nd cause of death after primary disease.

References

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