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MANTLE CELL LYMPHOMA COEXISTING WITH INFLAMMATORY BOWEL DISEASE IN AN EGYPTIAN PATIENT. A CASE REPORT

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INTRODUCTION

Inflammatory bowel disease (IBD) with a subsequent diagnosis of non-Hodgkin's lymphoma has been reported. Gastrointestinal tract involvement in mantle cell lymphoma (MCL) is rare and many case reports of MCL simulating IBD have been reported. Lymphomas have been reported in association with chronic ulcerative colitis (UC). The prognosis of lymphoma in patients with IBD is not well known.

AIM

This is a case report of a patient with UC and unusual presentation for MCL, raising a suspicion *whether is this a coincidence or gastric lymphoma.*

CASE PRESENTATION

A 56-year-old male was referred to our center for evaluation of thrombocytopenia and microcytic hypochromic anemia with a history of prior bleeding per rectum.

Clinical examination revealed ecchymosis, mild splenomegaly, and a small right submandibular lymph node.

Colonoscopy showed diffuse mucosal erythema and edema of the transverse, descending, sigmoid colon, and rectum; ulcers showed loss of the vascular pattern. Extensive ulcerative colitis had a Mayo score 1. Multiple biopsies were taken, and a microscopic examination revealed mild focal active colitis with multiple hyperplastic lymphoid follicles and no evidence of cellular atypia in the examined material.

Gastroenterologist started the patient on corticosteroids.

INTERVENTIONS

Virology screening, ANA, anti-ds-DNA, and Helicobacter pylori stool antigen tests were negative. The patient had recurrent episodes of melena and persistent thrombocytopenia; so, he was shifted to eltrombopag. As for his UC, mesalazine 500mg bid and proton pump inhibitors (PPI) were prescribed.

On further evaluation, Lymph node biopsy was also consistent with MCL [Fig. 1 A, B & C] and bone marrow examination revealed infiltration with small B-cell lymphomatous deposits (49%) positive for CD20, CD5, and Cyclin D1: MCL [fig.1 D, E & F].

A suspicion that IBD could be an extranodal lymphomatous infiltration was raised; revision of the GIT pathology was consistent with UC and no malignancy was detected [fig.2].

RESULTS

The patient received R-CHOP/DHAP protocol and achieved complete remission (CR). Now he is on rituximab maintenance and regular follow-up with gastroenterology for the management of UC.

CONCLUSION

We must pay special attention to lymphomas occurring in IBD; exclusion of extranodal infiltration is mandatory for patient management.

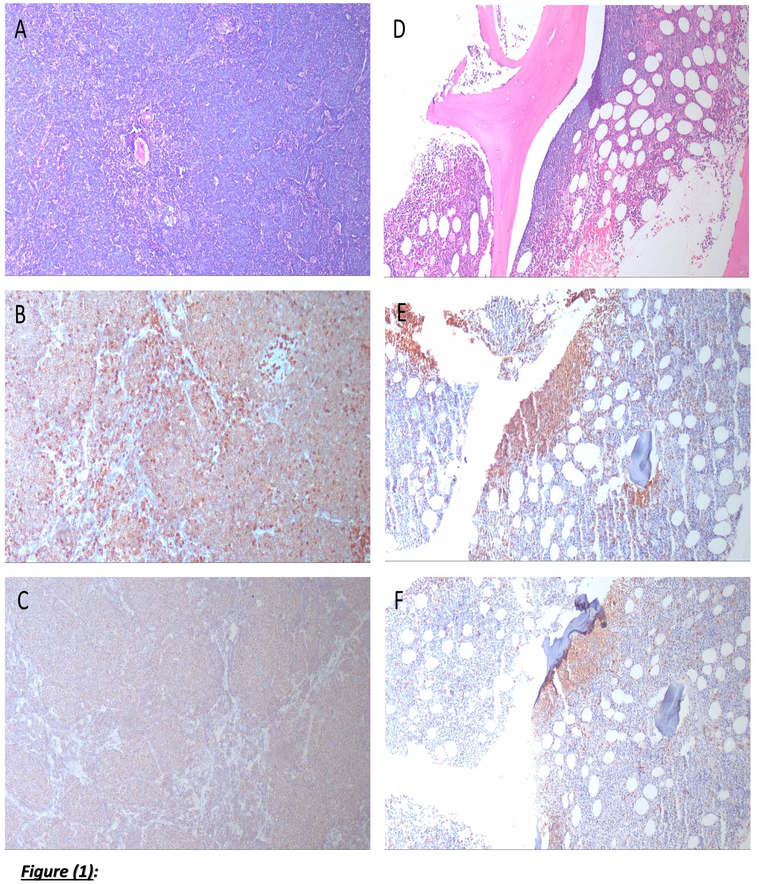


***Figure (1)*:**
Effaced nodal architecture with nodular proliferation of small-size lymphocytic cells (Figure A), diffusely positive for CD5 (Figure B) and CyclinD1 (Figure C).
Bone marrow biopsy positive for paratrabecular small-size lymphocytic cell deposits (Figure D), diffusely positive for CD5 (Figure E), and CyclinD1 (Figure F).

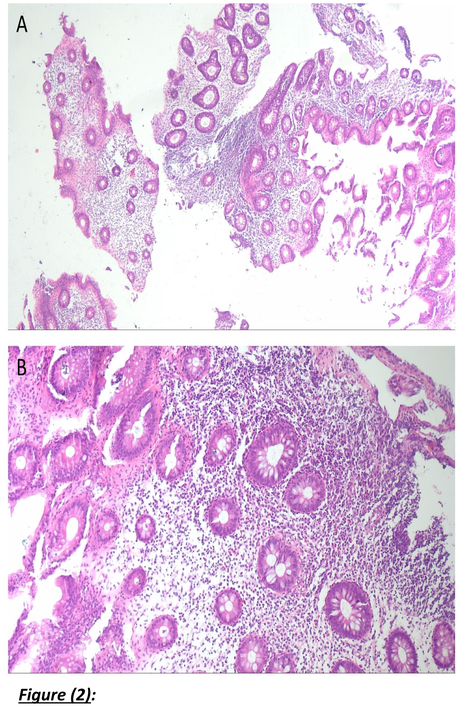


***Figure (2)*:**
Colonic biopsy representing moderate active ulcerative colitis under medical therapy with mild crypt architectural distortion (Figure A) and moderate cryptitis (Figure B).

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