Journal of the Postgraduate Institute of Medicine 2023; 10(1): E199 1-4

http://doi.org/10.4038/jpgim.8391

Case Report

Lymphadenopathy with colitis is a rare presentation of follicular lymphoma

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Key words: **ulcerative colitis, lymphoma colitis, non-Hodgkin lymphoma**

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Received: 03 Jun 2022, accepted revised version: 07 Jul 2022, Published: 16 Jan 2023

Competing Interests: Authors have declared that no competing interests exist

Introduction

Follicular lymphoma is a common subtype of non-Hodgkin lymphoma. There is uncontrolled proliferation of B cells which originate from the germinal centre and comprises up to 20% of all non-Hodgkin lymphomas. The Gastrointestinal tract (GIT) is the primary extra nodal site, and it may be a primary tumour or due to generalised lymphoma. [1,2] Most colorectal lymphomas are secondary to generalised lymphoma [1,3]. Approximately 40% of patients with lymphoma have extra nodal involvement, including the gastrointestinal tract (GI) and it represents 4 to 18% of cases of primary GI lymphoma or secondary GI manifestations of generalised lymphoma [4].The disease primarily affects males in their fifth to seventh decade of life [1,4].

Symptoms related to lymphoma vary according to the site of GI tract involvement. Lower intestine involvement is usually associated with diarrhoea or per rectal bleeding (90%), loss of weight (50%), abdominal pain (25%) and fever (10%). Endoscopy findings may resemble ulcerative colitis (55%), Crohn disease (20%) and multiple ulcers (5%). Colitis-like diffuse involvement is easily misdiagnosed and it should be suspected in cases of rapidly progressive colitis refractory to medical management [4].

We report a case of generalised follicular lymphoma with large bowel involvement simulating colitis. The rare presentation is highlighted to avoid misdiagnosis and failure of targeted treatment.

Case report

A 77-year-old retired development officer from Jaffna, a known patient with non-smoking chronic obstructive pulmonary disease (COPD), presented with loss of appetite and unintentional weight loss around 5kg of 4 month's duration. He had more than five

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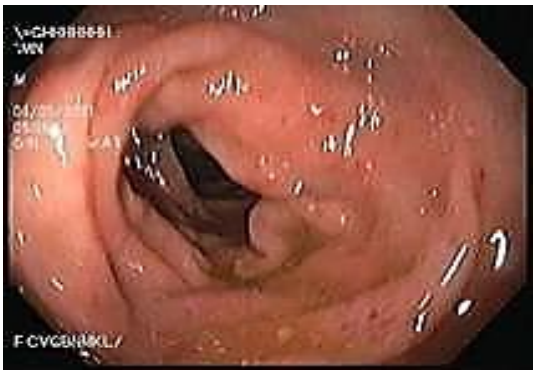
episodes of watery loose stool without blood and mucus in a two-week period that did not respond to fasting. He denied joint pain, oral ulcers and rashes and had no contact history of tuberculosis. He denied consuming alcohol. On further discussion, he denied recurrent admission with respiratory symptoms and diarrhoeal illness. He did not develop loose stools following dairy foods. He denied high risk sexual behaviour and intravenous drug abuse. He didn't have episodic flushing and wheezing. He had not undergone any bowel surgery or radiation therapy. He did not have a significant drug history.

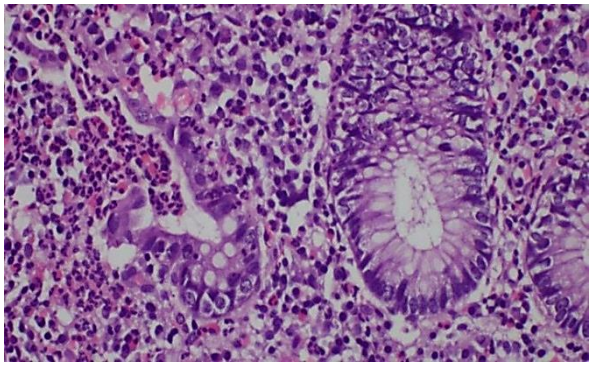
On examination, he was afebrile, emaciated and pale. There were multiple, tiny, non-tender cervical lymph nodes. He had no evidence of nutritional deficiency. Cardiac auscultation did not reveal right side heart valvular incompetent or stenosis. Respiratory and neurological examination findings were negative. His abdomen was soft and per rectal examination did not reveal anal tags. Sphincter tone was normal.

Diagnostic focus and assessment

His blood investigations showed a white cell count of 10700/mm^3 with a haemoglobin of 10.8g/dl with low MCV and a high normal platelet count. He had a normal CRP (10mg/l) with a high ESR value (55mm in the first hour). His liver enzymes were normal but he had low albumin (20g/l) and high globulin (45g/l). He had a mild elevation of LDH (294U/l) and uric acid (551 mmol/l). USS neck and abdomen showed left side, multiple, small, cervical lymph nodes (<1cm) in level I and IV area and multiple intra-abdominal lymph nodes at the level of para-aortic (2.4 cmx1. 6cm), mesenteric (2.6cmx1.3cm) and coeliac axis. Contrast CT of chest and abdomen revealed multiple intra-abdominal lymph nodes.



A. Colonoscopy appearance of colitis



B. Colonic biopsy view shows cryptitis and crypt abscess

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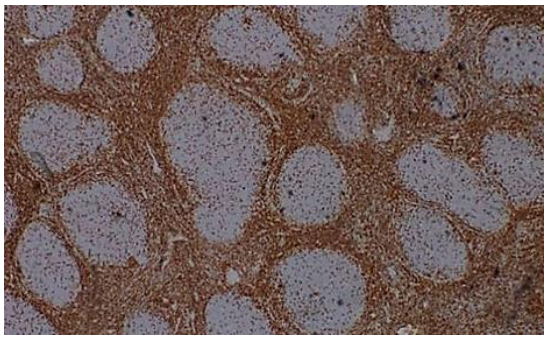	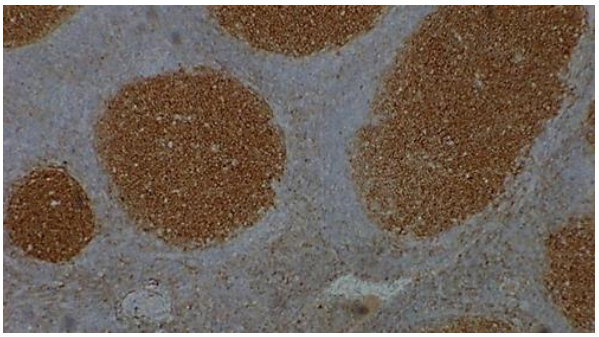
D. Lymph node biopsy CD3 positive	C. Lymph node biopsy CD 20 positive

Endoscopic and histological studies revealed ulcerative colitis like chronic colitis but it responded poorly to standard treatment. Meanwhile, his peripheral lymph nodes became progressively enlarged. He underwent an inguinal lymph node biopsy which revealed follicular lymphoma. The immunohistochemical study of a lymph node biopsy showed that both CD3 and CD20 were positive. Following discussion with a multidisciplinary team, including consultant physician, consultant gastroenterologist, histopathologist and oncologist he was given a diagnosis of generalized follicular lymphoma-associated colitis. He was then managed by the oncology team at Apeksha Hospital, Maharagama.

He received chemotherapy for three months and experienced symptomatic improvement. But unfortunately, he died as the result of acute coronary syndrome complicated by atrial fibrillation with a background of acute exacerbation of COPD.

Discussion

The most common site of extra nodal lymphoma is the gastrointestinal tract, and colorectal lymphoma represents between 10% and 20% of primary intestinal lymphomas. The diffuse involvement of colorectal lymphoma includes only a small proportion, and it mimics intestinal inflammatory disorders (IBD). In such contexts, it denominates as lymphomatous colitis. The time lapse between onset of symptoms to definitive diagnosis varies and is usually prolonged. But it is facilitated by nodal involvement. Diffuse lymphadenopathy is never observed in ulcerative colitis. However, cases of angio follicular lymph node hyperplasia have been reported to coexist with ulcerative colitis [5].Click or tap here to enter text.

Histological diagnosis of lymphomatous colitis is a challenge, especially if only small biopsy specimens are available and it simulates ulcerative colitis. Biopsy evidence of lymphocyte infiltration is seen in ulcerative colitis as well. However, immunohistochemical studies is used to verify cell origin and highlight the monoclonal proliferation of lymphocytes which is not observed in ulcerative colitis.

Despite multiple biopsies, detecting occult lymphoma with diffuse colonic involvement with no distinct mucosal alteration or mass lesion is challenging [6]. Lymph node excision biopsy is the preferred method for diagnosing non-Hodgkin lymphoma when lymph nodes are more than 2cm in single diameter or progressively increase in size and are persistently present for more than 4 to 6 weeks.

Most IBD-related lymphomas present late in the course of extensive [6,7]. Dawson's criteria are utilized to differentiate primary gastrointestinal lymphoma from secondary gastrointestinal manifestation of generalised lymphoma. They include the absence of peripheral lymphadenopathy at the time of presentation; no evidence of mediastinal lymphadenitis; normal peripheral differential white blood cell count; predominant bowel lesion with adjacent lymphadenopathy and no hepatosplenomegaly [1,4].

The prognosis for secondary gastrointestinal lymphoma is lower than for primary gastrointestinal lymphoma and it is further reduced by perforation, bleeding and obstruction [7].

Conclusion

Primary colorectal lymphoma or secondary GI manifestation of generalized lymphoma may masquerade as ulcerative colitis and is termed lymphomatous colitis. In such clinical presentations, it is crucial to come to a definitive diagnosis as it will change the prognosis and management as we encountered in this case of lymphomatous colitis.

Informed consent

Informed consent was obtained from the patient

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