CASE REPORT

Al Ameen J Med Sci (2010)3(1):88-90
ISSN 0974-1143

Non – Hodgkin's Lymphoma of Colon: An Unusual Presentation.

Sajid Ahamed Mudhol*, Sadhashivappa S. Bedar, Sushila P .Garag and Faizal Hammed N.

Department of Surgery, Al Ameen Medical College, Bijapur-586108,Karnataka, India

Abstract: Non Hodgkin's lymphomas are a diverse group of cancer which arises from lymphocytes. NHL of colon is rare and consequently extranodal lymphomas are poorly studied. The gastrointestinal tract is the predominant site of extranodal NHL. It accounts for about one third of all the primary extranodal NHL.

Key words: Non – Hodgkin's Lymphoma of Colon, Ileocaecal intussusceptions.

Introduction

Colon is an uncommon site of involvement in NHL. It accounts for about one third of all the primary extranodal NHL [1]. The GIT is most frequently involved site accounting 30% – 40% of all extranodal NHL, out of which only 6%-14% are reported from colon [2]. Lymphomas appear to arise from the B- cells of the gut, "Mucous- associated lymphoid tissue" (MALT). Since all the gut lymphoid tissue is mucosal and submucosal, early lesions appear as plaques like expansion of the mucosa and submucosal [3]. The most common symptom of colonic lymphoma are abdominal pain and weight loss with a palpable abdominal mass identified on physical examination in half the patients. Most common sites of involvement are ileocaecal region and caecum. We report a patient with an initial diagnosis of subacute intestinal obstruction, presented with mass abdomen with Ileocaecal intussusception who latter appeared to have Non Hodgkin's lymphoma of the colon.

Case History

A 48 year old female patient was hospitalized with one day history of pain abdomen and vomiting. H/O pain in the epigastric region. No H/O aggravating factors and radiation of pain. H/O constipation for 4 days and abdomen distension for one day. General condition of the patient was good, afebrile, PR – 76/ min and regular, BP – 100/80mm Hg, RR – 16 / min, CVS and RS was normal. Per abdomen there was distension and tenderness over the epigastrium and right hypochondrium. No mass was palpable, no organomegaly, bowel sounds were hyperperistaltic. Haemogram was normal except for an increase in the total count (11,300 cells/ cu mm). Blood glucose levels, renal and liver function tests were within normal limits. USG abdomen showed Cholelithiasis and a left side renal calculus (incidental finding); little collection in the pouch of Douglas was also seen. CT abdomen with Barium enema was done which revealed an Ileocaecal intussusception, so patient was taken up for laparotomy. Laparotomy revealed an Ileocaecal intussusception, with a caecal

mass, with multiple enlarged mesenteric lymph nodes. Right hemicolectomy done with an end to end Ileo-transverse anastamosis. Specimen was sent for HPR, which showed the mass to be Non – Hodgkin's lymphoma. Patient recovered well post operatively .Patient received chemotherapy latter.

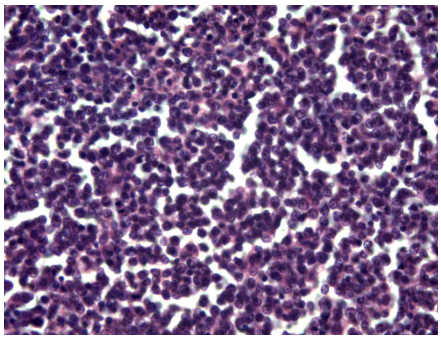

Fig 1 Histopathology photograph showing features of Non-Hodgkin's lymphoma

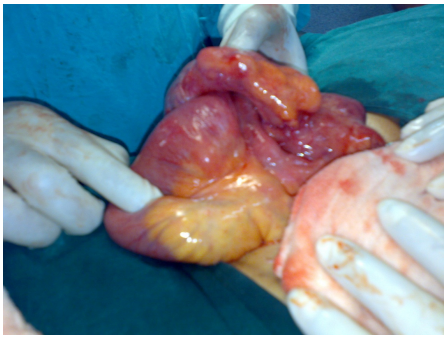

Fig 2. Intraoperative photograph showing ileocaecal intussusception

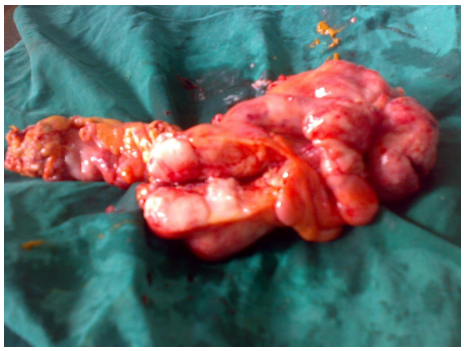

Fig 3. Photograph of the right hemicolectomy specimen showing cut section of the tumor

Discussion

The colon is an uncommon site of involvement of NHL. The most common symptom of colonic lymphoma is abdominal pain and weight loss with a palpable mass identified on physical examination. Primary GI NHL is commoner among males than females [1]. The most common site of involvement being the ileocaecal region and caecum, probably because of more lymphoid tissue present normally in the ileocaecal region than any other part of the colon [4]. The lack of specific complaints probably accounts for the delay in the diagnosis. Primary colonic lymphomas usually presents between the fourth and seventh decade of life. The radiographic findings on barium enema show a spectrum of changes that include an intramural mass, mucosal nodularity, endo or exocentric mass, mural infiltration and apthous lesions. Our patient presented with a very rare presentation, ileocaecal intussusception. Colonoscopy commonly discloses a large solitary mass suggesting a malignant tumor with mucosal ulcerations. In the rare cases of disease localized to the colon, surgical excision is the treatment of choice, whereas in the majority of cases of disseminated

disease, radiotherapy or chemotherapy is performed[5]. The best treatment for GI lymphomas of any location remains uncertain. Most authors recommend laparotomy and tumor resection. Surgery (a) provides important prognostic information including histology, tumor extent and stage; (b) may offer a chance for cure with or without adjuvant therapy; and (c) prevents complications such as hemorrhage, obstruction or perforation which may occur spontaneously. Post operative complications such as combination chemotherapy should be administered to prevent local or systemic relapse [4]. Our patient underwent Right hemicolectomy with an Ileo-transverse end to end anastamosis. The time course of our patient's disease before the diagnosis of lymphoma of colon was too short to fit a sequence of any other malignant condition. We therefore conclude that our patient presented with a very rare symptom, ileocaecal intussusception.

References

1 Fatin M. Al-Sayes. Gastrointestinal Non-Hodgkin's lymphoma: A clinico- pathological study. The Saudi journal of gastroenterology 2006 12(3):118-122.

2. Osnat Bairey M.D, Rosa Ruchlemer M.D and Ofer Shpilberg M.D M.P.H. Non-Hodgkin's lymphoma of colon. IMAJ 2006 vol 8 832-35.

3. James M. Crawford, The gastrointestinal tract, Pathology basis of disease.6th edition, Saunders publishers, 837.

4. Jaime Zighelboim, M.D., Mark V. Larson, M.D. Primary Colonic Lymphoma: Clinical presentation, Histopathologic features, and outcome with Combination Chemotherapy. J clin gastroenterol 1994; 18(4)291-7.

5. Yoram Maaravi, M.D., Dov Wengrower, M.D., and Gil Leibowitz, M.D. A Unique Presentation of Lymphoma of the Colon. J clin gastroenterol 1993;17(1) 49-51.

All correspondence to: Dr.Sajid A Mudhol, Associate Professor of Surgery, Al Ameen Medical College & Hospital, Bijapur586108, Karnataka, India. Email: sajidmudhol@indiatimes.com

