



Systemic multiple myeloma and colonic abnormalities

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A 72-year-old woman who presented with weight loss, arthralgias, thrombocytopenia, and anemia was diagnosed with multiple myeloma, confirmed by serum tests, immunofixation, and a bone marrow biopsy. In addition, because she had abdominal pain and loose stools, a colonoscopy was performed. Examination disclosed multiple ulcerated and umbilicated tumorous lesions throughout the colon, with morphology similar to subepithelial lesions (SELS) with ulcerations (Figs. 1-3). Bite-on-bite biopsy specimens were taken to obtain a submucosal component of the lesion. Biopsy specimens of colonic abnormalities were taken, and histopathology revealed infiltration of large lymphoid cells, expressing CD20, Bcl2, and high mitotic activity (Ki67 ~60%) (Figs. 4-6). PanCK and S100 staining were negative and ruled out neoplasm with epithelial origin and melanoma. No extracolonic lesions could be found on EGD, CT, or positron emission tomography scans. Infectious diseases, including HIV, were ruled out. A diagnosis of diffuse large B-cell lymphoma (DLBCL) limited to the colon was made based on positive staining for CD20 and Bcl2. The patient was treated for multiple myeloma and DLBCL with bortezomib, cyclophosphamide, thalidomide, and dexamethasone, followed by darbepoetin administration for the anemia. After 6 months of systemic treatment, the patient negated clinical symptoms, and a surveillance colonoscopy showed complete resolution of all lesions (Video 1, available online at www.videogie.org).

Although the GI tract is the leading extranodal location for DLBCL,¹ the large intestine is rarely invaded

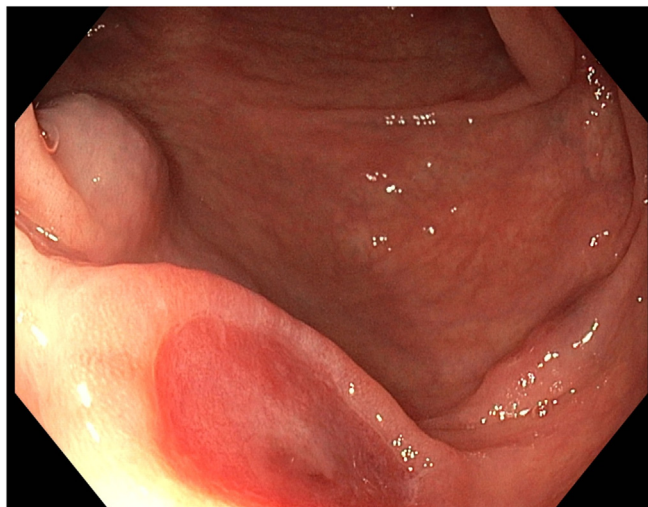


Figure 1. Endoscopic view of colon and lesion.

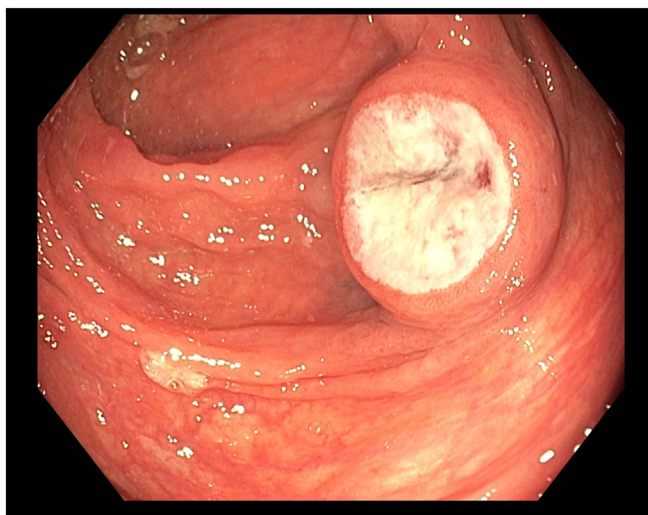


Figure 2. Endoscopic view of colon and lesion.

Abbreviations: DLBCL, diffuse large B-cell lymphoma; SEL, subepithelial lesion.

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(3% of cases). If affected, lesions appear focally, involving selected parts rather than the entire colon.² Clinical manifestations of colonic DLBCL are nonspecific. Endoscopically, lymphoma appears mainly as fungating and ulcerofungating, rather than ulcerative, infiltrative, ulcerofungating, or another ulcer infiltrative type.^{1,2} In our case, lesions were

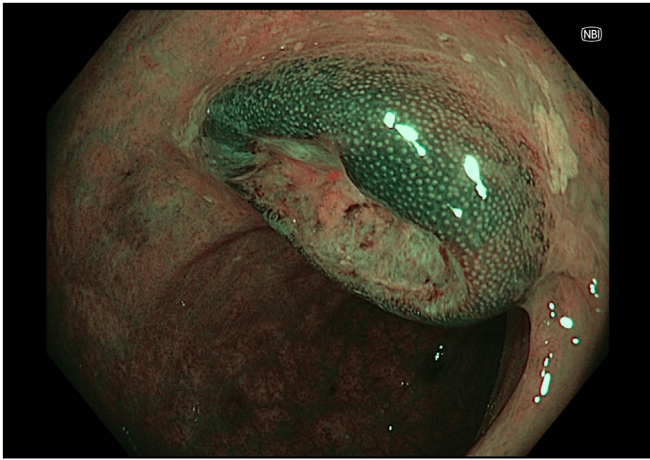


Figure 3. Endoscopic view of the lesion under narrow-band imaging.

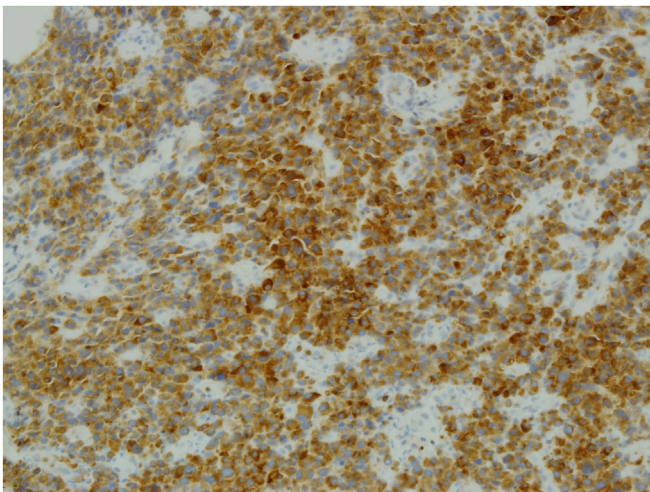


Figure 4. Bcl20; histochemical staining of biopsy samples (Bcl 2 immunohistochemical staining, orig. mag. $\times 200$).

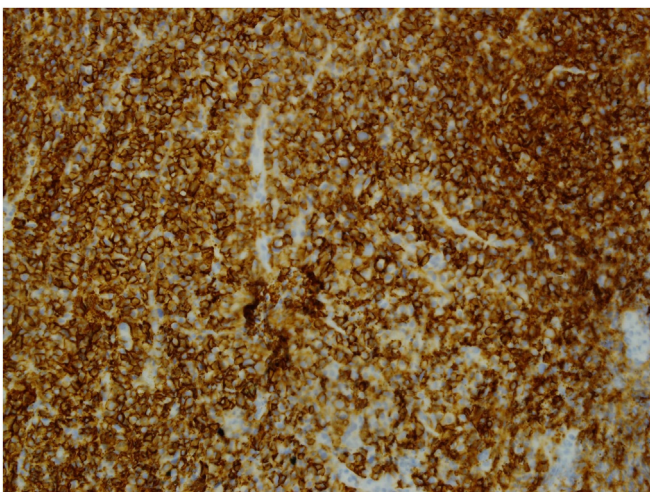


Figure 5. CD20; histochemical staining of biopsy samples.

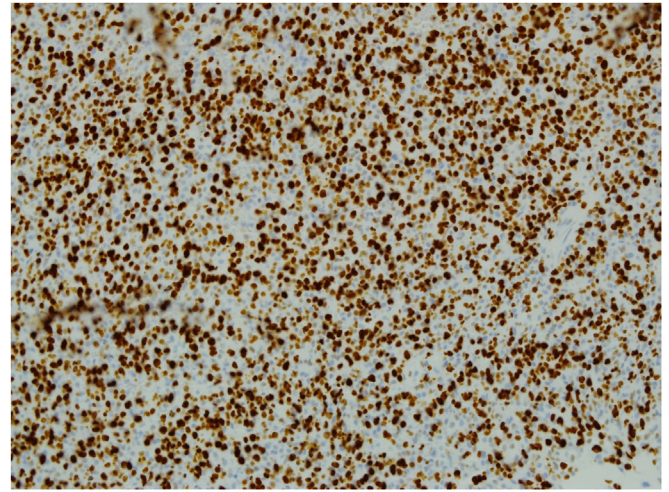


Figure 6. Ki67 60%; histochemical staining of biopsy samples.

mainly SEL-like with ulcerations on the surface, similar to GI tumors or schwannomas.^{3,4} Also, there was no polyp-like pattern in narrow-band imaging, or other common features.

The simultaneous occurrence of DLBCL and multiple myeloma is rare, and hematological neoplasms typically develop secondary to multiple myeloma.³ Mature B-cell neoplasms are the most common among all lymphomas.³ Given this, as well as the poorer prognosis of multiple myeloma with coexisting DLBCL,⁵ in-depth diagnostics should be provided in the case of GI tract manifestation.

DISCLOSURE

The authors did not disclose any financial relationships.

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