Non-Hodgkin's Lymphoma: An Important Differential Diagnosis in Inflammatory Bowel Disease

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To the Editor: The gastrointestinal tract (GIT) is the most common extranodal location of non-Hodgkin's lymphoma, but it represents only 0.4% of primary colonic malignancies.[1] Symptoms are nonspecific and may include diarrhea, constipation, abdominal pain, weight loss, and gastrointestinal bleeding. In colon, the most common types are conventional large cell lymphoma, mucosa-associated lymphoid tissue lymphoma, and T-cell lymphoma.[1-3]

The inflammatory bowel disease (IBD) diagnosis can be a challenging once several conditions can mimic its symptomatology, such as malignant lymphomas, hematopoietic neoplasms, and infections.[4,5]

A 35-year-old woman was admitted to our hospital in 2013 with intense abdominal pain on the left side, bloody diarrhea (5–6 times/day), and weight loss of 19 kg for 3 months. The colonoscopy showed a stenotic and ulcerated lesion of 4 cm × 8 cm in colon descendant, with fibrotic characteristics, not permeable to the endoscope with a fistulous hole. Histopathological examination showed the ulcer margin permeated by neutrophilic exudate and fibrin and cellular debris, with moderate architectural changes and absence of neoplastic.

The patient was diagnosed as having an ileum-colonic Crohn's disease with intestinal fistula and malnutrition. She received nutritional support, ciprofloxacin, corticosteroids, and azathioprine (2 $mg \cdot kg^{-1} \cdot d^{-1}$). After 14 days of hospitalization, she had a significant clinical improvement and weight gain and was discharged. Twenty-five days later, the patient returned to the hospital with severe abdominal pain. Computed tomography showed a fluid collection in the left flank, high-output fistula, and dilation of the proximal colon. The patient underwent urgency laparotomy that showed large amounts of purulent fluid in the cavity, small bowel edema, fistula between jejunum and colon descendant, and obstructive lesion in colon descendant and perforation adjacent to the fistula. It was performed a bowel resection, segmental colectomy, and Hartmann's colostomy. After surgery, the patient developed septic shock and acute renal failure followed by death.

Pathological examination of the biopsy specimens showed a poorly differentiated malignant neoplasm [Figure 1]. The immunohistochemical study demonstrated cells positive for cluster of differentiation 45 (CD45, the histogenesis of lymphoid neoplastic), CD20, and high proliferation index (Ki67). These findings indicate the diagnosis of diffuse large B cell lymphoma (DLBCL, OMS-2008).[4]

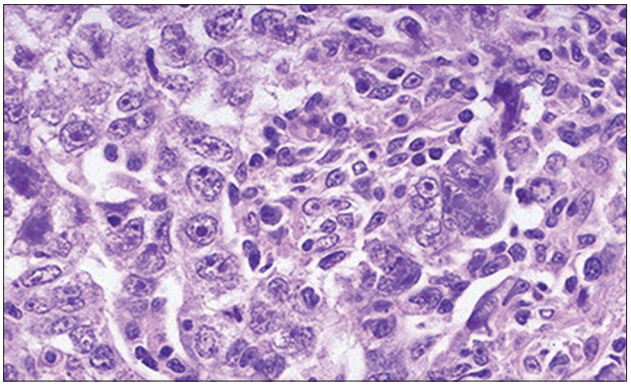

Figure 1: Hematoxylin and eosin staining of poorly differentiated malignant neoplasm (Original magnification ×200).

This case exposed the rapid evolution of DLBCL, culminating in the death of the patient. GIT lymphomas do not represent, in many cases, a simple diagnosis, either for a clinician or for a pathologist,[5] especially in the context of differential diagnosis of IBD. Although GIT lymphomas are rare, they must be considered in the differential diagnosis of IBD.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given her consent for her images and other clinical information to be reported in the journal. The patient understands that her name and initials will not

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Access this article online

Quick Response Code:

Website: www.cmj.org

DOI: 10.4103/0366-6999.232794

Received: 19-03-2018 **Edited by:** Peng Lyu
How to cite this article: Saad-Hossne R, De Sibia CD, Baima JP, Sassaki LY. Non-Hodgkin's Lymphoma: An Important Differential Diagnosis in Inflammatory Bowel Disease. Chin Med J 2018;131:1377-8.

be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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