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【 PICTURES IN CLINICAL MEDICINE 】

Mantle Cell Lymphoma with Multiple Lymphomatous Polyposis

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Key words: mantle cell lymphoma, multiple lymphomatous polyposis, gastrointestinal lymphoma

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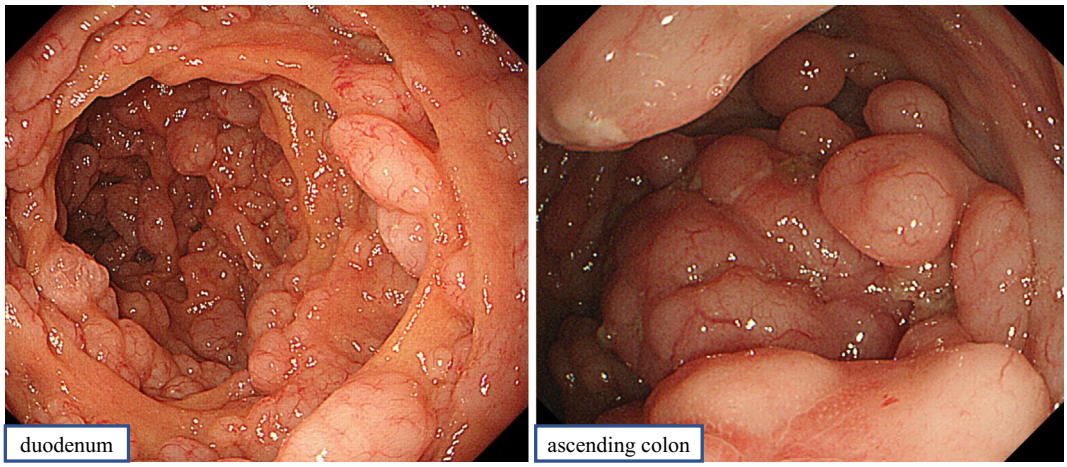
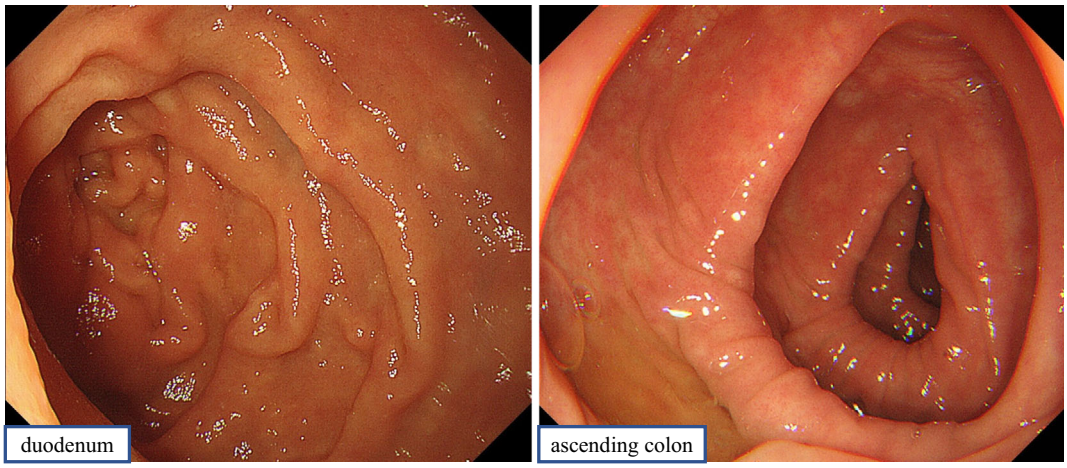


Picture 1.



Picture 2.

An 82-year-old man presented with abdominal discomfort, anorexia and diarrhea. The serum soluble interleukin-2 receptor concentration was 7,740 U/mL (normal range: 145-519 U/mL). Computed tomography revealed gastrointestinal

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wall thickening. Gastrointestinal endoscopy revealed multiple polypoid lesions throughout the gastrointestinal tract, especially in the duodenum and ascending colon (Picture 1). A specimen obtained from colonic lesions stained positive for CD20, CD5, Bcl-2 and cyclin D1. Fluorodeoxyglucose (FDG) positron emission tomography indicated an increased FDG uptake in the gastrointestinal tract, spleen, retroperitoneum, and left supraclavicular, axillary, and subdiaphragmatic lymph nodes. Fluorescence *in situ* hybridization studies of bone marrow showed t(11;14) translocation. We diagnosed the patient with mantle cell lymphoma (MCL) and multiple lymphomatous polyposis (MLP) (1, 2). Combination chemotherapy (rituximab and bendamustine) resulted in regression of the polypoid lesions (Picture 2). However, 12 months after the diagnosis, he died of tumor recurrence. Because approximately 50% of MCL patients with gastrointestinal involvement show MLP (3), MCL should be considered as an important differential diagnosis of MLP.

The authors state that they have no Conflict of Interest (COI).

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