

An unusual ileocecal tumor

Takato Inoue, Naonori Inoue ^{*}, Takuji Kawamura and Koji Uno

Department of Gastroenterology, Kyoto Second Red Cross Hospital, Kyoto, Japan

^{*}Correspondence address. Department of Gastroenterology, Kyoto Second Red Cross Hospital, Kyoto, Japan. Tel: +81-75-231-5171; Fax: +81-75-256-3451;

E-Mail: inoue_ahli@yahoo.co.jp

Abstract

We report the case of diffuse large B-cell lymphoma (DLBCL) with a fistula from the ileum to the cecum. A 57-year-old male came to the hospital complaining of abdominal pain. He underwent an abdominal computed tomography with contrast, which showed full-thickness wall thickening at the ileocecal region. He underwent a lower gastrointestinal endoscopy. No tumor was found at the ileocecal valve, and macroscopic findings were normal. The scope was advanced to the cecum, an additional outpouching was found. The outpouching appeared to be an ileocecal fistula. The diagnosis was DLBCL.

A 57-year-old male with a history of inguinal hernia surgery came to the hospital complaining of abdominal pain. His white blood cell count, CA 19-9 level, and CEA level were within the normal range. However, his interleukin-2 receptor (IL-2R) level was slightly elevated (516 U/ml). He underwent an abdominal computed tomography with contrast, which showed full-thickness wall thickening at the ileocecal region. He had no intestinal obstruction. He underwent a lower gastrointestinal endoscopy. No tumor was found at the ileocecal valve, and macroscopic findings were normal.

An attempt was made to advance the lower gastrointestinal endoscope superior to the ileocecal valve. However, the scope was unable to advance beyond the terminal ileum due to narrowing. When the scope was advanced to the cecum, an additional outpouching was found (Fig. 1a). The patient underwent a gastrointestinal angiography. The proximal ileum and the narrowed terminal ileum were imaged (Fig. 1b, white arrow indicates the narrowed terminal ileum). The ulcer appeared to be an ileocecal fistula. A biopsy was performed and the pathological diagnosis was diffuse large B-cell lymphoma (DLBCL). A lower gastrointestinal endoscopy 2 months prior, which was performed by another doctor, showed no abnormalities. It is possible that the terminal ileum and the cecum were not observed only by confirming the ileocecal valve. We experienced a case in which DLBCL pierced the gastrointestinal tract to form an ileocecal fistula, 'a pseudo-ileocecal valve'. He underwent ileocecal resection. After that, chemotherapy with rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone was performed. Tumor-induced intestinal fistulas are often caused by ovarian cancer and colon cancer [1]. Intestinal fistulas due to lymphoma are rarely encountered [2]. Fistula formation progresses through a chronic process. As the cancerous tissue grows, it invades the intestinal wall and forms an intestinal fistula [3]. Patients rarely experience symptoms during this period. In this particular case, no abdominal symptoms were experienced by the patient 2 months prior to the procedure.

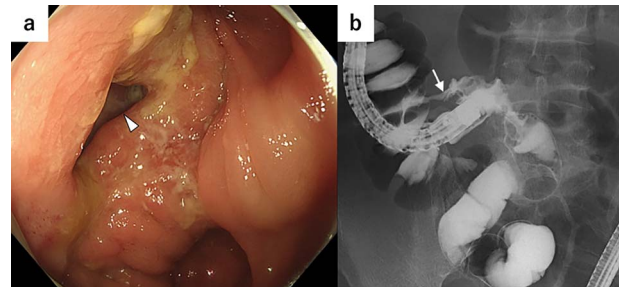


Figure 1. (a) When the scope was advanced to the cecum, an additional outpouching was found (white arrowhead). (b) The patient underwent a gastrointestinal angiography. The proximal ileum and the narrowed terminal ileum were imaged (white arrow indicates the narrowed terminal ileum).

CONFLICT OF INTEREST STATEMENT

None declared.

REFERENCES

1. Tirumani SH, Baez JC, Jagannathan JP, Shinagare AB, Ramaiya NH. Tumor-bowel fistula: what radiologists should know. *Abdom Imaging* 2013;**38**:1014–23. <https://doi.org/10.1007/s00261-013-9987-6>.
2. Senyondo G, Bella S, Saleem A, Mehdi SA, Sidhu J. Ileocolonic fistula due to diffuse large B cell lymphoma: unusual presentation of a rare disease. *Cureus* 2021;**13**:e12956. <https://doi.org/10.7759/cureus.12956>.
3. Ghai S, Pattison J, Ghai S, O'Malley ME, Khalili K, Stephens M. Primary gastrointestinal lymphoma: spectrum of imaging findings with pathologic correlation. *Radiographics* 2007;**27**:1371–88. <https://doi.org/10.1148/rg.275065151>.

Received: September 9, 2021. Revised: March 7, 2022. Accepted: July 14, 2022.

© The Author(s) 2022. Published by Oxford University Press. All rights reserved. For permissions, please e-mail: journals.permissions@oup.com

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<https://creativecommons.org/licenses/by-nc/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact journals.permissions@oup.com