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IMAGE | SMALL BOWEL

MALT Lymphoma Causing Gastric Outlet Obstruction

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Case Report

A 63-year-old man with a 3-month history of nausea, vomiting, and mid-abdominal pain presented for evaluation. He had an associated 11-kg unintentional weight loss and low-grade fevers. Physical examination showed a heart rate of 101 beats per minute, blood pressure of 111/81 mm Hg, and body mass index (BMI) of 19 kg/m^2. Blood work, including a complete blood count, basic metabolic panel, and liver enzymes, was normal.

Upper endoscopy revealed a tight narrowing at the distal third portion of the duodenum that could not be traversed and a 2-cm-wide, deep ulcer extending into the narrowing. The base of the ulcer had a cribriform appearance and was friable, but no mass could be identified (Figure 1). Biopsies showed acute and chronic duodenitis with congestion and hemorrhage. Gastric biopsies showed chronic inflammation with no *Helicobacter pylori* on immunohistochemical staining. Abdominal CT showed a 4.5 x 7-cm mass arising from the distal duodenum. Exploratory laparotomy with duodenal mass resection showed a firm, well-circumscribed, mass centered within the submucosa that extended into the mucosa, causing a 4 x 2-cm ulceration. There was diffuse lymphocytic infiltration throughout the entire thickness of the duodenal wall (Figure 2). Immunohistochemical stains showed the lymphoid cells were positive for CD 20, MUM-1, PAX-5, and focally positive for bcl-2 and bcl-6, consistent with a primary duodenal mucosa-associated lymphoid tissue (MALT) lymphoma.

Primary MALT lymphoma mostly occurs in the stomach and rarely arises from the duodenum. Patients present with abdominal pain, dyspepsia, and, rarely, gastric outlet obstruction. A single report of obstructive jaundice presentation has been described.[1] Although *H. pylori* acts as a culprit in gastric MALT lymphoma, this infection may be absent in MALT lymphoma

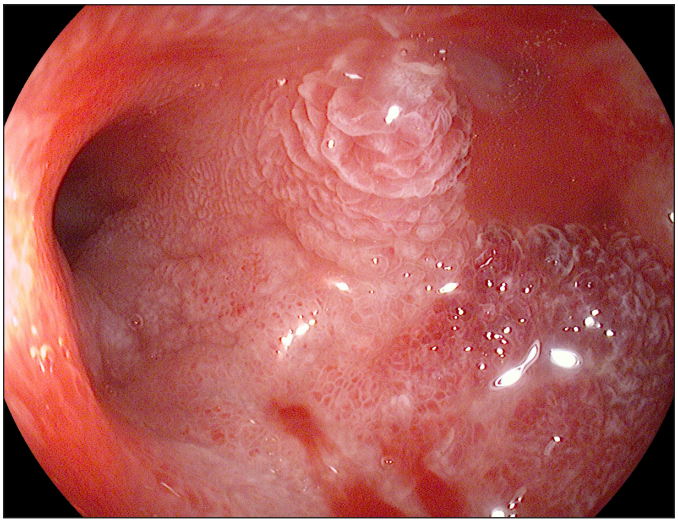

Figure 1. Ulcer with a cribriform and friable base found on upper endoscopy in the distal third portion of the duodenum.

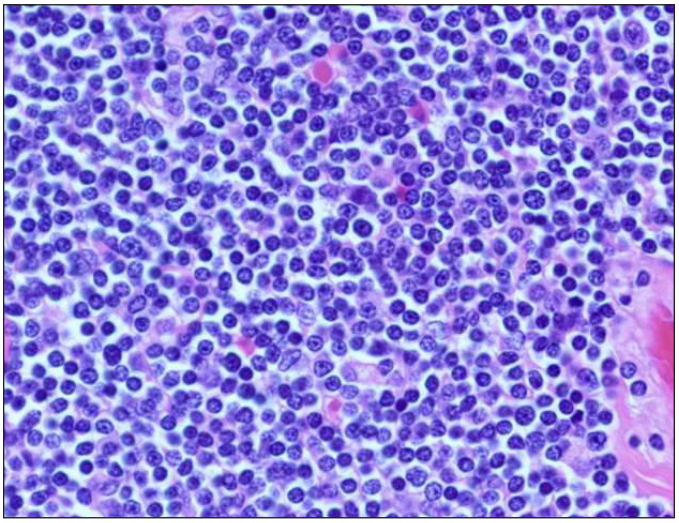

Figure 2. Biopsy of resected mass showing diffuse lymphocytic infiltration throughout the entire thickness of the duodenal wall.

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of the duodenum. In patients with duodenal MALT lymphoma and concomitant *H. pylori* infection, treatment of this bacteria leads to regression of the lymphoma.[2]

Disclosures

Author contributions: JG Hashash and N. Habib-Bein designed the study, acquired, analyzed, and interpreted the data, and drafted the manuscript. FF Francis designed and supervised the study, and acquired the data. JG Hashash is the article guarantor.

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References

1. Usmani SZ, Ding L, Abu-Rashed AH, Saleh HA. Duodenal MALT lymphoma presenting with obstructive jaundice: Report of a case and review of the literature. *J Gastrointest Cancer*. 2007;38(1):28–31.
2. Nagashima R, Takeda H, Maeda K, et al. Regression of duodenal mucosa-associated lymphoid tissue lymphoma after eradication of *Helicobacter pylori*. *Gastroenterology*. 1996;111(6):1674–8.