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A SYSTEMIC DISEASE WITH GI PRESENTATION - A CASE REPORT

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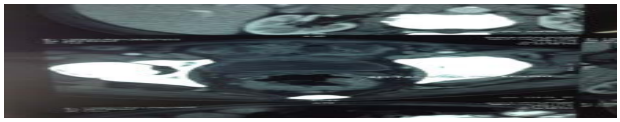
Abstract : INTRODUCTION Apart from the many disorders that affect the GI tract primarily like achalsia , carcinomas infections, inflammatory bowel disease and so on the GI tract can be prominently involved in a host of systemic disorders like connective tissue disorders, scleroderma, henoch scholein purpura ,HIV, carcinoids etc. The early identification of these also aid in the diagnosis and subsequently leading on to appropriate treatment which may lead to substantial reduction in both morbidity and mortality as in our case below.CASE REPORT A 63 years old male presented with a 6 months history of early satiety, malaise, easy fatigability and significant weight loss. On examination he was found to be pale with generalised lymphadenopathy and hepatosplenomegaly. Upper and lower GI endoscopies were done which showed nodular lesions which were biopsied sent for HPE which showed small round cells with central nucleus and a rim of cytoplasm but was inconclusive. Imaging studies were done which showed a greatly thickened gastric wall, sigmoid colon and rectum along with free fluid in both peritoneal and pleural cavities. In view of the lyphadenopathy suggesting a systemic aetiology it was excised and sent for HPE which showed enlarged follicles with germinal centres and was suggested further staining studies. The slides were sent for immunohisto chemistry with CD 20 which turned out highly positive thus confirming the diagnosis of NON HODGKINS LYMPHOMA. A peripheral smear was done which also supported the diagnosis showing 85 blast cells suggesting a AML-M2 type blast transformation of the NHL. He was subsequently referred to the oncology department where he was started on R-CHOP regimen chemotherapy along with further sub typing follow up of NHL.

Keyword :NON HODGKINS LYMPHOMA, IMMUNOHISTOCHEMISTRY, RITUXIMAB, A SYSTEMIC DISEASE WITH A GI PRESENTATION

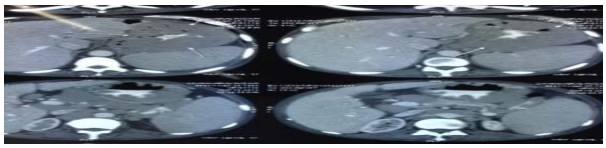
CASE REPORT

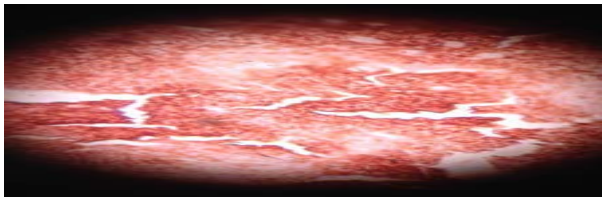
HISTORY AND INITIAL WORKUP

A 63 years old gentleman presented to the GI opd with a 6 months history of early satiety, malaise, easy fatigability and noticed significant weight loss. He was admitted for further evaluation. On examination he was found to be pale, had palpable cervical and axillary lymph nodes and organomegaly in the form of hepatosplenomegaly. Routine upper and lower endoscopic studies revealed a decreased stomach capacity along with multiple nodular lesions in the entire stomach and colon studied. These were biopsied from random sites and were sent for HPE whose reports suggested small round cells with a central nuclei and a rim of cytoplasm. It was suggested to send further tissue from either same or other diseased site for further study

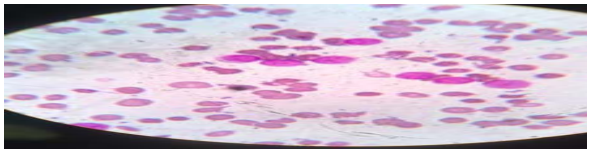


CT IMAGE CT

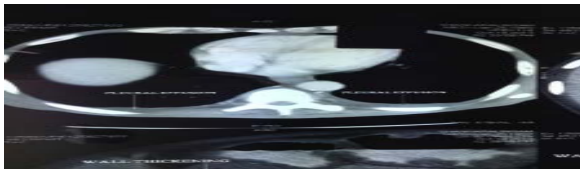


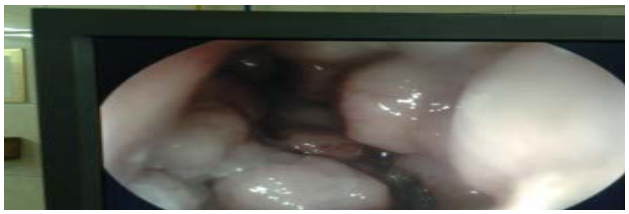


LYMPH NODE BIOPSY

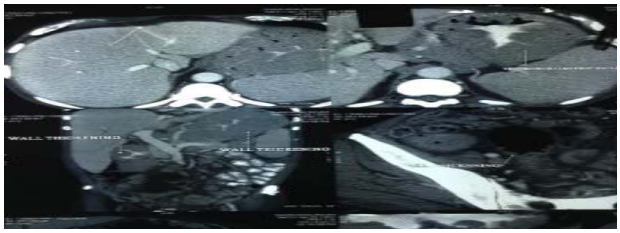


PERIPHERAL SMEAR STUDY





UGI SCOPY



CT IMAGES

IMAGING STUDIES: Initially an ultrasound was done followed by a contrast CT abdomen was done which showed the stomach wall to be greatly thickened along with the sigmoid colon and rectum. Apart from this free fluid was seen in both peritoneal and pleural cavities.

In view of the anaemia along with hepatosplenomegaly and generalised lymphadenopathy suggesting a lymphoid disorder one of these lymph nodes were subjected to excision biopsy.

LYMPH NODE BIOPSY:

The section that was studied showed enlarged follicles with germinal centres and was advised further special staining studies.

IMMUNOHISTOCHEMISTRY STUDIES:

The specimen was sent for immunohistochemistry studies with anti CD 20 which showed it to be highly positive suggesting a diagnosis of B CELL TYPE NHL.

PERIPHERAL SMEAR STUDY

Was done which showed increase in WBC count with predominant cells 85% being blasts whose morphology suggested an AML M2 type thereby further adding to the diagnosis as a leukemic transformation of a lymphoma.

FURTHER COURSE

He was staged as per lugano staging and IP score was found to be in stage 4 following which he was sent to the oncology department. There he was started on R-CHOP regimen of chemotherapy while further immune markers study and sub typing of the B cell lymphoma was planned along with follow up

DISCUSION:

GI tract is the most common site of extra nodal NHL with NHL being more common than Hodgkin's in our country. In our case the presentation was primarily due to involvement of the GI tract as the stomach & colon showed extensive thickening along with lesions in both endoluminal and CT scan imaging. But in view of the presence of anaemia along with lymphadenopathy and hepatosplenomegaly a systemic malignancy of the lymphoid system was suspected and the enlarged lymph node was biopsied. Initial HPE studies were unrevealing which warranted further immunohistochemistry studies using anti-CD 20 markers which confirmed the diagnosis of NHL. The PS study further added weightage of the diagnosis suggesting a AML-M2 acute leukemic transformation of the underlying B cell NHL. Recent advances made in the field of both diagnostics and therapeutics along with better availability of drugs like anti CD 20 rituximab along with the multimodal team based approach have lead to vastly improved outcomes for patients suffering from these disorders.

CONCLUSION

Though the symptomatology might indicate localised involvement of one particular organ as the GI tract in our case features like anaemia, lymphadenopathy, HSM should prompt one to think of And look for an array of systemic disorders / malignancies. Because on subsequent application of special diagnostic procedures like lymph node study, immune markers study etc one can arrive at a diagnosis like in our case B CELL NHL. When approached along with other specialists like oncologists and using array of treatment options like newly available chemotherapy drugs we can now offer a effective treatment option to these patients.

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