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Endoscopic diagnosis of primary and recurrent mantle cell lymphomas

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Authors contributions
Miguel Mascarenhas Saraiva: acquisition of data, writing and critical revision of the manuscript.
Tiago Ribeiro: acquisition of data, writing and critical revision of the manuscript.
Amadeu Corte Real Nunes: critical revision of the manuscript.
Guilherme Macedo: critical revision of the manuscript.

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Dear Editor,

A 64-year-old male presented to our center with epigastric pain, anorexia, fatigue, weight loss and anemia on a laboratory study. An abdominal ultrasound revealed thickening of the gastric walls. Upper endoscopy demonstrated a 40 mm ulcerated lesion at the incisura angularis. A biopsy of the lesion revealed a lymphocytic infiltrate expressing CD5, CD20 and cyclin D1, typical of mantle-cell lymphoma (MCL). Stage IV MCL was diagnosed after the description of a generalized lymph node enlargement
and extensive bone marrow invasion on cross-sectional imaging and bone biopsy, respectively. The patient underwent systemic chemotherapy and autologous hematopoietic stem cell transplant (HSCT). An upper endoscopy performed 100 days after HSCT for evaluation of postprandial epigastric discomfort showed multiple ulcerated polypoid at the fundus and a 40 mm polyp with central ulceration. Histopathologic characterization confirmed MCL relapse with microscopic features of aggressiveness (blastoid variant and increased proliferative index). A subsequent rapid progression of the hematologic disease led to patient’s death, approximately two months after the diagnosis of recurrence.

Discussion
Lymphoid neoplasms account for 1-4% of all gastrointestinal neoplasms. Gastrointestinal (GI) involvement is the most common form of extranodal disease (40%) and the stomach is the most frequently affected organ (1). Mantle cell lymphoma is rare (3% of all non-Hodgkin lymphomas) and typically has an aggressive course and poorer survival compared to other non-Hodgkin lymphomas (2). It most commonly involves the colon and rectum (72% of patients), where it represents the most common histologic type and frequently presents as lymphomatous polyposis (2-4). Gastric involvement occurs in almost 30% of these patients (4). Systematic endoscopic staging is required in symptomatic patients and in rare cases of patients with low stage disease (stages I and II) to evaluate for asymptomatic involvement of the GI tract, as the treatment depends on tumor stage (5).

References


Fig. 1. Upper endoscopy showing a large polypoid lesion with central ulceration at the incisura (A) and multiple polypoid lesions at the body and fundus (B).