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DOI: 10.17235/reed.2023.9872/2023
Link: PubMed (Epub ahead of print)

Please cite this article as:

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Primary rectal mucosa-associated lymphoid tissue lymphoma masquerading as proctitis

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Keywords: Rectal lymphoma. Colonoscopy. Proctitis.

Statement of ethics: this study did not require informed consent or approval by the appropriate ethics committee.

Author’s contributions: collection of data and writing: Jin-Yan Zhang; collection of data: Zhi-Kun Yin, Ji Li; final approval of the manuscript: Bao-Zhong Fu.

Conflict of interest: the authors declare no conflict of interest.

Dear Editor,
A 29-year-old male presented with recurrent mucous bloody stools for more than a year. Colonoscopy revealed ill-defined, mildly congested and edematous mucosa with scattered erosion spots in the lower rectum (Fig. 1A), highly suspicious for proctitis. Histopathology showed diffuse infiltration of small to medium-sized lymphoid cells in the lamina propria (Fig. 1B). Immunohistochemistry indicated that
these cells were positive for CD20 (Fig. 1C), CD79a, CD19, kappa and lambda light chains (partial), and negative for CD3, CD5, CD10, cyclin D and BCL-6. These results were consistent with mucosa-associated lymphoid tissue (MALT) lymphoma. Further investigations consisting of upper endoscopy, bone marrow biopsy and whole-body PET/CT scan did not detect any extra-rectal lesions. Based on these findings, a diagnosis of stage I primary rectal MALT lymphoma was made. The patient underwent 15 fractions of radiotherapy with a total dose of 30 Gy. His symptoms were alleviated following treatment. A follow-up colonoscopy performed 3 months later showed complete resolution of the lesion (Fig. 1D).

Discussion
MALT lymphoma, classified as an indolent form of marginal zone non-Hodgkin's B-cell lymphoma, primarily affects the stomach and is rarely found in the rectum (1). Most rectal MALT lymphomas are localized (stage Lugano I-II), while only a few cases have been reported in stage Lugano IV (1). The majority of rectal MALT lymphomas appear as one or multiple polypoid lesions or submucosal tumors on endoscopy, with a few cases exhibiting color change or inflammation (2), as is the case with this patient. This case highlights the importance of conducting a diagnostic biopsy even for benign looking lesions. Due to the rarity of this disorder, the optimal treatment strategy has not yet been fully established. There are several treatment approaches available, including Helicobacter pylori eradication, endoscopic resection, surgical intervention, chemotherapy and radiotherapy (3).

References

Fig. 1 A. Endoscopic image of the lesion. B. Hematoxylin-eosin 200× histological image showing diffuse infiltration of small to medium-sized lymphoid cells in the lamina propria. C. Immunohistochemical image showing these cells were positive for CD20 (200× magnification). D. Complete resolution of the rectal lesion on follow-up colonoscopy.