Fig: Submucosal colonic tumor shows arrangement of cells in syncytial whorls (H&E, 40X (left) and 100X). Inset (H&E, 400X) shows tumor cells with indistinct outlines and nuclei with delicate membrane.

Intra-abdominal FDC tumors, being more aggressive, require adjuvant chemotherapy after excision. The role of radiotherapy is not clear. FDC tumors were earlier described as being indolent, with potential for local recurrence. However, with metastasis being reported, these are now described as being of intermediate-grade malignancy. Though their biologic behavior is described as being unpredictable, intra-abdominal FDC tumors are known to be aggressive.

FDC tumors may not be rare, are aggressive and thus necessitate a close follow up.

References

Correspondence to: Dr Desai. Fax: (22) 414 6937. E-mail: sangetad@hotmail.com
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Mantle cell lymphoma presenting as solitary polypoid colonic lesions

SAADIA RASHID, SHAHID PERVEZ, MARYAM MOOSA KHAN, AKBER SHAH HUSSAINY
Department of Pathology, The Aga Khan University, P O Box 3500, Stadium Road, Karachi, Pakistan

Mantle cell lymphoma of the intestine is rare, usually presenting as multiple small polyps. We report three men with colonic mantle cell lymphoma in the form of single large polypoid mass. The clinical picture suggested adenocarcinoma; the diagnosis was made at histology and immunohistochemistry of the colectomy specimens. [Indian J Gastroenterol 2001; 20: 74-75]

Key words: Large bowel tumor, non-Hodgkin's lymphoma.
Mantle cell lymphoma is an intermediate-grade non-Hodgkin’s lymphoma commonly occurring in lymph nodes, spleen, Waldeyer’s ring, bone marrow and blood. The tumor generally occurs in older men, and median survival is 3 to 5 years. It has been reported infrequently in the gastrointestinal tract in the form of multiple small polyps in the small and large intestine (lymphomatous polyposis). Some cases have been associated with a bulky ileocecal mass in addition to numerous nodules. Presentation as a single polypl has not been reported.

Case 1: Partial colectomy was performed on a 64-year-old man with a clinical diagnosis of poorly differentiated adenocarcinoma of the colon made elsewhere. The colon contained a single large, polyoid polyp, measuring 10 cm x 5 cm x 6 cm, protruding into the lumen and involving the full thickness of the wall. The terminal ileum, cecum with appendix, ascending colon and part of transverse colon were normal. Microscopically, sections showed a neoplastic lesion composed of small to medium-sized lymphoid cells with scant pale cytoplasm and inconspicuous nuclei. Most cells showed cleaved nuclei (Fig). Paraimmunoblasts and immunoblasts were distinctly absent. All lymph nodes showed lymphomatous infiltration. Tumor cells showed strong positivity for leukocyte common antigen, pan B cell markers (CD20, CD23), and cyclin D1, and no reactivity with cytokeratin and pan T cell marker (UCHL1). A diagnosis of non-Hodgkin’s mantle cell lymphoma was made.

Case 2: A 35-year-old man presented with chronic constipation and clinical diagnosis of adenocarcinoma. Histology was equivocal. Partial colectomy was performed. Grossly, the rectum contained a single large polyp. Microscopy revealed a neoplastic lesion with morphology and immunohistochemistry identical to those in Case 1.

Case 3: A 26-year-old man with ill-defined gastrointestinal symptoms was referred for endoscopic biopsy of a large rectal polyp. Morphological and immunohistochemical features were identical to those in Cases 1 and 2.

All three cases received chemotherapy (CHOP; six cycles). Case 1 has remained in remission for 3 years; Cases 2 and 3 achieved remission, but have been lost to follow up.

Lymphomatous polyposis (the intestinal equivalent of mantle cell lymphoma) is a multifocal lesion, consisting of polyoid mucosal elevations, 0.5 cm to 5 cm in diameter, which usually do not ulcerate. It is more frequent in the ileum, cecum and ascending colon. Histologically, lesions contain centrocytic cells; these cases were usually diagnosed as diffuse, small, cleaved, non-Hodgkin’s lymphoma. They are analogous to mantle cell lymphoma and demonstrate B cell differentiation. A characteristic morphologic feature is the absence of paraimmunoblasts and immunoblasts among the neoplastic cells. This feature differentiates these lymphomas from small lymphocytic lymphoma. Our cases show that mantle cell lymphoma of the colon can present as a single polyp of variable size without adenomatous change.

Mantle cell lymphoma is positive for B cell markers. In addition, CD5, CD43 and CD10 may also be positive. Absence of CD23 is useful in distinguishing it from small lymphocytic lymphoma; CD5 is useful in distinguishing from follicle center and marginal zone lymphoma. Furthermore, immunohistochemistry is essential to exclude other lymphoma entities like B-cell lymphoma of mucosa-associated lymphoid tissue (MALT) type including Mediterranean-type lymphoma or alpha-chain disease, reactive lymphoproliferative disorders, and focal lymphoid hyperplasia. Mantle cell lymphoma of the colon shows a chromosomal translocation (t(11;14)) involving the bcl-1 locus on the long arm of chromosome 11. The translocation results in overexpression of cyclin D1, which can be detected using immunohistochemistry.

Patients with mantle cell lymphoma of the colon are likely to benefit from chemotherapy. One reported case was treated with etoposide and prednisolone. Colectomy may not be beneficial because dissemination may occur by the time of presentation.

Thus, the differential diagnosis of mantle cell lymphoma must be considered in patients with a single intestinal polyoid mass.

References

Fig: Microphotograph showing (left) typical morphology of mantle cell lymphoma with diffuse sheets of small cleaved cells (H&E, 40X) and diffuse membrane staining of all tumor cells using a monoclonal antibody against Pan-B antigen (CD20, L26) (20X)
Lymphocytic interstitial pneumonitis associated with autoimmune hepatitis

AMITA V DOSHI, DEVENDRA DESAI,*
ANITA BHADURI,** ZARIF F UDWAIDAD

Departments of Chest Medicine, *Gastroenterology and **Pathology, Hinduja Hospital and Medical Research Center, Veer Savarkar Marg, Mumbai 400 016

A 49-year-old woman was diagnosed as autoimmune hepatitis and started on steroids and azathioprine. Subsequently, she developed fever; chest radiograph showed lower lobe nodular opacities. Bronchoalveolar lavage and transbronchial lung biopsy confirmed the diagnosis of lymphocytic interstitial pneumonitis. [Indian J Gastroenterol 2001; 20: 76-77]

Key words: Chronic hepatitis

Lymphocytic interstitial pneumonitis (LIP) is a reactive lymphoid infiltrate with diffuse or multifocal pulmonary interstitial involvement. It occurs in the setting of several systemic illnesses such as Sjögren's syndrome, myasthenia gravis, chronic hepatitis and primary biliary cirrhosis. LIP has also been described in association with AIDS in children as well as in adults. Since it commonly presents with cough, dyspnea and fever, among patients receiving immuno-suppression it may be misdiagnosed as respiratory tract infection.

A 49-year-old lady presented with fatigue, nausea and jaundice. Total bilirubin was 6.2 mg/dL and transaminases were elevated (AST/ALT 1660/1680 IU/L; normal 0-40). HBSAg and markers for hepatitis A and C viruses were negative. At ultrasonography, liver was of normal size, had altered echotexture, and no mass was seen; there was no biliary dilatation. Bilirubin normalized over the next six weeks and AST/ALT were 70 IU/L each; this was accompanied by clinical improvement.

Five months later, she developed nausea, fatigue and jaundice. Total bilirubin was 2.5 mg/dL; transaminases were high (AST/ALT 1248/1344 IU/L) and alkaline phosphatase was 305 IU/L (normal 0-160); prothrombin time was normal. Serology for hepatitis viruses A, B and E, anti-nuclear antibody, antiliver kidney microsom antibody and antimitochondrial antibodies were negative. Alpha-antitrypsin level was normal. Abdominal echography revealed no hepatomegaly, mass or ascites; hepatic and portal veins were normal. Bilirubin level settled over a few weeks but transaminases remained mildly elevated.

Ten months later, bilirubin and alkaline phosphate were normal and transaminases mildly elevated (AST/ALT 55/76 IU/L). Liver biopsy revealed chronic hepatitis with piecemeal necrosis and marked activity. There was extensive fibrosis suggestive of cirrhosis. Quantitative iron studies on liver tissue did not reveal iron overload. With a diagnosis of autoimmune hepatitis, the patient was started on corticosteroids and azathioprine. Corticosteroids were tapered and stopped after a month as her diabetes was difficult to control; azathioprine was continued. Transaminases normalized after starting treatment.

One month later, she was admitted with high fever. Leukocyte count was 15,000/µL, bilirubin 1.4 mg/dL, AST/ALT 29/19 IU/L and alkaline phosphatase 64 IU/L. Chest radiograph showed nodular opacities in both lower lobes. There were no respiratory complaints except for occasional breathlessness; chest examination was normal. High-resolution computed tomogram of the chest showed patchy ground-glass densities interspersed with septal thickness. Diffuse nodular opacities were seen in both lungs. Fiberoptic bronchoscopy revealed a normal tracheobronchial tree. Bronchoalveolar lavage showed excess of lymphocytes, but no acid-fast bacilli, fungi, Pneumocystis carinii or other organisms. Transbronchial biopsy revealed moderately dense but patchy infiltrate of lymphocytes in septae, consistent with lymphocytic interstitial pneumonitis (Fig). Pulmonary function test revealed a restrictive defect with FVC of 1.4 L (55% of predicted) with normal PEV:FVC. Azathioprine was continued and 40 mg/day of prednisolone was started. One month later, FVC had improved to 2 L (88% of predicted) and repeat chest radiograph was normal.

The patient was treated with tapering doses of corticosteroids and azathioprine and at follow up after 3 months, liver and lung functions and CT scan of the chest were normal.

LIP is characterized histologically by diffuse infiltration with predominantly small lymphocytes and some plasma cells and histiocytes in the alveolar septa and along the lymphatic vessels. Lymphocytic bronchiolitis with limited involvement of the interstitium is a recognized complication of graft-versus-host disease following bone marrow transplantation. Abnormalities of serum globulin levels are found in more than 60% of patients with LIP.

LIP tends to progress to diffuse fibrosis, though evolution to malignant lymphoma and to lymphomatoid granulomatosis has also been described. The condition