LOOKING BEYOND THE USUAL

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Case 1

PRESENTING COMPLAINTS

76 yrs old male farmer by occupation, known case of
Type II diabetes mellitus since 5 years on oral medications was

Admitted with complaints of

- Weight Loss of 5 kg in last 2 months,
- Diffuse abdominal pain since 15 days,
- High grade continuous fever with chills since 7 days,
- Burning micturition with increased frequency since 5 days.
- No history of nausea ,vomiting ,loss of appetite,diarrhoea
- No significant past history

GENERAL EXAMINATION

Patient was conscious, oriented

- Pulse -98 /min regular,
- BP - 120/80 mmHg in Rt Arm supine position
- Febrile –T 101.2 F
- RR- 16/min
- Spo2- 98% on RA
- No cyanosis, clubbing, icterus, edema,
- No lymphadenopathy

SYSTEMIC EXAMINATION

On Per abdomen-

-Diffuse Tenderness was present on palpation,no rebound tenderness,no free fluid,no hepatosplenomegaly was present.

-No abdominal bruit present

- CVS , RS and CNS examination was normal.

INVESTIGATIONS

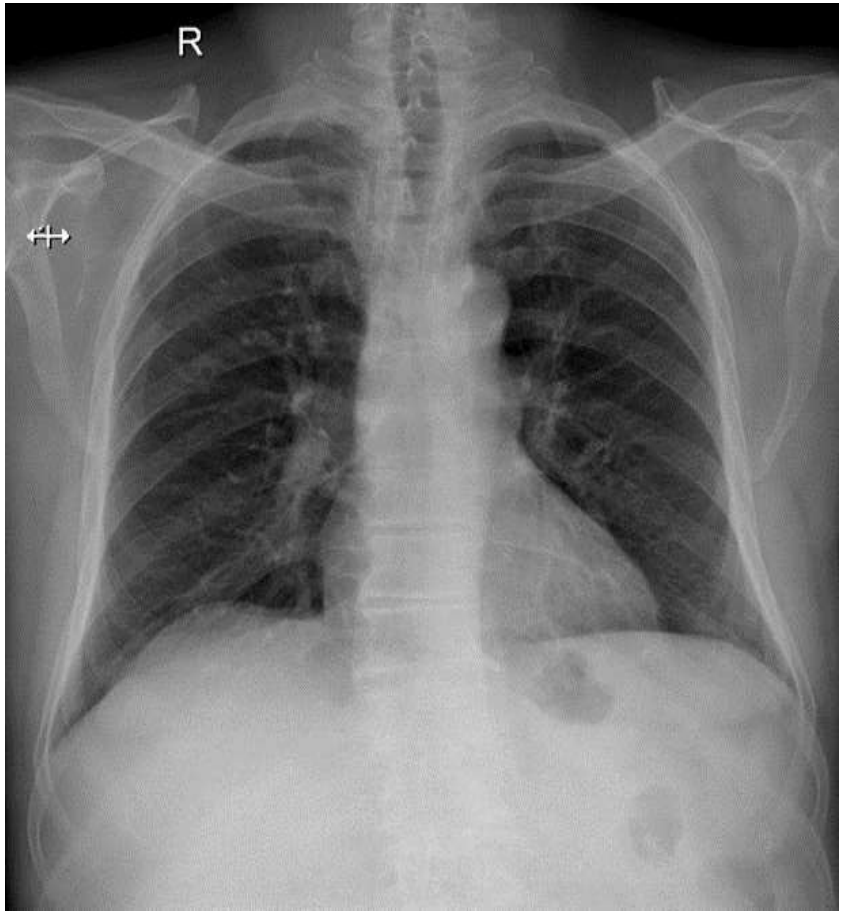
CBC	
Hb	10 gm%
TLC	18000 N-78
PLT	310000
PCV	28
MCV	64
LFT	
Total bilirubin	1.15
Direct	0.48
Indirect	0.67
SGPT	34
SGOT	60
ALP	118

RFT	
Urea	28
Creat	1.06
S.Electrolyte	
Na/K/Cl	137/4.5/102
ESR	35
CRP	15
HbA1C-	8.9
UPCR-	1.01

Urine R/Ms	
PUS CELL	80-90
Glucose	++
D-dimer	7000
Procalcitonin	0.9
Lactate	20
TFT	Normal
Mantaux test	Negative

Urine culture and blood culture was sent.

INVESTIGATIONS



Chest X-ray- Normal,

- ECG-Normal sinus rhythm;
- Echocardiography- EF-60%; NO RWMA;

INVESTIGATIONS

- **USG ABDOMEN PELVIS**

•Left renal non obstructive calculi. (17mm in size)
•B/L renal minimal simple exophytic cyst
•Few air foci in lower pole calyces-
likely s/o **Emphysematous pyelonephritis.**

- **Urine Culture & sensitivity-**

s/o **E.coli** sensitive to
1)Piperacillin tazobactam ,
2)Trimethoprim sulphomethoxazole

Resistant to nitrofurantoin and ciprofloxacin.

TREATMENT

- Patient was started on Inj. piperacillin tazobactam 3.375gm 6 hourly for 14 days .

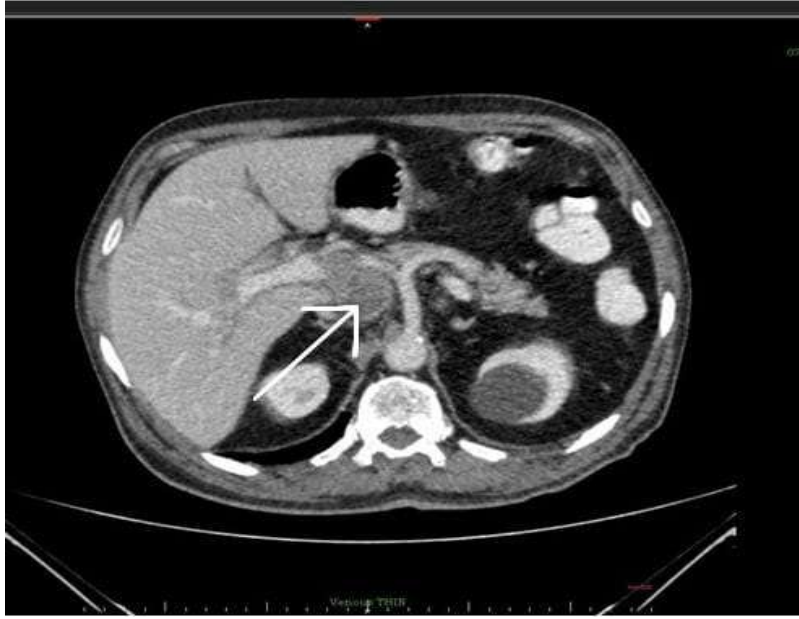
- **Patient became afebrile and was symptomatically better ,but was constantly complaining of deep seated abdominal pain.**

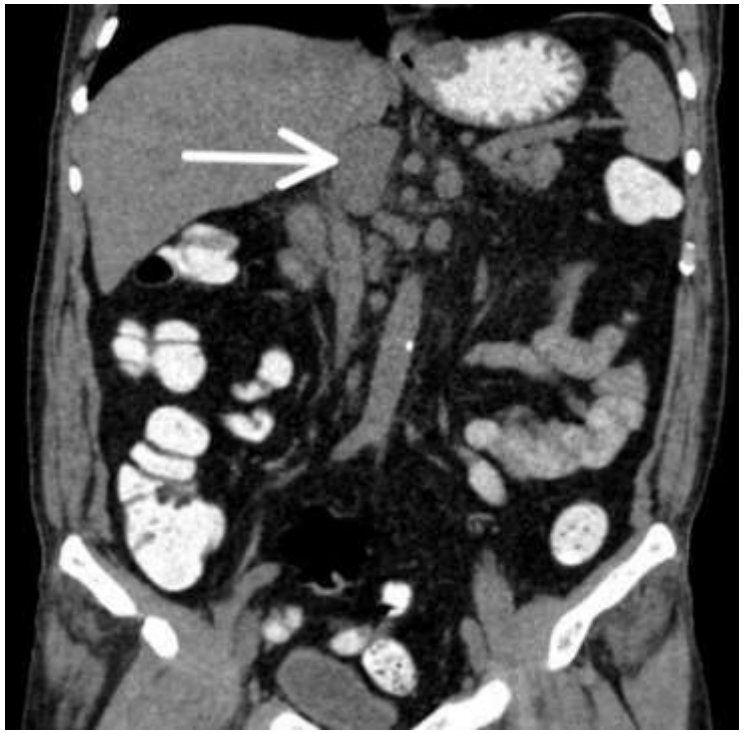
- So to investigate the constant abdominal pain**,CECT (abdo+pelvis)** was done.

CECT ABDOMEN PELVIS

- Left renal calculi (**16*11 mm in size**) with air foci in the collecting system- s/o Emphysematous pyelonephritis

- Retro-peritoneal necrotic lymphadenitis in peripancreatic, periportal, paraaortic region with largest being **4*5 cm**, with mass effect and compression of lower CBD and mild IHBR dilatation. - likely Koch's infection/necrotic metastasis.

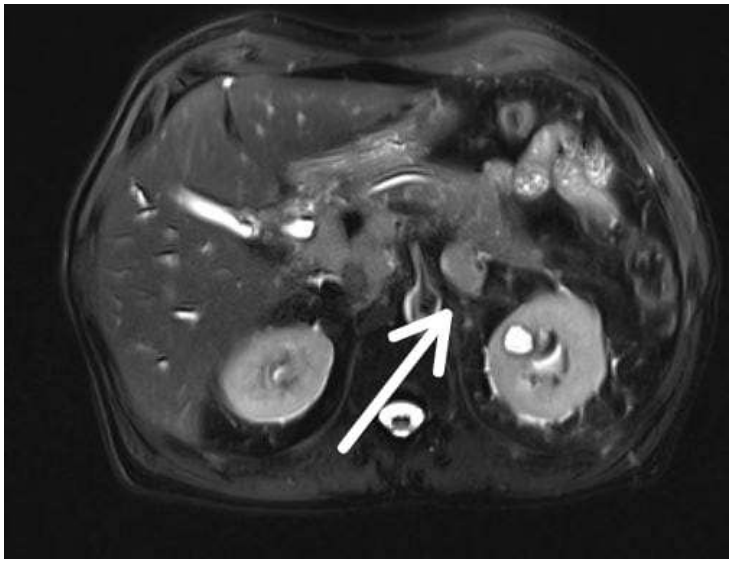


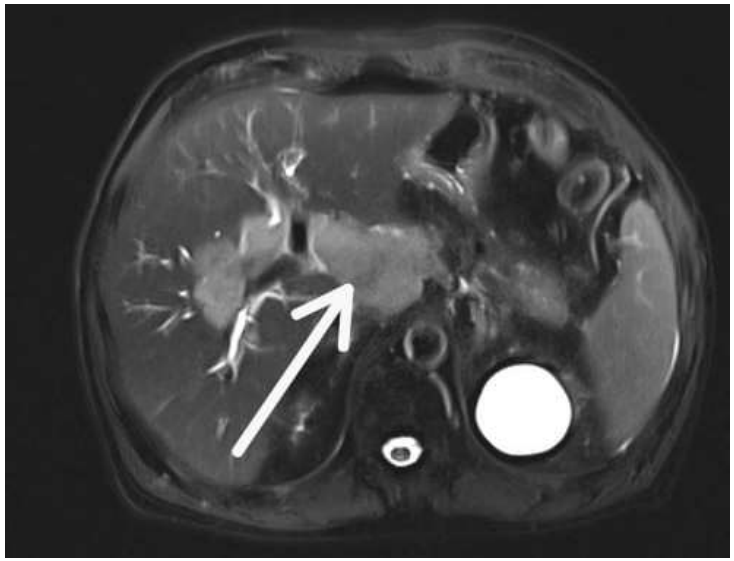


MRI ABDOMEN

- Well defined solid lesion with lobulated outlines of 5.5cm*4cm*4.3cm in peri portal space adjacent to right Portal vein in Rt hepatic lobe ?Neoplastic aetiology- ?infiltrating cholangiocarcinoma or ?Lymphoma.

- Multiple LN at porta hepatis, peripancreatic, periportal, paraaortic and aorto caval region.





DIFFERENTIAL DIAGNOSIS

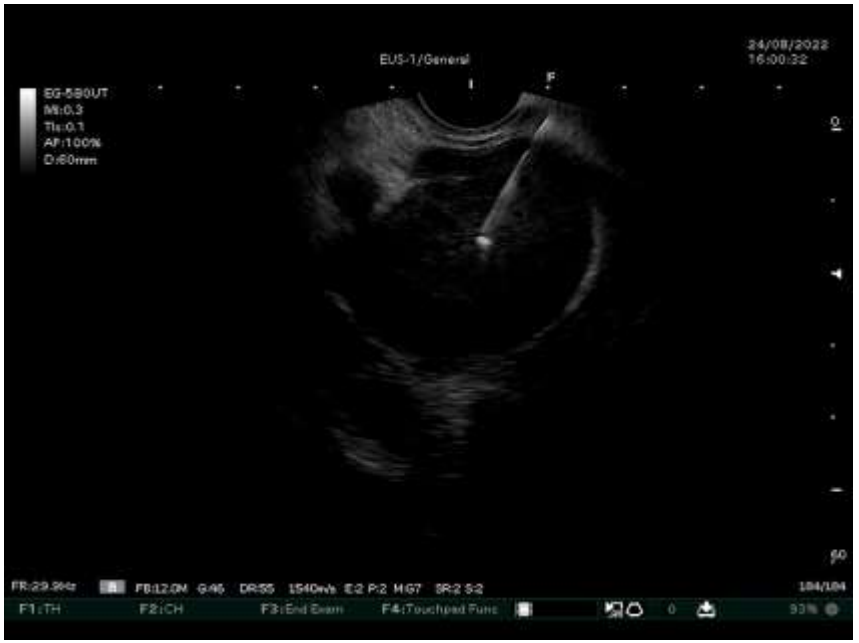
- Type II Diabetes Mellitus with urinary tract infection with B/L Emphysematous Pyelonephritis with
- Peri-portal, Peri-pancreatic lymphadenopathy under evaluation-

  Tuberculosis / Lymphoma.

- For the diagnosis we decided to get a biopsy for HPE.
- CT Guided biopsy was not possible due to deep seated lymph node.
- Gastroenterologist was requested for Endoscopic USG guided biopsy.

ENDOSCOPIC USG Guided Biopsy

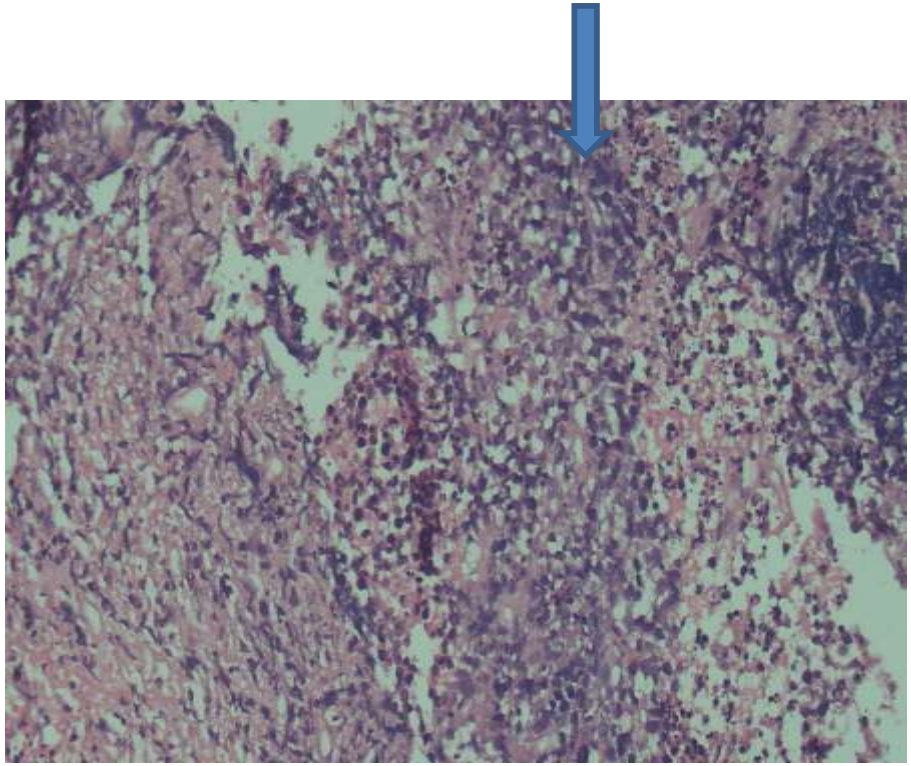
EUS showed large necrotic LN between PV and IVC.



Fine Needle Aspiration Biopsy (FNAB) was taken and sample was sent for histopathological investigation.

HISTOPATHOLOGICAL EXAMINATION

Shows a poorly differentiated malignant tumor cells arranged in different sheets.



Tumor cells were large in size and have hyperchromatic nuclei, prominent nucleoli and scanty cytoplasm with increased mitoses.

-

s/o High grade B cell NHL.

IMMUNOHISTOCHEMISTRY MARKERS

Neoplastic cells were

-Positive for

- CD 20,
- BCL2,
- C- Myc

-Negative for CD3, CD10, Bcl-6

-MiB-1 proliferative index was 90%.

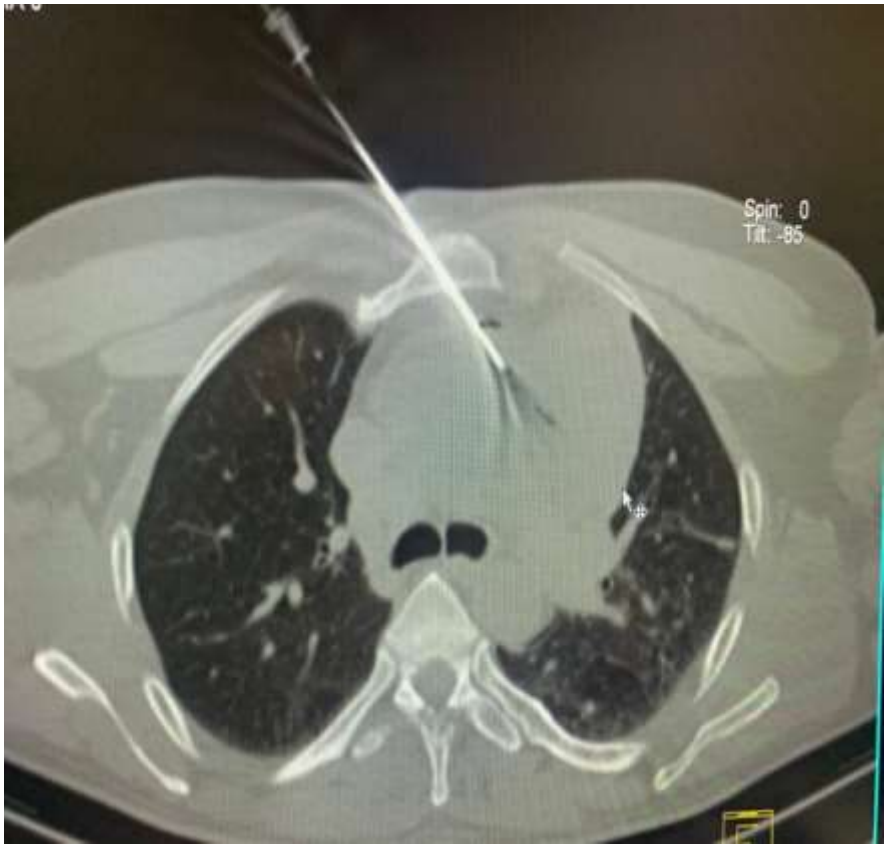
FINAL DIAGNOSIS

HIGH GRADE B CELL NON HODGKINS LYMPHOMA WITH DIABETES MELLITUS TYPE 2

- After the discussion with the Medical oncologist,
- Patient is advised to complete 6 cycles of R-CHOP chemo regimen therapy at an interval of every 21 days.
- Patient is on regular follow up, has completed 5 cycles of chemotherapy till date and is tolerating well.

- **R-CHOP regimen :**
- Inj. Rituximab 500mg iv infusion
- Inj. Cyclophosphamide 900 mg iv infusion
- Inj. Vincristine 2 mg iv push over 10 mins.
- Tab Prednisolone 50 mg BD for 5 days

CASE 2



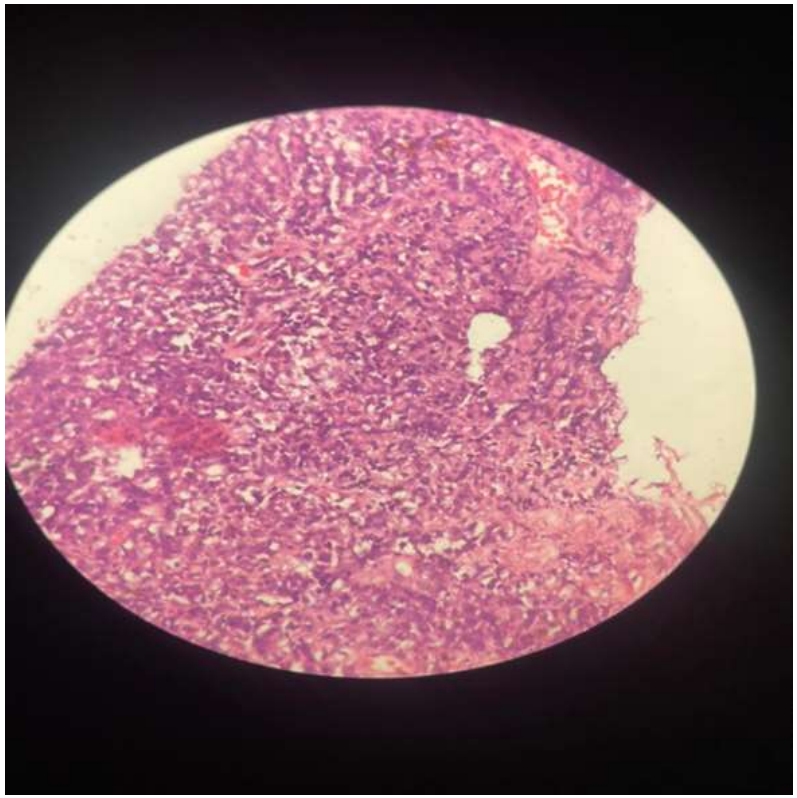
CT guided biopsy of Mediastinal mass was done and sample was sent for the HPE.

Similar case of 70 yrs old male

Chest x-ray s/o-mediastinal widening and cardiomegaly.

-2d Echocardiography-s/o moderate pericardial effusion

HRCT CHEST -s/o- Homogenously enhancing mass lesion with epicenter in the left anterior-superior part of mediastinum; Moderate Pericardial Effusion



•**HPE**: shows large pleomorphic nuclei and pale cytoplasm **s/o Diffuse large B cell Lymphoma**

IHC:

CD 20 positive in large cells

CD 3 positive in other cells

Ki-67- 80%

PAN CK- negative

Final Diagnosis-DIFFUSE LARGE B CELL LYMPHOMA (DLBCL) WITH PERICARDIAL EFFUSION.

DISCUSSION

Usual presentation of patient with Lymphoma

THORACIC PRESENTATION

- Cough
- Chest discomfort
- Chest pain
- May present without symptoms but with an abnormal chest radiograph.

ABDOMINAL PRESENTATION

- Chronic pain
- Abdominal fullness
- Early satiety
- Symptoms associated with
  - Visceral obstruction
  - Acute bowel perforation
  - GI hemorrhage

-An elevated LDH (77%) and B symptoms (47%) are common.

UNUSUAL PRESENTATION

- Patient may present with pleural and pericardial effusions.
- Superior vena cava syndrome is a frequent complication.
- Relapses can occur locally or in extranodal sites, including the

  - Liver
  - GI tract
  - Kidneys
  - Ovaries and CNS.

- Patient may present with renal or any other organ abnormality as a primary presentation.

. Source: DeVita, Hellman and Rosenberg's Cancer principles and practice of oncology.

TAKE HOME MESSAGE

- Approximately 25 to 40% of NHL arise in tissues other than lymph node (termed as extra nodal NHL), of which the most common pathological variant is DLBCL.

- If DLBCL is diagnosed early and treated with R-CHOP regimen, it has 5 years overall survival (OS) rate of 92%, so it’s highly treatable condition.

- While High grade B cell NHL have very poor prognosis and if not treated timely can be fatal.

- Hence there should be high clinical suspicion to diagnose such atypical presentation of NHL, as they are treatable and have good prognosis if treated timely.

REFERENCES

- Harrisons Principle Of Internal Medicine ; Dennis L. Kasper, Anthony , s.fauci, Md, Stephen L. Hauser, J. Larry Jameson; 20th edition 2018; 1763-1769
- DeVita VT, Lawrence TS, Rosenberg SA. Cancer: principles & practice of oncology: primer of the molecular biology of cancer.
- Lippincott Williams & Wilkins; 2012 Mar 28:2947-3010.2. Caron A. Jacobson, Dan L. Longo, Non Hodgekins lymphoma, Loscalzo J, Fauci A, Kasper Longo D, Jameson J. et al,
- Harrison's principles of internal medicine, 21st edition 2022, volume 1, 841-852.3. Greer JP, Arber DA, Glader BE, List AF, Means RM, Rodgers GM.
- Wintrobe's clinical hematology. Lippincott Williams & Wilkins; 2018 Nov 19. 4. Kumar V, Abbas AK, Aster JC. Robbins basicpathology e-book. Elsevier Health Sciences;

THANK YOU