Mini-Review

Mantle Cell Lymphoma And Synchronous Colon Cancer: Interesting Co-Existence And Therapeutic Challenge

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ABSTRACT

Mantle cell lymphoma (MCL) is an aggressive type of lymphoma with frequent involvement of the gastrointestinal (GI) tract. The spectrum of GI involvement is highly variable, from clinically overt disease to the insidious disease which can be diagnosed with multiple biopsies and even electron microscopic examinations. Here a case with MCL and accompanying colon cancer without GI symptoms has been presented and literature has been reviewed.

INTRODUCTION

59 year-old-man admitted to our unit with the diagnosis of MCL. He had been diagnosed as MCL stage III disease at another center. He had been treated by 8 cycles of R-CHOP (Rituximab plus cyclophosphamide-doxorubicin-vincristin-prednisolone) and had been referred for high dose chemotherapy and autologous stem cell transplantation. Physical examination revealed pallor and cervical- axillary lymphadenopathies (2-4 cm diameters). PET CT showed widespread lymph nodes, relative hyperactive areas at liver, and hypermetabolic focus at intestinal wall at left lower quadrant, this image was evaluated as compatible with sigmoid colon (Figure 1). Rectosigmoidoscopic examination was performed and biopsy showed well differentiated adeno cancer. Patient was operated and left hemicolectomy was performed. Pathological examination showed well differentiated adeno carcinoma-colon, 66 lymph nodes were resected: four of them showed adeno cancer metastases and 62 showed MCL infiltration.

After surgery repeated laboratory tests showed: Alkaline phosphatase: 395 IU (upper limit: 240), Lactic dehydrogenase: 645 U, Carcinoembryonic antigen: 11IU, Carbohydrate
antigen 19-9: 114.6, Beta 2 Microglobulin: 5.39
(Upper limit 2.70).

**DISCUSSION**

MCL is a well recognized entity under WHO classification of hemopoietic neoplasias. This entity is characterized by the translocation (11:14) and comprises 5-7% of the cases with non-Hodgkin’s lymphoma (NHL) [1]. Extranodal involvement is an important feature of this type of lymphoma and the majority of the cases with MCL are presented in advanced stage disease [2]. GI involvement in MCL is seen in up to 30% of the cases and most of these cases are asymptomatic for this site of involvement. For this reason GI involvement in MCL is generally underestimated [3-8]. To detect the GI involvement, upper and lower endoscopic examinations must be performed and multiple biopsies must be taken from normal and/or abnormal appearing mucosae. Using molecular techniques, the incidence of GI involvement in MCL is very high, and in some series it has been reported as high as 90% [2, 9]. Our case was asymptomatic for GI involvement but PET-CT suggested GI infiltration. However endoscopic biopsy showed adenocancer and he was operated for this cancer. There were metastases in four lymph nodes but additionally 62 lymph nodes were infiltrated with MCL. This finding showed that our case had colon cancer and lymph node metastases compatible with Stage III colon adenocancer and simultaneously Stage III MCL.

There are some reports about the co-existence of colon cancer and colonic lymphoma in the same patient [10-12]. So far only 5 cases with MCL and colon cancer have been reported. These cases had synchronous MCL and colon cancer or MCL preceded colon cancer. In a retrospective study covering 156 cases with MCL, colonic adenocarcinoma was detected in one case and preceded MCL in this case [13]. Hopster reported a patient with adenocarcinoma of the colon associated with MCL [14]. Kanehira reported two cases of intestinal MCL and co- incidental colon adenocarcinoma [15]. Padmanabhan reported a patient who had adenocarcinoma of the cecum simultaneously with MCL of the colon and terminal ileum with regional involvement of the lymph nodes [16]. Among these cases, MCL developed after 20 months of colon cancer treatment in only one case [17].

Our patient had MCL and PET CT was done
for staging. Although our case had no GI symptoms, PET/CT findings suggested GI involvement by MCL and surprisingly co-incident colonic cancer was detected. If we did not perform PET/CT, probably we could not detect colonic cancer. PET/CT has been found to be a valuable tool to demonstrate the GI involvement of MCL [18]. It is known that Fluoro deoxy glucose (FDG) uptake in GI canal is not rare and it is critical to differentiate the physiologic uptake from pathologic uptake due to carcinomatous, lymphomatous or sarcomatous involvements. If we did not perform colonic biopsy probably it would be evaluated as colonic involvement by MCL.

It is known that MCL requires high dose chemotherapy ad stem cell transplantation for consolidation. Our case had stage III colon cancer requiring adjuvant chemotherapy containing oxaliplatin. On the other hand he had relapsed/advanced stage MCL requiring aggressive-non-cross resistant chemotherapy. Firstly operation was performed for colonic cancer. For salvage chemotherapy of his MCL there was several options: R-Hyper CVAD/MTX (cyclophosphamide-vincrisitin-doxorubicin-dexamethason/methotrexate), R-DHAP (rituximab-dexamethason-cytosine arabinoside-cisplatin), R-ICE (rituximab-ifosfamide-carboplatin-etoposide) or others. On the other hand, gemcitabine containing regimens are useful for relapsed/refractory cases with NHLs. We preferred R-GEMOX (rituximab-gemcitabin-oxaliplatin) for our case and we planned autotransplantation after this salvage regimen. However response could not be achieved. After that he was treated by bortezomib containing regimen but pelvic infection developed and he died.

**CONCLUSION**

GI involvement in MCL, without GI complaints, is not rare and must be thought in cases with MCL. PET/CT used for systemic evaluation of cases with MCL is a useful tool to detect the GI involvement. However biopsy confirmation may show some additional lesions. If all the uptakes are evaluated as GI involvement of underlying lymphoma other lesions cannot be determined accurately.

**REFERENCES**


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