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Commentary

An Unusual Presentation of Extra-Nodal Pelvic Diffuse Large B-Cell Lymphoma

Danial Z Bell, Adel Ekladious*

Department of Medicine, South West Health Campus, Bunbury, Australia

ABSTRACT

An 80 years old man with a history of Rheumatoid Arthritis and Charcot-Marie-Tooth disease presented with urinary retention, constipation, weight loss and anorexia. CT imaging showed a large presacral mass, with tissue biopsy identifying diffuse large B cell lymphoma. PET imaging did not identify any lymphadenopathy. This case illustrates a rare pelvic manifestation of a common haematological malignancy.

Keywords: Rheumatoid arthritis; B-cell lymphoma; Lymphadenopathy

BACKGROUND

Diffuse Large B-Cell Lymphoma (DLBCL) is a common subtype of Non-Hodgkin's Lymphoma (NHL) accounting for 40% of cases [1,2]. Extra-nodal NHL cases have been reported in the literature with primary gastro-intestinal, testis, central nervous system, bone, head and neck, breast and skin lymphomas [3-10]. There is a reported case of a ureteric primary DLBCL with CNS involvement in a 37 years old male, but it is noted that presacral primary lesions are extremely rare [11]. We present a case of pelvic extra-nodal DLBCL remarkable for the lesion location and size.

CASE PRESENTATION

An independent and highly functioning 80 years old man presented to a Western Australian Regional Hospital with four weeks of pelvic pain and increasingly difficult bowel and bladder emptying. This was associated with loss of appetite and weight loss of 4 kg over four weeks. Community investigation with an abdominal Computerised Tomography (CT) identified a large presacral soft tissue mass posterior to the prostate and abutting the right rectal wall. The mass measured 93 × 84 × 87 mm in size exerting external compression on the bladder and rectum.

A CT-guided core biopsy was performed and sent for histological analysis. This identified a Diffuse Large B-Cell Lymphoma. After being transferred to a Metropolitan tertiary hospital for treatment under the care of the haematology department, investigation with a Positronic Emission Tomography (PET) scan revealed intense activity related to the large right pelvic mass without pelvic or distant lymphadenopathy. No splenic or marrow involvement was demonstrated. He was treated for a Stage 2 Diffuse Large B-Cell Lymphoma with cyclophosphamide/vincristine/prednisolone.

On admission his corrected serum calcium was elevated at 3.34 mmol/L, which was refractory to several weeks of IV fluid and bisphosphonate therapy. This was thought to be due to the high tumour burden. His hypercalcaemia of malignancy resolved one week after initiation of anti-neoplastic therapy.

DISCUSSION AND CONCLUSION

This is an atypical case of a sacral DLBCL without musculoskeletal involvement or surrounding tissue or lymph node infiltration with characteristics not previously found on review of the literature. Although sacral primary DLCBL is extremely rare, it should be considered in a patient presenting with a large pelvic tumour. Likewise, this diagnosis also makes the case for pelvic imaging to investigate for NHL, looking for atypical manifestations of this disease. These considerations are crucial as they allow for early identification and diagnosis, which have implications for effectiveness of treatment.

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Correspondence to: Dr. Adel Ekladious, Department of Medicine, South West Health Campus, Bunbury, Australia, E-mail: ekladiou@hotmail.com

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