

A Primary Bone Diffuse Large B-Cell Lymphoma with Ocular Adnexal Involvement

Oküler Adneks Tutulumu Olan Kemiğin Primer Diffüz Büyük B Hücreli Lenfoması

Rafet Eren¹, Ceyda Aslan¹, Cihan Gündoğan², Osman Yokuş¹, Mehmet Hilmi Doğu¹, Elif Suyanı¹

¹Istanbul Training and Research Hospital, Clinic of Hematology, İstanbul, Turkey

²Istanbul Training and Research Hospital, Clinic of Nuclear Medicine, İstanbul, Turkey

To the Editor,

Primary bone lymphomas (PBLs) [1,2] and ocular adnexal (OA) lymphomas [3,4] are rare types of extranodal lymphomas. Coexistence of these two rare entities without lymph node infiltration has not been reported previously.

A 55-year-old man presented with left hip pain without a history of trauma. His medical history and physical examination did not reveal any remarkable findings. The X-ray radiographs of the pelvis and left hip showed multiple lytic lesions. Body ¹⁸fluorodeoxyglucose positron emission tomography/computed tomography (¹⁸F-FDG PET/CT) demonstrated multiple osteolytic bone lesions in the left zygomatic bone, vertebral column, bilateral iliac bones, left caput femoris, and trochanter major of the femur with increased ¹⁸F-FDG uptake (SUVmax: 31) (Figure 1a). Tru-Cut biopsy of the caput femoris showed atypical lymphoid cells that were pancretatin (-), s-100 (-), CD138 (+), CD30 (-), CD20 (+), CD3 (-), CD5 (-), CD10 (-), bcl-6 (+), and MUM-1 (+), consistent with diffuse large B-cell lymphoma. Laboratory data were as follows: erythrocyte sedimentation rate, 37 mm/h; lactate dehydrogenase level, 405 U/L; hemoglobin, 12 g/dL; white blood cell count, 6.74x10⁹/L; platelet count, 250x10⁹/L; normal liver and renal function tests. Bone marrow aspirate and core biopsy were normal. A rituximab, cyclophosphamide, doxorubicine, vincristine, and prednisolone (R-CHOP) regimen was planned. However, prior to the first chemotherapy day, the patient was admitted with swelling of the eyelids, exophthalmos, proptosis, and vision loss in his left eye that developed progressively over 3 days. Magnetic resonance imaging (MRI), which was performed two months after the initial ¹⁸F-FDG PET/CT, showed an orbital mass with diameters of 36x21x38 mm eroding the superior wall of the orbita and adjacent soft tissue (Figure 1b). After the detection of orbital involvement, investigations for central nervous system (CNS) involvement were negative. Chemotherapy treatment was commenced immediately without doing a biopsy because of the patient's vision loss. After 4 cycles of R-CHOP chemotherapy, the patient's left hip pain, left eye swelling, exophthalmos, and proptosis resolved completely, but his vision did not improve. Control ¹⁸F-FDG PET/CT showed marked regression of bone

lesions with decreased ¹⁸F-FDG uptake (SUVmax: 4.6). Orbital MRI also showed that the mass had regressed to 14x12 mm in size. After obtaining this response, 2 cycles of R-CHOP, radiotherapy to the left orbita, and two cycles of high-dose methotrexate for CNS prophylaxis were planned.

Considering the extensive lytic bone lesions and recent emergence of the OA tumor, the primary site of the disease must have been the bones in the presented case. Thus, the diagnosis can be categorized as PBL with OA involvement. An orbital mass was detected two months after diagnosis by means of MRI, but not by ¹⁸F-FDG PET/CT performed at diagnosis. It would be speculative to claim that such a large mass had arisen in a two month period. Taking into account that MRI is the gold standard imaging technique in evaluation of OA tumors [3], the orbital mass, which was probably small at the beginning, could not have been noticed on ¹⁸F-FDG PET/CT. This case emphasizes that a high suspicion index of OA involvement in PBL cases with any symptoms regarding the eyes and prompt assessment of the patients with MRI might prevent undesirable consequences.

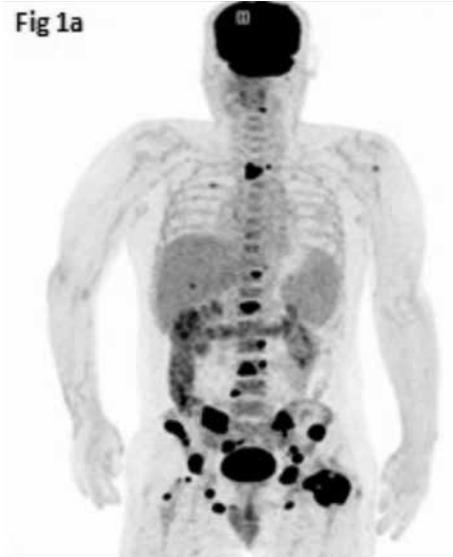


Figure 1a. ¹⁸Fluorodeoxyglucose positron emission tomography/computed tomography image of the patient at diagnosis.



Figure 1b. Magnetic resonance imaging image of orbital adnexal mass.

Keywords: Primary bone lymphoma, Ocular adnexal lymphoma, Diffuse large B-cell lymphoma

Anahtar Sözcükler: Primer kemik lenfoma, Oküler adneks lenfoma, Diffüz büyük B hücreli lenfoma

Ethics

Ethics Committee Approval: Not applicable; Informed Consent: Not applicable.

Authorship Contributions

Surgical and Medical Practices: Rafet Eren, Elif Suyanı; Concept: Rafet Eren, Ceyda Aslan, Cihan Gündoğan, Osman Yokuş, Mehmet Hilmi Doğu, Elif Suyanı; Design: Rafet Eren, Ceyda Aslan, Cihan Gündoğan, Osman Yokuş, Mehmet Hilmi Doğu, Elif Suyanı; Data Collection or Processing: Rafet Eren, Ceyda Aslan, Cihan Gündoğan, Osman Yokuş, Mehmet Hilmi Doğu, Elif Suyanı; Analysis or Interpretation: Rafet Eren, Ceyda Aslan, Cihan Gündoğan, Osman Yokuş, Mehmet Hilmi Doğu, Elif Suyanı; Literature Search: Rafet Eren, Ceyda Aslan, Cihan Gündoğan, Osman Yokuş, Mehmet Hilmi Doğu, Elif Suyanı; Writing: Rafet Eren, Ceyda Aslan, Cihan Gündoğan, Osman Yokuş, Mehmet Hilmi Doğu, Elif Suyanı.

Conflict of Interest: The authors of this paper have no conflicts of interest, including specific financial interests, relationships, and/or affiliations relevant to the subject matter or materials included.

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Address for Correspondence/Yazışma Adresi: Elif SUYANI, M.D.,
İstanbul Training and Research Hospital, Clinic of Hematology, İstanbul, Turkey
Phone : +90 212 459 63 04
E-mail : elifsuyani@hotmail.com

Received/Geliş tarihi: December 12, 2015

Accepted/Kabul tarihi: March 25, 2016

DOI: 10.4274/tjh.2015.0424

Cerebral Sinovenous Thrombosis Mimicking Intracranial Mass

Intrakranial Kitleyi Taklit Eden Serebral Sinovenöz Tromboz

Derya Özyörük

Ankara Children's Hematology and Oncology Training and Research Hospital, Ankara, Turkey

To the Editor,

Cerebral sinovenous thrombosis is rare in children [1]. Most common signs and symptoms are seizure, lethargy, and headache [1,2,3]. We herein report a case diagnosed as cerebral sinovenous thrombosis mimicking an intracranial mass and presenting with increased intracranial pressure symptoms in an adolescent girl.

A 16-year-old girl was admitted to our emergency service with complaints of headache, vomiting, and confusion. Her past medical history was unremarkable. Physical examination revealed facial paralysis and motor weakness on the left side. Magnetic resonance (MR) imaging disclosed a mass (65x42x55 mm) in the right temporal lobe shifting the midline structure from right to left (Figure 1). Because of herniation findings, surgery was performed immediately. Histopathologic investigation showed