Primary Mediastinal Large B-Cell Lymphoma As an Incidental Finding: Report of a Case

Tesadüfen Tanı Konulan Primer Mediastinal Büyük B Hücreli Lenfoma Olgusu

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To the Editor,

A 21-year-old female was examined for an incidentally detected left parahilar mass on chest radiograph which was taken at the time of job application (Figure 1a). Thoracic computed tomography revealed a mass of 10x9x5 cm with irregular lobulated borders in the anterior mediastinum invading the pericardium (Figure 1b). Histopathological examination of the anterior mediastinotomy material revealed large neoplastic B cells staining positive for CD20 and MUM-1, negative for CD10, and with a high Ki-67 proliferation index (80%-90%) (Figure 2). On positron-emission tomography scan, only the mediastinal mass showed increased fludeoxyglucose uptake (SUV_{max}: 18) (Figure 1c). Final diagnosis was stage 1A primary mediastinal large B-cell lymphoma (PMBCL). After 6 cycles of R-CHOP, PET scan showed partial anatomical and metabolic response. R-CHOP was completed to 8 cycles followed by mediastinal radiation. She has now been disease-free for 2 years.

PMBCL, accounting for 2%-4% of all non-Hodgkin lymphomas, often presents as a bulky anterior mediastinal mass and often

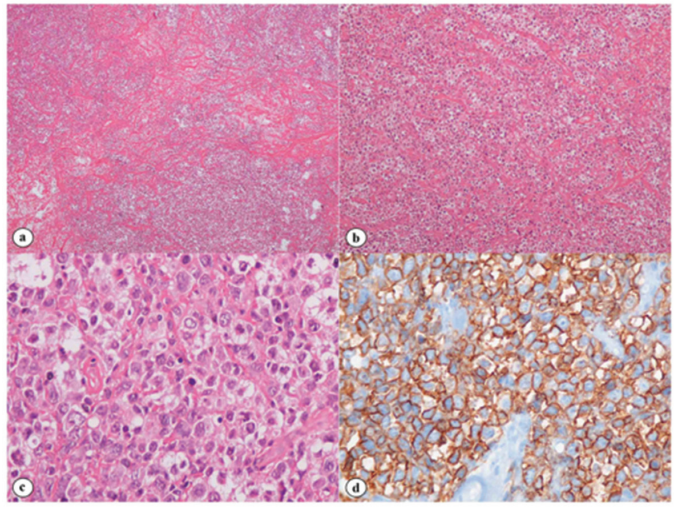

Figure 2. Histopathological examination of the mass. a) Diffuse neoplastic infiltration on a partially sclerotic background (hematoxylin and eosin stain, 40x). b) The clear-cell appearance of the tumor cells (hematoxylin and eosin stain, 100x). c) The appearance of round nuclei (centroblast-like) and clear cytoplasm (hematoxylin and eosin stain, 400x). d) Infiltrated cells with CD20 expression (hematoxylin and eosin stain, 400x).

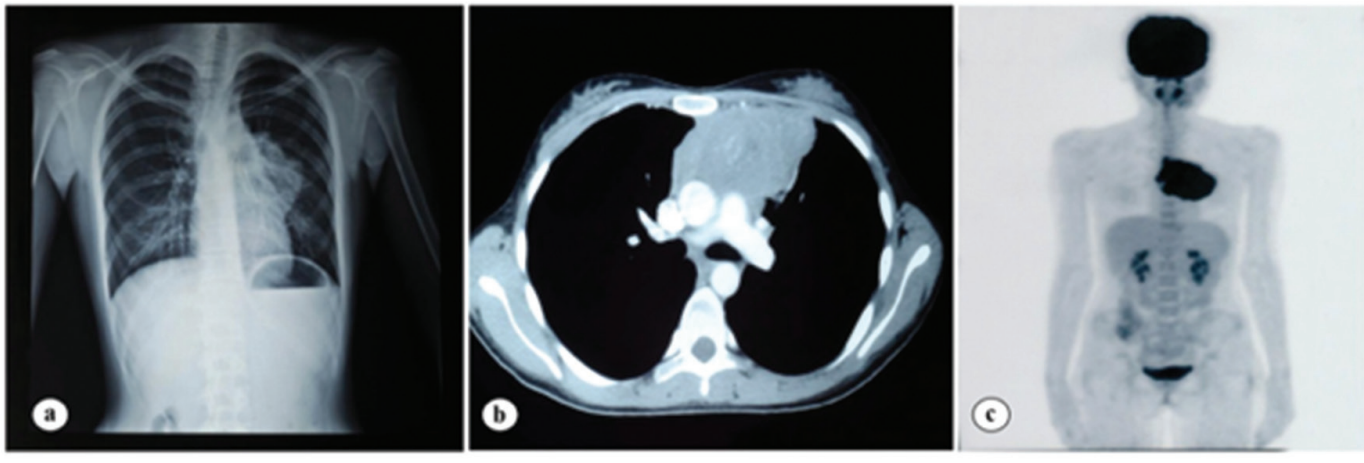

Figure 1. Radiological findings of primary mediastinal B-cell lymphoma. a) Appearance of the left parahilar mass on chest plain film. b) Thorax computed tomography depicts a mass of 10x9x5 cm in the anterior mediastinum with irregular lobulated borders invading the pericardium. c) Positron-emission tomography scan shows increased fludeoxyglucose uptake in the tumor.

invades surrounding structures such as the heart, lungs, pleura, and superior vena cava [1,2]. Patients often present with cough, dyspnea, chest pain, and superior vena cava syndrome [3]. R-CHOP plus consolidative mediastinal radiation is often an option [4]. Herein, we report a rare case of asymptomatic PMBCL with bulky mediastinal mass in which the patient achieved complete remission after R-CHOP and mediastinal radiation.

Keywords: Mediastinal neoplasm, B-cell lymphoma, PMBCL

Anahtar Sözcükler: Mediastinal kitle, B hücreli lenfoma, PMBCL

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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A Rare Late Complication of Port Catheter Implantation: Embolization of the Catheter

Nadir Görülen Bir Port Kateter Geç Komplikasyonu: Kateter Embolizasyonu

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To the Editor,

Children with cancer need long-term venous access due to the long duration of therapy. Long-term totally implantable port devices (TIPDs) are widely used in these patients for administration of chemotherapeutic agents, parenteral nutrition, fluids, and blood products [1,2]. Fracture and embolism of TIPDs are rare complications but may cause serious results and mortality, including pulmonary artery embolism, sepsis, arrhythmias, and perforation of the caval vein [3,4,5]. Herein, we present a 9-year-old male patient with pre-B acute lymphoblastic leukemia who was admitted to the outpatient pediatric hematology and oncology clinic at the 13th month of maintenance therapy due to new onset of non-flushing catheter. The patient had no other complaints. On posterior anterior chest X-ray, the catheter was found to be disconnected from its reservoir (Figure 1). Echocardiography

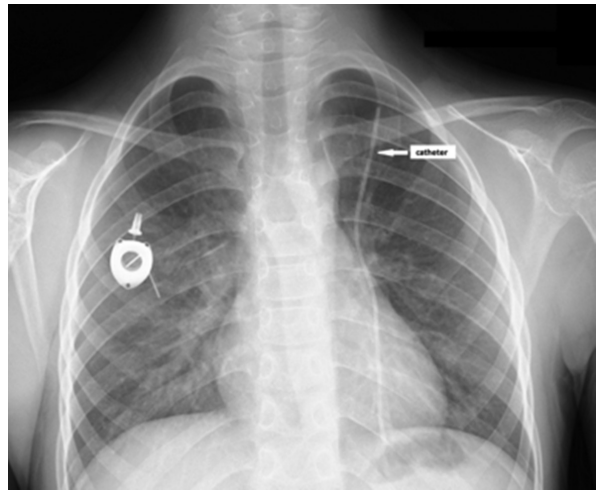

Figure 1. Chest X-ray showing disconnection of the catheter from its reservoir.