Case Report

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Primary Lymphoma of the Rectosigmoid Colon in Patient Cured Previously from the Esophageal Cancer: A Case Report

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ABSTRACT

The vast majority of malignancies in colorectum are carcinoma, which are responsible for about 98% of cases. Located in rectosigmoid junction, it usually deteriorates bowel emptying and is the cause of anal bleeding. As a rule, it presents radiologically with tumor mass and then biopsy taken during endoscopy confirms the diagnosis of carcinoma. In patients treated previously from esophageal malignancy, a secondary carcinoma in the alimentary canal is not an unusual event. However, in our patient treated successfully from esophageal cancer 10 years earlier, we discovered malignant lymphoma in rectosigmoid junction, what happens very rarely in this part of the colon. The diagnosis was made after surgery because preoperatively taken biopsies had not suggested any malignancy in tumor tissue.

Keywords: Lymphoma; Rectosigmoid Colon Malignancy; Esophageal Cancer

Introduction

Secondary carcinoma in the digestive tract in patients treated previously and cured from esophageal carcinoma is not unusual. Synchronous and metachronous secondary carcinoma occur in about 5,8% of patients [1,2]. Carcinomas located in the rectosigmoid junction typically deteriorate bowel emptying with diarrhea and constipation alternately, and are the cause of anal bleeding. The same symptoms can be manifested by other malignancies in this location [3-5]. The clinical symptoms of malignant lymphoma resemble those from carcinoma, together with the same endoscopic and radiological findings [6-9]. Differently from carcinoma, usually nonsurgical oncological treatment is sufficient to cure the patient from lymphoma [6,8,10-14]. Therefore, diagnosis must be confirmed microscopically before any treatment. If pathological analysis of biopsied specimen taken endoscopically fail to recognize the type of malignancy, the patient is subjected to elective surgical treatment with the aim of open biopsy or tumor resection. In more advanced cases, surgery is provided for surgical indications such as: ileus, risk of ileus, or heavy bleeding [7]. Many of these have occurred in our patient.

Case Report

An 83-year-old non-smoking woman, with co-morbid hypertension, atrial fibrillation, and heart failure, was admitted to our department in September 2021. She has been presenting abdominal pain, nausea, constipation and flatulence. She also had complaints of changes in bowel habits, weight loss, and intermittent fever for the last 2 months. Neither palpable mass in digital rectal examination nor peripheral adenopathy were found. Ten years earlier in 2012, she was successfully treated for esophageal squamous cell carcinoma (pT1b-N0M0) with surgical resection (Akiyama procedure). She remains without any signs of recurrence of esophageal cancer. Colonoscopy

revealed circumferential tumor significantly narrowing lumen of the bowel, with inferior tumor border 18 cm from the anal verge. Biopsy specimen had been taken but only purulent inflammatory granulation without any malignancies was diagnosed microscopically. Abdominopelvic computed tomography in accordance with abdomen ultrasound examination revealed the thickening of the rectosigmoid junction wall as 4 cm long. Uterine and small intestine infiltration was suspected. Neither distant nor nodal involvement was seen, or any other signs of dissemination were discovered. The levels of tumor markers like CEA, CA 19-9, CA 125 were in normal range. Clinically, the growing symptoms of subileus motivated the surgical team to perform an operation before the results of pathological estimation of biopsy specimen were taken again from the tumor.

After the abdominal cavity was opened by laparotomy, the large tumor of rectosigmoid colon was found to be infiltrating the uterine wall anteriorly and terminal ileum posteriomedially. No other organs had been involved with malignancy. The anterior rectal resection was performed in one piece with distal sigmoid, two segments of ileum, and a part of posterior wall of the uterine. Histopathological estimation intraoperatively did not reveal any kind of malignancy in the resected specimen. Postoperatively, at the 7th day, eventeration was diagnosed and the patient was subjected to a relaparotomy with successful suturing of the wound. The rehabilitation process for this 83 year old patient with frailty syndrome symptoms was supported by parenteral nutrition, cardiological supervision, and physical exercises with physiotherapists. Finally, after 35 days of hospitalization, we discharged the patient home in a good general condition. Microscopically, diffuse large B cell lymphoma (DLBCL) of the rectum was diagnosed (Figure 1). Results of immunohistochemical staining were as follow: CD20 (+), bcl-6 (+), bcl-2 (-), Ki-67 (+) in about 70 % of cells, EMA (-), CD10 (-), MUM (-), CycD1 (-), c-myc (-), EBV (-), CD30 (-), S-100 (-), CK (-) (Figures 2 & 3). The patient had started chemotherapy with the CHOP scheme (cyclophosphamide, doxorubicin, vincristine, prednisolone). Unfortunately, after the 1st cycle she fell and broke her femur. After recovery, she had cardiological problems and had stimulator implanted. According to her oncologist, this disqualified her of chemotherapy continuation. Despite all of this, no signs of disease recurrence had been discovered until now (December 2022).

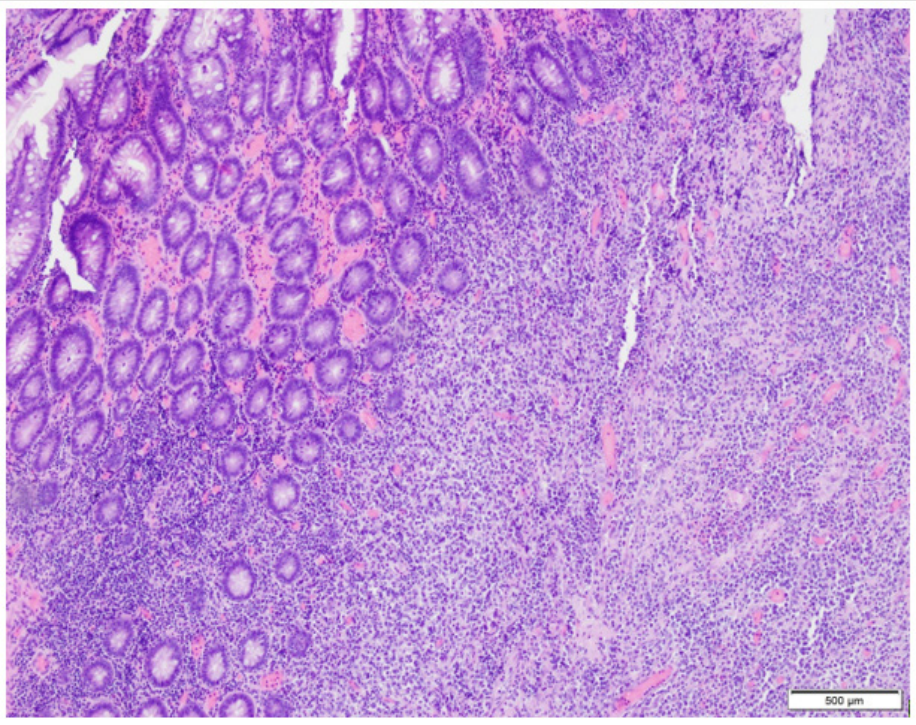

Figure 1: Diffuse large B-cell lymphoma, H&E staining, magnification x10.

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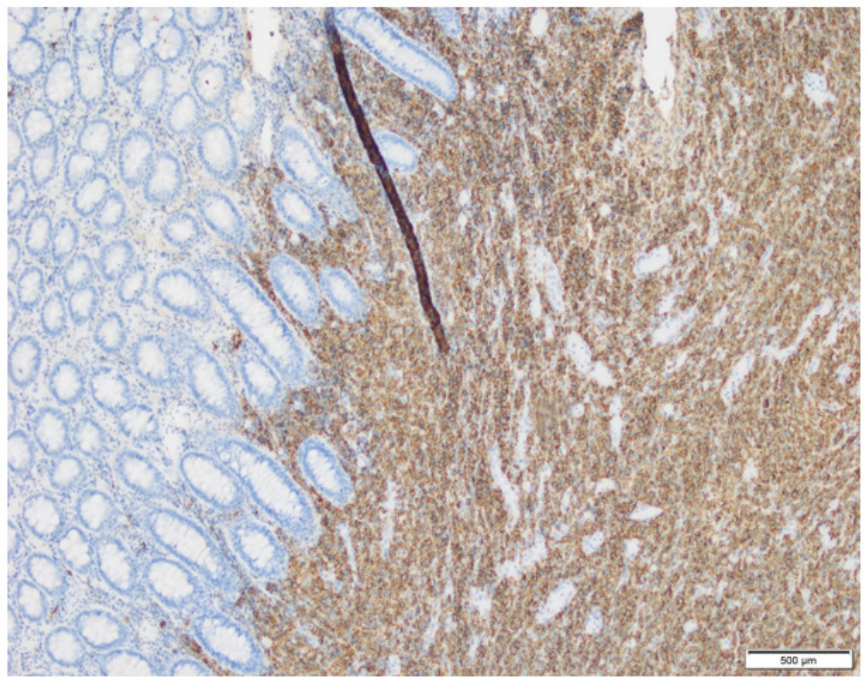

Figure 2: Diffuse large B-cell lymphoma, immunohistochemistry positive for CD20, magnification x10.

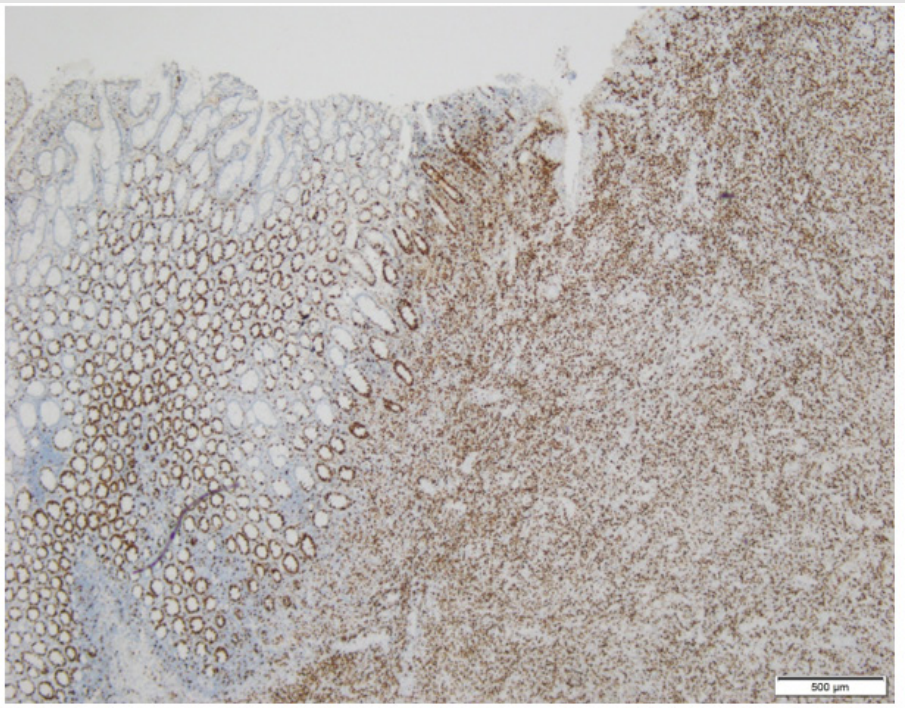

Figure 3: Diffuse large B-cell lymphoma, immunohistochemistry positive for Ki-67, magnification x4.

Discussion

Malignant lymphomas compose a heterogenous group of diseases which have one common feature of lymphocytes clonal growth. We can classified them as Hodgkin's and non-Hodgkin's [15,16]. The most frequent histological subtype occurring in colorectal locations, is non-Hodgkin's Diffuse large B cell lymphoma (80-90 %). Other subtypes are MALT, Burkitt, enteropathy-associated T-cell, mantle cell and follicular lymphoma [4]. According to anatomical presentation, we can divide it into two groups: nodal and extranodal. Among extranodal lymphomas, about 30% are located in the gastrointestinal tract and only 5% of them arise into colon and rectum. The most frequent site of colorectal lymphoma is appendix and caecum (60-70%), followed by the right (20%), and the left colon (10%). However, primary rectal lymphoma is responsible for only 0.05% of all primary rectal malignancies [4]. Since 2006, of more than 1200 patients treated with surgical resections for rectal and rectosigmoid malignancies, this was the first one to have a malignant lymphoma. Per epidemiological data, it occurs most often in people in their 6th decade of life with the male/female ratio of 1,5: 1. The American Cancer Society estimated its incidence in 2010 as about 1 case per 50,000 of population per year [4]. There are still many different approaches used in primary rectal lymphoma management. It is not possible to provide unified guidelines, like in case of colorectal carcinoma, because of the lack of randomized trials as well as cohort studies comparing surgery, chemotherapy, radiotherapy and combination of all these methods. However, the results of adjuvant chemotherapy after surgery seem to improve prognosis [17].

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Authors Contributions

WJK operated on patient and designed case report. MS, WJK, ŁF collected and analyzed all substantial data. RL processed and described histopathological specimen. ŁF took part in patient treatment and drafted manuscript. WJK verified it critically. All authors read and approved the final version of the manuscript.

Competing Interests

The authors declare that they have no competing interests.

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