Plasmablastic lymphoma of the rectum, a rare cause of lower gastrointestinal bleeding: A case report☆

Linfoma plasmablástico de recto. Causa poco frecuente de hemorragia digestiva baja: reporte de un caso

Primary colorectal lymphomas are a rare disorder, corresponding to 0.05% of all colonic neoplasias and 0.1% of primary tumors of the rectum.[1,2] Plasmablastic lymphoma (PL) is a very rare subtype of diffuse large B-cell lymphoma (DLBCL),[3] defined by the WHO as a ''diffuse proliferation of large cells, the majority of which resemble B cells, but have a plasmacytic immunophenotype''.[4] It has distinctive pathologic and clinical characteristics, such as the absence of CD20 expression, positivity for Epstein-Barr virus, an aggressive clinical course, and a close association with the human immunodeficiency virus (HIV). It usually affects the oral cavity but has recently been reported in other extraoral sites.[5] It involves the gastrointestinal tract in 14% of patients and very few cases of rectal involvement have been reported.[6]

We present herein the case of a female patient with PL. A 58-year-old woman with a history of morbid obesity and peripheral venous insufficiency arrived at the emergency service due to deep vein thrombosis in the left leg, associated with phlebitis and severe sepsis. During her hospitalization, she presented with hematochezia that caused hypovolemic shock. Rectosigmoidoscopy revealed a lesion in the rectum that was large, granular, flat, raised, and growing laterally (fig. 1A) that affected 75% of the circumference of the rectum. The superficial mucosa was whitish (fig. 1B and C) with stigmata of recent hemorrhage: multiple small clots adhered to the lesion (fig. 1D). Abdominopelvic tomography showed no intra-intestinal or distant tumor activity.

In the hematoxylin and eosin (H&E) staining of the biopsies taken during the endoscopic study, neoplastic cells mixed with small mature lymphocytes were observed

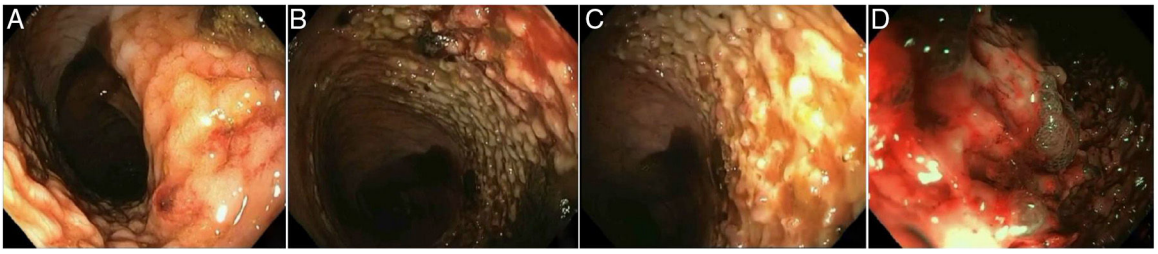

Figure 1 Large, nodular lesion of the rectum with lateral growth (A-C) and stigmata of recent hemorrhage (clots) (D).

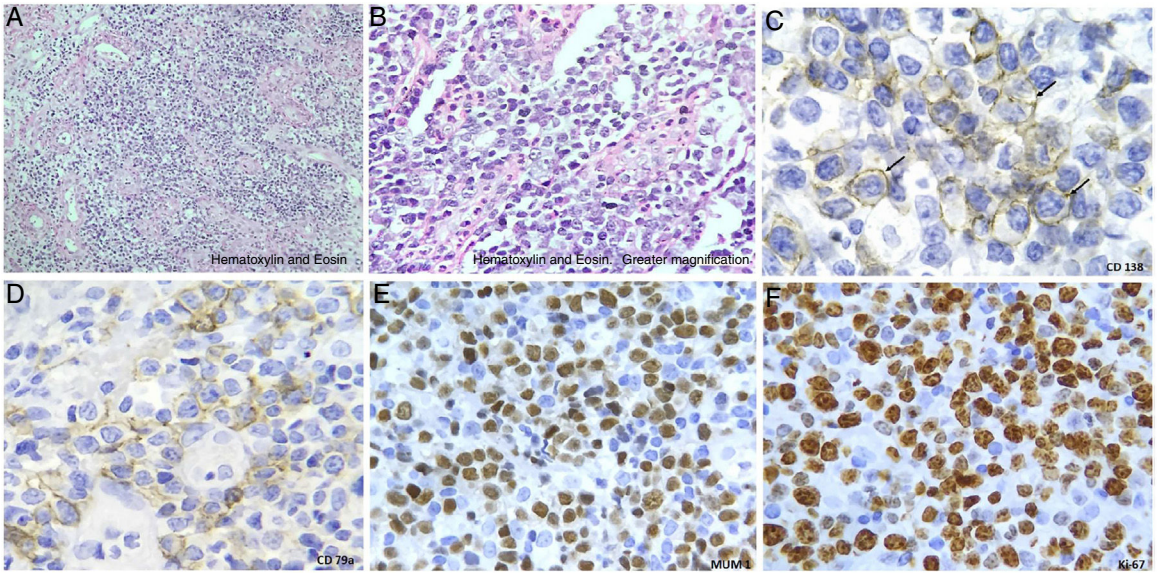

Figure 2 Staining of endoscopic biopsies. A and B) H&E staining showing neoplastic cells mixed with mature lymphocytes, as well as small vessel vasculitis. The neoplastic cells were positive for CD138 (C), CD79a (D), MUM1 (E), and Ki-67 (F).

☆ Please cite this article as: Pérez-Mendoza A, Zárate-Guzmán AM, Lázaro-Pacheco IB, Navarrete-Pérez JJ. Linfoma plasmablástico de recto. Causa poco frecuente de hemorragia digestiva baja: reporte de un caso. Revista de Gastroenterología de México. 2019;84:519–520.

(fig. 2A and B) . Non-Hodgkin's lymphoma was originally reported, for which immunohistochemical staining was carried out. The tumor cells stained positive for CD138 (plasmatic cell membrane marker), CD79a (immature B-cell marker), MUM1 in the nuclei of the tumor cells, and Ki-67 (90%), establishing a high proliferation rate of neoplastic cells (fig. 2C-F). The complete immunohistochemistry panel included: positive Epstein-Barr encoding region (EBER) performed through *in situ* hybridization; positive, focal, and weak Bcl-6; and negative ALK-1, HHV-8, CD20, CD3, Bcl-2, CD5, and CD56. The report's conclusion was plasmablastic lymphoma.

The clinical course was aggressive, with persistence of the septic focus (*Pseudomonas aeruginosa* was isolated) and bleeding recurrence. The patient died 30 days after hospital admission due to hypovolemic and septic shock. The diagnosis was made *post mortem* and it was not possible to look for HIV infection.

Financial disclosure

No financial support was received in relation to this article.

Conflict of interest

The authors declare that there is no conflict of interest.

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2255-534X/

Mid-gastrointestinal bleeding secondary to a gastrointestinal stromal tumor of the jejunum: A case report☆

Hemorragia digestiva media secundaria a tumor estromal gastrointestinal de yeyuno: reporte de caso

Gastrointestinal stromal tumors (GISTs) are considered the most common mesenchymal neoplasias of the digestive tract, with a current incidence of 10 to 20 cases per million inhabitants, according to the latest case series.[1]

A 66-year-old woman with an unremarkable past medical history, had disease onset one month prior, presenting with intermittent colicky abdominal pain of mild intensity, associated with sporadic events of scant-quantity melena, for which she sought medical attention with a private-sector physician. She was diagnosed with gastric ulcer and *Helicobacter pylori* infection and had partial improvement with the prescribed treatment. Two days before hospital admission, abdominal pain reappeared with the same characteristics, but was persistent and more intense. She also had numerous episodes of vomiting of the food content of the stomach. On the day of admission, she presented with 6 episodes of hematochezia, associated with fainting sensation. Clinical examination revealed hemodynamic instability, for which she was given intravenous resuscitation with crystalloids, with partial response. The patient also presented with skin and mucosal pallor and abdominal pain upon deep palpation at the level of the mesogastrium. The findings in the rest of the physical examination were normal. The patient's hemoglobin level was in the severe normocytic-normochromic anemia range (Hb: 6.5 mg/dl), and so she underwent transfusion with 3 units of red blood cells. Later control showed Hb at 8.5 mg/dl. Conventional endoscopic studies were normal. Abdominal tomography scan identified a contrast-enhanced lesion with irregular edges and a 5-6 cm diameter, with hypodense areas in its interior. The lesion was dependent on the small bowel, with no signs of metastasis (fig. 1A). The patient continued to present with daily episodes of hematochezia and melena during her hospitalization. Because our hospital does not offer capsule endoscopy or enteroscopy, the patient underwent exploratory laparoscopy that revealed a multi-

☆ Please cite this article as: Aliaga Ramos JJ, Espinoza Ríos J, Pinto Valdivia JL, Salas Dueñas Y, Chancafe Morgan R. Hemorragia digestiva media secundaria a tumor estromal gastrointestinal de yeyuno: reporte de caso. Revista de Gastroenterología de México. 2019;84:520–522.