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Case Report

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CUTANEOUS METASTASIS IN ABDOMINAL WALL FROM NON-HODGKIN'S LYMPHOMA OF ORAL CAVITY- A RARE PRESENTATION

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INTRODUCTION

Lymphomas are malignant neoplasm of the lymphocyte cell lineages and are classified mainly as Hodgkin's disease and non-Hodgkin's lymphoma (NHL).[1] Hodgkin's lymphoma mostly presented as nodal disease, with a predilection for neck and mediastinal nodes. Approximate 40% NHL presents at an extranodal site.[2] NHL arise from tissues other than lymph nodes and from sites which do not contain any lymphoid tissue, referred to as primary extranodal lymphoma.[3] At least one-fourth of the lymphomas are extranodal origin.[3] Approximate 2% of these extranodal lymphoma may arise primarily in the oral cavity.[2] In the oral cavity, tongue, palate, gingiva, buccal mucosa, floor of the mouth and lips are the primary site of all extranodal lymphomas.[1] Peripheral extra nodal NHL is most common in older age group with male predominance.[1] B cell NHL in the most common lymphoma in oral cavity in nonimmunocompromised adult.[4] Most of the oral lymphoma is a component of a disseminated disease process which involve regional nodes.[2]

In oral cavity, regional lymph nodes are the most common site of metastasis. Non lymphatic distant metastasis accounts for approximately 10% of cases and found typically in lungs, brain, bones and skin.[4] Distant metastasis of oral cancer is rare and cutaneous metastasis of oral cancer is also very rare and it accounts for less than 1% of cases.[5] We herein present a case of NHL of oral cavity with cutaneous metastasis;both of which being extra nodal in nature.

CASE REPORT

A 60 years female presented with anterior abdominal wall swelling since 15 days. On examination swelling measured 2.5x2 cm firm, tender, reddish, non mobile with no ulceration of overlying skin (Fig. 1). FNAC of the lesion was advised, which showed heterogenous population of small to medium size atypical cells with high N:C ratio. Cells had round to oval nucleus, inconspicuous nuclei with scanty cytoplasm. Numerous stripped nuclei, lymphocytes macrophages were also seen. Atypical features indicating the malignant nature were present (Fig. 2). Patient also gave history of swelling in hard palate 2 months back. Excision Biopsy of palatal lesion was performed and on histopathological examination show stratified squamous epithelium covered tissue, diffusely infiltrated by atypical cells (Fig. 3&4). These atypical cells were strongly positive for CD20 (Fig. 5) and patchy positive for CD5. It was thus, diagnosed as non-Hodgkin's lymphoma of B cell type. Distant metastasis was ruled out and appropriate chemotherapy was initiated. Keeping in view the previous history of diagnosed B cell NHL of oral cavity, diagnosis of non-Hodgkin's lymphoma of umblical region swelling presenting as cutaneous metastasis at second extranodal region was made.

Further, PET scan revealed metabolically active disease involving right cervical region, mediastinal mass and left anterior abdominal wall (Fig.6).

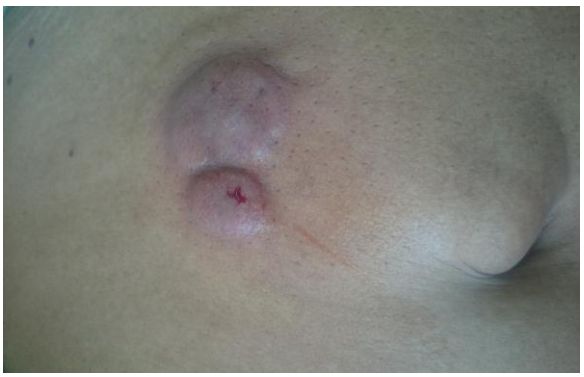

Fig.1: Firm, reddish, tender swelling on anterior abdominal wall.

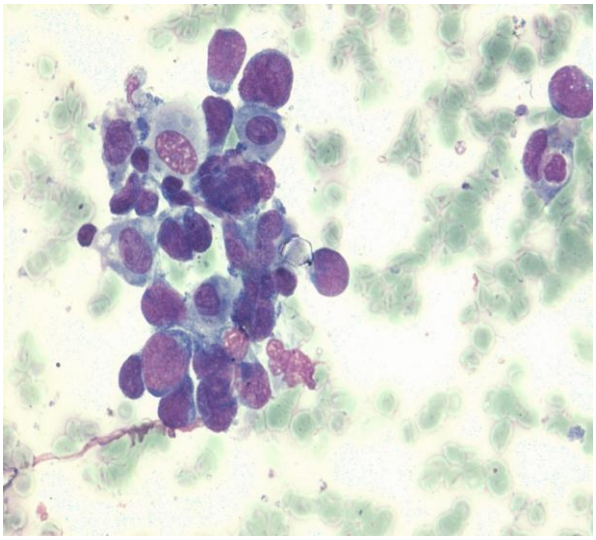

Fig.2: FNAC showing atypical population of cells with high N: C ratio. (Leishman stain: 400 X)

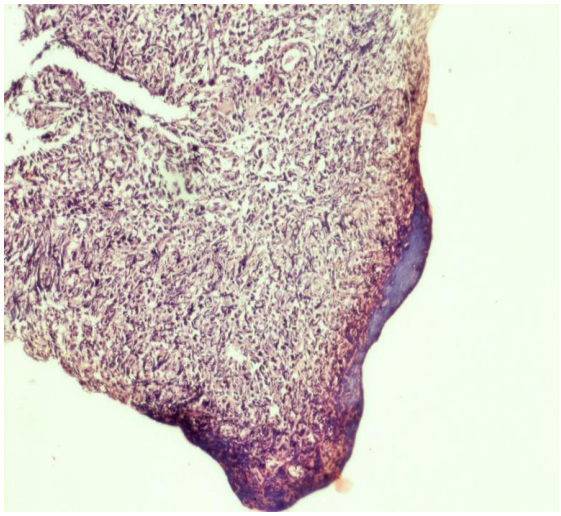

Fig.3: Biopsy of palatal growth (H&E 40 X)

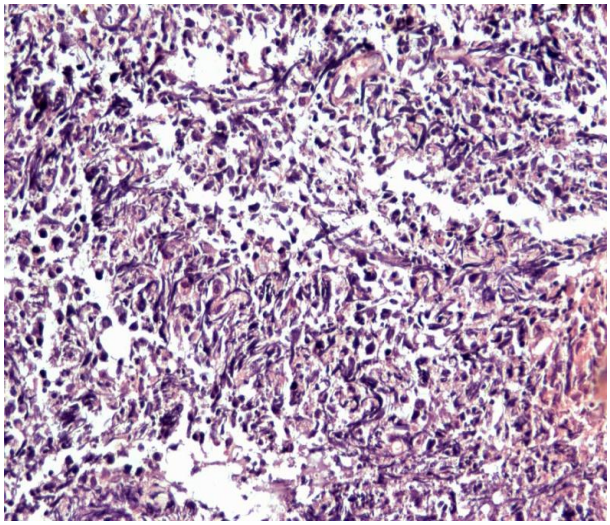

Fig. 4: On high power, diffuse infiltration of mucosa by atypical lymphoid cells. (H&E 100X)

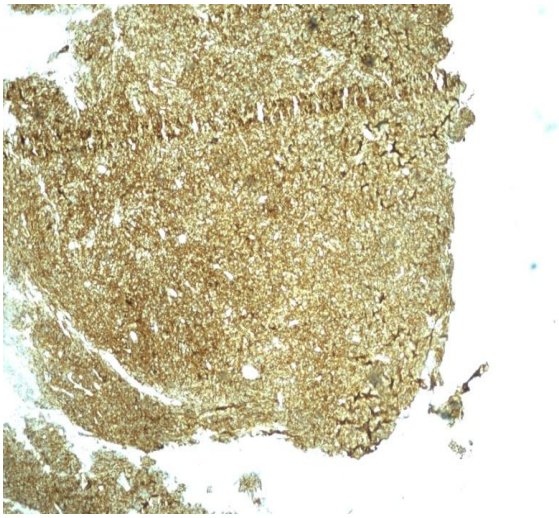

Fig.5: On IHC CD 20 positive (40 X)

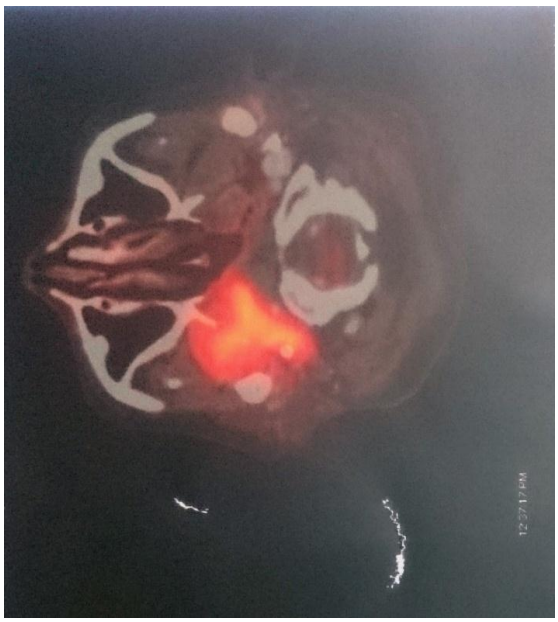

Fig.6: PET CT showing metaboloically active areas

DISCUSSION

Extranodal NHL are often seen in head and neck[1], but intraoral locations are less frequent. B cell NHL presenting with metastasis in skin is also very unusal presentation. Literature mentioned few cases in which primary extra nodal presentation of diffuse large B cell NHL was seen in the gingiva and lip with ulceration of overlying skin.[1] In a study, simultaneous presentation of cutaneous and oral lesion were seen which were misdiagnosed as apthous ulcer and nodular fibroma.[4] On being non responsive to tropical treatment; excision biopsy of the lesion was performed and a diagnosis of B-cell NHLwas made. Differential diagnosis of any oral and skin lesions should include lymphoma which if left undiagnosed lead to fatal morbidity and mortality due to delayed treatment. Extranodal lymphomas by definition remains a controversial issue. Lymphomas are primarily extranodal if 1) absence palpable superficial lymph node. 2). Dominant lesion at extranodal site. 3.) WBC within a

normal range. 4). Absence of mediastinal lymph adenopathy.[3]

FNAC can diagnose a variety of tumors in the skin and support the diagnosis of a metastasis in case of a known primary and offer a clue to underlying malignancy in case of an occult primary.

CONCLUSION

Cutaneous metastasis of an primary lymphoma of oral cavity is a very rare presentation as both the sites are unusual and extra nodal in nature The role of FNAC is important in investigating cutaneous and subcutaneous nodules in patients with known malignancy or as a primary manifestation of an unknown malignancy.

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