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Case Report

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HIV INDUCED NON HODGKINS LYMPHOMA OF LIVER AND PANCREAS: A CASE REPORT

Dr. Pyntyllilang Sanmiet*, Dr. Albert T Pochury, Prof. S. Bhagyabati Devi and Dr. Duyu Hanang

Regional Institute of Medical Sciences Imphal West Manipur, Imphal, Manipur, India.

***Corresponding Author: Dr. Pyntyllilang Sanmiet**

Regional Institute of Medical Sciences Imphal West Manipur, Imphal, Manipur, India.

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INTRODUCTION

Gastrointestinal tract is the second most common site of Non-Hodgkin's lymphomas (NHLs) after nodal lymphoma, accounting for 15-20% of all NHL cases.[1] Stomach is the most common site of extranodal gastrointestinal lymphoma. Although secondary involvement of the pancreas is seen often in cases of gastrointestinal lymphoma, primary pancreatic lymphoma (PPL) is an extremely rare disease that can mimic pancreatic carcinoma. Fewer than 2% of extra-nodal malignant lymphomas and 0.5% of all pancreatic masses constitute PPL. The incidence is expected to be higher in patients of human immunodeficiency virus (HIV) but occurrence of PPL in acquired immunedeficiency syndrome (AIDS) is limited to case reports. The liver is most commonly involved in non-Hodgkin lymphomas (NHL) next to lymph nodes, spleen, and bone marrow. In the vast majority of cases hepatic involvement reflects secondary dissemination in advanced disease.[2]

History and Examination

A 46 year old male patient Presented with c/o generalized weakness and right upper abdominal pain for 1 month the patient was diagnosed as seropositive for HIV 1 antibodies with CD4 count of 120 and was started on TLE regime. The patient was clinically emaciated with jaundice with no obvious abnormality clinically. Per abdominal examination showed no abnormality except for mild tenderness in right upper quadrant.

Investigations

Mild anaemia, raised ESR, decreased leucocyte count, raised bilirubin, liver enzymes (ALT/AST) and ALP and markedly raised LDH(strongly pointing towards malignancy).Alpha Feto Protein, CEA, CA 19-9 levels were within normal range and patient tested negative for HBsAg, HCVAb.

CECT abdomen showed hepatomegaly with multiple hypodense lesions largest one with 2.3cm and pancreatic head shows ill defined hypodense lesion 1.7x1.8cm without significant contrast enhancement with prominent peripancreatic nodes. The provisional differential diagnosis of HCC with metastasis was made. MR abdomen(fig. 2) revealed multifocal nodular lesion in liver with bulky tail of pancreas with cystic lesion s/o HCC. However on FNAC from SOL of liver and pancreas showed immature lymphoid cells in the background of few mature lymphocytes and lymhoglandular bodies s/o hemato lymphoid malignancy.

A CT guided biopsy(fig.2&3) showed HPE high grade lymphoid cells on IHC positive for CD20(B cell marker), CD45(leucocyte common antigen), negative for CD[3] (T cell marker). Hence the diagnosis of Primary NHL involving liver and pancreas was made.

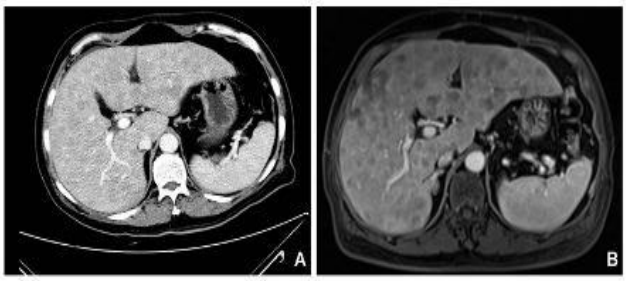

Fig-1. MR abdomen revealed multifocal nodular lesion in liver with bulky tail of pancreas with cystic lesion.

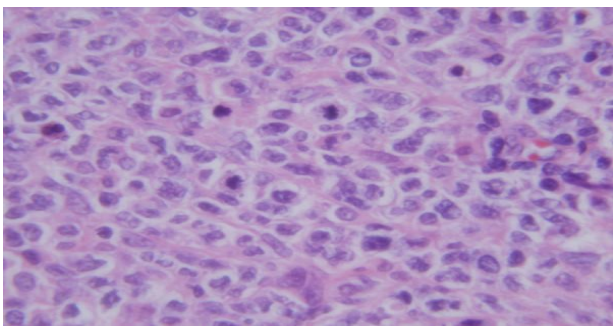

Fig. 2. CT guided biopsy HPE showed high grade lymphoid cells.

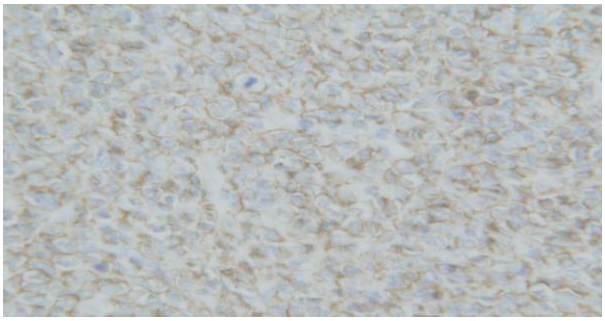

Fig. 3. IHC positive for CD20 and CD45.

DISCUSSION

Lymphomas are classified as Hodgkin's and non-Hodgkin's types. NHLs often involve extra-lymphatic organs, but Hodgkin's lymphomas rarely do so. NHLs may originate from extra-lymphatic organs, and pancreas may be involved about 30% times. Isolated PPL is very rare, and most of them are NHLs3. Liver involvement occurs in 10% of patients and is a sign of advanced disease.[4]

AIDS with NHL of liver and pancreas is a rare occurrence, and a percutaneous biopsy is warranted in such patients before embarking upon surgery. Non operative diagnosis may avoid the need for surgery, as outcomes with chemotherapy and radiotherapy without surgical resection compare favorably to surgical series. The role of surgery and radiotherapy in the treatment of PPL is controversial. Surgery would not be recommended unless nonsurgical diagnosis is unsuccessful, the most common of surgery being a lack of preoperative diagnosis.[5]

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