Case Report

Malignant Lymphoma of the pelvis – A case report

P. Jijiya Bai[1], E. A. Ashok Kumar[2*]

[1]Professor, Department of Pathology, M N R Medical College & Hospital, Sanga Reddy, Telangana, India
[2]Professor, Department of Medicine, M N R Medical College & Hospital, Sanga Reddy, Telangana, India
[*]Corresponding author email: **ashokedla@gmail.com**

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Abstract

Malignant Lymphoma is uncommon in female genital tract. A rare presentation of Malignant Lymphoma of the vagina has been reported here. A 61 years old woman presented with postmenopausal bleeding of 10 days duration. On examination per vaginum, the patient had firm nodular infiltrative growth involving entire posterior vaginal wall and full thickness of recto-vaginal septum. Bleeding ulcer was seen at the superior part of the growth which is extending up to introitus. Cervix was free. Per rectal examination showed infiltration of anterior rectal wall. There was no lymphadenopathy or hepato-splenomegaly. C.T. Scan of abdomen revealed a large malignant soft tissue tumor involving the walls of vagina and infiltrating the rectum. Histopathology of the tumor revealed Diffuse Histiocytic lymphoma.

Key words

Malignant Lymphoma, Pelvis, Vagina, Rectum.

Introduction

Initial manifestation of Malignant Lymphoma in the female genital tract is an unusual occurrence, although involvement of internal and external genitalia by lymphomas is often seen at autopsy and in late stage of the disease. In reviewing the files of the Armed Forces Institute of Pathology by Charlton, et al. [1], it was found that the uterus and vagina were the sites of involvement once in every 730 lymphomas. Most reports have therefore been limited to either single case or small series of patients. Crisp, et al. [2] reported that with the increasing incidence of lymphomas, we may see an increase in pelvic disease, therefore, Gynecologists should be aware of the

manifestations of lymphomas. The diagnosis may be difficult to establish but should be suspected in cases of enlarging, asymptomatic, retroperitoneal masses; in patients with chylous ascitis; or in cases in which the Papanicolaou (Pap) smear shows marked inflammatory changes although many authorities have doubted the existence of primary lymphoma in genital organs. The initial presentations if disease in the genital organs may bring the patient to the attention of the Gynecologist. While laparotomy may often be required for further diagnosis, the surgeon should understand the radical surgery is not curative for a lymphoma. Adequate staging should be done, including biopsies of all nodal groups [2].

Case report

A 61 year old woman reported to M N J Cancer Hospital, Hyderabad on 4-5-1988 with postmenopausal bleeding of 10 days duration. She has 7 children, last child 28 years old, attained menopause 10 years ago.

On examination per vaginum, the patient had firm nodular infiltrative growth involving entire posterior vaginal wall and full thickness of recto-vaginal septum. Bleeding ulcer was seen at the superior part of the growth which is extending upto introitus. Cervix was free. Per rectal examination showed infiltration of anterior rectal wall. There was no lymphadenopathy or hepato-splenomegaly. C.T. Scan of abdomen revealed a large malignant soft tissue tumor involving the walls of vagina and infiltrating the rectum. Histopathology of the tumor revealed Diffuse Histiocytic lymphoma. Her hemoglobin was 11.6 gm%, WBC count was 12,400 cells/mm^3. Bone marrow was uninvolved. X-Ray chest P.A. view was normal. Blood Sugar was 81 mg%; Blood Urea was 26 mg%; S. Uric Acid was 3.6 gm%; LFT was normal; Renal functions were Normal.

Final Diagnosis of Diffuse Histiocytic Lymphoma, Stage IIE was made. Patient received induction Chemotherapy of continuous CHOP for 1 year, consisting of Inj. Endoxan 600 mg/m^2 I.V weekly for 8 weeks, Inj. Adriamycin 60 mg/m^2 I.V on day 1 of 1^{st} week and 5^{th} week, Inj. Vincristine 1.4 mg/m^2 I.V weekly for 8 weeks and Tab. Predinisolene 40 mg/m^2 orally foe 6 weeks, tapered of over next 2 weeks followed by external radiotherapy. External radiotherapy was given with tele cobalt 4000 rads/ 20F/ 5 days a week, 200 rads daily 100 PA (4 weeks) to pelvis, 100 AP Midline dose. She also received continuous maintenance chemotherapy consisting of 4 weeks of CHOP alternating with 4 weeks of drug free interval (Adriamycin on day 1 only) for 1 year. Patient was periodically reviewed. At the fourth visit on 5-7-1989, patient was asymptomatic with complete regression of vaginal rectal infiltration and disease was well under control.

Discussion

Non - Hodgkin's Lymphoma involving the lower genital tract (Uterus, Cervix, Vagina) has been reported under many terms, such as lympho-sarcoma, or reticulum cell sarcoma [3, 4, 5, 6, 7, 8] many of these cases have been initially misdiagnosed. However, the authors [3, 4, 5, 6, 7, 8] have noted that the lesions tend to present early and are responsive to therapy [8]. Several recent reviews have shown that abnormal bleeding is the most common symptom associated with genital tract lymphoma, occurring in 54 to 70 percent of patients [1, 9, 10]. The lesions in the lower genital tract tend to present as expansile lesions enlarging the cervix or uterus or vagina and causing discomfort [9, 10]. The major differential diagnosis is sarcoma and undifferentiated carcinoma, either primary or secondary [1, 9]. Careful examination will demonstrate that in lymphoma the cells infiltrate around the normal tissue (Cervical glands, Vessels) without destroying the normal tissue, as sarcomas or carcinomas do [1]. The use of a touch preparation will often help differentiate lymphoma from carcinoma or sarcoma [9]. While it may be difficult to distinguish a granulocytic sarcoma from a lymphoma, the use of special stains is helpful [6, 9]. This lesion must be distinguished as it represents a form of

acute myelogenous leukemia, which always requires systemic chemotherapy or bone marrow transplantation. Almost 75 percent of patients present with the stage IE disease in the lower genital tract of the uterus, cervix, and vagina are considered as a single organ [9]. This appears to be a reasonable assumption, since they all fall within the local radiation field. Harris and Scully [9] recently reported an overall 73 percent 5 year survival rate for all patients and 89% 5 year Survival rate for stage IE disease. Twelve stage IE patients treated with local therapy alone were without any evidence of relapse. These results are similar to Extra Nodal Non Hodgkin's Lymphoma reported for other organs. Local control for stage I disease, of adequately staged, can be obtained with radiation therapy [9, 10] or even with hysterectomy without radiotherapy if the disease is truly state IE [8]. Disease also involving other lymph node groups (Stage –II and beyond) requires radiation therapy and/or chemotherapy depending on the stage of disease, with chemotherapy required in diffuse disease.

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