Relapse of Mantle Cell Lymphoma as A Pelvic Mass

Kumari Rashmi1, Amar Ranjan1, Harshita Dubey1, Pranay Tanwar1 And Monika Jain1

1Pathology, Jlnmch, Bhagalpur.Lab Oncology Unit, Itrch, AIIMS, New Delhi. Gmc, Bhopal, India

Background: Mantle cell lymphoma (MCL) is a rare B-cell non-Hodgkin lymphoma. It presents with lymphadenopathy, bone marrow involvement and splenomegaly. Extranodal sites can also be involved. We present a case of metastatic mass lesion in pelvis on relapse.

Materials and Method: Case study

Results: A 52 year old male, farmer by occupation presented with easy fatiguability, lymphadenopathy (cervical, axillary & inguinal) and bone pain for last 2 month. On examination hepato-splenomegaly was present. Hemogram showed anaemia & thrombocytopenia. On Peripheral blood smear and Bone marrow (BM) aspirate examination showed near total replacement by abnormal lymphoid cell. BM biopsy showed lymphoid cells positive for CD 20 & Cyclin D1. Flow cytometry showed atypical B-lymphoid cells positive for CD 19, CD 20 and CD 5 & FMC 7 and negative for CD 10, CD 3, CD 23 and CD 200. FISH study showed CCND 1-IGH /t(11,14) positive. CECT confirmed lymphadenopathy & hepato splenomegaly. The diagnosis of mantle cell lymphoma (MCL) stage 4 was made with MIPI score 7/12. Therapy started with Cyclophosphamide 500 mg for 2 days & Dexamethasone 8 mg for 5 days followed by Lenalidomide (Len) + Rituximab 3 doses. But after 3 doses Lenalidomide + Rituximab (R-mab), mild hepatomegaly and enlarged left axillary lymph node (2x1 cm) was persisting. So, Lenalidomide was replaced by Bendamustine. After 4 cycle of BR, clinical improvement was seen with no lymphoma infiltration in BM aspirate. But after completion of 6 # BR, follow up PET-CT showed focal increase in FDG uptake in both humerus and both femur with corresponding cortical irregularity. Scan showed evidence of metabolically active disease involving the left obturator lymph node and multiple skeletal and marrow sites, suggesting recurrence of lymphoma. Now palliative Radiotherapy followed by Len + R-mab which showed clinical improvement with normal counts. After 10 days he presented with left sided flank pain. USG showed moderate hydro-ureteronephrosis (left); managed by Percutaneous Nephrostomy. After 5 months, he had Total Leucocyte Count- 1680/cmm and Absolute Neutrophil Count- 800/cmm. He was managed conservatively. Follow up CT showed lung nodules (bilaterally), B/L multiple renal deposits, mild hydronephrosis (left), Pelvic mass originating from prostate that was involving the pelvic wall & infiltrating bladder. USG guided biopsy from pelvic mass shows lymphoid cells which are positive for CD20 and cyclin-D1 while negative for CD3. MIB-1 labeling index is around 90%, suggesting MCL (blastoid morphology). After that the patient was followed up locally, didn't turn up to our hospital again. Patient died after 40 months of diagnosis.

Conclusion: The most common extranodal sites of involvement are GI tract, Waldeyer’s ring, lung, liver, spleen, bone and skin. In our case pelvic lesion was noticed on relapse, which raised a suspicion of any other solid malignancy. Histopathology along with immunohistochemical examination is an important component for correct diagnosis.

Keywords: Mantle cell lymphoma, Metastasis, Soft tissue lesions