

## CASE REPORT

### PRIMARY COLORECTAL LYMPHOMA: A RARE CASE WITH A PECULIAR PRESENTATION

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**ABSTRACT:** Primary colorectal lymphoma (PCL) is a rare disorder constituting only 20 % of GIT lymphomas and less than 0.6 % of all colorectal neoplasms. Primary colorectal lymphoma involving the recto sigmoid region is reported very rarely in the literature. Our patient is a 22 year old female who presented with a peculiar symptom – acute retention of urine, and was diagnosed as a case of PCL on evaluation.

**KEYWORDS:** Primary colorectal lymphoma; colorectal lymphoma; NHL of colon; GIT lymphoma.

**INTRODUCTION:** Primary colorectal lymphoma (PCL) is a rare disease, constituting less than 20 % of primary gastrointestinal lymphomas.<sup>[1]</sup> The most common site of involvement in large bowel is caecum, probably due to the presence of extensive lymphoid tissue in this region.<sup>[1]</sup> Second common site is the ampullary region of rectum probably due to retention of intestinal contents at this site.<sup>[2]</sup> Here we present an interesting case of primary colorectal lymphoma involving the rectosigmoid junction, rectum and anal canal.

**CASE REPORT: CASE HISTORY:** A 22yr old female presented to our casualty with acute retention of urine. She had the history of altered bowel habits since one month, with occasional blood and mucus with stools. There was no history of loss of weight or appetite. Examination revealed a distended urinary bladder, and a globular mass on per rectal examination at about 2 cms from anal verge. Patient was catheterized, and evaluated by imaging and colonoscopy.

**IMAGING:** Contrast enhanced CT of the abdomen and pelvis revealed a concentric asymmetrical hypodense wall thickening involving the recto sigmoid junction, distal sigmoid colon, rectum and proximal anal canal. Peri rectal fat plane was maintained and there was no significant loco regional lymphadenopathy. Liver and spleen were normal. (FIGURE I – Top – normal liver and spleen, Bottom – circumferential growth involving the rectum) Few microliths were noted in bilateral kidneys. PLAIN CT of chest did not show any significant mediastinal lymphnodes.

**COLONOSCOPY:** Colonoscopy revealed a circumferential ulceroproliferative growth extending 2 cms from the anal verge to about 15 cms into the rectum and involving the recto sigmoid junction. Biopsy was taken from multiple sites.

**HISTOPATHOLOGY:** Histo pathological examination was suggestive of Non hodgkins Lymphoma – Diffuse B cell type, positive for CD 45 and CD 20 (FIGURE II – From top right corner clockwise – CD 45 – Positive, CD 20 – positive, Normal T cells showing CK positivity, CD 3 – negative). Aspiration of the bone marrow yielded a dry tap.

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**BLOOD INVESTIGATION:** No peripheral leukemia, or lymphoid transformation were noted. CEA level was 1.660ng/ml.

**DIAGNOSIS:** Patient was diagnosed as Primary Non hodgkins Lymphoma involving recto sigmoid junction, rectum and anal canal, stage – II E.<sup>[3]</sup>

**TREATMENT:** Patient did not have intestinal obstruction, so she was managed conservatively. Chemotherapy was initiated with CHOP (Cyclophosphamide 750 mg/m<sup>2</sup> day 1, Doxorubicine 50 mg/m<sup>2</sup> day 1, Vincristine 1.4 mg/m<sup>2</sup> day 1, and prednisone 50 mg/m<sup>2</sup> day 1 to 5) regimen. First cycle of chemotherapy was completed. Bladder catheter removed and she voided urine normally. Patient is on surveillance, and advised for review.

**DISCUSSION:** Colorectal lymphomas may occur as either Primary colorectal lymphoma or as a part of generalized lymphoma. Primary colorectal lymphoma is diagnosed based on the following guidelines

1. No palpable superficial lymphadenopathy.
2. No enlargement of mediastinal lymphnodes.
3. Normal total and differential counts.
4. Predominant bowel lesion with only the loco regional lymphnode involvement.
5. Liver and spleen appear free of tumour.
6. Normal bone marrow biopsy.<sup>[2]</sup>

Our patient was well within these guidelines, hence the diagnosis of PCL was made.

Of all NHL, GIT NHL constitutes only 5 %. Among this, colorectal region constitutes only 10 to 20 % of the cases.<sup>[2],[1]</sup> Colorectal lymphomas comprise less than 0.6 % of all colorectal tumours (2). The peak age of occurrence is 50 to 65 years.<sup>[1]</sup>

Common symptoms of presentation of PCL in descending order of frequency include abdominal pain at presentation, weight loss change in bowel habit, weakness, nausea and vomiting, anorexia, fever and bleeding per rectum.<sup>[2]</sup> Our patient presented with acute retention of urine which is not reported in the literature so far.

Macroscopically the tumours may be intraluminal protuberant mass, infiltrative intra or extramural growths. There can also be diffuse involvement of the colon with or without polyps.<sup>[2]</sup>

Diffuse large B cell lymphoma is the commonest histological type. Follicular non hodgkins lymphoma is the rarest histological presentation.<sup>[2],[1]</sup>

Immuno compromised conditions and inflammatory bowel disease are found to be risk factors for the occurrence of PCL. None of these were found in our patient. Operability, size and macroscopic appearance of the tumour appear to be important prognostic factors. Loco regional lymphadenopathy does not affect the survival.<sup>[2]</sup>

The efficacy of combination of surgery and chemotherapy versus chemotherapy alone is not widely studied. Seokjinkim et al in 2011 concluded that combination of surgery and chemotherapy improves survival in localized disease.<sup>[4]</sup> Whereas Beaton C et al, in their study in 2012 have recommended that chemotherapy be the principal mode of treatment and surgery be reserved for patients with clinical indication.<sup>[5]</sup> Our patient was treated with chemotherapy, and surgery was deferred since there was no evidence of obstruction.

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**CONCLUSION:** PCL is a rare condition with non-specific symptoms diagnosed serendipitously. Clear differentiation between PCL and generalized Lymphoma is paramount. The treatment options of PCL is not clear enough as the available literature on the subject is very limited. We report this case for its rarity and peculiar clinical presentation

**ETHICAL STATEMENT:** We warrant that the patient's rights and confidentiality have been well protected in all aspects and she consented to the study described in the Work. All relevant ethical safeguards have been met in relation to patient protection.

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