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**SHORT COMMUNICATION**

# RARE LYMPHOMA, RITUXIMAB AND THE ESOPHAGUS

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**CASE REPORT – SHORT COMMUNICATION**

A 24 year old man with high grade fever, drenching night sweats and significant un-intentional loss of weight of 2 months was started on empirical anti tubercular therapy by a local physician. In view of worsening symptoms and extreme fatigue, he was referred to our centre for specialized investigations. Physical examination revealed tender, rubbery to hard nodular hepatomegaly and a lumpy bumpy splenomegaly in the presence of grade II ascites. Imaging and blood work up suggested hepatomegaly with multiple hypodense necrotic lesions studded in both lobes, additional multiple enlarged necrotic lymph nodes encasing portal vein, aorta, celiac axis and renal vessels and enlarged spleen studded with multiple hypodense heterogeneously enhancing lesions [PANEL A, yellow arrows], normocytic normochromic anaemia, leucocytosis, thrombocytopenia, hyperuricemia, hyperferritenemia and high lactate dehydrogenase (LDH) with preserved liver and renal function with normal alfa-feto protein, CA 19-9 and carcino-embryonic antigen with hepatitis B, C and HIV serology being negative. Biopsy from the liver SOL revealed presence of extensive liver parenchymal infiltration with histiocytes, immunoblastic and centroblastic small and large lymphoid cells with cleaved nuclei, [PANEL B, black arrows] positive for CD 20, [PANEL C] CD 3, CD 68 and negative for CD 30 and CD 15. A diagnosis of non-Hodgkin's lymphoma (T cell/Histiocytic rich B cell, T/HRBCL) was made and the patient started on R-CHOP regimen.

After first dose of therapy, he developed massive hemetemesis for which an esophagogastroduodenoscopy done revealed extensive ulcerative esophagitis. [PANEL D] The patient died subsequently after 2 days of intensive care support. T/HRBCL is an uncommon morphologic variant of diffuse large B-cell lymphoma (DLBCL) predominantly affecting young males, presenting with more 'B' symptoms, involving mainly liver and spleen, with higher LDH levels (than other lymphomas), distinguished by <10 malignant B cells amid major population of reactive T lymphocytes and histiocytes [1]. Treatment is similar to DLBCL +/- anti CD 20 therapy [2]. A rare complication of Rituximab therapy is extensive ulcerative mucositis, seldom reported in medical literature [3]. In such an event, even in the presence of aggressive management, salvaging the patient is difficult.

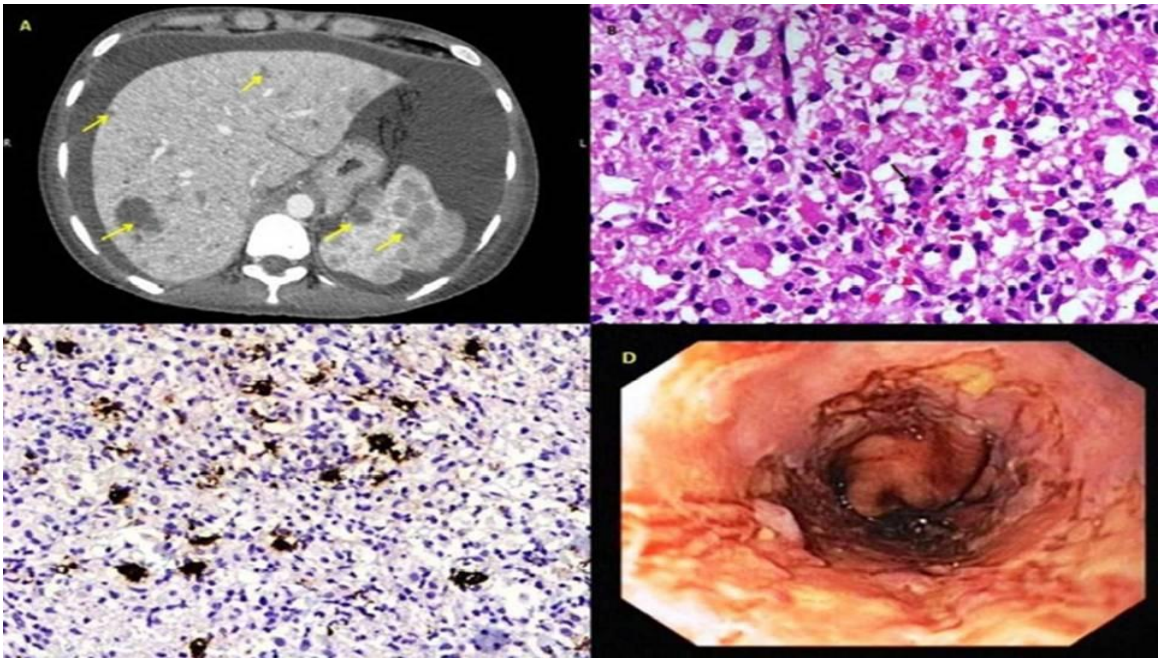


**Figure 1. Computed tomography of abdomen showing hepatomegaly with multiple hypodense necrotic lesions studded in both lobes, additional multiple enlarged necrotic lymph nodes encasing portal vein, aorta, coeliac axis and renal vessels and enlarged spleen revealing multiple hypodense heterogeneously enhancing lesions [PANEL A, yellow arrows]; Biopsy from the liver lesion (H&E stain, 40x) revealing presence of extensive liver parenchymal infiltration with histiocytes, immunoblastic and centroblastic small and large lymphoid cells with cleaved nuclei, [PANEL B, black arrows] positive for CD 20, [immuno-histochemical stain, PANEL C] CD 3, CD 68 and negative for CD 30 and CD 15; Esophagogastroduodenoscopy showing extensive ulcerative esophagitis after first dose of Rituximab [PANEL D].**

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