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Case Report

Intravascular Large B-Cell Lymphoma: A Rare Case Report

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Abstract

Diffuse large B-cell lymphoma is characterized by the infiltration of small vessels by lymphoid cells. These cells are not seen in the systemic circulation. Depending on the involvement location, it may present with different clinics such as central nervous system and skin involvement. Therefore, diagnosis may delay. Diagnosis is based on pathology. Herein we presented a rare patient who initially presented with cellulitis and was ultimately diagnosed with intravascular large B-cell lymphoma.

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Introduction

Diffuse large B-cell lymphoma is a common hematological malignancy that usually presents with signs of peripheral lymphadenopathy, hepatosplenomegaly, and bone marrow suppression, and/or symptoms such as fever, night sweats, and weight loss. Intravascular large B-cell lymphoma is an aggressive and rare tumor characterized by neoplastic cells' tendency to remain in the vessel. Most of the patients are in the middle or advanced age group. The symptoms are related to the lesions caused by the tumor cells' occlusion in the small vessels. Findings related to the central nervous system (convulsions, neurological deficits, progressive dementia) or skin involvement (subcutaneous nodules, plaques) are frequently observed. In patients with skin lesions, the prognosis is better than those with only central nervous system involvement, as early diagnosis can be made by skin biopsy.[1]

Case Report

A 71-year-old female patient with known hypertension was examined with complaints of redness, warmth, swelling, and pain in the legs for about 3 months. Systemic examination revealed

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redness, increased warmth, and edema in the lower extremities. Multiple lymph nodes, the largest of 2x1 cm, were palpated in the bilateral inguinal area. There was no organomegaly. Cellulite and deep vein thrombosis were excluded, skin punch biopsy was performed from the lower extremity. Its pathology resulted in "LCA positive Ki-67 blast lymphoid cell groups with high proliferative activity in subcutaneous vessel lumens". Leukocyte was 6,500/mm³, neutrophil 3,308/mm³, hemoglobin 8.6 g/dL, platelet 181,000/mm³, and sedimentation rate 71 mm/h. The peripheral blood smear was unremarkable. No infiltration was detected in the bone marrow biopsy. Intravascular large B-cell lymphoma Stage 3B was evaluated. R-CHOP chemotherapy was planned for the patient. Since hypermetabolic lymph nodes in the mediastinum and hiluses persisted after 8 cycles of R-CHOP chemotherapy, R-BENDA was planned as a second-line treatment. Lenalidomide+Rituximab was chosen as the treatment plan for the patient who was evaluated as stable disease by PET-CT after 4 cycles of R-BENDA. The follow-up and treatment of the patient continue in Bursa Uludag University Faculty of Medicine Hematology Department.

Discussion

Although diffuse large B-cell lymphoma is the most common subtype among non-hodgkin lymphomas, its variant, intravascular large B-cell lymphoma, is a scarce form.[2] The diagnosis can be easily missed due to nonspecific presentations, infective and vascular problems included in the differential diagnosis. The main diagnosis is based on pathology. Neoplastic cells are rarely seen in the bone marrow, and peripheral blood smears, so intravascular large B-cell lymphoma diagnosis is difficult. Most of the reported cases have been confirmed by autopsy or cutaneous biopsies.[3] In conclusion, we think it would be appropriate to evaluate the skin lesions that could not be diagnosed specifically in lymphoma infiltration.

Conflict of Interests

Authors declare that there are none.

Acknowledgment

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