CUTANEOUS AND SYSTEMIC LYMPHOMAS OF CONCORDANT OR DISCORDANT B- AND T-CELL PHENOTYPE IN THE SAME PATIENT: TWO CASE REPORTS

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BACKGROUND

The development of two different Non-Hodgkin lymphomas in the same patient is an unlikely coincidence due to the low prevalence of each malignancy. However, a significantly increased risk of developing a second lymphoma was observed in patients with cutaneous T-cell lymphoma (CTCL) in both population-based and clinic-based data[1]. Most cases reported describe the occurrence of concomitant lymphomas of discordant B- and T-cell phenotypes, mainly MF and Chronic Lymphocytic Leukemia[2]. On the opposite, few cases of concomitant systemic and cutaneous B-cell lymphomas have been reported[3,4].

CASE 1: A YOUNG WOMAN WITH THE DIAGNOSIS OF THREE B-CELL LYMPHOMAS

37 Years-old

- Right cervical cutaneous nodule
- Treatment: excision

PRIMARY CUTANEOUS MARGINAL ZONE LYMPHOMA (pcMZL)

3 years later

RELAPSE pcMZL

- Temporal region nodule
- Treatment: excision

1 year later

- Isolated right cervical lymphadenopathy
- Diagnosis on excisional biopsy
- Ann Arbor stage I
- Treatment: Chemotherapy CHOP* x 6 cycles with Complete Response.

Systemic DIFFUSE LARGE B-CELL LYMPHOMA

2 years later

SYSTEMIC FOLICULAR LYMPHOMA

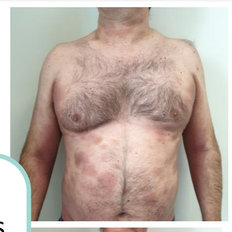
- Asymptomatic cervical and inguinal lymph node enlargement
- Diagnosis on inguinal lymph node biopsy
- Watch & wait for 10 years
- Extra-nodal involvement motivated treatment with R-FC[§] followed by radiotherapy → PR[&].
- Progressed twice in following 3 years, treated with radiotherapy, achieving PR[&].

5-year follow-up: asymptomatic

** CHOP: cyclophosphamide, doxorubicin, vincristine and prednisolone; § R-FC: rituximab-fludarabine and cyclophosphamide; & PR: partial response.*

CASE 2: A PATIENT WITH TWO LYMPHOMAS OF DISCORDANT PHENOTYPE

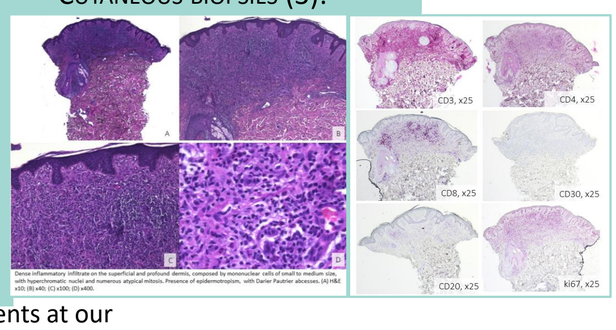
51 Years-old



Cutaneous erythematous patches and plaques on the abdómen and upper limbs for 10 years

Presents at our dermatology clinic

CUTANEOUS BIOPSIES (3):



Dense inflammatory infiltrate on the superficial and profound dermis, composed by mononuclear cells of small to medium size, with hyperchromatic nuclei and numerous atypical mitosis. Presence of epidermotropism, with Darier Pautrier abscesses. (A) H&E x10; (B) x40; (C) x100; (D) x400.

MYCOSIS FUNGOIDES (MF) stage IB

WORKUP:

PET Scan: without lymphadenopathy nor hepatic or splenic infiltration

Bone marrow biopsy: without infiltration by lymphoma

Chemoimmunotherapy: R-CHOP* x 6 cycles

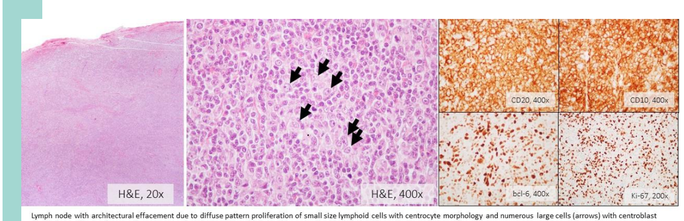
Downstaging to MF IA

FOLLOW-UP:
MF IA
DLBCL CR

10 years — 3 months — 5 months — 1 year

Bilateral inguinal lymph node enlargement

Excisional biopsy: folicular lymphoma



Lymph node with architectural effacement due to diffuse pattern proliferation of small size lymphoid cells with centrocyte morphology and numerous large cells (arrows) with centroblast morphology. The neoplastic cells are positive for CD20, CD10 and Bcl-6 and negative for CD5, CD43,Bcl-2, cyclin D1, MUM-1 and c-myc.

PATHOLOGY EXAMINATION REVIEW AT OUR HOSPITAL

DIFFUSE LARGE B-CELL LYMPHOMA (DLBCL), NON-GERMINAL CENTER TYPE Ann Arbor II

Complete Response (DLCBCL)

** R-CHOP: rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone..*

DISCUSSION

We report the cases of two patients with systemic and primary cutaneous lymphomas, one of which with concomitant diagnosis of lymphomas of discordant lineage and another with sequential diagnosis of 3 lymphomas of concordant lineage. Both situations represent diagnostic challenges and enhance the importance of pathological examination to confirm relapse or lymph node involvement. In the cases we present, this led to diagnosis of another type of lymphoma that otherwise would have been missed, probably leading to treatment delay.
In the face of the diagnosis of two simultaneous lymphomas in the same patient, multidisciplinary specialized care should guide stagging in order that both diseases are accurately staged and specific treatment for each disease is implemented when applicable.

CONCLUSIONS

The occurrence of concomitant systemic and cutaneous lymphomas of discordant or concordant lineages may represent a diagnostic challenge.
As the treatment of each lymphoma is often different, their correct identification is critical for optimal management of both diseases.

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