Acta Scientific Gastrointestinal Disorders (ISSN: 2582-1091)

Volume 8 Issue 7 July 2025

Case Report

An Case of A Weight Loss Due to Primary GI Lymphoma of Colon with Jejunum

Jaya Ghosh Chatterjee[1]*, Suman Sarkar[2], Rajib Bhattacharjee[3] and S Mndol[4]

[1]*Senior Consultant Gastroenterologist, Peerless Hospiotal Kolkata, India*

[2]*YR Post Doctoral Trainee, Gastroenterology, Peerless Hospital, India*

[3]*Oncologist, Peerless Hosiptal, India*

[4]*Senior GI Surgeon, Peerless Hospital, India*

***Corresponding Author:** Jaya Ghosh Chatterjee; Senior Consultant Gastroenterologist, Peerless Hospiotal Kolkata, India.

Received: May 27, 2025

Published: June 14, 2025

Abstract

Primary GI lymphoma is not a very common entity. It constitutes about 1-4% of all Gi malignancies. In contrast to the common extra nodal intestinal lymphoma, intestinal lymphoma of primary origin is obscure. We report an interesting case of 63-year-male presented with a history of significant weight loss associated with bilateral pedal swelling and generalized weakness over 2 months. Colonoscopy revealed a large nodular ulcerated growth in caecum and ascending colon with a deformed IC valve and narrowing which was not passable. Surgical biopsy following exploratory laparotomy with resection and anastomosis was suggestive of Diffuse Large B Cell Lymphoma of colon. As primary GI lymphoma is colon is rare along with simultaneous jejunal lesion , also the presentation with a large right colonic mass without any features of intestinal obstruction, except weight loss and fatigue, we found it to an interesting case to report.

Keywords: Weight Loss; Primary GI Lymphoma; Colon; Jejunum

Case Report

A 63-year-old gentleman presented with H/o progressive unintentional weight loss and extreme fatiguability and marked anorexia for the past 2 months. He also noticed bilateral pedal swelling for the last 2 weeks and consulted us worrying that he might have some liver related illness. there was no significant history of abdominal pain, vomiting, nausea. His bowel habits are regular, with no definite history of diarrhea or any recent alteration of bowel habit. No fever, night sweats, cough, jaundice, pruritus', hematemesis, melena. There was no significant history of blood transfusion and surgery in the past with no significant family history. He was a retired person with a sedentary lifestyle. He is non-diabetic, hypertensive, dyslipidemia on medications - on Telmisartan and Atorvastatin and has no history of alcohol and smoking. Physical examination showed- mild pallor, no palpable lymph node. Oral cavity normal. No clubbing, jaundice, neck veins not engorged. He had bilateral pitting pedal edema. BP was 110/65 mmHg. Pulse-89/ min regular. Body weight of 54 kg - lost 8 kg in 2 month. He was afebrile. Chest and Cardiovascular system was unremarkable. Per abdomen- there was no palpable mass, with no shifting dullness, normal liver span. Per rectal and genitals were normal.

His blood reports showed anemia, low albumin, hyponatremia. Hb 8.6, TC 4530, DC N 72% L15%, M6%, E4%, B3% Platelet 2.25 lakh, PBS- no abnormal cells, normocytic normochromic anemia. Na 126, K 4, Total bilirubin 0.4, ALT 16, AST 20, Albumin 1.52, Globulin 2.68, Alkaline Phosphatase 107, GGT 13, Creatinine 0.92. Echo done Showed Normal Sized Cardiac Chambers, No RWMA, EF 60%, USG abdomen - no significant findings obtained.

Urine routine was normal.

CT abdomen on 02/03/2024 CECT abdomen showed a mass lesion in caecum and proximal ascending colon with peri serosal fat stranding and paracolic nodes, retroperitoneal and mesenteric lymph nodes. no ascites, liver, spleen normal, duodenal diverticula.

Colonoscopy on 03/04/2024 showed large nodular ulcerated growth in caecum and ascending colon, deformed IC valve, angioectasia right colon, left colonic divericula, scope was non negiotable through the mass , HPE suggestive of lymphoproliferative malignancy .

Patient underwent right hemicolectomy with loop ileostomy + Jejunojejunal bypass on 13.04.2024 as large caecal mass extending upto proximal ascending colon. multiple skip lesions in small bowel causing subacute intestinal obstruction at jejunum.

Histopathology of the surgically resected specimen from both colon and jejunum revealed Diffuse large B cell Lymphoma, Non-GCB type. On IHC tumor cells were diffusely positive for PAX 5, CD 20, CD 79a, bcl 2, bcl 6, Cyclin D1. Ki 67 proliferative index was 75-80%.

He was referred to our oncology team, Whole Body PET-CT study (03/05/2024) - Status post right hemicolectomy with ileostomy. Hypermetabolic enhancing non-obstructive wall thickening in pyloric antrum, first & second parts of duodenum, multiple segments of jejunum and ileum? consistent with lymphomatous involvement. Hypermetabolic supra as well as Infra-diaphragmatic (mediastinal, right hilar, internal mammary, multiple mesenteric and retroperitoneal) lymphadenopathy? lymphomatous involvement. Hypermetabolic enhancing pleural thickening on right side? represent lymphomatous deposits. Minimal right pleural effusion. No other metabolically active lesion in rest of the whole body survey. Overall imaging features are suggestive of lymphomatous involvement on both sides of diaphragm with extranodal dissemination? stage IV.

He received 6 cycles of R - Pola - CHP regimen (CT6 - 11.09.2024), He then received 1 maintenance RITUXIMAB (As per POLARIX 1 protocol).

But then he was admitted with severe loose motion. Inj. OCTRIDE (100 mcg) S/C was started on loose motion and could not be controlled. Probiotic support given. Stool was negative for Cl. Difficile toxin. Routine stool no pus cells, or RBC, Antibiotic coverage was with METROGYL and RIFAXIMINE. 8th cycle RITUXIMAB was cancelled due to diarrhoea.

Whole body PET CT Scan (22/10/2024) continued remission. Patient gained weight, appetite improved and ileostomy closure was done by surgical team in jan 2025. Now he is on follow up.

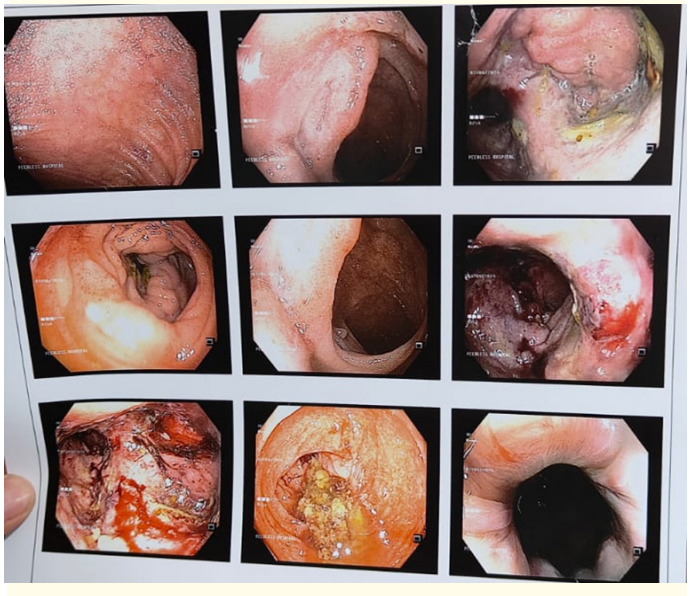

Figure 1: Showing a large nodular ulcerate growth in caecum and ascending colon.

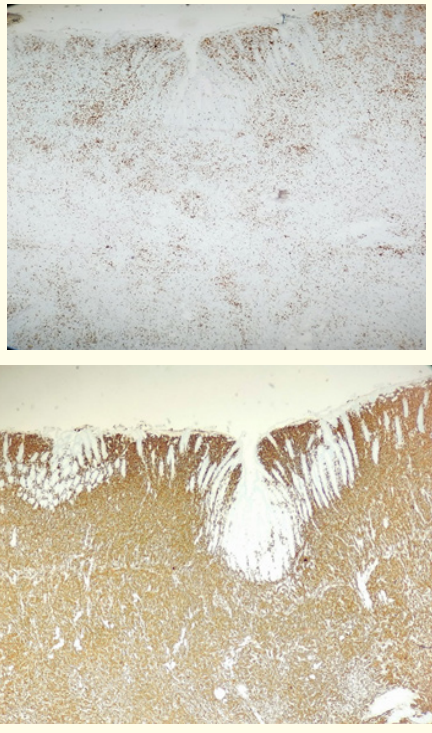

Figure 2: IHC staining cells are diffusely positive for PAX 5, CD 20, CD 79a, bcl 2, bcl 6, Cyclin D1.

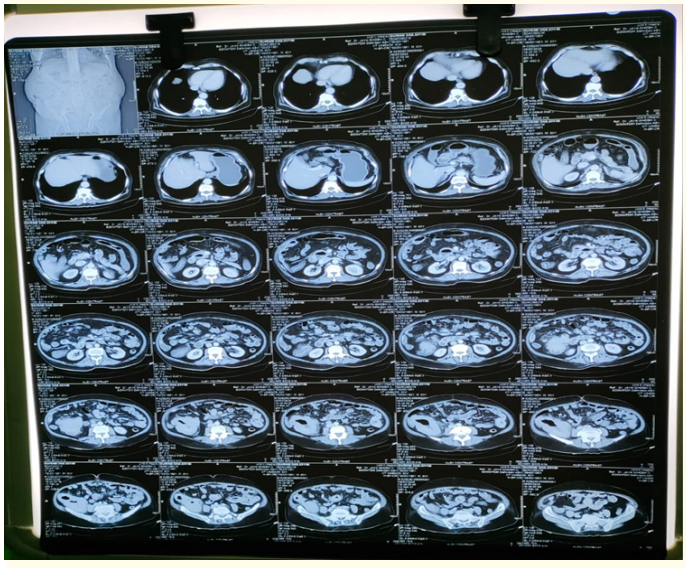

Figure 3: CT SCAN-Mass lesion in caecum and proximal ascending colon.

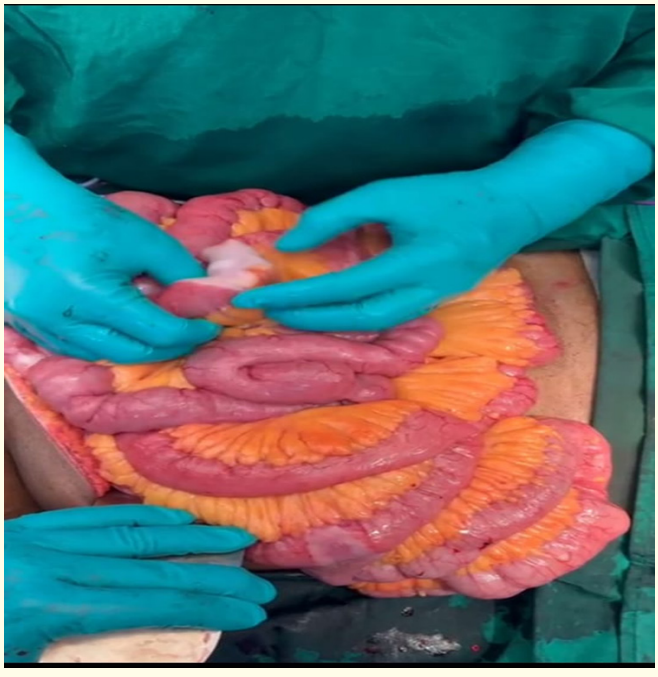

Figure 4: Surgical specimen showing jejunal involvement showing evidence of simultaneous involvement.

Discussion

Gi tract is the most common extra nodal site involved by lymphoma accounting for 5-20% of all cases [1]. Primary GI lymphoma is a rarity and comprised 1-4% of all gi malignancies and 10-15 % of all NHL and can occur in any part of GI tract most commonly in stomach followed by small intestine, and colon is a rare site of involvement. It is frequently observed in 6th decade of life with a male preponderance. Isolated colonic involvement is a rare occurrence. Stomach is the commonest site in developing countries whereas small intestine involvement is common in middle east. Certain risk factors have been implicated in the pathogenesis of gastrointestinal lymphoma including Helicobacter pylori (H. pylori) infection, human immunodeficiency virus (HIV), celiac disease, Campylobacter jejuni (C. jejuni), Epstein-Barr virus (EBV), hepatitis B virus (HBV), human T-cell lymphotropic virus-1 (HTLV-1), inflammatory bowel disease and immunosuppression [3,4]. In this case growth was limited to ascending colon and caecum and involvement of jejunum. Dawson's criteria are used for labeling primary gastrointestinal lymphoma, that include [1] absence of peripheral lymphadenopa-

thy at the time of presentation; [2] lack of enlarged mediastinal lymph nodes; [3] normal total and differential white blood cell count; [4] predominance of bowel lesion at the time of laparotomy with only lymph nodes obviously affected in the immediate vicinity; and [5] no lymphomatous involvement of liver and spleen [5]. The peculiarity of this case is despite being such a large mass no signs of bowel obstruction and altered bowel habit were present. simultaneous involvement of jejunum is also not common. and B symptoms are generally absent in DLBCL however in this patient B symptom in the form of weight loss was present.

Histopathological examination done on the surgical specimen revealed Diffuse Large B cell Lymphoma. IHC revealed that in terms of the cell of origin classification, the lymphoma was of Non Germinal B Cell type. In a recent phase 3 study, POLARIX trial, it was seen that among patients with previously untreated intermediate-risk or high-risk DLBCL, the risk of disease progression, relapse, or death was lower among those who received pola-R-CHP than among those who received R-CHOP [6]. The Polatuzumab is an antibody drug conjugate which had shown overall survival benefit in a post hoc subgroup analysis in Stage 4 DLBCL and Activated B Cell type of DLBCL [6]. Our patient had a diagnosis of non-GCB type of DLBCL and a majority of non GCB types are ABC. Furthermore, He had a stage 4 disease and his IPI Score was high. In all these subgroups, Adding Polatuzumab to RCHP produced survival advantage.

Conclusion

Colon as site for primary GI lymphoma is rare among all GI lymphoma- NHL. Simultaneous colon and jejunal occurrence are also not common . B symptoms are not frequent in DLBCL although he had significantly weight loss, anorexia without any features of bowel alteration, which made this case to be interesting to present.

Bibliography

1. Freeman C., *et al.* "Occurrence and prognosis of extra nodal lymphomas". *Cancer* 29 (1972): 252-260.

2. Herrmann R., *et al.* "Gastrointestinal involvement in non-Hodgkin's lymphoma". *Cancer* 46 (1980): 215-222.

3. Nakamura S and Matsumoto T. "Gastrointestinal lymphoma: recent advances in diagnosis and treatment". *Digestion* 87 (2013): 182-188.

4. Sabattini E., *et al.* "WHO classification of tumors of hematopoietic and lymphoid tissues in 2008: an overview". *Pathologica* 102 (2010): 83-87.

5. Dawson IM., *et al.* "Primary malignant lymphoid tumors of the intestinal tract. Report of 37 cases with a study of factors influencing prognosis". *British Journal of Surgery* 49 (1961): 80-89.