Ileocaecal Lymphoma Presenting as Ileocolic Intussusception in a 7 Year Old Male

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Received: 12 March 2015 / Accepted: 14 April 2015 / Published online: 14 May 2015
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Sir,

Intussusception is a common cause of intestinal obstruction in children. It commonly occurs between 6 and 24 months and associated with Peyer's patch hyperplasia secondary to adenovirus, enterovirus, rotavirus or human herpes virus type- 6 infections. Above 2 years true pathological lead points like Meckel's diverticulum, hamartomatous polyp, hemangiomas, lymphomas and even invaginated appendicular stump can be demonstrated. [1] Primary gastrointestinal lymphoma constitutes only 1.4 % of all gastrointestinal malignancies and is a rare cause of intussusceptions. [2, 3] We report a case of ileocaecal lymphoma presenting as ileocolic intussusception.

A 7 year old boy came with history of abdominal pain since 1 month. Pain was gradual in onset and progressive in nature. Colicky type distributed throughout the umbilical region with no aggravating or relieving factors. There was history of melaena and loss of weight. There was no fever or vomiting. On examination an oval mass measuring 4X4 cms was seen in the left hypochondrium having smooth borders and well de-

fined margins. Ultrasound and barium swallow revealed ileocolic intussusception. Hydrostatic reduction was tried but was in vain. Hence, emergency laparotomy with right partial hemicolectomy was performed. Post operative period was uneventful. Grossly, we received distal part of ileum, caecum, appendix and part of ascending colon. On dissection an exophytic polypoid growth measuring 5X4 cms was seen in the ileocaecal junction forming the intussusceptum (Fig. 1a, b). There were no locoregional lymph nodes. Microscopically, diffuse proliferation of monotonous population of large atypical lymphoid cells having single prominent nucleoli (immunoblasts) infiltrating all the layers of the distal ileum and caecum (Fig. 1c, d). Immunohistochemistry was positive for CD20 (Fig. 2) and BCL 6. The final diagnosis of ileocaecal diffuse large B cell lymphoma-immunoblastic type causing ileocolic intussusception was made. Patient was put on chemotherapy who tolerated well and on 2 year follow he is doing well without any recurrence or metastasis.

The first report of intussusception was made in 1674 by Barbet of Amsterdam. In 1871 Jonathan Hutchinson was first to successfully operate on a child with intussusception. [4] Mucosa associated lymphoid tissue (MALT) and diffuse large B cell lymphomas (DLBCL) are the two histologic subtypes most commonly observed in intestinal lymphomas. [2] The risk factors include helicobacter pylori infection, inflammatory bowel diseases, autoimmune disorders, immunodeficiency disorders, transplantation, celiac disease and nodular lymphoid hyperplasia. [3, 4] Its classical imaging features include the target or doughnut sign in the transverse view and the pseudo kidney, sandwich or hayfork

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Fig 1 **a** Gross specimen consisting of distal part of ileum, appendix, caecum and exophytic polypoid growth forming intussusceptum. **b** Cut section of the growth showing homogeneous grey white areas. **c** Low power microphotograph displaying ulcerated colonic mucosa with diffuse infiltration of monotonous lymphoid cells in the submucosa and muscularis propria. (H&E stain X10x) **d** High power view displaying intermediate to large sized atypical lymphoid cells having single prominent nucleoli (immunoblasts) (H&E stain X45x)

sign in the longitudinal view. [4] Abdominal CT is currently considered the most sensitive radiological method for confirming intussusception with a reported diagnostic accuracy of 58 % to 100 %.[3, 4] The clas-

sical clinical symptoms include pain abdomen, currant jelly stools and vomiting which is seen in only in 20 % of cases. Hence, high degree of clinical suspicion and CT scan is warranted to diagnose intussusception. Surgery is indicated whenever surgical lead point is identified and followed by histopathological examination. Although rare, ileocaecal lymphoma should be considered as a differential diagnosis in patients above 2 years coming with intussusception.

Fig 2 Immunohistochemistry staining for CD20 displaying strong membrane positivity

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