

Gastric non-Hodgkin's lymphoma

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A 42-year-old female patient was admitted due to epigastric pain and weight loss. Her past medical history was otherwise negative apart from cigarette smoking. Her physical examination was unremarkable. C-reactive protein and erythrocyte sedimentation rate were raised up to 14.8 mg/dL and 51 mm/h respectively, platelets were 453,000, while the remaining laboratory tests were normal.

Upper gastrointestinal endoscopy revealed a well-defined polypoid mass in the fundus with a diameter of about 2 cm (Fig. 1A). A computed tomography scan followed, showing protruding irregular gastric lesions and a pancreatic mass (Fig. 1B). Histopathological examination of the gastric lesions revealed infiltration of gastric mucosa by diffuse large B-cell lymphoma (mitotic index Ki-67 60%) (Fig. 1C). The patient commenced on standard chemotherapy with good response.

Extranodal non-Hodgkin's lymphoma (NHL) may be initially seen as primary gastrointestinal (GI) lymphoma (rare) or as disseminated nodal disease secondarily involving the GI tract. Diffuse large B-cell lymphoma is the most common NHL subtype [1]. GI tract and especially the stomach is the most frequent extranodal site in NHL. Endoscopically the secondary gastric NHL might present as polypoid in ulcerative and infiltrative lesions; it can involve all parts of the stomach, usually with multifocal tumors [2,3]. Endoscopists should be aware of the diverse appearance of this neoplasm.

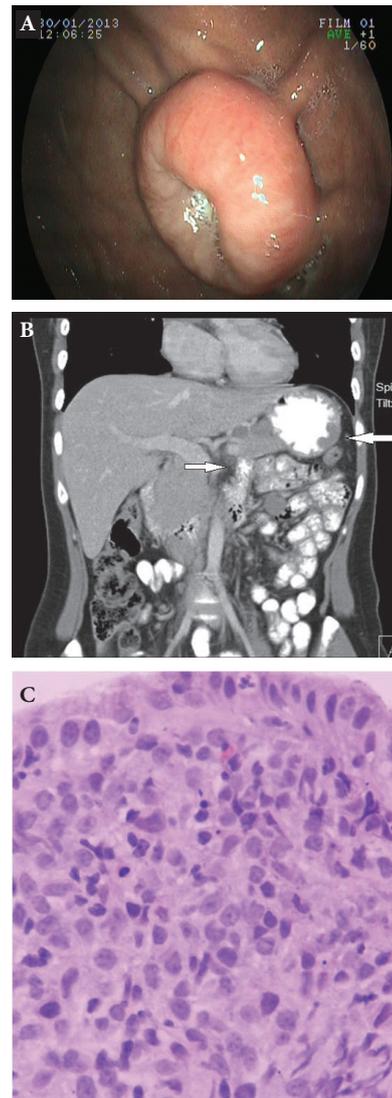


Figure 1 (A) Polypoid lesion in the fundus. (B) Coronal computed tomography scan demonstrating a compact mass lesion in the fundus of the stomach (thick arrow), with local thickening of the wall and a central crater with smooth contour. Furthermore it shows a compact heterogeneous lesion in the neck of the pancreas with malignant characteristics (thin arrow). (C) Gastric mucosa infiltrated by diffuse large B-cell lymphoma (H & E X 400)

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