Rare cause of pancolitis

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Accepted 3 February 2016

DESCRIPTION

A 63-year-old Caucasian man was admitted to the emergency department due to hematochezia. He also referred mild abdominal pain, constipation and tenesmus intermittently in the past 4 months. He had been submitted to a colonoscopy 1 year before, and it was unremarkable. A new colonoscopy was performed and showed pancolitis with areas of deep ulceration, areas with linear ulcers with cobblestone appearance and multiple pseudopolyps (figure 1). Biopsies were performed, which showed a dense lymphocytic infiltrate with small and medium size cells D20+, CD5+, BCL2+, cyclin D1+, CD3– and CD 10–, compatible with a mantle cell lymphoma in colonic mucosa with areas of blastoid variant cells (figure 2). Cervicothoracoabdominopelvic CT showed extensive lymphadenopathy and splenomegaly, and a lymph node biopsy confirmed the diagnosis. The patient was started on chemotherapy and is currently alive, 6 months after diagnosis, despite the poor prognosis.

The patient's age, symptoms and endoscopic appearance were compatible with inflammatory bowel disease (IBD), however, obtaining biopsy specimens was essential to a correct diagnosis. In the differential diagnosis of pancolitis, not only

IBD but infectious and neoplastic conditions should also be considered. Involvement of the colon and rectum by lymphomas is rare (<1% of all non-Hodgkin's lymphomas (NHL)).¹ Mantle cell lymphoma is a rare NHL that affects mainly males in the seventh decade of life.² If the lower gastrointestinal tract is involved, colonoscopy can show ulceration, a single large mass (even in these cases occlusive symptoms are rare), a diffuse lymphomatous polyposis (endoscopically similar to adenomatous polyposis), or a combination of these.^{2 3}

Learning points

- Mantle cell lymphoma is a cause of pancolitis, and its differential diagnosis including IBD can be challenging, mainly if symptoms, patient's age and endoscopic appearance are suggestive.
- Both diseases can present with involvement of the entire colon (pancolitis) with ulceration, diffuse polyposis, a (pseudo) tumoural mass, or a combination of these.

Figure 1 Colonoscopy showing pancolitis with areas of linear ulcers with cobblestone appearance (A), multiple pseudopolyps (B) and deep ulceration of the ileocaecal valve (C).

Figure 2 Histology of colonic biopsies showing a dense lymphocytic infiltrate with small-sized and medium-sized cells. (A) H&E staining, magnification $\times 10$. (B) H&E staining, magnification $\times 40$. (C) Positive immunohistochemical for cyclin D1, magnification $\times 20$.

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To cite: Carmo J, Marques S, Ilgenfritz R, et al. *BMJ Case Rep* Published online: [please include Day Month Year] doi:10.1136/bcr-2016-214468

Contributors JC wrote the manuscript. SM and DS were responsible for the revision of its contents. JC and SM followed the patient. DS performed the endoscopic examination. RI performed the histopathological analysis of the colonic biopsies.

Competing interests None declared.

Patient consent Not obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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