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Case Report

Acute Diverticulitis as a form of Presentation of Follicular Lymphoma of the Colon

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Abstract:

Follicular lymphoma is the second most-common subtype of non-Hodgkin lymphoma, after Diffuse large B-cell lymphoma. Primary lymphomas of the gastrointestinal tract are rare, with secondary intestinal involvement being more common. We present the case of a 68-year-old male patient who was diagnosed with colonic follicular lymphoma during the study for recurrent acute diverticulitis.

Key words: lymphoma; follicular; diverticulitis; lymphadenopathy; colon

Introduction

Follicular lymphoma (FL) is the second most prevalent non-Hodgkin lymphoma, although colonic involvement is rare. The usual clinical presentation is diarrhea, abdominal pain, constipation and micro or macroscopic bleeding [1].

Below, we present the case of a patient who was diagnosed with colonic follicular lymphoma during the study of recurrent acute diverticulitis.

History and current illness:

A 68-year-old man with no relevant history except for an episode of acute diverticulitis in April 2021, with involvement of the mesosigma and Hinchey type I B intramural collection, which was managed conservatively. In the outpatient follow-up of this process, after several weeks of antibiotic therapy, an abdominopelvic CT scan was performed, which showed a practical resolution of the intramural collection but with persistence of retroperitoneal lymphadenopathy of significant size, as well as abundant mesenteric, mesosigma, and iliac lymph nodes. A colonoscopy was performed that showed an edematous and stenotic area about 20 cm from the anal sphincter that appeared to be post-inflammatory. Proximal to this, a mucosa with spontaneous bleeding was observed that was biopsied. No malignant lesions were detected. In the meantime, while waiting for the anatomopathological results, the patient presents with acute abdominal symptoms (pain, distension and absence of bowel movements) for which he goes to the emergency room and is admitted.

Physical exploration:

Cardiorespiratory examination without relevant findings, the abdomen was soft, painful on deep palpation in the hypogastrium and left iliac fossa, although without signs of peritonism, rectal examination without alterations.

Supplementary tests:

The initial blood analysis revealed a leukocytosis of 15,000/µL (4,000-11,000/µL) with neutrophilia and C-reactive protein (CRP) of 245 mg/L (0-0.5 mg/L), as well as anemia with a profile of chronic disorders. The abdominal x-ray showed abundant gas without signs of intestinal obstruction. An abdominopelvic CT with intravenous contrast was performed (Figure. 1, 2 and 3) in which radiological data compatible with a new episode of diverticulitis were observed, as well as an abscess on the lower surface of the sigmoid.

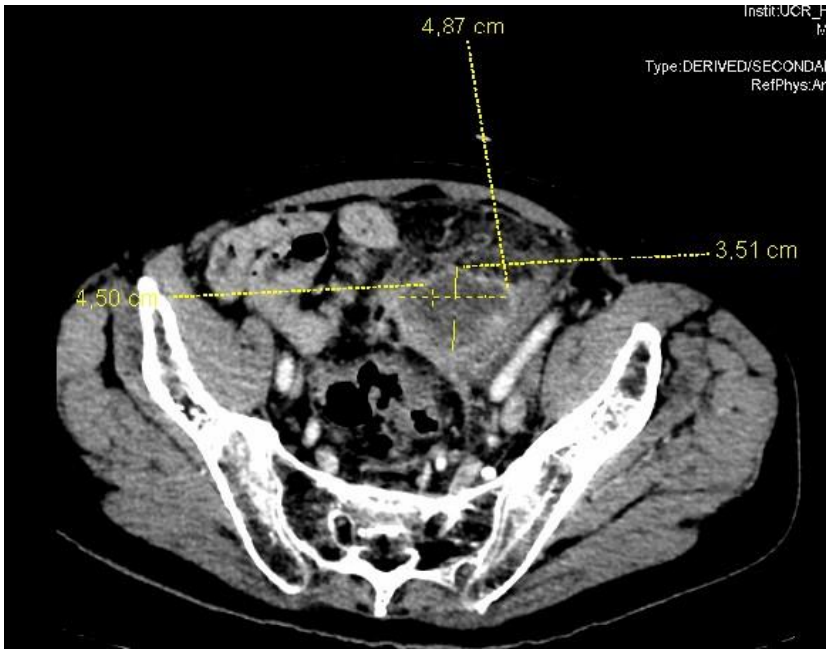

Figure 1: Transverse section of abdominopelvic CT, with abscess measuring 4'87x3'51cm

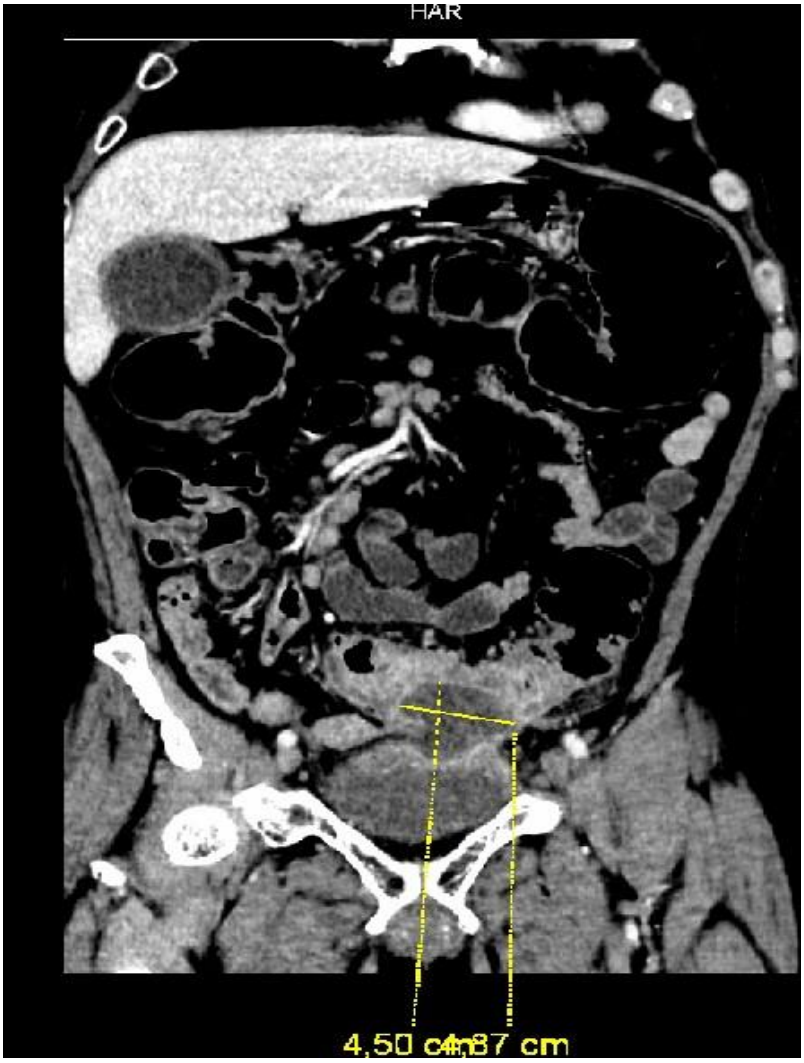

Figure 2: Coronal section of abdominopelvic CT, with abscess measuring 4.5 x 4.87 cm

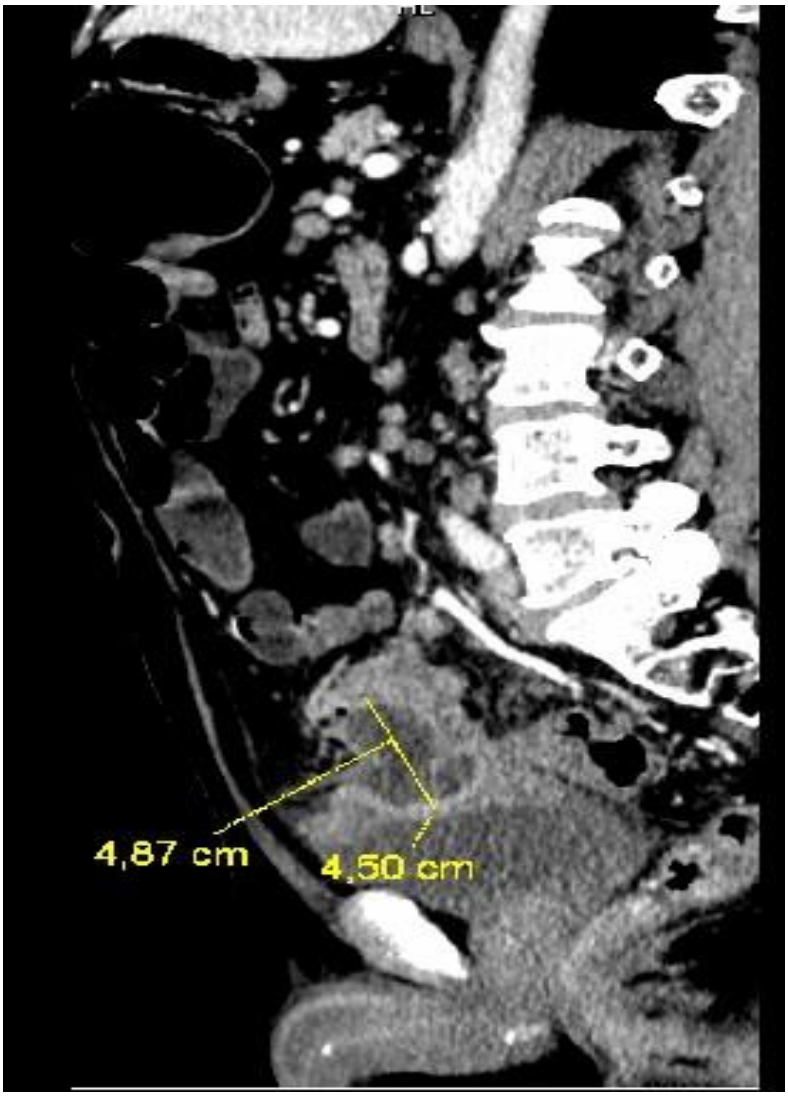

Figure 3: Sagittal section of abdominopelvic CT, with abscess measuring 4.87 x 4.5 cm

In addition, multiple pathologically sized lymphadenopathy, already present in the previous study, was observed on CT. Pathology results from outpatient colonoscopy showed CD10-positive tumor cells.

Evolution:

Despite parenteral antibiotic therapy (piperacillin/tazobactam), a poor clinical, analytical and radiological evolution was observed, with growth of the abdominal abscess, for which surgical treatment by open sigmoidectomy with terminal colostomy was indicated. The study of the surgical specimen confirmed the presence of numerous diverticula with acute leukocyte and histiocytic infiltrate, leukocyte accumulations in the intestinal wall with abscessed areas. In addition, an extensive neoplastic proliferation of lymphoid habit was observed that formed nodules with a focal tendency to fusion, and that appeared transmurally in the intestinal wall and in the subserous adipose tissue, as well as in the 19 isolated lymph nodes. These neoplastic follicles were formed by a mixture of small and intermediate sized lymphocytes (centrocyte type) with others of larger size and centroblast morphology, accounting for <15 centroblasts/CGA. They presented a CD20+ /CD79+/ BCL2+/ BCL6+ / CD10 +/ CD3 -/ CD5-/ CD23-/CD21-/ MUM1 - /CD30- / IgD - / IgM immunophenotype. No diffuse areas of growth were observed and the proliferative index (Ki 67), although variable, was low (between 5-10%). The diagnosis was low-grade follicular B lymphoma (G2) with a predominant nodular pattern.

The extension study (cervico-thoracic CT) revealed subcentimeter lymph nodes in the right supraclavicular region, upper abdomen, lower mesenteric chain, ileocolic and in the retroperitoneum. The bone marrow aspirate and biopsy detected a minority clonal B population compatible with follicular lymphoma.

The first cycle of chemotherapy with Rituximab-Bendamustine was started. In the second cycle, the patient presented fever, diarrhea and elevated reactants that resolved with parenteral antibiotic therapy, as well as a red eye compatible with CMV chorioretinitis (bendamustine was suspended) that responded to treatment with ganciclovir and prednisone. Subsequently, rituximab was administered bimonthly for two years, with complete metabolic remission persisting on Positron Emission Tomography (PET-CT).

PARAMETER	ADVERSE FACTOR
Age	>60 years
Stadium	III or IV*
Hb level	<12 gr/dl
DHL level	>AI upper normal limit
No. affected lymph node area	>4

Risk Category	Nº. Prognostic Factors	Survival %	
		5 years	10 years
Low	**0-1**	**91**	**71**
Intermediate	**2-3**	**78**	**51**
high	**4-5**	**52**	**36**

Table 1: FLIPI scale. International Index for Follicular Lymphomas.

In patients in stage I, the curative treatment is radiotherapy. In asymptomatic patients with low tumor burden, regardless of stage (II, III, IV), close observation (watchful waiting) can be performed, postponing active treatment at the onset of symptoms or if the disease progresses (3,4).

In our patient, disease progression was observed, with greater lymph node and colonic involvement in the second abdominal CT. Furthermore, he had a FLIPI 4 (high risk category) so treatment with rituximab and bendamustine was started (5).

Other treatment options are:

1.- Rituximab as monotherapy, used in our patient after the first two cycles of combined therapy due to the appearance of relevant infectious complications.

2.- R-CHOP (cyclophosphamide, doxirubicin, vincristine, prednisone and rituximab), which becomes the second choice due to a greater number of adverse reactions (6).

3.- Targeted therapy with a kinase inhibitor, monoclonal antibody or lenalidomide. 4.- Immunotherapy with CAR T Cells, is an option for patients with multiple falls. Because most patients with relapsed FL have favorable outcomes with other, less toxic treatment options, CAR-T therapy is generally reserved for patients with multiple relapses with short durations of prior remission (e.g., <24 months). Axicabtagene ciloleucel (axi-cel), tisagenlecleucel (tisa-cel), and Lisocabtagene maraleucel (liso-cel) are CD19-directed CAR-T immunotherapies that have received accelerated approval by the FDA for the treatment of adults with relapsed or refractory FL after two or more lines of systemic therapy. Cytokine release syndrome (CRS) and neurotoxicity syndrome associated with immune effector cell, serious complications of CAR-T therapy, are possible (7,8).

5.- Bone marrow/stem cell transplant.

Highlights:

Colon follicular lymphoma is a very low prevalence process and can simulate or be associated with inflammatory/infectious intestinal pathology. However, the presence of multiple intra-abdominal lymphadenopathy strongly supports its diagnosis.

Bibliografía:

1. Sant M, Allemani C, Tereanu C, et al. Incidence of hematologic malignancies in Europe by morphologic subtype: results of the HAEMACARE project. Blood 2010; 116:3724.
2. Dreyling M, Ghielmini M, Rule S, et al. Newly diagnosed and relapsed follicular lymphoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol 2021; 32:298.
3. Solal-Céligny P, Roy P, Colombat P, et al. Follicular lymphoma international Prognostic index. Blood 2004; 104:1258.
4. Batlevi CL, Sha F, Alperovich A, et al. Follicular lymphoma in the modern era: survival, treatment outcomes, and identification of high-risk subgroups. Blood Cancer J 2020; 10:74.
5. Burke JM, van der Jagt RH, Kahl BS, et al. Differences in Quality of Life Between Bendamustine-Rituximab and R-CHOP/R-CVP in Patients With Previously Untreated Advanced Indolent Non-Hodgkin Lymphoma or Mantle Cell Lymphoma. Clin Lymphoma Myeloma Leuk 2016; 16:182.
6. Casulo C, Byrtek M, Dawson KL, et al. Early Relapse of Follicular Lymphoma After Rituximab Plus Cyclophosphamide, Doxorubicin, Vincristine, and Prednisone Defines Patients at High Risk for Death: An Analysis From the National LymphoCare Study. J Clin Oncol 2015; 33:2516.
7. Fowler NH, Dickinson M, Dreyling M, et al. Tisagenlecleucel in adult relapsed or refractory follicular lymphoma: the phase 2 ELARA trial. Nat Med 2022; 28:325.
8. Jacobson CA, Chavez JC, Sehgal AR, et al. Axicabtagene ciloleucel in relapsed or refractory indolent non-Hodgkin lymphoma (ZUMA-5): a single-arm, multicentre, phase 2 trial. Lancet Oncol 2022; 23:91.

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