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A Case Report of Gastric Diffuse Large B-Cell Lymphoma treated with Three Line of Chemotherapy & Radiotherapy in Portsudan Oncology Center Period August 2018 - July 2021

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Introduction

A case of 55 yrs. An old, male, from a rural area in Sudan was diagnosis with NHL in July 2018 his main symptoms were upper abdominal mass and mild discomfort, marked wet loss, nausea and vomiting. No prolonged history of chronic diseases or other comorbidities. He did not smoke cigarettes, drink alcohol, or use illicit drugs. Family history is insignificant for any malignancy Working as a driver. A review of systems and physical examination showed that he had unintentionally lost more than20 kg in the last 6 months. he also had increased paleness and decreased exercise tolerance. irregular hard mass at the epigastric and left hypochondriac region recognized. Findings of a manual examination of peripheral regional lymph nodes were negative, wt. 45 kg, hit 155 cms.

Diagnostic tests

Lap investigation, Echocardiography normal EF 55% abdominal U/S appearance diffuse sickness with infiltrative mass originated at the fundus of the stomach expanding to the cavity, abdominal CT scan

shows a huge irregular infiltrative mass with diffuse mural sickness extending from the fundus to the gastric cavity, size 9 x 8,5cms, enlargement of celiac lymph nodes the largest 3 x 2,5 cms otherwise normal, CT of the neck, thorax and pelvis was unremarkable.

GIT endoscope gastric ulceration and erosion associated and ulcerative mass occupying the greater curvature of the fundus and the body. Pylorus, duodenum and the rest of GIT normal.

Biopsy revealed diffuse proliferative cell of lymph origin probably NHL DLBCL. IHC was positive to CD20, CD45 while negative to CD5

Discussion:

Diffuse large B-cell lymphoma DLBCL represents a group of heterogeneous diseases that originated from lymphoid tissues, an aggressive disease with rapid progression. DLBCL is the most common type of NHL about 35% of 40% of all cases. Etiology associated with genetic factors, viral infections, immune dysregulation, environment and exposure factors DLBCL divided to nodal and extranodal disease. The extranodal arises lymphoid cells in different tissues, GIT, bone marrow and brain.

More than 60% of the cases of DLBCL can be cured with R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone). Relapse and refractory cases have a poor outcome with BMT cornerstone for treatment. Molecular gene studies have delineated two distinct molecular subtypes of DLBC, The germinal center B-cell like (GCB)with PFS 75% and the activated B-cell-like (ABC) with PFS of 40%--50%, This specific pathway has led to the investigation of the utility of ibrutinib in the treatment of this type of lymphoma at relapse or. prognosis of DLBCL depend on the age of the patients, Stage of the disease, serum LDH, performance and more than one extra node sites

Outcome:

Port Sudan Oncology Center is a small center that was established in 2015 with simple capabilities and serves cancer patients for the people of the state. The state is far from the capital, Khartoum. Therefore, we treat with available options. We follow guidelines usually, ESMO guidelines as far as possible Some investigations have been sent to Khartoum as biopsy and immunohistochemistry while we ignore others who need the presence of the patients as bone marrow biopsy. Also covid19 pandemic limited the options of patients referring to other centers.

The patient was DLBCL stage IIE??

The patient received 8 cycles of CHOP beginning 20/5/2018 after 4 cycles CT scan show partial response resolution of the gastric mass and persistent celiac mass. the patient suffered from neutropenia and anemia even after each cycle especially the last four cycles, but no blood transfusion or hospital admission Repetitive hematological complications cause prolonged schedule of the course, by 24th of March 2019 Patient complete his chemotherapy Then we lost touch with Patient 0n 10/July/2019 patient came back with abdominal discomfort and GIT symptoms. A new workup was done CT scan showed multiple mesenteric lymph nodes the largest 4 x 3,5 cms Endoscope no gastric mass but ulceration and erosion

Biopsy was not done and diagnosis clinically as relapse or refractory DLBCL Patient treated with rituximab 375 mg/m2 every 21 days for 8 cycles

By the end of treatment CT show regression of mesenteric mass To 2,4 x2 cms but new appearing gastric ulcerative mass 3×2.5 cms we referred the patients to Madani Cancer Institute for the option of radiotherapy and received RTX 30GY/15 to the gastric region and mesenteric lymph nodes.

Then the patient was on regular follow up with CT scan and endoscope With regression rate to both lesions until the first of February 2021 The mesenteric lymph mass got in an increase in size to 3,5 × 2,5 cms.

With a resolution of gastric mass. The patient did not offer for a new workup or was Referred for a chance of BMT.

We did only baseline lap investigations and gave him another line of chemotherapy regime ICE 8 cycles, There were no significant side effects Ended July 2021.

Now on regular fellow up with regression of mesenteric mass to 2×2.2 cms. Is this still an active lesion?? PET Scan needed

The last visit was on September 2021. I convinced him to go to EGYPT, and He Seeks hardly to offer for that He still doing well with ordinary activities, driving his car and keeping his weight 45 kg.

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