Diffuse Ductal Dilation in Diffuse Large B-Cell Lymphoma

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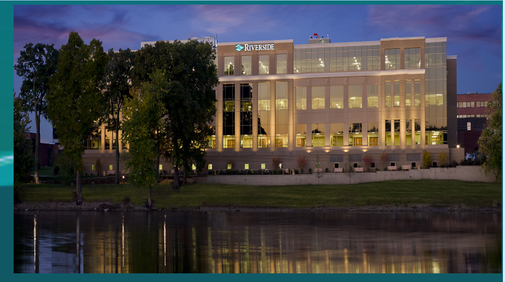

Introduction

Diffuse Large B-cell Lymphomas (DLBCL) are a well-studied subtype of Non-Hodgkin's Lymphoma (NHL) known to cause rapid and drastic enlargement of lymph nodes. It is not uncommon for these enlarged lymph nodes to cause external compression on neighboring structures as their course progresses. Although rare, specifically less than 4% of all cases, obstructive jaundice can be the presenting complaint.

Case Presentation

We present a 67-year-old female who initially presented due to progressing nausea and vague right upper quadrant (RUQ) pain of one month duration. During this time, she also noticed light colored stools as well as dark urine. On physical exam, she was noted to have jaundiced skin, scleral icterus, and RUQ tenderness. Labs on presentation were consistent with cholestatic pattern of hepatic injury with ALP 1010, ALT 305, and AST 158. Total bilirubin was 3.0 and predominantly direct. Ultrasound of the gallbladder was obtained showing common bile duct (CBD) dilation of 10mm with subsequent CT abdomen pelvis revealing an enlarged lymph node in the porta hepatis. Further evaluation with MRCP revealed 1.5cm CBD dilation with numerous enlarged lymph nodes (Image 1). Gastroenterology was consulted and ERCP/ EUS was performed during hospitalization. EUS did confirm large periportal lymph nodes, largest measuring 21 x 14mm with core needle biopsy taken. ERCP with sphincterotomy and 10 Fr x 7 cm plastic stent placement was then completed with brush cytology obtained. CBD brushings were negative for malignancy. Lymph node biopsy was positive for CD20 and Bcl-6 consistent with DLBCL. Patient was referred to oncology and subsequently started on R-CHOP therapy. PET/CT scan after therapy showed essentially complete resolution of abnormal lymph node activity (Image 2).

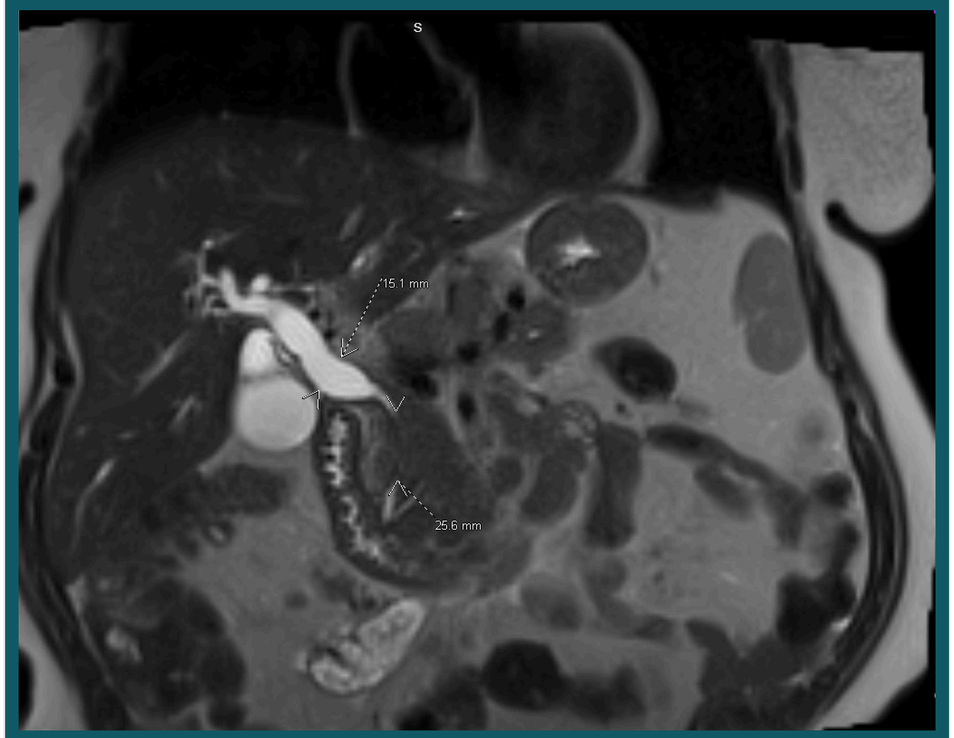

Image 1: MRCP revealing 1.5 cm common bile duct dilation with nearby enlarged lymph nodes

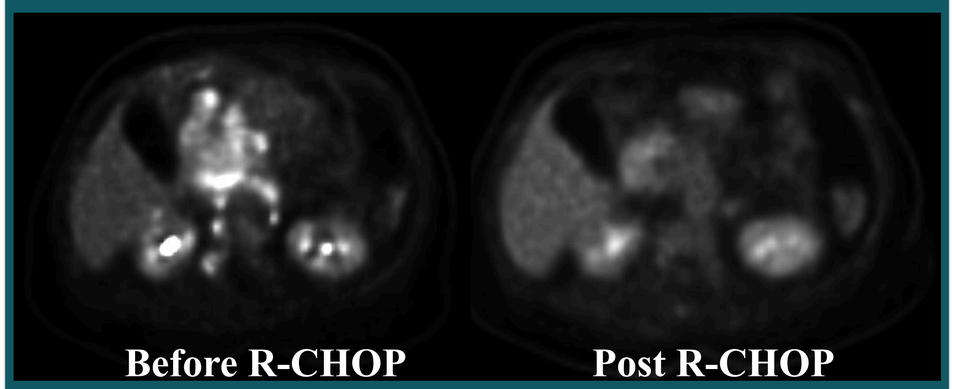

Image 2: PET/CT abdomen pelvis prior to initiating R-CHOP with hypermetabolic adenopathy (left) and repeat PET/CT after 6 cycles of R-CHOP without focal areas of hypermetabolism (right)

Discussion

- DLBCL is the **most common** of the NHL typically presenting at the highest frequency in males in their 6th and 7th decade of life[1].
- Most commonly, presenting symptoms include painless adenopathy and "B symptoms" such as **fever**, **night sweats**, and **weight loss[1]**.
- Although roughly 40% of all NHL are DLBCL, **less than 4%** of these cases present initially as obstructive jaundice[1].
- Obstructive jaundice can manifest secondary to intraductal stricture or compression of the biliary tree from enlarged lymph nodes.
- Recent studies evaluating R-CHOP therapy (rituximab + cyclophosphamide + doxorubicin + vincristine + prednisone) have detailed a **resolution rate of 73%[2].**
- Due to current effectivity of treatment**,** **early recognition** of DLBCL as a potential etiology of obstructive jaundice should be considered.

Disclosures

None to report

References

1. Chaudhari D, Khan S, Saleem A, et al. Obstructive jaundice as an initial manifestation of non-hodgkin lymphoma: treatment dilemma and high mortality. *Case Rep Med*. 2013;2013:259642. doi:10.1155/2013/259642
2. Al-Sarayfi D, Brink M, Chamuleau MED, et al. R-miniCHOP versus R-CHOP in elderly patients with diffuse large B-cell lymphoma: A propensity matched population-based study. *Am J Hematol*. 2024;99(2):216-222. doi:10.1002/ajh.27151