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An EBV Reactivation Leads to the Appearance of a Second Lymphoma Despite Virulent Immunochemotherapy

Ghanem H[1*] and Atzpodien J[1]

[1]Department of Hematology and Oncology, Franziskus-Hospital Harderberg, Niels-Stensen-Kliniken, Georgsmarienhütte, Osnabrueck, Niedersachsen, Germany

[*]Corresponding author:

Hosam Ghanem,
Department of Hematology and Oncology,
Franziskus-Hospital Harderberg,
Niels-Stensen-Kliniken,
Georgsmarienhütte, Osnabrueck, Niedersachsen,
Germany.

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1. Clinical Image

A 47-year-old woman presented with an enlarged and tender right sided inguinal lymph node in addition to fatigue and weight loss. The excisional biopsy of the inguinal lymph node revealed histologically and immunohistochemically an infiltration of a Diffuse Large B-cell non-Hodgkin Lymphoma (DLBCL).

Based on Ann Arbor staging system was the patient in an initial stage IVB with lymphadenopathy submandibular, cervical an abdominal, a splenomegaly, in addition to a patchy lymphoma infiltration of the bone marrow. Otherwise belongs the patient to a high-intermediate risk group with an aaIPI score of three points.

A contrast-enhanced Computed Tomography (CT) after two cycles from the immunochemotherapy with R-CHOP-14 protocol (Rituximab, Doxorubicin, Cyclophosphamide Vincristine and Prednisolone) reveals a discordant finding with newly emerged pulmonary foci on the left lung with simultaneous significant regression of the initially detected lymphadenopathy and the pre-existing splenomegaly. A histological and immunohistochemical examination of a wedge resection of the left lung segment 9 shows a secondary Pulmonary Lymphomatoid Granulomatosis (PLG) grade 1 with EBV-activity (Epstein-Barr virus), which correlated with a serologically proven EBV-Reactivation [1].

According to the current WHO lymphoma classification, this entity is managed as an independent lymphoma. The CT/controlling under continuing the Therapy with R-CHOP-14 reveals a Regression of the pulmonary lymphomatoid granulomatosis with continued remission of the manifestations of the diffuse large-cell B-NHL, in spite of a chemotherapy dose reduction to 50% meanwhile because of its hematotoxicity.

The reason for the occurrence of a secondary PLG described here during an effective immunochemotherapy can be explained in the context of the EBV reactivation.

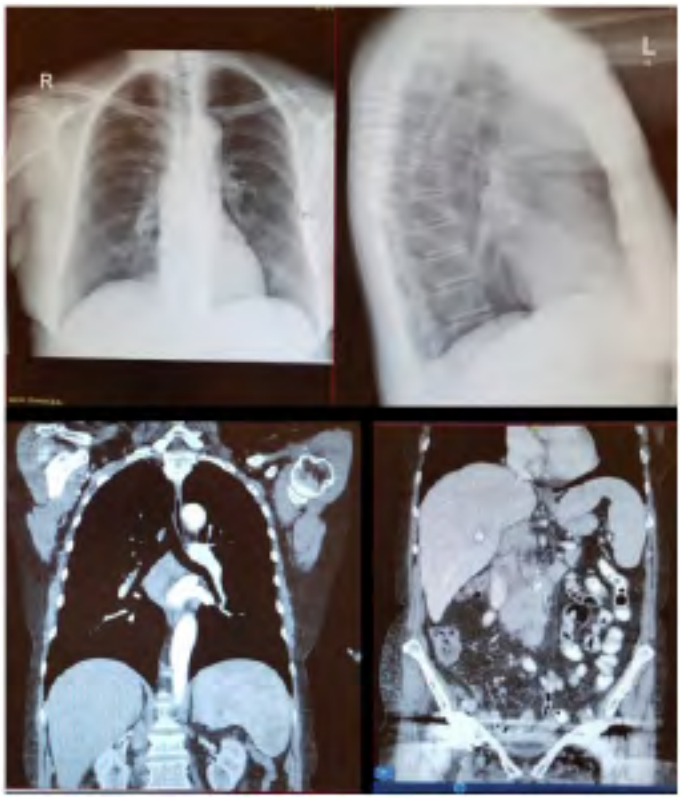

Figure 1: at the Time of Diagnosis