CASE REPORT

Mucosal Follicular Small B-Cell Mucous Follicular Lymphoma. Report of a case.

Mirtha E. Meneses,* Melany L. Ayala, Carolina Feraudy,*** Delfo Carballo******

* *Dermatologist, Dermatologist, Hospital Obrero No1, La Paz, Bolivia.*
* *2nd year Dermatology Resident, Hospital Obrero No1, La Paz Bolivia*
*** *Medical Pathologist, Hospital de Clínicas, La Paz Bolivia*
**** *Medical Pathologist, La Paz Bolivia.*

Corresponding author: melanyayala.95@gmail.com

Palabras clave: Non-Hogkin's lymphoma, Epstein Barr virus, Follicular B-cell lymphoma, R-CHOP

Fecha de recepción: 22/12/2022
Fecha de aceptación: 05/05/2023

RESUMEN

We present the case of a 39-year-old female patient who presented with a clinical picture of 4 years of evolution, characterized by a lesion that occupies the entire soft palate. Three histopathological studies were performed, reporting a chronic inflammatory process. Serology for Epstein Barr Virus was requested, which was positive, and the 4th histopathological study reported atypical lymphocytes, with positive CD20 imunohistochemistry result, concluding in the final diagnosis of follicular small B-cell lymphoma in soft palate.

This case is presented because of the importance of the association between EBV and lymphoproliferative processes and should be taken into account in a patient with a long-standing lesion in the palate.

CLINICAL CASE PRESENTATION

Female patient of 39 years of age with no relevant history, from and resident of Oruro, Bolivia, occupation secondary school teacher, denies toxic habits COMBE (-).

With a history of a hospitalization in February 2022 at Hospital Obrero No. 1, by the Infectious Diseases Department, for the study of mucosal leishmaniasis.

She went to the Dermatology Outpatient Clinic with transfer from Infectious Diseases, due to a long-standing clinical picture of 4 years of evolution, characterized by ulcerative lesion in the soft palate, accompanied by cough with purulent expectoration, dysphagia and odynophagia. He was treated with antifungals and antimicrobials for long periods of time.

Three histopathological studies were performed and reported a severe chronic inflammatory process. The condition was exacerbated approximately 1 year ago, with a lesion occupying the entire uvula.

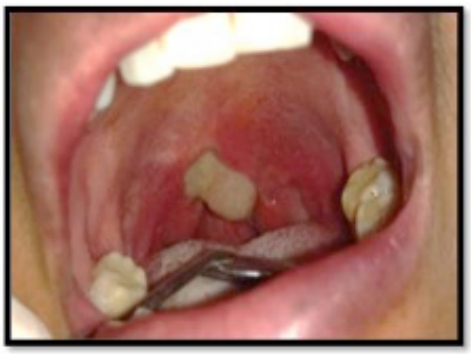

Figure 1

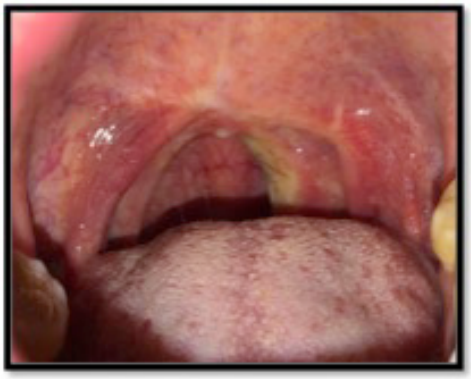

Figure 2

TABLE 2. VIRAL PANEL	
HIV	NEGATIVE
EBV (IG-G)	**POSITIVE**
CMV (IG-G)	POSITIVE
VHB	NEGATIVE
HCV	NEGATIVE
VHS (IG-G)	POSITIVE
RUBEOLA (IG-G)	POSITIVE

The segmental dermatologic physical examination revealed ulcerative fibrous eroded oral mucosa in the soft palate, with absence of the uvula.

In case of suspicion of an infectious-contagious disease, studies for tuberculosis and leishmaniasis were requested and reported: Negative Ziehl Neelsen stain in sputum, negative intradermal reaction, negative Polymerase Chain Reaction for Leishmaniasis in lesion aspirate.

In view of the granulomatous lesion and tomographic findings, immunological profile studies were completed, which were negative. In addition, a viral panel was requested, which was also reported: There is evidence of positivity for certain viruses in the chronic phase, but the most important is the positivity for EBV and its relationship with both immunological and lymphoproliferative diseases.

With EBV positivity and persistence of occupational lesion in palate, immuno-histochemical study was requested for a third histopathological study, which reports: Marked presence of lymphoplasmacytes and neutrophils, with the presence of prominent lymphoid follicles, reactive.

In the face of diagnostic doubt, immunohistochemistry was requested, which reported the following: CD 20 ++, CD79a, Ki67++, Bcl2+, CD3-, CD56-, Grandzime B-. Reactive B lymphocytes.

Diagnostic conclusion: Eroded mucosa with necrotic foci and proliferation of atypical lymphocytes compatible with small B-cell lymphoma , follicular of low

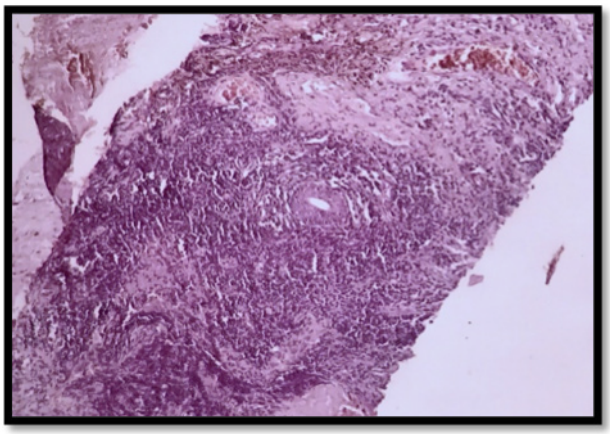

Figure 3.

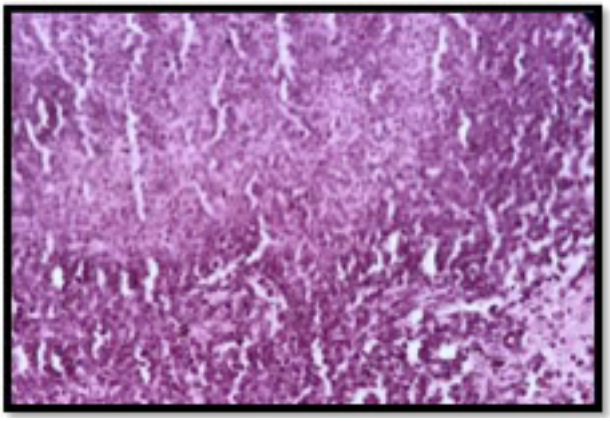

Figure 4.

Figure 5.

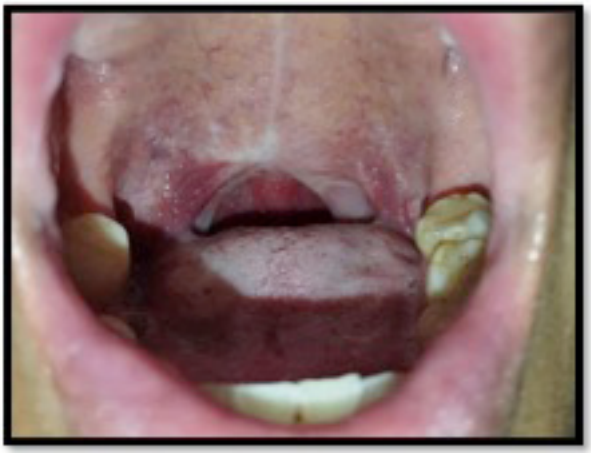

Figure 6.

histological grade. Histopathological and immunohistochemical studies confirmed the clinical suspicion of a lymphoproliferative disease of Non-Hodgkin's Lymphoma type in oral mucosa.

After the initial diagnosis, the patient was transferred to Oncology, where he received 6 sessions of R-CHOP chemotherapy with complete resolution of the condition.

DISCUSSION

Malignant tumors of the oral cavity represent 5% of the tumors of the entire human body, of which 90% correspond to Epidermoid Cell Carcinoma (EC) and the remaining 2-10% to lymphomas, which can be Hodgkin's (HCL) and Non-Hodgkin's (NHL).[1]

Of these, Follicular Lymphoma represents 30% of NHL. The etiopathogenesis is based on alterations in the proliferation of B lymphocytes and in different stages of maturation. In addition, a close relationship has been found with Epstein Barr Virus, HCV, HHV-8, HTLV-1, H. pylori, among others. The clear relationship with EBV establishes that it could remain latent in B lymphocytes, with certain capacity to immortalize cells, which makes it a factor of poor prognosis and tumor progression.[2,5] In our case, EBV positivity is presented, evidencing the migration to a lymphoproliferative process.

Mature small B-cell lymphomas are associated with a 14 and 18 translocation of q23, q21; resulting in fusion of the IGH and BCL-2 genes. Within the epidemiology it is said to affect males more, with an average of the seventh decade of life.[3,4]

Generally there are no B symptoms unlike the other lymphomas and the site of predilection for presentation is the palate. Microscopically there is evidence of follicular growth pattern, with scattered centrocytes and centroblasts. The immunophenotype is CD20+, CD10+, BCL6+, BCL2+, CD23+/-, CD43.[3]

Mucosal Leishmaniasis, Granulomatosis with Polyangiitis and Mucosal Tuberculosis are cited as the main differential diagnoses, however, PCR studies for leishmania, negative immunological profile (P-ANCA, C-ANCA, ANA) and Negative Ziehl Neelsen stain in sputum, all of them are encompassed within the Midline Syndrome. The last and main differential diagnosis includes T-cell lymphoma (NK), which differs in its histological lineage and its high mortality (up to 60%).[6]

It can be concluded that it is a rare entity, with many differential diagnoses, which should be taken into account in a patient with a long-standing ulcerative lesion in the oral cavity, in association with a coinfection with EBV, in order to prevent long-term sequelae or even death.

REFERENCES

1. Ofelia J. Malignant lymphoma of the oral cavity and the maxillofacial region: Overall survival prognostic factors. Med Oral Patol Oral Cir Bucal. 2013 Jul 1;18 (4): 619-26.
2. Vinitzky I. Linfoma no Hodkin de celulas granes B en cavidad oral: presentacion de un caso y revisión de la literatura. Odontol. Sanmarquina 2020; 23(2): 181-18.
3. Petersen V. Linfoma de cerlulas del manto, linfoma de malta, linfoma de linfocitos pequeños y linfoma folicular de la cavidad oral: una actualizcion. J Oral Pathol Med.2021;50:622-630.
4. Guidry J. Epstein Barr Virus in the Pathogenesis of Oral Cancers. Oral Dis. 2018 May ; 24(4): 497-508Barone S. Linfoma no Hodgkin maligno oral: un estudio retrospectivo de un solo centro. En J Medio Ambiente. 2022; (19) 6:1-10.
5. Falk R. Granulomatosis con polangeitis y polangeitis microscopica: manifestaciones clinicas y diagnostico. In: Lee S, ed. UpToDate. Waltham, Mass.: UpToDate, 2022.
6. Mozas P. Actualización en el diagnóstico, pronóstico y tratamiento del linfoma folicular. Medicina Clinica. 2021: 2-9.

7. Abufon P. Linfoma folicular sistémico con afectación cutánea y recidiva únicamente cutánea. Cartas cientifico clínicas. 1-3.Guerra A. Linfoma No Hodgkin. Conceptos Generales. 2013; 8 (1): 23-24.
8. Granado A. Leishmaniasis cutánea y mucocutánea. Actas Dermo Sifilio-Graficas. 2021; 111 (2): 601-618.
9. Mollinedo J. Leishmaniasis en Bolivia: revisión y estado actual en Tarija, frontera con Argentina. Biomedica. 2020. 40 (1); 45-61.
10. Deep K. A Disguised Tuberculosis in oral buccal mucosa. Dental Research Journal. 2011; 8 (3): 1-6.
11. Santiago H. Caracterizacion de lesiones letales de la línea media del Hospital Escuela Universitario, Honduras entre 2011-2014. CIMEL 2017; 22(1) 6-10
12. Chavarriaga M. Presentación de caso clínico Linfoma No Hodgkin. 2013.
13. Andreou A, Thermos G, Sklavounou-Andrikopoulou A. Linfoma extraganglionar de células NK/T, tipo nasal con afectación del paladar: reporte de un caso raro y revisión de la literatura. Patología de cabeza y cuello. 2021 junio; 15 (2): 621-627.