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An Uncommon Case of Multiple Lymphomatous Polyposis, a Manifestation of Gastrointestinal Mantle Cell Lymphoma

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Abstract

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Mantle cell lymphoma (MCL) is a rare, aggressive subtype of B-cell non-Hodgkin lymphoma that can involve the gastrointestinal tract as multiple lymphomatous polyposis (MLP). MLP is often associated with advanced Ann Arbor stage III/IV disease and can mimic benign or neoplastic polyposis syndromes, making early recognition and biopsy essential for diagnosis and management. We present a 61-year-old man with a positive fecal immunochemical test 4 months prior to presentation, for which gastroenterology evaluation had not occurred. He presented with one week of progressively worsening left upper quadrant abdominal pain, one month of fatigue, 10-pound weight loss, and still changes. In the ED, he was found to have elevated lactate and severe symptomatic anemia. Computed tomography (CT) angiography of the abdomen and pelvis showed marked splenomegaly, hepatomegaly, and bulky mesenteric and retroperitoneal lymphadenopathy. Esophagogastroduodenoscopy (EGD) revealed severe erosive and nodular gastritis with diffuse friability. Colonoscopy revealed a large ulcerated fungating mass in the distal transverse colon with multiple additional large ulcerated polyps throughout the colon and rectum. Subsequent CT imaging revealed additional colonic masses and intussusception. Biopsies taken during EGD and colonoscopy revealed immunohistochemistry positivity for BCL1, CD20, CD5, and SOX11, confirming MCL with diffuse gastrointestinal involvement presenting as MLP. He was started on Bendamustine and rituximab with tumor lysis prophylaxis given his high tumor burden. This case illustrates MCL presenting as MLP with diffuse gastrointestinal involvement, bulky lymphadenopathy, splenomegaly, and high tumor burden, consistent with Ann Arbor stage IV disease. This case highlights how MCL presenting as MLP may initially manifest with non-specific gastrointestinal symptoms rather than classic lymphoma features, contributing to diagnostic uncertainty. Since MLP can mimic colonic neoplasms or other polyposis syndromes, recognition of this endoscopic pattern with prompt biopsy is essential for diagnosis and initiation of appropriate systemic therapy.

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Introduction

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Mantle cell lymphoma (MCL) is a rare and aggressive subtype of mature B-cell non-Hodgkin lymphoma, comprising approximately 5% of all non-Hodgkin lymphomas (1). A recognized extra-nodal manifestation of MCL is the gastrointestinal tract, accounting for 5 - 20% of cases (2). Extranodal MCL located in the gastrointestinal (GI) tract can present as multiple lymphomatous polyposis (MLP), characterized by the presence of numerous polypoid lymphomatous lesions involving one or more segments of the GI tract (3). MLP can closely resemble hereditary or neoplastic polyposis syndromes, including familial adenomatous polyposis, thus endoscopic biopsy confirmed diagnosis with immunohistochemistry is essential to guide appropriate management. MLP is not an isolated endoscopic finding, rather it often reflects disseminated extranodal involvement and advanced Ann Arbor stage III or IV disease, requiring prompt systemic staging to assess nodal, extranodal, splenic, and bone marrow involvement (4 -5). Early recognition is clinically important because MLP is often associated with advanced disease and an aggressive clinical course. Timely diagnosis allows prompt initiation of lymphoma-directed therapy, tumor lysis syndrome risk stratification, and avoidance of unnecessary colorectal surgical interventions for a presumed primary colorectal process.

We present a case of MCL with diffuse GI involvement presenting as MLP, highlighting the importance of biopsy confirmed diagnosis, systemic staging, and multi-disciplinary treatment planning.

Case Presentation

We present a 61-year-old man with a history of microcytic anemia with no transfusions and a positive fecal immunochemical test 4 months prior to presentation, for which gastroenterology evaluation had not occurred. He presented to the emergency department (ED) with one week of progressively worsening left upper quadrant abdominal pain that radiated to his shoulder. Further history revealed fatigue for 1 month, 10-pound weight loss, and changes in stool consistency to paste-like stools and possible hematochezia. In the ED, he was found to have elevated lactate at 9.9 mmol/L and severe symptomatic anemia, with hemoglobin of 6.2 g/dl, requiring transfusion of 1 unit packed red blood cells. Digital rectal exam and stool hemoccult was negative. Computed tomography (CT) angiography of the abdomen and pelvis showed marked splenomegaly, hepatomegaly, and bulky mesenteric and retroperitoneal lymphadenopathy concerning for a neoplastic process.

CT Angiography of the Abdomen and Pelvis immediately warranted a GI referral and Hematology/Oncology result. At this time the working diagnosis, per Hematology/Oncology, was suspected hematological malignancy versus malignancy associated with chronic blood loss anemia. Esophagogastroduodenoscopy (EGD) revealed

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severe erosive and nodular gastritis of cardia, body, antrum with diffuse friability. Multiple biopsies were taken from these areas. Colonoscopy revealed a large ulcerated fungating mass in the distal transverse colon with multiple additional large ulcerated polyps involving the splenic flexure, descending colon, proximal sigmoid colon, and rectum. Multiple biopsies were taken from various parts of the colon. At this time the working diagnosis, per GI, was Familial Adenomatous Polyposis. All biopsies taken during EGD and colonoscopy revealed Mantle Cell Lymphoma affecting the gastric antrum, gastric body, duodenum, distal transverse colon, sigmoid colon, and rectum. Immunohistochemistry staining revealed positivity for BCL1, CD20, CD5, and SOX11 with negativity for CD10, CD23, and BCL-6, confirming MCL with diffuse gastrointestinal involvement presenting as MLP. Subsequent CT Chest/Abdomen/Pelvis imaging revealed additional masses in the cecum, ascending colon, and hepatic flexure, as well as signs of intussusception in the ascending colon.

Colorectal evaluation determined that the patient did not need colectomy at this time as the mass was primary lymphoma rather than colorectal, as well as the patient was not obstructed–thus chemoimmunotherapy was initiated. A 6 cycle regimen of Bendamustine and Rituximab (BR) was selected based on National Comprehensive Cancer Network category 1 recommendation, given its association with prolonged progression-free survival and favorable toxicity profile compared to other alternative regimens (6 -7). The patient exhibited a high tumor burden and bulky disease, placing him at elevated risk for both spontaneous and chemotherapy-induced tumor lysis syndrome (TLS). Due to the high risk of TLS, the initial cycle of BR was administered inpatient following port-a-cath placement, allowing for close monitoring. TLS prophylaxis consisted of intensive intravenous hydration initiated 24 - 48 hours following the completion of each cycle, with daily Rasuricase administered in accordance with the patients uric acid levels and overall TLS risk stratification. Supportive care, including antiemetic therapy, antiviral prophylaxis with acyclovir, antibacterial prophylaxis with trimethoprim sulfamethoxazole, and granulocyte stimulating factor due to myelosuppressive nature of chemoimmunotherapy, were initiated in line with NCCN supportive care guidelines.

Following Day 1 of Cycle 1, the patient demonstrated both subjective and objective clinical improvement with no signs of tumor lysis syndrome. Beginning with Cycle 2, Acalabrutinib was incorporated into the treatment regimen in accordance with TRIANGLE trial protocol, which has demonstrated that the addition of Bruton's tyrosine kinase inhibitor (BTKi) significantly improves failure-free survival compared to standard chemoimmunotherapy alone (8). Interim PET/CT imaging obtained after Cycle 1 revealed resolution of mesenteric and retroperitoneal lymphadenopathy, as well as resolution of the mass-like thickening involving the bowel. Overall, the patient has demonstrated favorable hematological recovery and maintained stable organ function throughout the course of treatment.

Discussion

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This case highlights how GI-predominant MCL can lack a classic lymphoma presentation despite extensive disease burden. Although MCL typically presents with advanced nodal disease, it has a well-recognized tropism for the GI tract, manifesting as MLP (9). Our patient exemplifies this classic presentation, with biopsy-confirmed MCL spanning from the gastric antrum to the rectum, accompanied by additional masses in the cecum, ascending colon, and hepatic flexure identified on cross-sectional imaging. Despite this extent of disease, he did not present with overt B symptoms classically associated with lymphoma, such as recurrent fevers, drenching night sweats, and the timeframe of his 10 lb weight loss was unclear. Instead, his presentation was predominantly gastrointestinal, including abdominal pain, stool changes, possible hematochezia, severe anemia, and a previously positive fecal immunochemical test (4). This GI-predominant presentation contributed to diagnostic uncertainty and initially raised concern for a primary colorectal or hereditary polyposis syndrome.

A critical teaching point from this case is the initial working diagnosis of familial adenomatous polyposis (FAP), which is a common pitfall of diagnosis that is well-documented within the literature as MLP can closely mimic FAP or other neoplastic polyposis syndromes on endoscopic appearance (10). Distinguishing between these entities is essential, as management differs substantially. A new diagnosis of FAP in a 61 year old without family history of polyposis would be extraordinarily rare. This case highlights the importance of routine biopsy with immunohistochemistry for any diffuse polyposis syndrome, particularly in older adults.

Our patient presented with hemoglobin of 6.2 g/dL and a markedly elevated lactate of 9.9 mmol/L, reflecting the consequences of chronic GI blood loss from friable, ulcerated lymphomatous masses combined with high tumor burden. The negative stool hemoccult on digital rectal examination despite a positive fecal immunochemical test 4 months prior demonstrates the intermittent nature of GI bleeding that presents with MLP. This scenario highlights the importance of endoscopic evaluation following a positive FIT test, which could have led to an earlier MCL diagnosis with lower tumor burden. The NCCN guidelines list endoscopy/colonoscopy as “useful under certain circumstances” in the workup of MCL and note it is essential for confirmation of stage I-II disease (11). In our patient, endoscopy was pivotal in revealing the full extent of GI involvement that was not apparent in the initial CT imaging. Furthermore, GI tract recurrences were identified in 59.1% of patients with initial GI involvement and some recurrences were detected only with endoscopic examinations, supporting the role of endoscopic surveillance during follow up (12).

The finding of intussusception in the ascending colon is a recognized but uncommon complication of GI lymphoma where the intraluminal bulky masses serve as lead points

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(13). Lee et. al. reported a similar case of MCL with MLP complicated by intussusception requiring a right hemicolectomy (14). In our patient, the decision to defer the colectomy was appropriate given that the mass was a primary lymphoma expected to respond to systemic therapy and that there was no obstruction. However, this finding warrants close monitoring during treatment as tumor response could alter mechanical dynamics of the GI tract, and conversely tumor swelling earlier in treatment could precipitate obstruction.

Treatment selection was based on a combination of the StiL trial, ECHO trial, and the TRIANGLE trial. The selection of BR as induction therapy is well-supported by the StiL trial which demonstrated that bendamustine in combination with rituximab was superior to rituximab-CHOP (R-CHOP) in indolent lymphomas and MCL, with longer median long-term progression-free survival and fewer toxic effects (15). The addition of acalabrutinib to BR is supported by the ECHO trial, which demonstrated BTKi addition improved progression-free survival with manageable toxicity in patients 65 years or older with previously untreated MCL (16). The rationale of the addition of the BTKi is evidenced by the TRIANGLE trial which demonstrates the addition of a BTKi to immunochemotherapy improved failure-free survival rate compared to immunotherapy and autologous stem cell transplant (ATSC) alone, challenging the standard of care of ATSC (8). Given the patient's response to treatment with the inclusion of the BTKi, he did not necessitate consolidative stem cell transplant, further supporting the TRIANGLE trial treatment efficacy.

Conclusion

This case demonstrates several important clinical lesions regarding MCL in terms of diagnosis and treatment selection. MLP should be considered a differential diagnosis of any diffuse polyposis syndrome, particularly in older adults, and routine biopsy with immunohistochemistry is essential in detection. Endoscopy plays a critical role in diagnosis and staging of MCL, as the extent of GI involvement may be underestimated in cross-sectional imaging alone. The combination of BR and acalabrutinib represents an evidence-based approach for MCL patients not suitable for intensive induction, with the addition of BTKi reshaping treatment landscape, reducing the need for autologous stem cell transplant.

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Figure 1. CT Chest/Abdomen/Pelvis Axial Slice. Large mass in the hepatic flexure area measuring at least 7.3 cm in length and 4.8 cm in thickness.

Figure 2. CT Chest/Abdomen/Pelvis Coronal Slice. Significant splenomegaly with heterogenous enhancement.