Govaresh/ Vol.18, No.1, Spring 2013;62-4.

Case Report

Lymphoid Follicular Hyperplasia as a Cecal Mass: A Case Report and Review of the Literature

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ABSTRACT

We described a case of lymphoid follicular hyperplasia that arose from the ileum of a 52-year-old woman. Her colonoscopy revealed a large mass in the cecum associated with multiple polypoid lesions in the ileum. Histologic examination demonstrated severe lymphocytic infiltration and lymphoid follicles with regular germinal centers, without evidence of malignancy. A right hemicolectomy was performed, which confirmed the diagnosis of lymphoid follicular hyperplasia.

Keywords: Lymphoid hyperplasia; Small intestine; Large intestine

please cite this paper as:
Taher M, Ebrahimi Daryani N, Shirzad S, Ajdarkosh H, Zare Mehrjerdi A, Keshvari A. Lymphoid Follicular Hyperplasia as a Cecal Mass: A Case Report and Review of the Literature. *Govaresh* 2013;18:62-4.

INTRODUCTION

Lymphoid hyperplasia of the small intestine and colon is an uncommon disorder, presenting as a single polyp or multiple polypoid lesions(1). Differentiation between malignant lymphoma and benign lymphoid hyperplasia is extremely challenging(2). In this paper, a unique case of lymphoid hyperplasia of the ileum, presenting as multiple polyps is described.

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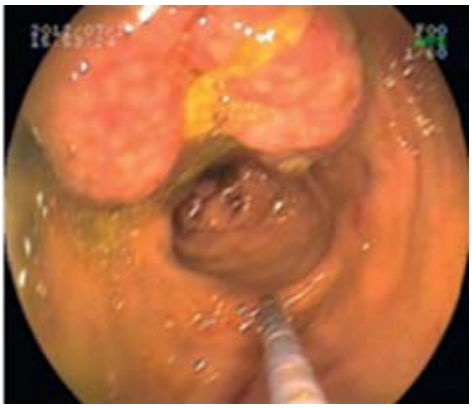
Received : 30 Jan. 2013
Edited : 17 Mar. 2013
Accepted : 18 Mar. 2013

CASE REPORT

A 52-year-old woman was referred to our clinic for evaluation of a five-month history of watery diarrhea and intermittent colicky abdominal pain. Her abdominal pain was aggravated by eating food and associated with loss of appetite. She had a history of a seven kilogram weight loss over an eight month period. Her family and past histories were unremarkable. Physical examination revealed no abnormalities. All routine laboratory tests, including hematocrit, C-reactive protein, erythrocyte sedimentation rate (ESR), stool exam for occult blood, ova and parasites, biochemical and immunological parameters.

Colonoscopic examination revealed a multilobulated cecal mass (approximately 8cm in diameter) with innumerable 2-5mm diameter polyps in the ileum; the remaining segments of the colon were reported as normal (Figures 1).

Histologic assessment revealed ileal and cecal



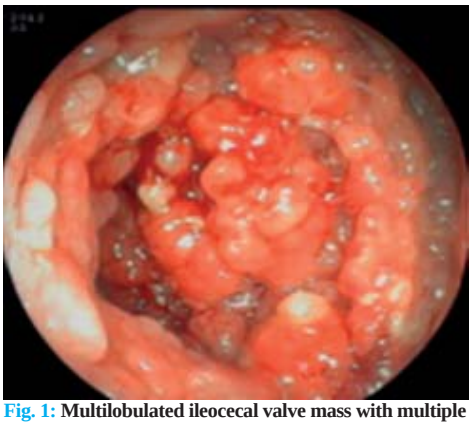
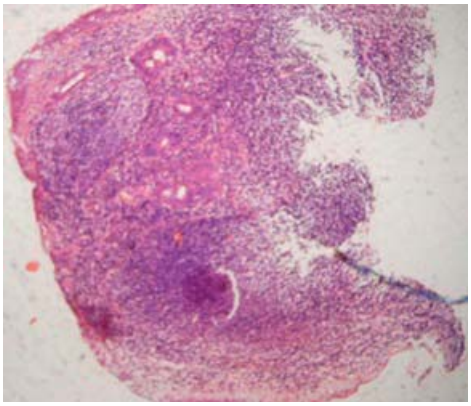


Fig. 1: Multilobulated ileocecal valve mass with multiple terminal ileum polyps as visualized by colonoscopy.



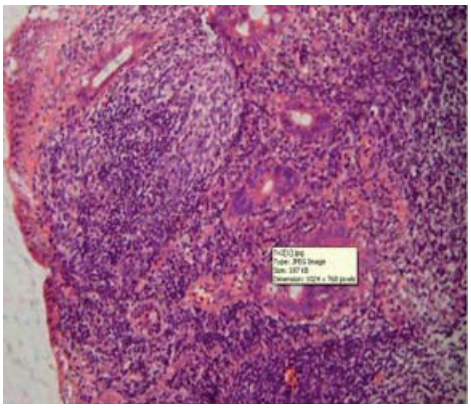


Fig. 2: Histopathologic examination revealed severe small lymphocyte infiltration with lymph follicles and regular germinal centers

mucosa with gland distortion due to severe small lymphocyte infiltration with lymph follicles and regular germinal centers. Areas of reepithelialization were noted. No evidence of malignancy was apparent (Figures 2).

DISCUSSION

Immunohistochemically, there were predominant CD20 positive B cells intermingled with CD3 and CD5 positive T cells. Germinal centers were BCL-2 negative, however other cells were positive. No reaction for cyclin-D1 and BCL-6 were reported. Ki-67 positive cells were only seen in the germinal centers. Thus, a diagnosis of lymphoid follicular hyperplasia was proposed.

The patient underwent an extended right hemicolectomy with mesenteric lymph node dissection. Her postoperative period and subsequent follow up have been uneventful (Figure 3).

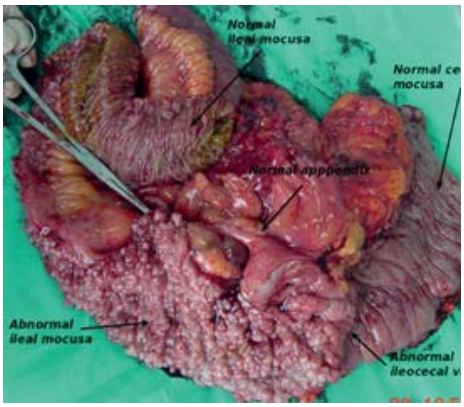


Fig. 3: Surgically removed terminal ileum and abnormal ileocecal valve.

Lymphoid hyperplasia of the ileum and colon is a rare disorder most often seen in patients with dysgammaglobulinemia , Giardia infections or isolated

IgA deficiency(3,4). This disorder is also found in patients with ulcerative colitis and regional enteritis(5). Evidence of Yersinia enterocolitica infection was noted in one adult patient with lymphoid hyperplasia of the terminal ileum(2). However, our patient had normal immunological parameters that included serum immunoglobin levels. Additionally, there was no clinical and colonoscopic evidence of inflammatory bowel disease.

Focal follicular lymphoid hyperplasia usually occurs in children and young adults, most often involving the cecum, appendix or rectum(6,7). Our case was unique in that multiple polypoid lesions were confined to the terminal ileum. We have encountered four cases of multiple polypoid lesions of the colon(8-11). However, lymphoid hyperplasia of the small intestine may be more common than colonic disease, but due to technical difficulties, these lesions often go undetected(12).

In benign lymphoid hyperplasia, there is no tendency for the interfollicular infiltrate to invade the follicles(2).The most important tools to differentiate lymphoid hyperplasia from malignant lymphoma are immunohistochemical analysis and monoclonal immunoglobin gene rearrangement(10). In the present case immunohistochemical findings revealed polyclonality, which made it possible to distinguish this case from lymphoma(13).

In conclusion, lymphoid hyperplasia is a rare benign disease with challenging issues in terms of diagnosis and treatment. The potential for malignancies associated with lymphoid hyperplasia is the most conflicting factor when deciding on therapeutic measurements.

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