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Case Report

Gastric Post-Transplant Lymphoproliferative Disorder after Allogenic Stem Cell Transplantation

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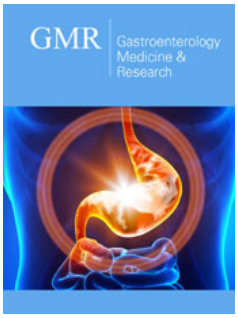

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Case Report

Post-Transplant Lymphoproliferative Disease (PTLD) is a well-known complication following transplantation. Its estimated incidence is 2.5% at 1 year after bone marrow transplantation [1,2]. PTLD consists of excessive (most frequently B) lymphocyte proliferation in immunosuppressed patients. Most cases are associated with primary EBV infection and occur within the first year after transplantation. Staging ranges from plasmocytic hyperplasia to lymphoma. PTLD can be potentially fatal and treatment is based on reduced immunosuppression, antiviral therapies, B cell proliferation blockers, chemotherapy and most recently T-cell therapies [1,3]. We present the case of an 18-year-old young man, who presented with a 48-hour history of low-grade fever, anorexia, abdominal discomfort and vomiting. In 2011 he had been diagnosed with acute T cell lymphoblastic leukaemia, which was treated with chemotherapy. Three years later he developed a second leukaemia (mixed phenotype acute leukaemia), for which he received a BMT from an unrelated donor 4 months prior to admission. Upon presentation, he was receiving immunosuppressive treatment with mycophenolate and anti-infectious prophylaxis with acyclovir, co-trimoxazole and posaconazole. A CT scan showed an area of inflammation in the gastric antrum (Figure 1). Subsequently, he underwent an upper GI endoscopy that showed nodularity and bleeding in the gastric body (Figure 2). Biopsies were obtained indicating a B cell lymphoma (Figure 3 & 4), following which a PET/CT scan was performed showing multisystemic lymphoproliferative infiltration. His EBV PCR in blood was 85,200 copies/ml. Unfortunately the PTLD was progressive, refractory to different therapies, and fatal in 5 months after PTLD diagnosis. Gastric PTLD is a very rare entity with only a few cases having been reported in the literature [1,4]. Diagnosis and management of EBV gastrointestinal PTLD is difficult in many patients, but a multidisciplinary approach and a prompt biopsy to identify the PTLD subtype are important for appropriate therapy. In this case, gastric biopsies showed an aggressive B-cell

lymphoma. Because treatment modalities can vary significantly, it is essential to differentiate between PTLD and other conditions such as tumor relapse, GVHD or infection in transplanted patients with abdominal symptoms.

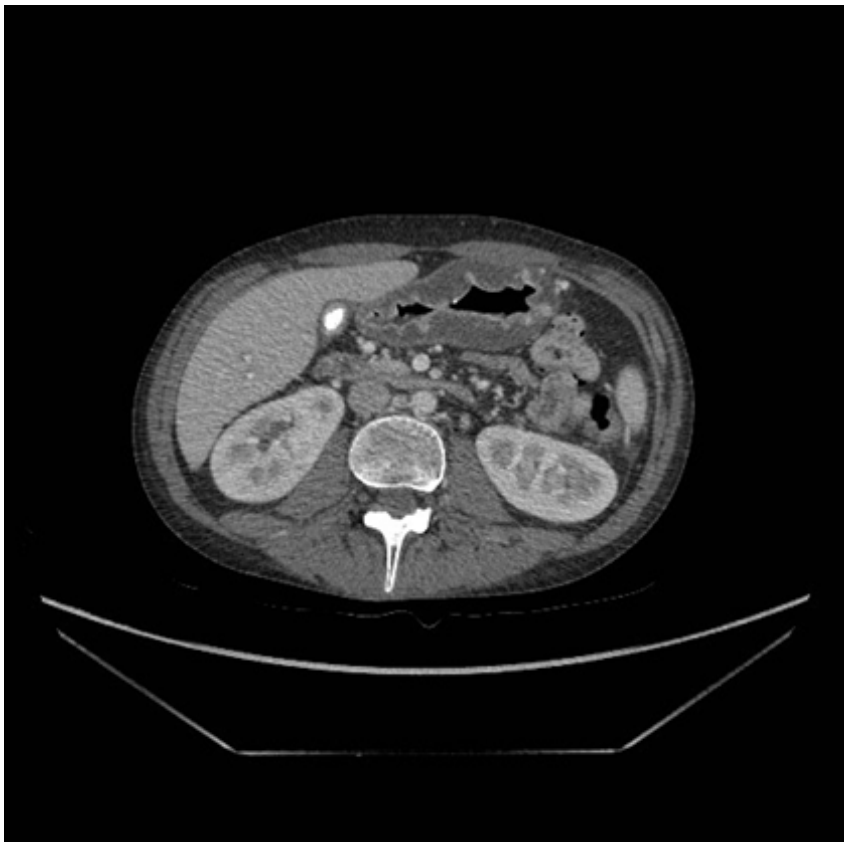

Figure 1: Abdominal CT scan showing a circumferential wall thickening in the gastric antrum and an incidental finding of an uncomplicated gallstone.

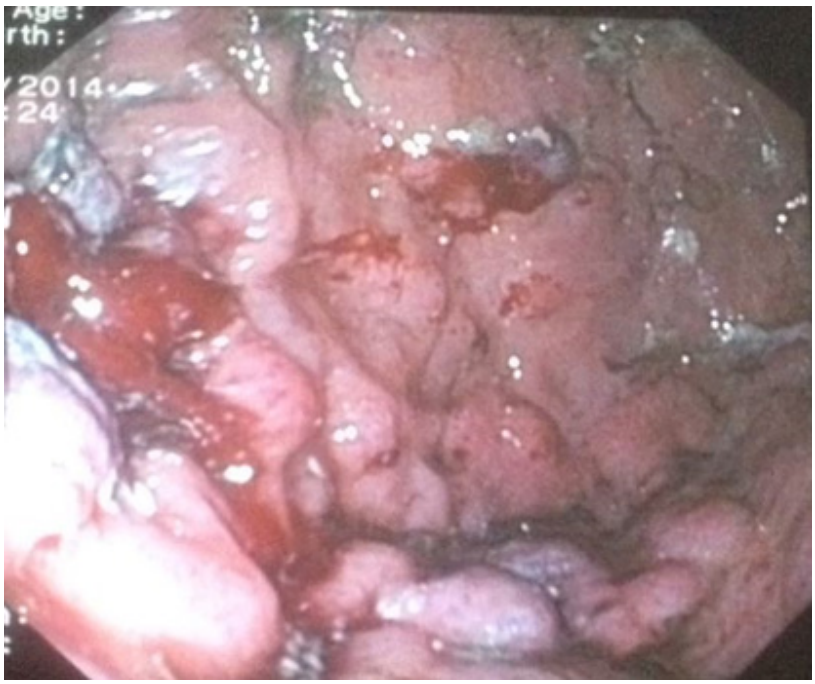

Figure 2: Upper GI Endoscopy findings.

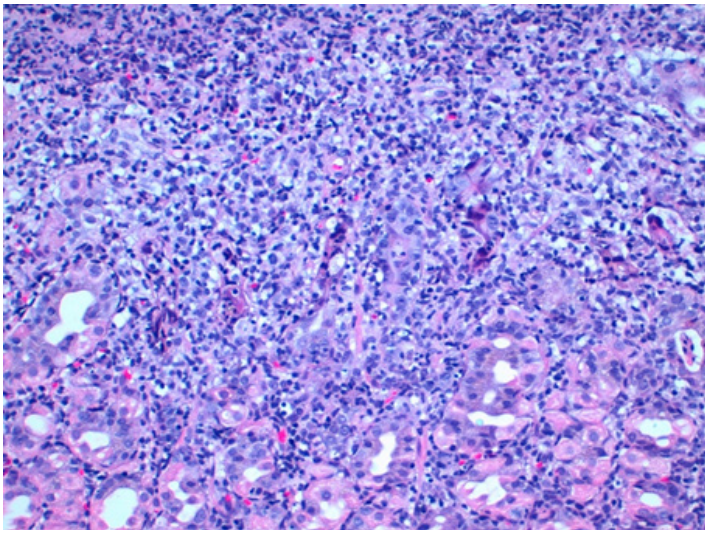

Figure 3: Gastric body biopsies. HE stain.

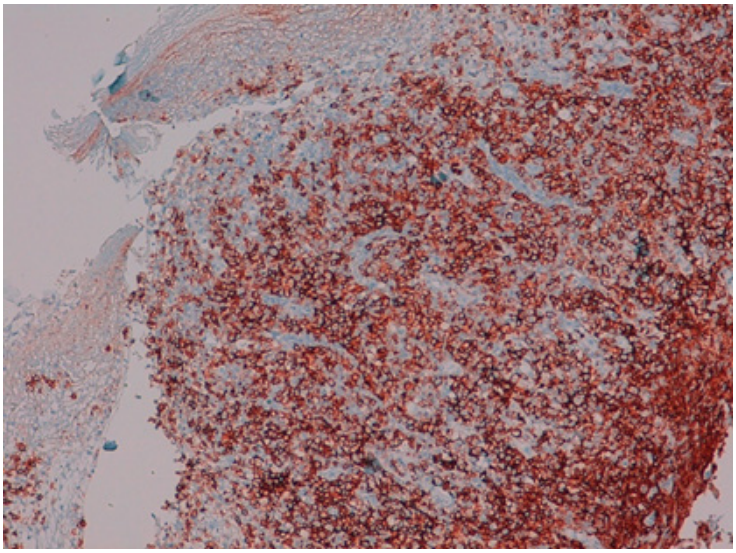

Figure 4: Gastric body biopsies. CD 20 stain.

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