Caso 19

RBTA
Hospital San Cecilio de Granada

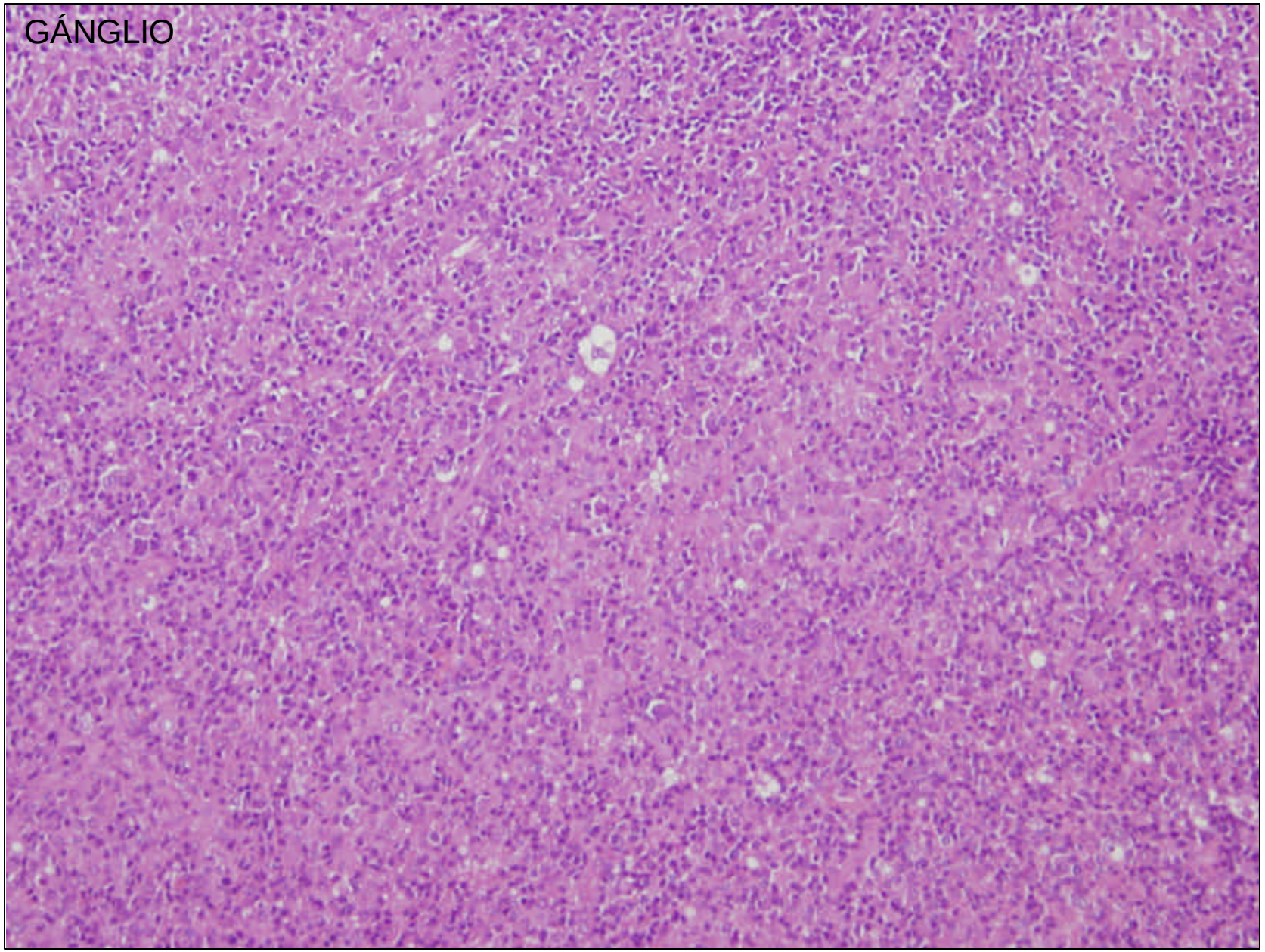
Agradecimientos:
Hospital de Osuna
Patólogo: Manolo Medina
Hematólogo: Francisco José Jiménez Gonzalo
Hospital Virgen del Rocío:
Hematólogo: Eduardo Ríos Herranz
CNIO. Laboratorio de linfomas

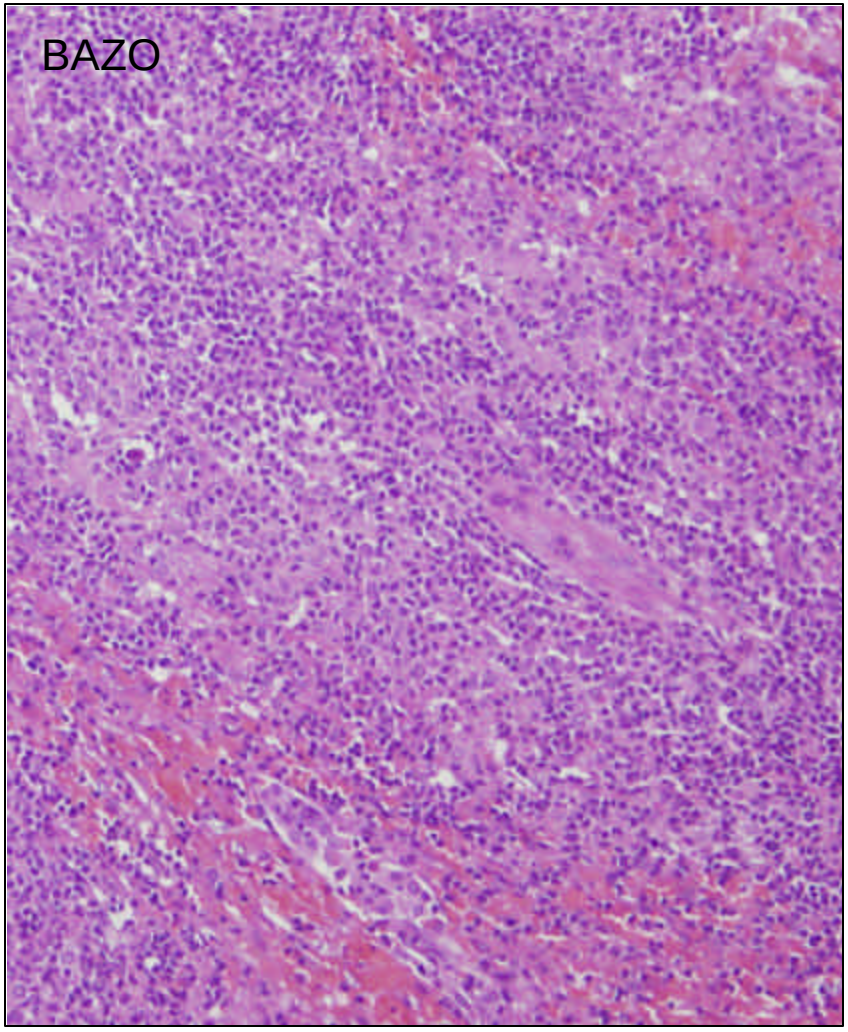
Presentación clínica

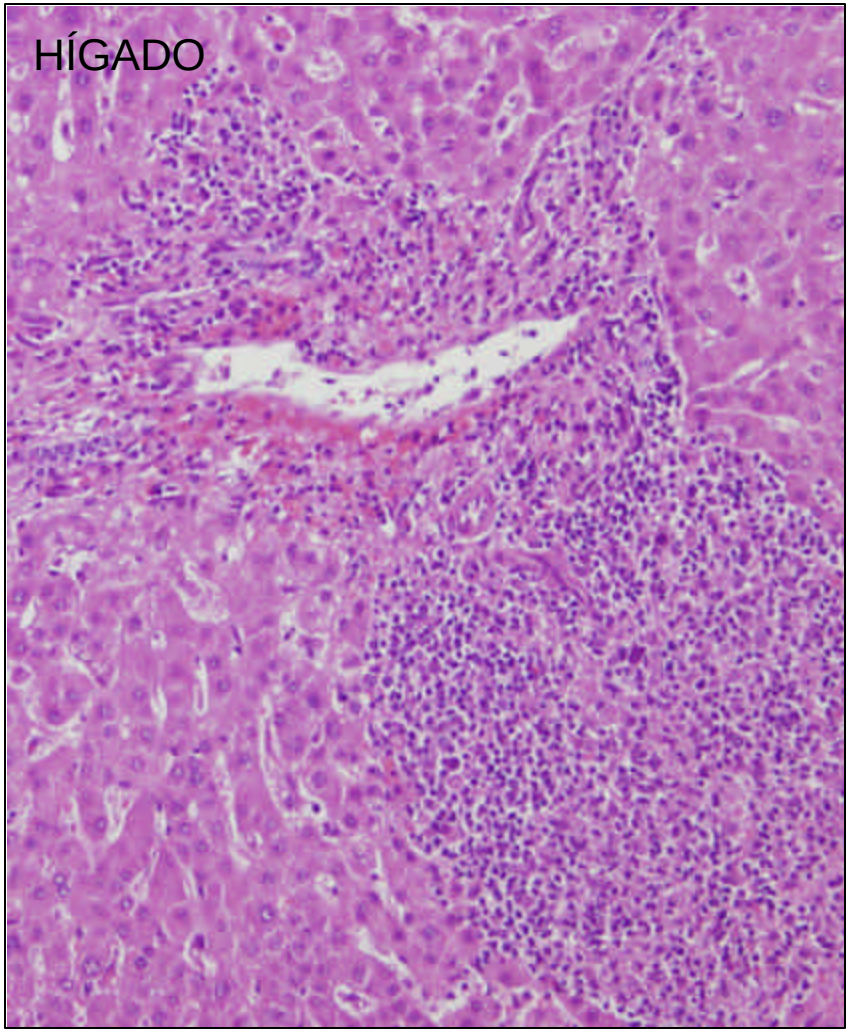
- Varón, 39 años
- Desde octubre de 2005: lesiones eczematosas en tratamiento con corticoides tópicos
- Consulta en enero de 2006 por pérdida de peso, sudoración nocturna y anorexia de intensidad progresiva
- No adenopatías periféricas
- TAC y ecografía tóraco-abdominal:
  - múltiples adenopatías junto a cava, aorta e hilio hepático y esplénico hasta bifurcación de iliacas
  - esplenomegalia con lesión focal de 4 cm
  - Ligera hepatomegalia

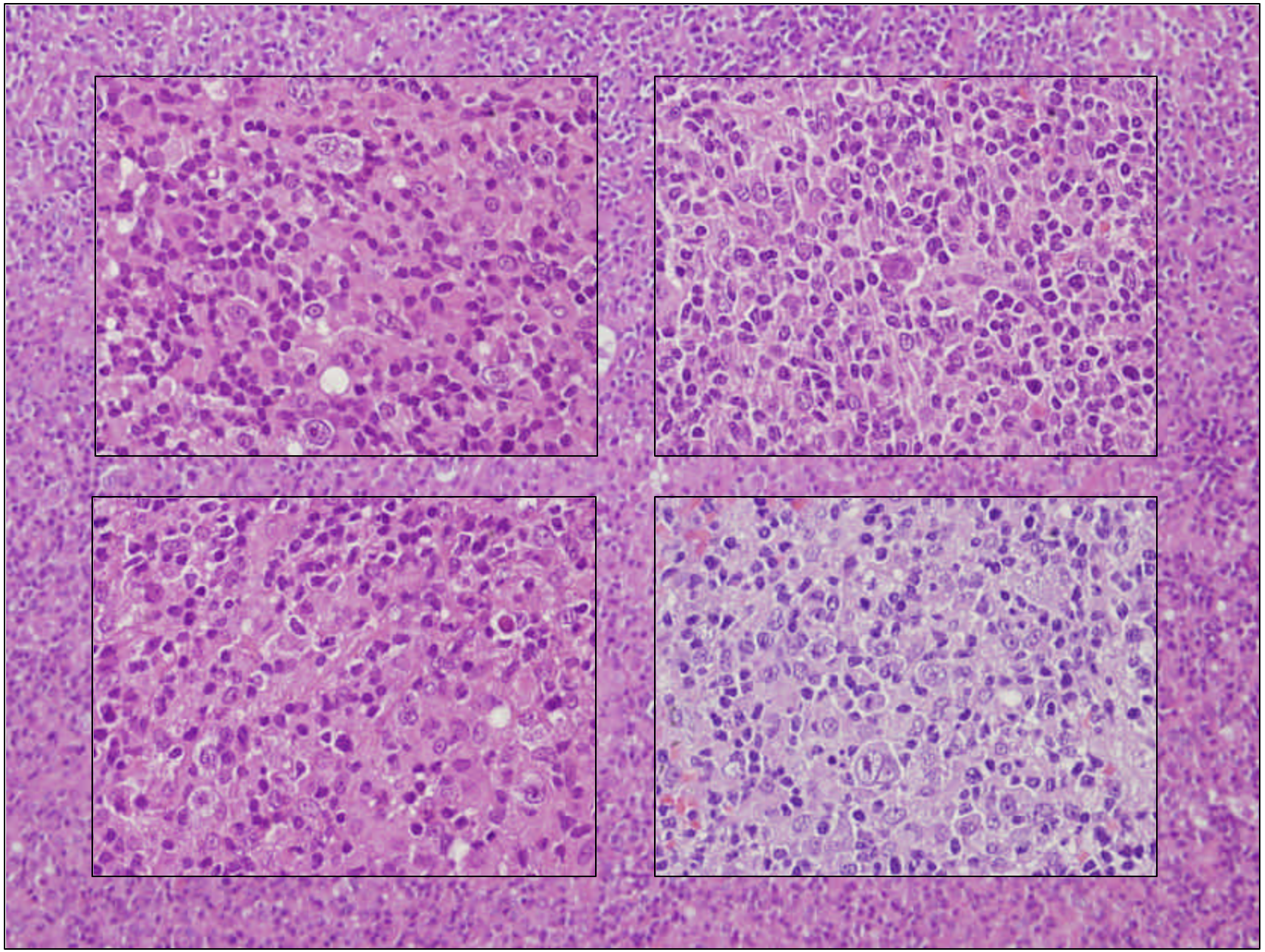
Presentación clínica

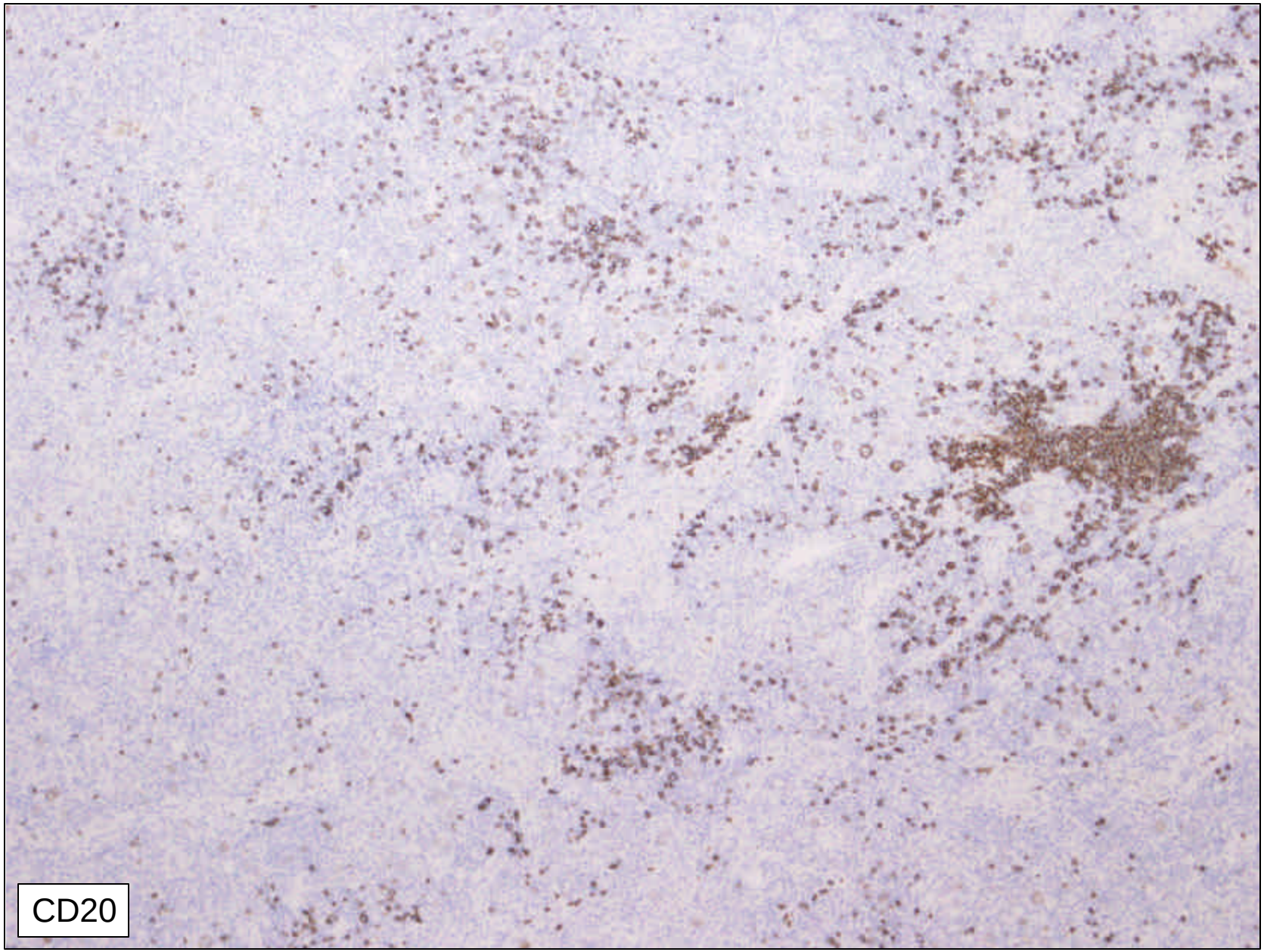
- Esplenectomía diagnóstica en feb/2006. Se extirpan con el bazo numerosas adenopatías del hilio esplénico y una cuña hepática
- Estudio de extensión:
  - Sangre periférica: Sin alteraciones. BCL2 y BCL1 negativo
  - Médula ósea: Mínima población clonal B kappa. BCL2 y BCL1 negativo

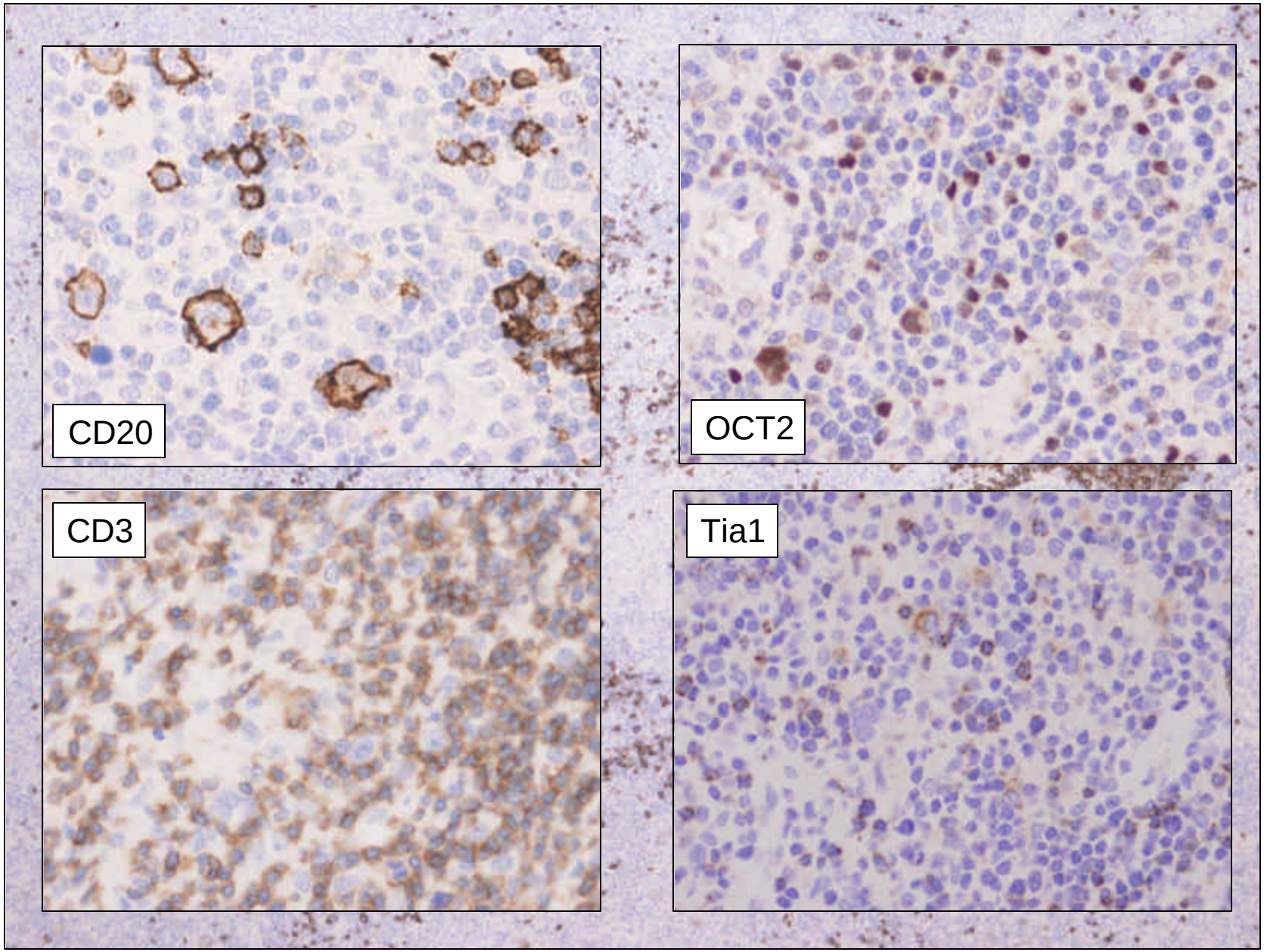

GÁNGLIO

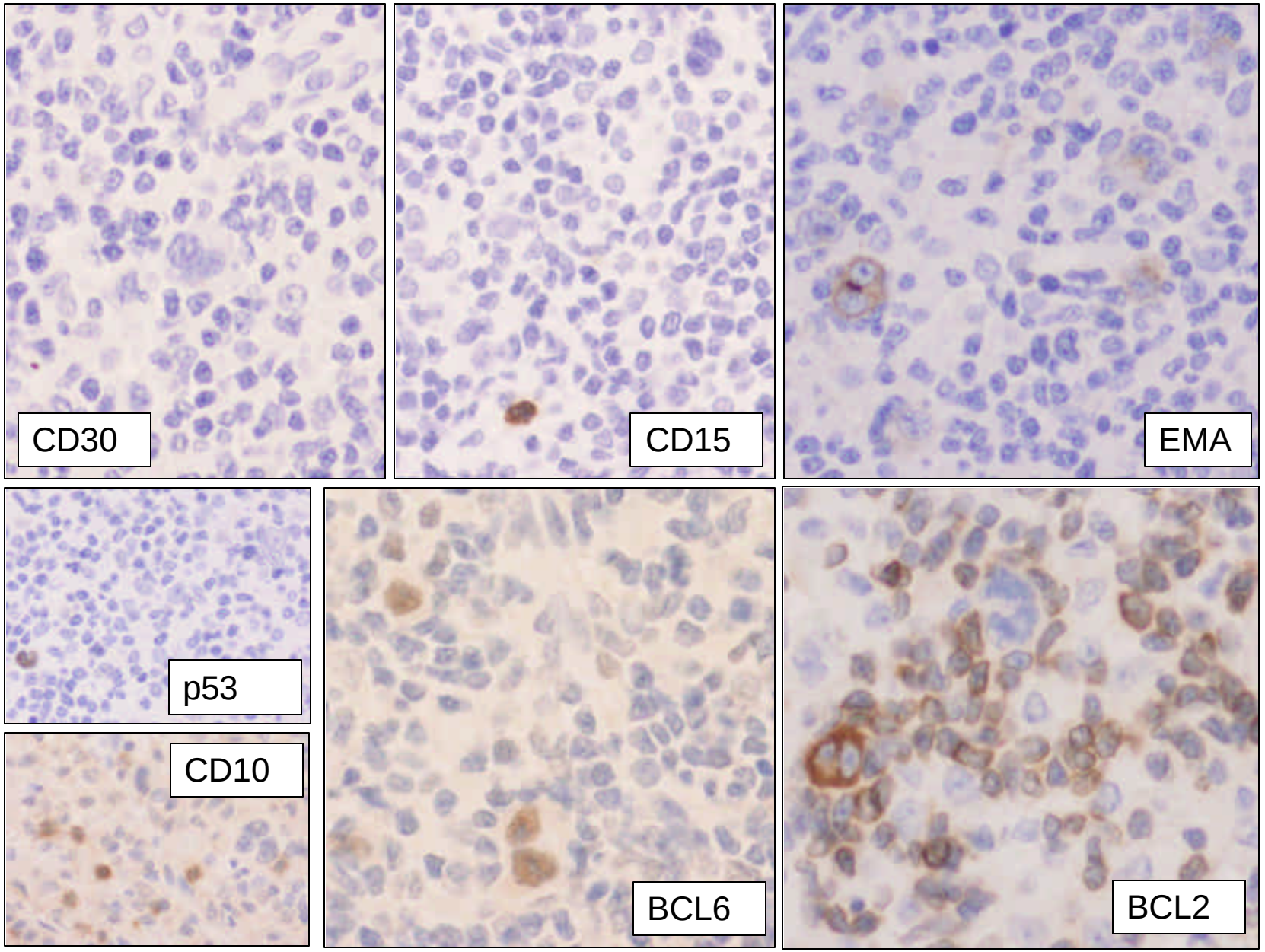

BAZO

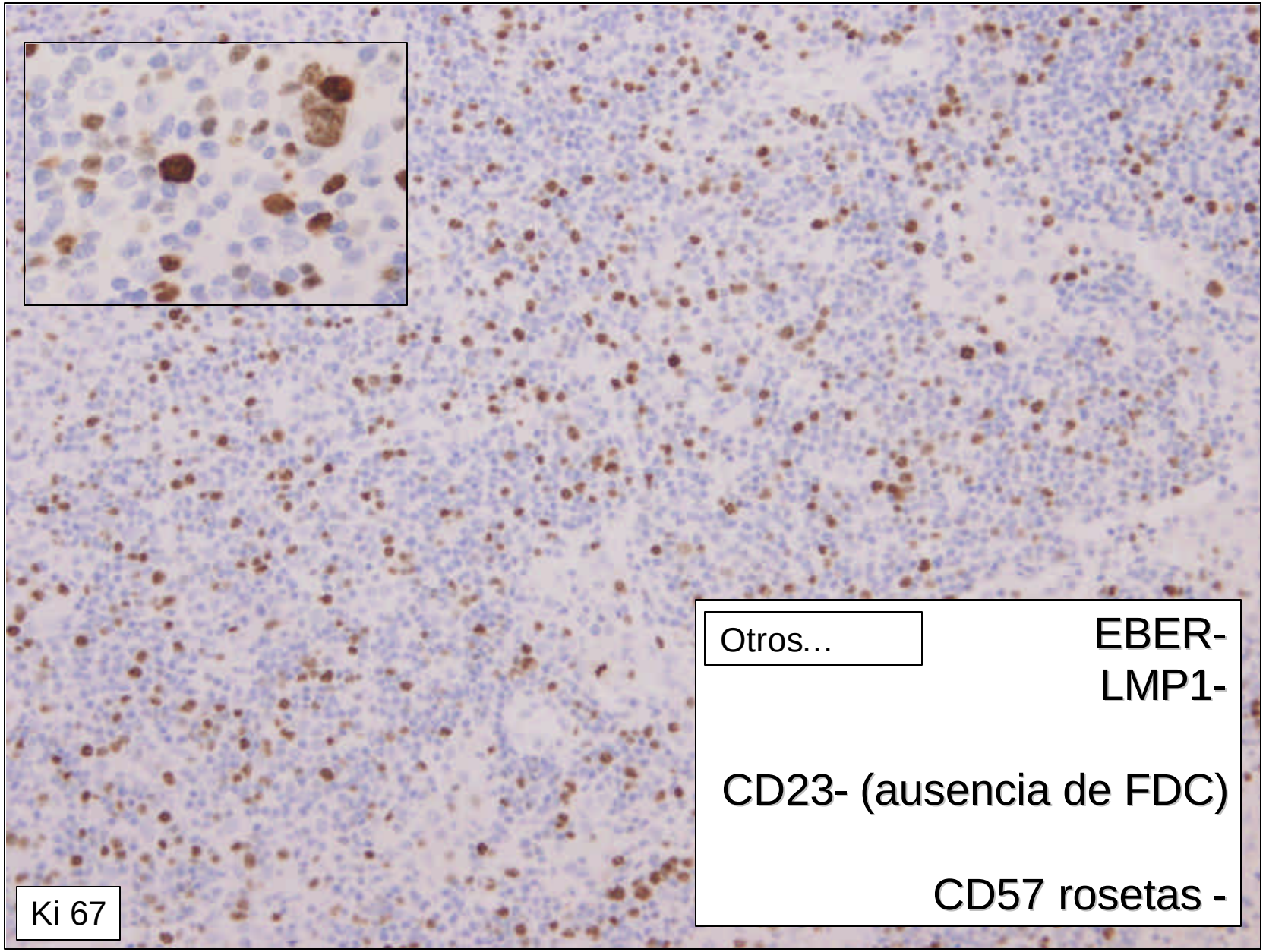

HÍGADO




CD20


CD20
OCT2
CD3
Tia1


CD30
CD15
EMA
p53
CD10
BCL6
BCL2


Ki 67
Otros…
EBER-
LMP1-
CD23- (ausencia de FDC)
CD57 rosetas -

Diagnóstico

? Propuesta local: Linfoma de Hodgkin,
"pero, consúltese con un experto"

? Diagnóstico del experto:
Linfoma difuso de células grandes B rico en células T

? IPI = 3
  ? estadio IV-B con afectación hepática, esplénica
  ? y probable EMR en médula ósea

? Tratamiento: R-CHOP
? Seguimiento: vivo, tras 1 año.

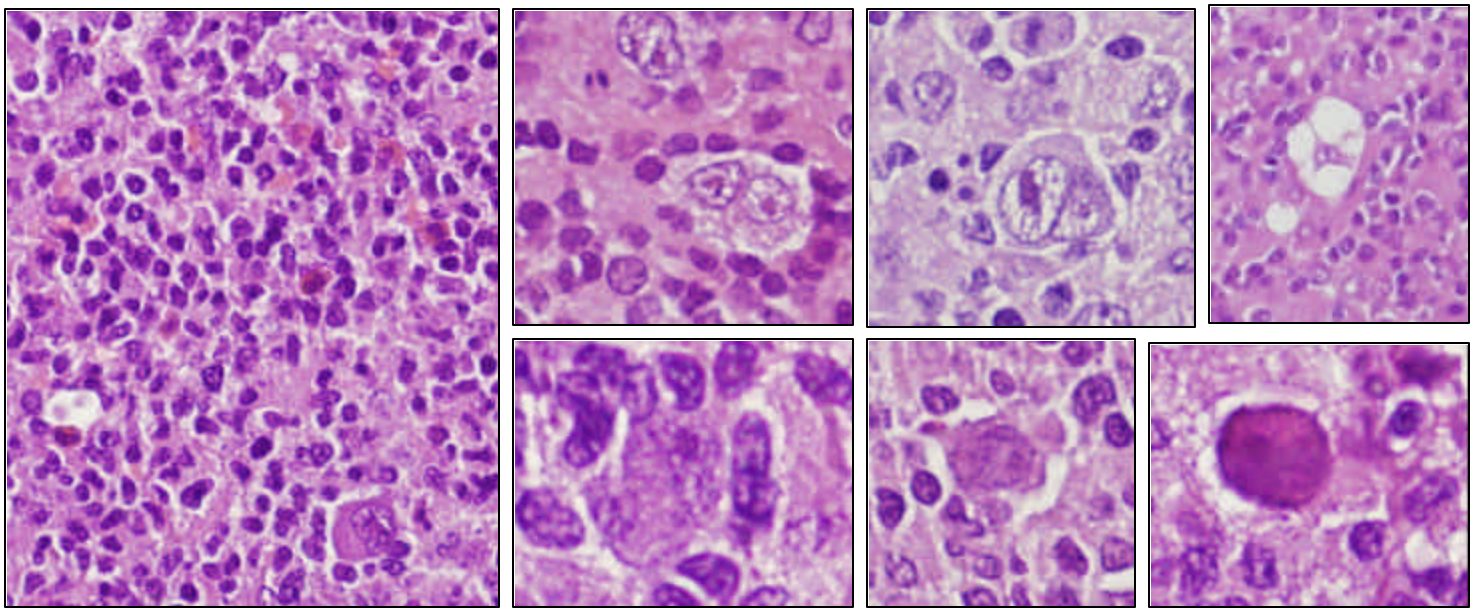
Diagnóstico diferencial

	TCHRLBCL	CHL	LPHL
Crecimiento	difuso (nodular?F)	nodular (difuso?F)	nodular (difuso?F)
Células B atípicas	grandes	grandes y medianas	grandes y medianas
Otras células	linfocitos T, histiocitos	linfocitos T y B, histiocitos	linfocitos B>T
Infiltrado T	CD8/Tia1>CD57	CD57>CD8/Tia1	rosetas CD57

Fenotipo de la célula B atípica

CD20, OCT2	+	+/-	+
EMA	+	-	+
CD30, CD15	-	+	-
EBV	-	+	-

… la célula de HD como elemento confusor



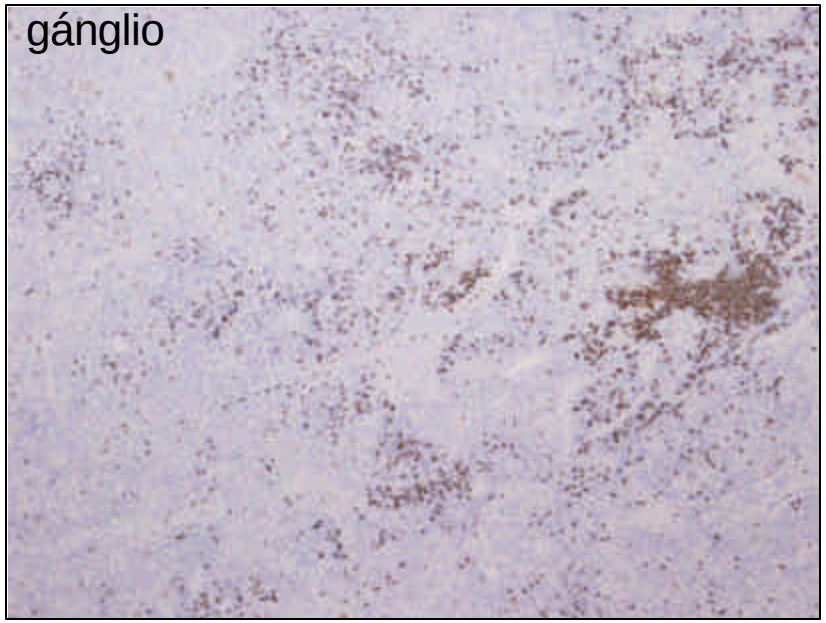
T-cell/histiocyte-rich large B-cell lymphomas may exhibit Reed–Sternberg-like cells, closely mimicking lymphocyte-rich classical Hodgkin's lymphoma, or polylobated L&H-like cells, causing confusion with lymphocyte predominance Hodgkin's lymphoma.[4,5,9–17]

Histopathology 2002, **41**, 216–229

Based on the morphologic appearance of the neoplastic cells (see *Results*), the cases were assigned to one of the following groups: 1) centroblastic, 2) immunoblastic, 3) L&H-like, and 4) Reed-Sternberg (RS) cell-like. In each case the classification was based on the morphologic appearance of >50% (majority) of the neoplastic cells.

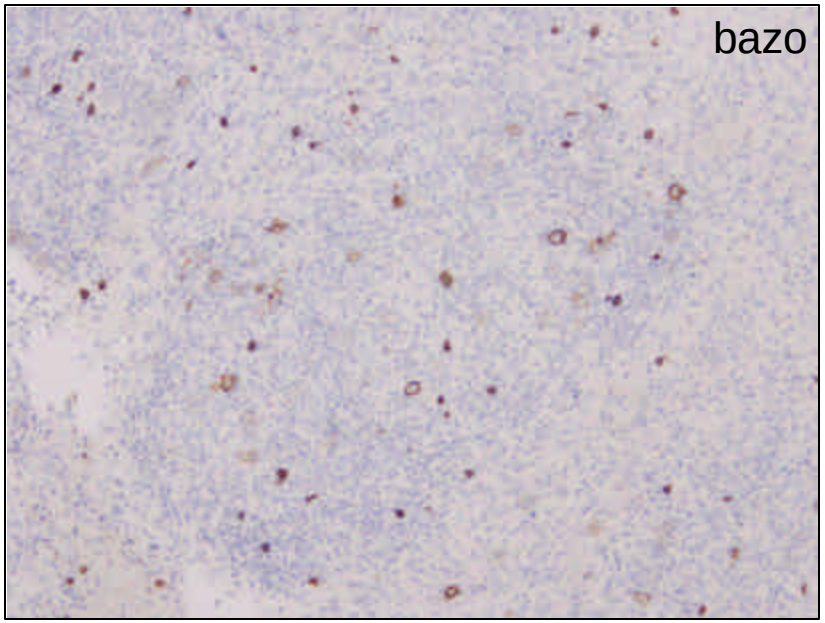
The American Journal of Surgical Pathology *26(11): 1458–1466, 2002*

… la población linfoide acompañante



In classical Hodgkin's lymphoma, in addition to small T-lymphocytes (CD3+, and more frequently expressing CD8/TIA1 than CD57), a significant proportion of the non-neoplastic cells expressed B-cell markers, either as small nodules, follicles (residual or reactive), or as a more sparse cell population. A follicular dendritic cell component was highlighted by CD23 or CD21 immunostaining in association with the B-cell aggregates in five cases.

Histopathology 2002, **41**, 216–229



In T/HRBCL, the tumor B cells made up less than 10% of the diffuse infiltrate, which was composed mainly of T cells and histiocytes, usually not forming granulomas. No FDC meshworks were detected, and small B cells were rare to absent.

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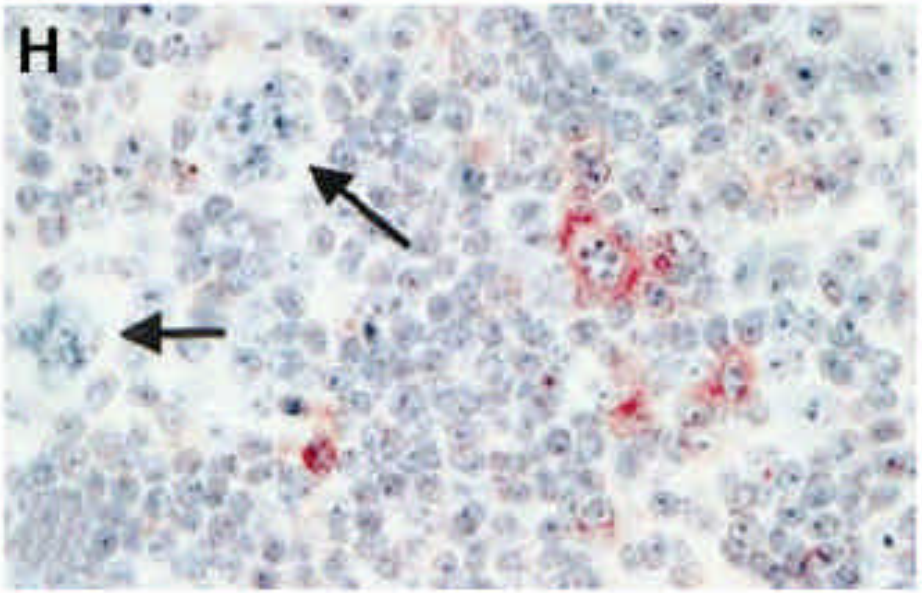
However, the background was unusual for Hodgkin's disease in that it consisted mainly of small lymphocytes and histiocytes, without eosinophils, neutrophils, or plasma cells.

Am J Surg Pathol, Vol. 26, No. 11, 2002

… el fenotipo de las células



(H) Immunostaining for CD30 (using the monoclonal anti-CD30 antibody Ber-H2 and the APAAP method) disclosed that the neoplastic cells (highlighted by arrows) did not express this antigen. The CD30+ cells corresponded to small mononuclear blasts.

. However, closer evaluation disclosed that the CD30+ cells were usually smaller than L&H cells, their nuclei were unfolded, their nucleoli were rodlike, and they lacked strong CD20 expression. Thus, these CD30+ cells corresponded to extrafollicular mononuclear blasts, which are regularly encountered in non-neoplastic reactive lymphoid tissues (Figure 2H).

BLOOD, 1 SEPTEMBER 2000 • VOLUME 96, NUMBER 5

In conclusion, in the differential diagnosis between NLPHL and T/HRBCL, all cases exhibiting tumor cells in a meshwork of FDCs should be regarded as NLPHL, regardless of the nature of accompanying small lymphocytes. In diffuse areas, abundant accompanying small B cells characterize a diffuse growth of NLPHL. Only when tumor cells are diffusely scattered in a T-cell and histiocyte-rich background devoid of small B cells, should T/HRBCL be diagnosed. In some cases, areas of both NLPHL and T/HRBCL coincide; these we regard as secondary T/HRBCL progressed from NLPHL.

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