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Case Report
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MALT Lymphoma (MALToma) Causing Massive Hematemesis: A Rare Presentation

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Abstract

Malt lymphoma (MALToma) is an uncommon primary gastrointestinal lymphoma, which rarely present with massive GI bleed. Here we report such a case which was diagnosed after persistent efforts and was treated with *Helicobacter pylori* eradication causing dramatic resolution of the neoplasm.

Keywords: MALToma, Hemetemsis, *Helicobacter pylori*

Background

Massive upper Gastrointestinal (GI) bleed is a life threatening medical emergency that can cause significant mortality and needs urgent intervention. Most common cause of upper GI bleed are peptic ulcer disease, varices, Mallory Weiss tear, vascular malformations etc.

Gastric Mucosa associated Lymphoid Tissue (MALToma), a type of Non-Hodgkin Lymphomas (NHL) are an uncommon cause of gastric neoplasm even though stomach is the most common extranodal site of involvement in lymphoma. Also upper GI bleed is a rare presentation in MALT lymphoma.

Here we present a case of MALT lymphoma presenting as massive upper GI bleed.

Case Presentation

A 57 year old gentleman presented to our emergency with three to four episodes of hematemesis and melena of one day duration associated with syncope but without any abdominal pain. He was taking medications for Type 2 Diabetes and Hypertension (Insulin, metformin, glimeperide and amlodipine). There was no history of alcohol usage, smoking, NSAID intake, previous ulcer disease etc.

Pertinent clinical examination revealed pallor, tachycardia, hypotension and no stigmata of chronic liver disease. Abdominal examination revealed epigastric tenderness, but no organomegaly and per rectal examination showed melenic stools.

Baseline investigations confirmed pallor (Hb-6.2 mg/dl and PCV-32). Since Glasgow Blatchford score was 20, he was admitted in ICU, stabilized with crystalloids, blood transfusion and pantoprazole infusion and was taken up for upper GI endoscopy.

Endoscopy revealed erythematous shallow ulcers within the antrum and body with ragged edges and active ooze. Endoscopic hemostasis was achieved after mucosal epinephrine injection and biopsy was taken from involved areas few days later. Since malignancy was suspected and CECT abdomen showed stomach wall thickening and multiple perigastric lymph nodes around 10 mm. However biopsy report was inconclusive. An endoscopic ultrasound guided lymph node biopsy was taken, reported as reactive lymphadenopathy.

Since there was a diagnostic dilemma, we preceded with deeper biopsy using Endoscopic Mucosal Resection (EMR) knife from edge of involved area. Biopsy revealed lymphoblastic infiltration suggestive of chronic gastritis associated with presence of *Helicobacter pylori*. Hence in view of suspicion of lymphoma, Immunohistochemical (IHC) workup was done, which was positive for CD20, BCL2 and CD43 and non-reactive to cyclin D and CD6.

Post procedure he did not have any bleed, hemoglobin improved (Hb-10.2). He was commenced on triple therapy for *Helicobactor pylori* eradication (twice daily) triple drug combination of pantoprazole 40 mg, amoxicillin 1000 mg and clarithromycin 500 mg for two weeks.

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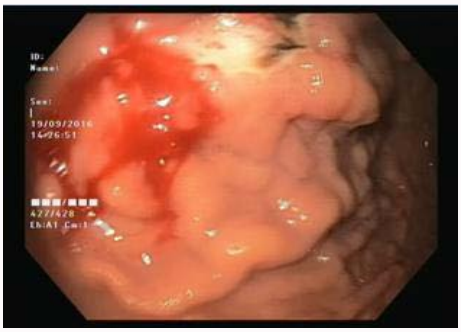

Figure 1: First endoscopic view of the lesion.

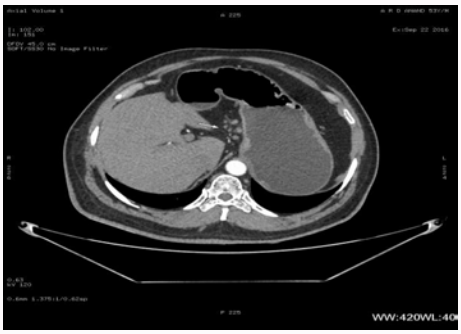

Figure 2: CECT abdomen showing gastric wall thickening and perigastric lymph nodes.

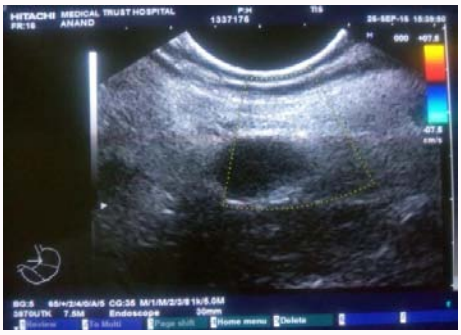

Figure 3: First Endoscopic Ultrasound (EUS) showing prominent perigastric lymphnode.

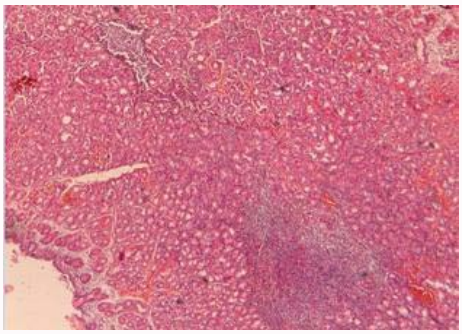

Figure 4: Histology of EUS guided lymph node biopsy showing reactive lymphocytosis.

A follow up endoscopy showed normal stomach mucosa, normal histology and no lymph nodes on follow up endosonography. His hemodynamics and baseline blood parameters remained stable. He was reviewed three months later, was asymptomatic and was further lost to follow up (Figures 1-9).

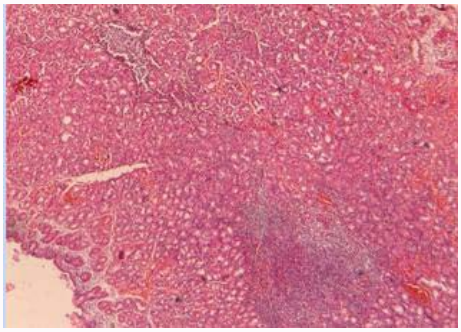

Figure 5: Low power view of gastric tissue showing chronic gastritis.

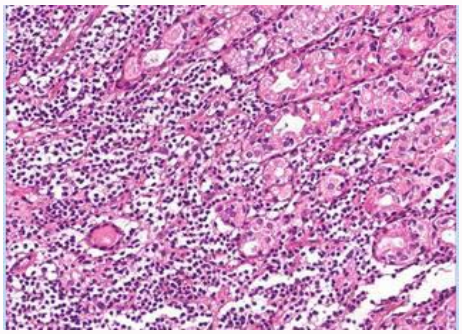

Figure 6: High power view of gastric tissue showing chronic Hpylori gastritis with lymphoplasmocytic inflitrate.

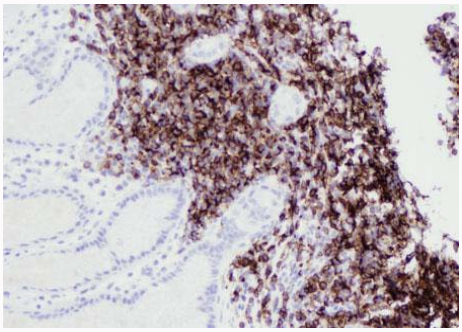

Figure 7: Immunohistochemical (IHC) work up positive for CD20, BCL2 and CD43, non-reactive to cyclin D, CD6.

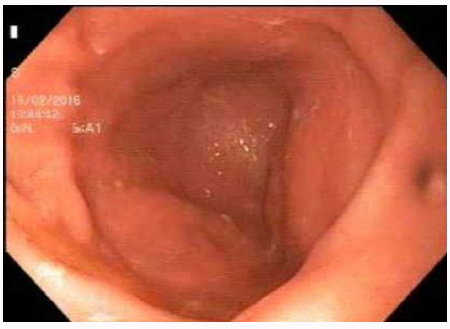

Figure 8: Follow up endoscopy shows healed lesion.

Discussion

Stomach is the most common site of extranodal Non-Hodgkins

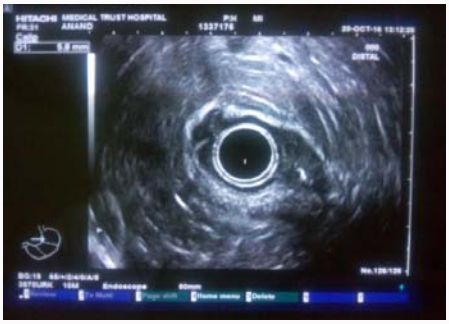

Figure 9: Follow up EUS shows resolved perigastric lymphadenopathy.

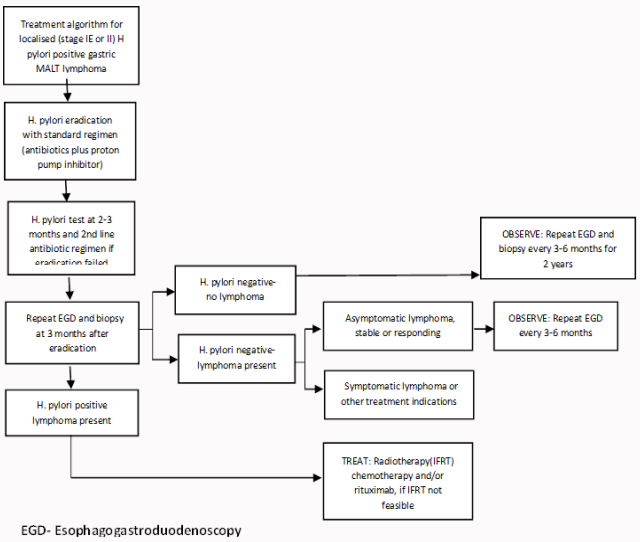

Figure 10: Algorithm for management of MALT lymphoma.

Lymphoma (NHL), even though the most common of primary GI lymphoma, MALT lymphoma is rare (1% to 6%) [1]. Chronic *H. Pylori* infection is associated with ninety percent of MALTomas. Even then, the incidence of MALTomas presenting as life threatening GI bleed is very rare [2,3] (Figure 10).

In our case, early endoscopy and hemostasis was achieved within six hours of the bleed, which has been cited by previous studies as game changer in non-variceal bleed [4,5]. The diagnosis of our patient was established by repeat deeper biopsy and histopathological examination including Immunohistochemical examination (IHC) after initial result was inconclusive. The importance of *H. pylori* eradication is cornerstone in management of MALT lymphoma, taking into account the recent guidelines which advocate *Helicobacter pylori* eradication itself can be curative in 75% in localized disease as ours, and even in advanced disease or nonresponsive cases, has to be combined with chemo/radiotherapy (flowchart) [6,7]. The eradication therapy has benefit in survival with 1 and 5 year survival rates of 90.3% and 76.2%, [8,9].

To summarize, gastric MALT lymphoma is an uncommon GI neoplasm, and even rarer cause of upper GI bleed.

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