

## Case Report

# An unusual case of dyspepsia

Abdul Khalid and M. Tariq Baqai

Department of Medicine Azad Jammu & Kashmir Medical College, Muzaffarabad, Azad Kashmir, Pakistan

## Abstract

A fifty six years old man presented with post prandial upper abdominal discomfort that gradually worsened over the last three months. There was history of anorexia and vomiting associated with early satiety and weight loss.

On physical examination, the patient had normal physical examination except that he was pale. Patient's upper gastrointestinal endoscopy showed poorly distensible stomach with diffuse nodular growth involving distal part of body of stomach. The biopsy showed poorly differentiated large cell lymphoma of stomach. Less than 15% gastric malignancies account for lymphomas. The majority of these tumors are Non-Hodgkin's lymphomas of B-cell origin. Patient received chemotherapy (CHOP + Rituximab). Follow up endoscopic biopsies and PET scan at six was normal with no residual tumor activity.

**Keywords:** Gastric malignancy, lymphoma, dyspepsia

## Case presentation

A fifty six years old Kashmiri gentleman presented with post prandial upper abdominal discomfort which had gradually worsened over the last three months. There was H/O anorexia, regurgitation of food and occasional vomiting. Anorexia was associated with early satiety and weight loss. Pallor was noted and reported by his family members. His food intake had reduced significantly. There was no history of hematemesis, melena, constipation, diarrhea or any alteration in the bowel habit. He had received H-2 receptor antagonists, proton pump inhibitor and anti motility agents. There was initial subjective, mild but transient response with recurrence of more severe symptoms later. Patient's previous medical history and professional was insignificant. He did not smoke, drink alcohol or use illicit drugs.

On physical examination, the patient was pale, well preserved. His radial pulse was 78/ minute regular; BP 130/80 mmHg; Temp 98.6 F. JVP was not raised and was not jaundiced or cyanosed. There was no lymphadenopathy or pedal oedema. Heart sounds were normal, pulmonary examination revealed bilateral normal vesicular breath sounds.

Abdominal examination showed epigastric fullness and

Correspondence to:

Dr. Abdul Khalid

Email: khalid\_awanajk@yahoo.com

mild tenderness on deep palpation. Liver and spleen were not palpable. There was no shifting dullness and bowel sounds were normal.

CBC showed Hemoglobin 10.8 gm/dl, MCV 68.2 fl with normal leukocyte and platelet counts. The routine biochemistry, LFTs, Urine analysis was normal. Screening for Hepatitis B and C was negative.

The chest radiograph was normal. Ultrasonography of abdomen showed thickened antral wall of stomach. CT scan abdomen confirmed the abnormal, increased thickening of gastric wall. Patient's upper GI endoscopy was performed under local pharyngeal anaesthesia with 4% Xylocaine spray. It showed poorly distensible stomach with diffuse nodular growth involving distal part of body and extending to few cm. of antrum. Oesophagus, proximal part of body of stomach, distal antrum and duodenum were normal. (Figure 1 & 2)

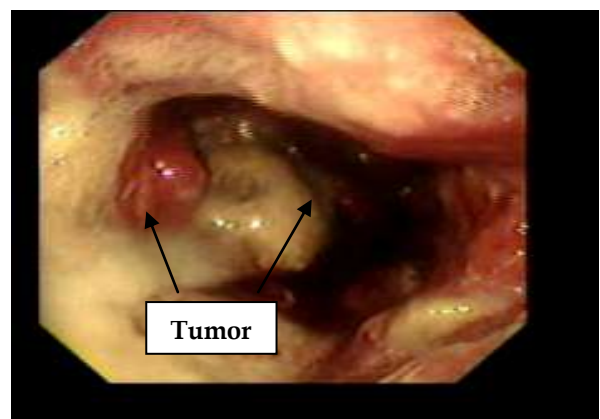


Figure 1

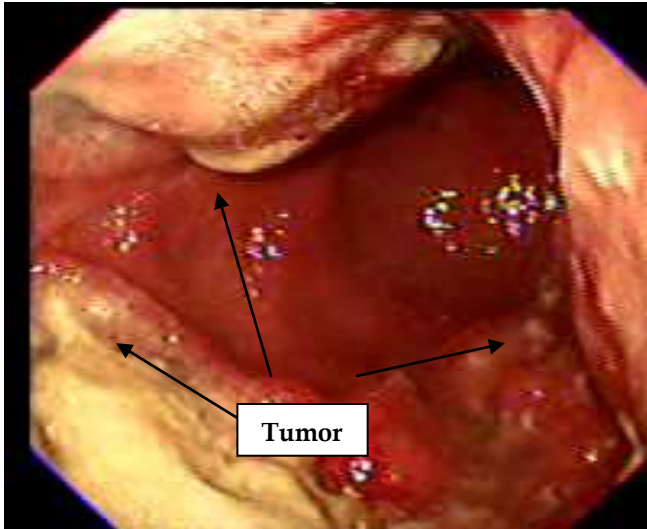


Figure 2

### Initial diagnostic endoscopy

Multiple biopsies were taken from the site. On histopathological examination poorly differentiated large cell lymphoma of stomach was diagnosed. Patient received chemotherapy (CHOP + Rituximab).

### Follow up endoscopy

Patient's symptoms improved after completion of chemotherapy. There was resolution of the tumor, though distal part of body was thickened and antrum was deformed. Follow up endoscopic biopsies at 6 months showed thickened gastric mucosa and deformed antrum with no evidence of tumor. PET scan was normal with no residual tumor activity. Anaemia and weight loss recovered with improved appetite. Patient resumed his professional duties.

### Discussion

Suspicion of gastric malignancy should always be an important consideration in all patients presenting with new onset of dyspepsia after forty years of age.<sup>1</sup> All patients with ALARM symptoms (Anaemia, loss of weight, anorexia, red vomiting and malena) need evaluation with endoscopy. There may be few or no early symptoms of gastric malignancy and physical examination may be normal or non-specific. Hence, high level of suspicion and prompt endoscopic evaluation is key to early diagnosis and management.<sup>2</sup> Adeno-carcinomas account for 85% of all gastric malignancies and less than 15 % are gastric

lymphomas. The majority of these tumors are Non-Hodgkin's lymphomas of B-cell origin but may range from well differentiated, superficial involvement MALT (Mucosal associated lymphoid tissue) to high grade, poorly differentiated large cell lymphomas.<sup>3</sup> It is clinically difficult to differentiate these tumors; radiological studies may be inconclusive, abnormal and non diagnostic. The direct visualization of the size and extension of the tumor with upper GI endoscopy and availability of the biopsy tissue makes it an efficient diagnostic tool. Histopathology and immunohistochemistry is recommended to stain specific markers on the malignant cell that favor the diagnosis of lymphoma. It is important and essential to differentiate gastric lymphoma from adenocarcinoma because the prognosis and modalities of treatment differ significantly.

Diffuse large B-cell lymphomas of the stomach are primarily treated with chemotherapy with CHOP with or without Rituximab.<sup>4</sup> Surgery is reserved for refractory cases, or in the setting of complications, including gastric outlet obstruction. In these cases Subtotal gastrectomy, with post-operative chemotherapy is undertaken.<sup>5</sup>

### Conclusion

Primary gastric lymphoma is far more easily treatable disease than adenocarcinoma. Early and correct diagnosis is mandatory. Primary lymphoma of stomach is uncommon but stomach is the most common site for extra nodal lymphoma.

Patients who respond to chemotherapy need periodic endoscopic surveillance and follow up.

### References

1. Ferreri AJ, Montalban C. Primary diffuse large B-cell lymphoma of the stomach. *Critical reviews in oncology/hematology*. 2007; 63(1):65-71
2. Medina-Franco H, Germes SS, Maldonado CL. Prognostic factors in primary gastric lymphoma. *Annals of surgical oncology*. 2007; 14(8):2239-2245
3. Chan JK. The new World Health Organization classification of lymphomas: the past, the present and the future. *Hematological oncology*. 2001; 19(4):129-150
4. Ferrucci PF, Zucca E. Primary gastric lymphoma pathogenesis and treatment: what has changed over the past 10 years? *British journal of haematology*. 2007; 136(4):521-538
5. Fauci, Braunwald, Kasper, Hauser, Longo, Jamson, Loscalzo (2008). *Harrison's principles of Internal Medicine* (17<sup>th</sup> ed.). McGraw-Hill companies, Inc. pp 573.