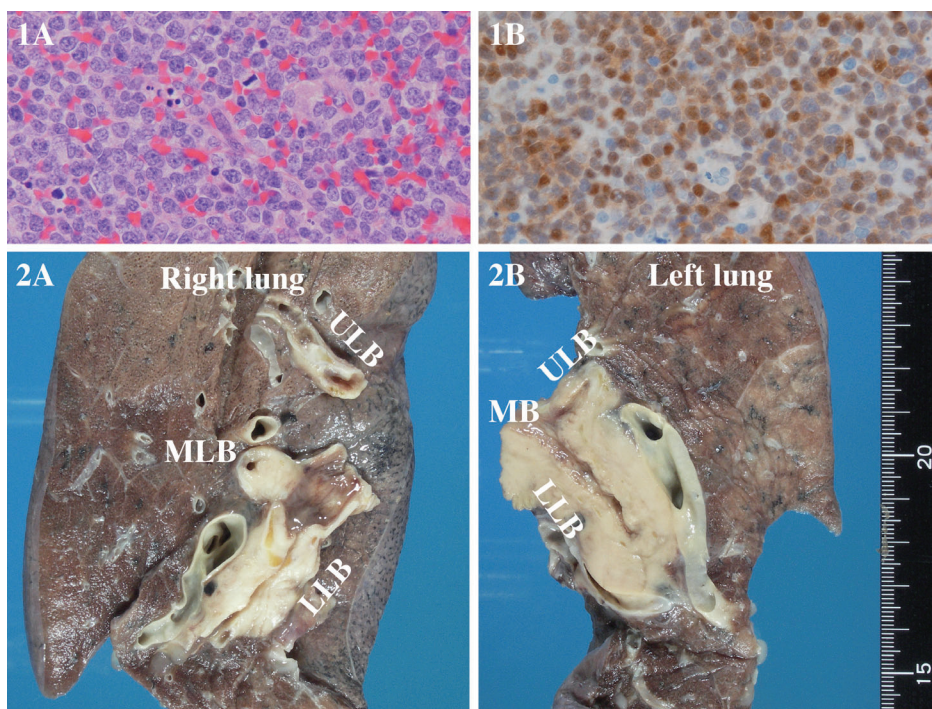


Bilateral Endobronchial Involvement in Mantle Cell Lymphoma

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Picture 1. Biopsy of the neck lymph node. (A) Diffuse medium cell lymphoma (mantle cell lymphoma) (HE stain). (B) Positive immunostaining of lymphoma cells with anti-cyclin D1 antibody.

Picture 2. Formalin-fixed (A) right and (B) left lungs showing major bronchi with marked thickening of the wall and a pencil lead caliber. MB, main bronchus; ULB, upper lobe bronchus; MLB, middle lobe bronchus; LLB, lower lobe bronchus.

A 70-year-old woman with generalized lymphadenopathy was referred to us. An abdominal CT scan showed splenomegaly and paraaortic lymphadenopathy. A cervical lymph node biopsy demonstrated diffuse medium cell lymphoma (Fig. 1A). The surface immunophenotype of the lymphoma cells were CD5⁺, CD19⁺, CD20⁺, CD22⁺, CD25⁺, and

κ⁺. They were positive for cyclin D1 by immunohistochemistry (Fig. 1B). Chromosome analysis disclosed complex structural abnormalities. Although t(11; 14)(q13; q32) was not detected, a diagnosis of mantle cell lymphoma was made. She was given ten courses of CHOP (cyclophosphamide, doxorubicin, vincristine, prednisolone) and achiev-

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ed complete remission that lasted for over 2 years. Subsequently, her clinical course had relapses and short remissions, even though each relapse was treated with modified chemotherapy regimens. In her fifth relapse, lymphomatous skin nodules (0.5-2 cm in diameter) appeared on the trunk and lower extremities. Two weeks before death, she developed stridor associated with rapidly progressive respiratory failure. She died 5 years after diagnosis. Postmortem examination revealed marked stenosis of the major bronchi of both lungs due to intramural and intraluminal infiltration of lymphoma cells (Fig. 2). Lymphomatous nodular lesions (0.5-3 cm in diameter) were seen in many organs including the larynx, trachea, thyroid, heart, lungs, stomach, small and large intestines, mesentery, peritoneum, pancreas, and kid-

neys. Also present was mediastinal, hilar, and paraaortic lymphadenopathy. Mantle cell lymphoma is a distinct clinicopathologic subtype of non-Hodgkin lymphoma that commonly involves extranodal organs and carries a poor prognosis. Airway obstruction due to primary tracheal lymphoma or tracheobronchial compression by enlarged nodal lymphoma is well recognized. In the present patient, bilateral bronchial occlusion was caused by massive endobronchial growth of lymphoma cells. Endobronchial non-Hodgkin lymphoma is extremely rare and usually occurs in the presence of disseminated disease. Bronchoscopic examination with biopsy is essential for the prompt diagnosis of this condition.