The esophagus is an infrequent site for primary presentation of human immunodeficiency virus (HIV)-associated extranodal non-Hodgkin’s lymphoma (NHL) [1]. Although rare, this disease should be suspected in patients with acquired immunodeficiency syndrome (AIDS) who have recurrent esophageal symptoms and esophageal ulcerations or a mass not responding to antiviral or antifungal therapy [2]. Endoscopy is essential to pathologic diagnosis, serving as a useful tool for differential diagnosis of esophageal diseases seen in AIDS patients. We report a completely healed case of esophageal NHL in an HIV-seropositive patient.

A 39-year-old man diagnosed as having AIDS 6 years ago presented with odynophagia and dysphagia since 2 months for both solids and liquids. Esophagogastroduodenoscopy (EGD) revealed two lesions (Fig. 1): the lesion in the upper esophagus showed mild inflammatory changes around an ulcer with a dirty base, whereas the mid-esophageal lesion, which was protruding into the lumen, consisted of an ulcer with irregular margins and a whitish layer on the top. Pathologic examination confirmed these lesions as NHL of diffuse large B-cell type (Fig. 2).

There was no notable abnormality in the thorax, abdomen, or pelvis, except for suspected mild wall thickening in the upper and mid-esophagus on computed tomography. Bone marrow biopsy showed normocellular marrow and normal karyotype, resulting in a definitive diagnosis of primary malignant lymphoma confined to the esophagus. Combination chemotherapy with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) was administered every 3 weeks, in conjunction with highly active antiretroviral therapy (HAART) (zidovudine, lamivudine, and indinavir). After 6 cycles of chemotherapy, the patient has been in a state of complete remission for nearly 3 years. A follow-up EGD 4 years after diagnosis (Fig. 3) showed completely healed lesions with a minute persistent deformity.

The endoscopic findings of HIV-seropositive primary esophageal lymphoma are variable, with no proven pathognomonic features. Histologic diagnosis is challenging; therefore, repeated endoscopic biopsies followed by empirical therapy and follow-up examinations are important and required for confirmation of diagnosis [3].
S. Park, Y. T. Jeen, Y. D. Kwon, B. Keum, Y. S. Seo, Y. S. Kim, H. J. Chun, S. H. Um, C. D. Kim, H. S. Ryu
Department of Internal Medicine, Institute of Digestive Disease and Nutrition, Korea University College of Medicine, Seoul, Korea

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