A 62-year-old man had been passing small stool for 2 months. He had been diagnosed as having mantle cell lymphoma of the spleen 8 years ago, and complete remission was achieved after chemotherapy. A computed tomography (CT) scan of the abdomen, taken to evaluate the intra-abdominal lymph nodes, revealed a rectal mass with perilesional lymphadenopathy. A primary rectal cancer was suspected (Fig. 1, 2). Colonoscopy revealed an ulcerative rectal mass with loss of rectal glandular structure confirmed with narrow-band imaging (Fig. 3, 4). Histological examination of the biopsy specimens showed numerous lymphocytic infiltrations (Fig. 5, 6), which were positive for cyclin D1 for B cells. Recurrent mantle cell lymphoma was diagnosed and the patient was treated with rituximab-based chemotherapy.

A large solitary ulcerative rectal mass is a typical presentation of primary rectal cancer. Intestinal involvement of mantle cell lymphoma, in contrast, typically presents with multiple lymphomatous polyposis [1, 2]. The stomach is the favored location [2]. Rates of involvement as documented in previous endoscopy reports are: esophagus 6%, stomach 74%, duodenum 34%, ileum 48%, cecum 14%, colon 57%, and rectum 48% [4]. Intestinal lesions of mantle cell lymphoma presented as multiple lesions in nearly 80%, whereas a protruding mass was found in 18% [2]. Narrow-band imaging of mantle cell lymphoma of the stomach has revealed loss of normal glandular structure and tree-like appearance of abnormal blood vessels [3]. The present rectal mantle lymphoma showed hypervascularity of the mucosa with loss of standard rectal glandular structure. Immunohistochemical staining provides a definite diagnosis, and infiltrates of small, atypical lymphocyte-like cells, which stain positive with pan B-cell marker, T-cell CD5, and cyclin D1, are
characteristic of the disease. Typically the disease is aggressive and the median survival is 3–5 years despite aggressive chemotherapy [4].

Competing interests: None

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