

Burkitt lymphoma presenting as multifocal doughnut-shaped masses in the stomach of a patient with AIDS



Fig. 1 Abdominal computed tomography (CT) scan showing gastric wall thickening and a non-enhancing hepatic lesion.

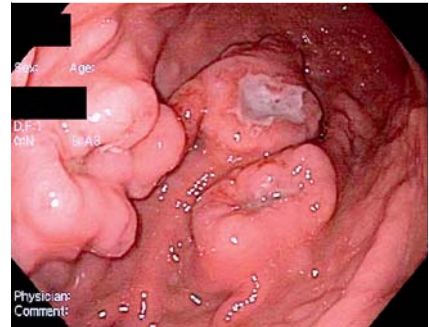


Fig. 2 Multiple ulcerated doughnut-shaped masses seen on endoscopy in the body and fundus of the stomach.

A 46-year-old man presented with a 1-month history of epigastric pain. His medical history was significant for human immunodeficiency virus (HIV) infection but he was not on treatment for this. His physical examination and initial blood test results were unremarkable, other than the finding of a CD4 count of 198/ μ L and a viral load of 370 000 copies/mL.

An oral and intravenous contrast-enhanced computed tomography (CT) scan of the abdomen showed an ulcerated and thickened posterior gastric wall and multiple liver lesions suspicious of metastatic gastric adenocarcinoma (Fig. 1). An esophagogastroduodenoscopy (EGD) was performed and showed multiple ulcerated doughnut-shaped masses of 1–3 cm in size in the gastric body and fundus (Fig. 2). Endoscopic ultrasound (EUS) revealed multiple heterogeneous liver masses up to 3 cm in size.

Forceps biopsy of the gastric masses and EUS-guided core biopsy of a liver lesion revealed diffuse proliferation of lymphocytes with round nuclei, scant cytoplasm, and numerous tangible body macrophages, which imparted a starry-sky appearance (Fig. 3 a, b). The neoplastic lymphoid cells were positive with immu-

nohistochemical staining for the CD20 (Fig. 3 c), CD10, and BCL6 (B-cell lymphoma 6) proteins (Fig. 3 d) but were negative for the BCL2 antigen. The proliferative activity, as determined by a Ki-67 immunostain, was nearly 100%. Fluorescence in situ hybridization was positive for the *MYC/IGH* fusion and negative for the *BCL2* rearrangement. These findings were diagnostic of Burkitt lymphoma.

Lymphoma can be classified into Hodgkin and non-Hodgkin types, with the latter being the type more commonly found in the gastrointestinal tract. The stomach is the most frequently involved organ and accounts for 60%–75% of all gastrointestinal lymphomas, which are usually diffuse large B cell lymphomas or extranodal marginal zone lymphomas of mucosa-associated lymphoid tissue (MALT) lymphomas [1].

The gastrointestinal tract is a common site of involvement by Burkitt lymphoma in pediatric and HIV-positive populations and should be considered in the differential diagnosis [2–4]. The majority of HIV-positive patients diagnosed with Burkitt lymphoma present with disseminated disease and are treated with intensive immunochemotherapy [5].

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Competing interests: None

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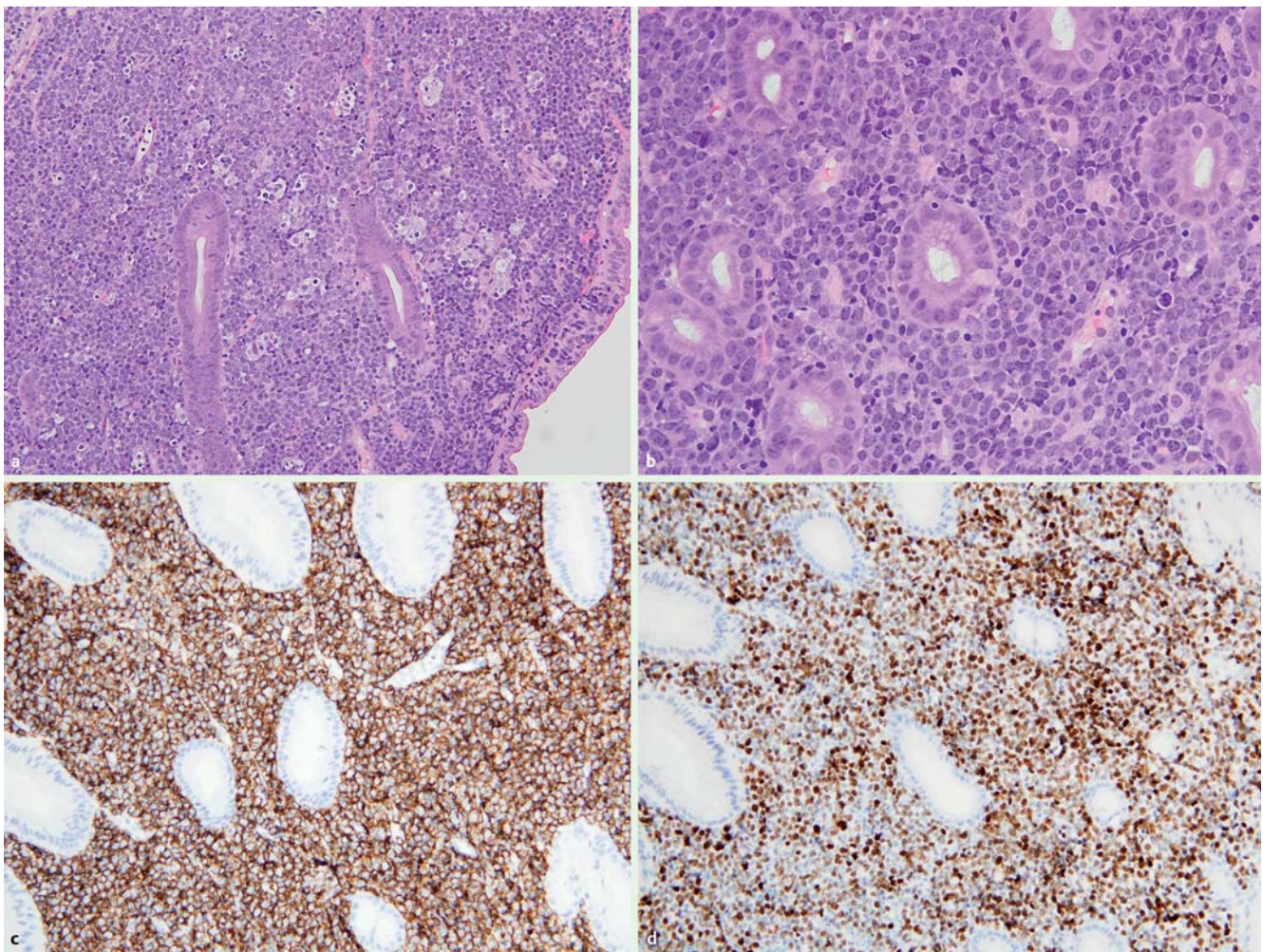


Fig. 3 Morphologic and immunohistochemical features of Burkitt lymphoma as illustrated by: **a** an extensive diffuse lymphoid proliferation with the classic starry-sky pattern; **b** neoplastic lymphoid cells that are medium sized with predominantly round nuclei, inconspicuous nucleoli, and scant cytoplasm; **c** strong immunoreactivity with a CD20 immunostain; **d** positivity of the neoplastic lymphoid cells with the BCL6 immunostain.

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