Unusual Hyperechoic Appearance of Hodgkin’s Lymphoma in the Liver

Introduction

Liver lesions of Hodgkin’s lymphoma and other lymphoma types usually appear as hypoechoic lesions in grayscale abdominal ultrasound. Here we describe the unusual case of hyperechoic liver nodules caused by Hodgkin’s lymphoma.

Case Description

A 40-year-old female presented at our hospital for work-up of a retroauricular ulcer that had persisted for weeks. She reported painless enlargement of cervical lymph nodes and significant weight loss during the last few months. Biopsy of the ulcer with subsequent pathological examination demonstrated a massive infiltration of T-cell dominating lymphocytes, granulocytes, and plasma cells. Immunohistochemical examination of the lymphoproliferative infiltrates revealed the diagnosis of Hodgkin’s disease. Staging examinations including contrast-enhanced computed tomography (CT) of the neck, chest, and abdomen showed additional hypodense lesions in the liver and spleen (Fig. 1).

An ultrasound examination of these lesions in B-mode using an Acuson, Sequoia, 512 scanner (Siemens Medical Solution) revealed multiple hyperechoic masses in the liver up to 2 cm in size (Fig. 2 upper panels) and hypoechoic masses inside the spleen up to 8 cm in size (Fig. 2 lower panels). Contrast-enhanced ultrasound of the liver lesions using Sonovue contrast medium (Bracco SpA, Milan Italy) revealed an isoechoic enhancement pattern compared to the surrounding liver tissue in the arterial phase. During the portal-venous and parenchymal phase, the lesions rapidly washed out the contrast medium and appeared hypoechoic in comparison to the surrounding liver tissue. Splenic lesions showed a pronounced homogeneous hypoechoic enhancement pattern during all recorded phases compared to the surrounding splenic tissue. Due to the fact that lymphoma involvement of the liver usually does not present a hyperechoic pattern in B-mode and that the contrast-enhanced examination indicated malignant lesions, we performed a biopsy of one of the liver masses using a 18-gauge needle with a throw of 33 mm. Differential diagnosis of hyperechoic liver lesions include metastatic carcinoma and multifocal hepatocellular carcinoma. Both diagnoses were less likely because there were no known primary and no signs of liver cirrhosis present. Pathological examination revealed next to the normal liver tissue a lymphocytic infiltrate associated with formation of intracellular fat in the surrounding hepatocytes. The density of vessels indicated by immunohistochemistry using antibodies against CD31 and CD34 was increased in the infiltrated areas (Fig. 3). Further immunohistochemical analyses confirmed liver infiltrates of Hodgkin’s lymphoma. Using the Ann Arbor Staging System the patient was staged as grade IV, BSH. Chemotherapy using the BEACOPP regimen (Cyclophosphamide, Adriaamycin, Etoposide, Procarbace, Prednisolone, Neulasta) was started. Follow-up examinations using PET-CT after two cycles of chemotherapy presented regression of all lesions including the cervical lymph nodes, liver and spleen masses.

Discussion

Hodgkin’s lymphoma accounts for approximately 10% of all lymphomas. The incidence in Europe is about 2.4 cases per 100,000 persons (Sant M et al. Blood. 2010 Nov; 116(19): 3724–3734). Liver involvement of lymphomas in general can be found up to 50% of cases (Castroagudín JF et al. Ultrasound Med. 2007 Jun; 26(6): 791–796). The vast majority of sonographic findings are lesions with a hypoechoic appearance. A small portion of cases present with a heterogeneous sonographic appearance of the focal lesions (Soyer P et al. Abdom Imaging 1993;18(4): 339–343). Here we present the first detailed report to our knowledge of a Hodgkin’s lymphoma presenting as hyperechoic liver lesions. This case was part of a cumulative analysis of the contrast-enhanced ultrasound pattern of hepatic lymphoma (Trenker C et al. Ultraschall Med. 2014 Apr; 35(2): 142–148). Increased echogenicity of liver lesions has been attributed to fat deposition (Caturelli e al. Gastroenterology 2005; 130(6): 1678–1682). One form, the fatty liver disease also known as nonalcoholic fatty liver disease, can present as patchy or focal hyperechoic areas inside the liver (Gorg C et al. Onkologie 2005; 28(12): 659–664). Other examples of hyperechoic liver lesions include liver adenomas. Liver adenomas with a hyperechoic appearance can also reveal intratumoral fat deposition in histological analysis which is the main factor contributing to the echogenicity (Hung CH et al. Abdom Imaging. 2001 Sep–Oct; 26(5): 500–506). Additional lesions presenting with a hyperechoic pattern are hemangiomas. Increased vessel density contributes in these cases mainly to the high echogenic-
ity of the lesions. In the case of the hyper-
echoic lesions presented by our patient,
histopathological work-up revealed fat
deposition in hepatocytes surrounded by
immune cell infiltrates. The adjacent nor-
mal liver parenchyma presented no fatty
deposition. This supports the hypothesis
that fat deposition is responsible for the
echogenicity. Additionally, small to
medium-sized vessels may have contrib-
uted to the hyperechogenicity. A thor-
ough review of the literature revealed a
few case reports of lymphomas that have
been associated with liver masses with a
heterogeneous appearance on ultrasound
(Castroagudin JF et al. J Ultrasound Med.
660.). Unfortunately no correlation
between the sonographic appearance
and the presented histopathological pic-
ture was made. The most similar descrip-
tion of a hyperechoic non-Hodgkin’s
lymphoma liver mass was written by Kim
and colleagues (Kim H et al. J Clin Ultra-
sound 2008; 36(7): 437–439.). The
authors described an echogenic mass that
infiltrated the liver. Fat deposition was
attributed to the echogenicity of the
lesion. The pathological specimen dis-
played adipose tissue diffusely merged
with hepatocytes and immune cells. In
contrast, our patient displayed the fat
deposition inside the hepatocytes sur-
rounded by lymphoma infiltrates. Degen-
erative fat accumulation inside the
hepatocytes triggered by the lymphoma
may be the cause for this phenomenon.
Further investigations are necessary to
correlate the sonographic appearance of
liver lesions to the histopathological
characteristics of the tissue.

Fig. 2 Contrast-enhanced ultrasound of liver (upper panels) and spleen (lower panels) lesions. Baseline ultrasound of the liver a and spleen e followed by
the contrast-enhanced arterial phase b, f, portal venous phase c or parenchymatous phase g and late parenchymatous phase d, h demonstrates the character-
istics of the lesions.

Fig. 3 Liver biopsy of 40-year-old female patient with dense lymphoid infiltrate between macroves-
icular steatosis (F). The lymphoid infiltrate with partly granulomatous pattern (G) and corresponding
to an infiltration of the Hodgkin’s lymphoma. To the left, inconspicuous liver tissue (L). The small
inset depicts immunohistochemistry for the endothelial marker CD34 with small to medium-sized
capillaries in the lymphoma infiltrate.