Odontogenic-Like Pain in Partial Edentulism: An Unusual Presentation of Diffuse Large B-Cell Lymphoma of the Mandible

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Introduction

Non-Hodgkin lymphomas (NHLs) are the most common lymphoid malignancies in adults. Diffuse large B-cell lymphoma (DLBCL) accounts for 31% out of all NHLs, and it is the most frequent histological type, usually occurring in adults between the sixth and seventh decades.1,2 DLBCL is a very aggressive lymphoma, but highly responsive to the current therapies, even in advanced stages.

However, the increasing number of elderly patients often makes their management challenging, due to the presence of comorbidities. Thus, an early and prompt diagnosis is crucial for patient outcome.

Between 25 and 40% of NHLs may have an extranodal spread1,4 and the head and neck region represents the second most common onset site, after gastrointestinal tract. However, primary NHL rarely occurs in maxilla or mandible accounting only for 0.6% out of all NHLs.3 These percentages reflect the general low incidence of primary bone lymphomas (~5% out of all extranodal NHL and 2% out of all lymphomas).5,6

Abstract

Primary bone lymphoma is a rare entity and it usually occurs in long bones. Primary mandibular involvement is very rare, and it usually shows unspecific features, mimicking odontogenic inflammatory lesions. We present the unusual case of a diffuse large B-cell lymphoma (DLBCL) of the right mandibular body in a 91-year-old woman, who presented with acute pain in the mandibular region initially suspicious for odontogenic abscess. No significant findings were seen on orthopantomography (OPG) and her almost complete edentulism made the diagnosis of abscess unlikely. Computed tomography and magnetic resonance images showed an expansive mass around the right mandibular body with erosion of cortical bone and involving the right mandibular canal and nerve. Final diagnosis of DLBCL was pathologically proven. The presence of odontogenic-like pain in nearly complete edentulism should be suspicious for malignancy, and it needs further diagnostic workup despite the absence of signs on OPG.

Keywords

► computed tomography
► diffuse large B-cell lymphoma
► magnetic resonance
► mandible
► orthopantomography

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Lymphoma of the jaw does not have any specific clinical and radiological features; it often appears as an odontogenic process, thus delaying the diagnosis.

We present imaging findings of a rare case of DLBCL arising from mandibular body in an elderly woman, who was almost completely edentulous.

**Case Report**

A 91-year-old woman was referred to our center to undergo orthopantomography (OPG) for possible odontogenic abscess. She complained of right mandibular pain for 2 months. Physical examination showed mild swelling in the right mandibular region, without any other signs or symptoms. Laboratory findings were normal, and there were no relevant events in her medical history. The OPG showed almost complete edentulism without other abnormalities, especially in the painful area (Fig. 1), thus the hypothesis of odontogenic abscess was unlikely. As the pain worsened despite the anti-inflammatory therapy, the patient underwent a computed tomography (CT) without contrast agent injection. CT showed the presence of a 4.3-cm expansive mass centered in the right mandibular body, involving the adjacent submandibular and sublingual spaces. Erosion of the cortical bone and involvement of the right mandibular canal were evident (Fig. 2A, B). Mandibular nerve, which runs through the mandibular canal, was also involved, thus explaining the pain. No locoregional lymphadenopathies were evident.

The patient also underwent contrast-enhanced magnetic resonance imaging (MRI) to precisely evaluate locoregional extension of the disease and the possible presence of perineural spread along the mandibular nerve. MRI confirmed the presence of an expansive lesion of the right body of the mandible, involving the mandibular canal and nerve. The lesion showed the same intermediate signal of muscles on T1-weighted images and high signal intensity on fat-suppressed T2-weighted images; mild homogeneous enhancement was evident after administration of contrast agent (Fig. 3). High signal intensity on high b-value was also demonstrated on diffusion-weighted imaging (DWI) with low signal intensity on corresponding apparent diffusion coefficient (ADC) map, as usually occurs in hypercellular lesions. No signs of perineural spread were evident along the course of inferior alveolar nerve. The lesion also involved mylohyoid, anterior belly of digastric, buccinator, and platysma muscles.

A biopsy of the mass was performed and histological diagnosis of DLBCL with high proliferation rate (>90% Ki-67+) was done. Contrast-enhanced total body CT was also requested for staging, and it showed the presence of two osteolytic lesions in the seventh and eighth dorsal vertebrae and a 1.8-cm hypodense lesion of the spleen (Fig. 4). The patient was referred to the hematology department for treatment. After a multidisciplinary counseling, locoregional radiotherapy was started because of the size of the lesion, the presence of pain not responsive to the medical therapy, and the age of the patient.

**Discussion**

DLBCL accounts for ~30% out of all NHLs, and it is the most common lymphoma in adults, occurring usually between the sixth and seventh decades. DLBCL is classified in different types and subgroups according to morphologic variants, molecular and immunophenotypic features.
confined to the initial center of the lesion and may or may not spread to the adjacent soft tissues. The presence of extensive bone destruction and/or bone destruction with soft tissue infiltration is suspicious of a permissive or malignant process. 

The World Health Organization classifies solid mandibular lesions as benign or malignant, according to the predominant odontogenic tissue involved by disease. Both benign and malignant odontogenic mandibular lesions often occur in young people, without acute symptoms (e.g., pain and rapid-onset swelling). In elderly, infectious etiologies (e.g., abscess or osteomyelitis) and primary nonodontogenic lesions (e.g., sarcomas, lymphoma, and metastasis) should be considered.

Radiographic findings on OPG images may be absent in up to 20% of lymphomas and usually they are unspecific. The most common appearance of primary bone lymphomas is a permissive pattern, characterized by spread of tumor cells from the bone marrow through small vascular channels that go through the cortex into the surrounding soft tissue. The result is an extensive marrow disease centered in a bone segment with a surrounding soft tissues mass without an extensive cortical destruction, causing lack of significant radiological signs.

When signs are present, an area of radiolucency with ill-defined borders is the most common finding. Low mineral content in patients with osteoporosis can reduce sensitivity of radiographic bone evaluation. Sometimes indirect signs may be present, such as displacement of teeth and loss of the mandibular canal wall, often due to the presence of malignancies.

CT is sensitive in detecting the presence of a lesion and defining its extension. The most common finding is the bone cortex destruction with bone marrow replacement by the tumor, often extended to the adjacent soft tissues. It is rare to see perioskeletal reaction, which is usually more suggestive for the presence of osteomyelitis or osteosarcoma. However, all these signs are unspecific and, even if they suggest the presence of malignancies, tissue biopsy is necessary to clarify the real nature of the lesion.

Even MRI findings are variable. Usually, lymphomas show intermediate signal intensity, similar to the adjacent muscles on T1-weighted images, higher signal intensity on T2-weighted images, and variable degrees of enhancement, usually homogeneous, after injection of contrast agent.

Fluorodeoxyglucose positron emission tomography/CT or total body CT is necessary for staging and evaluating the presence of disseminated disease after histological diagnosis of lymphoma, even if extranodal lymphomas are most frequently localized than disseminated.

In summary, in this case, the presence of acute pain in the right mandibular body without any other symptoms was initially suggestive for inflammatory disease. However, the absence of any significant radiographic finding and persistence of symptoms despite the anti-inflammatory therapy needed further evaluation with CT and MRI, which showed findings highly suspicious for malignancy. In particular, the epicenter of the lesion was the mandible and replacement of bone marrow suggested bone primitivity rather than a tumor arising from soft tissues. Osteosarcoma is the most frequent diagnosis among bone malignant lesions, but the possibility of other diagnoses should always be considered.

Conclusion
This case report underlines that, even if rare, lymphoma should still be considered in the differential diagnosis of mandibular lesions presenting with signs and symptoms typical of inflammatory disease.

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Conflicts of Interest
None declared.
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