Intestinal follicular lymphoma is uncommon, and its endoscopic appearance has seldom been described [1-4]. We report five patients with primary intestinal follicular lymphoma in whom the whole of the gastrointestinal tract were examined using esophagogastroduodenoscopy (EGD), colonoscopy, and double-balloon enteroscopy [5].

The clinical and endoscopic features of the five patients are summarized in Table 1. All the patients underwent EGD, colonoscopy, and double-balloon enteroscopy via antegrade and retrograde approaches (Fujinon-Toshiba ES Systems Co., Tokyo, Japan). Four patients (80%) had lesions in multiple sites in the gastrointestinal tract. The most frequent site was the jejunum, followed by the duodenum and the ileum. In three patients, EGD revealed multiple small, whitish nodules in the duodenum, predominantly around the ampulla of Vater. On colonoscopy, one patient was found to have a superficially elevated lesion with aggregates of small nodules in the rectum in patient 3.

Double-balloon enteroscopy revealed multiple polypoid lesions resembling lymphomatous polyposis in long segments of the jejunum or ileum in four patients (80%) (Figure 2a, b). The remaining patient also showed lymphomatous polyposis-like lesions in the ileum, but multiple biopsies failed to reveal lymphoma cells. Swollen Kerckring folds with mass formation was observed in three patients, and severe jejunal stenosis in two (Figure 2c, d). In all the patients, a histologic diagnosis of grade 1 follicular lymphoma was made by endoscopic biopsy, with infiltration of neoplastic cells positive for CD20, CD79a, CD10, and BCL2 but negative for CD3, CD5, and cyclin D1.

A variety of endoscopic features of intestinal follicular lymphoma were observed. Lymphomatous polyposis is considered to be one of the most characteristic findings, and this can often be detected using double-balloon enteroscopy. Double-balloon enteroscopy is a valuable tool for

Table 1 Clinical and endoscopic features of five patients with primary intestinal follicular lymphoma

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age/Sex</th>
<th>Symptoms</th>
<th>Stage</th>
<th>Sites involved</th>
<th>EGD findings</th>
<th>Colonoscopic findings</th>
<th>DBE findings</th>
<th>Treatment</th>
<th>Response to treatment</th>
<th>Clinical outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>55/M</td>
<td>None</td>
<td>I</td>
<td>D</td>
<td>Multiple small nodules (D)</td>
<td>Normal</td>
<td>LP-lyke* (I)</td>
<td>Antibiotics †</td>
<td>Not evaluated</td>
<td>Alive with disease, 3 months</td>
</tr>
<tr>
<td>2</td>
<td>58/M</td>
<td>Abdominal pain, emesis</td>
<td>II, 1</td>
<td>D, J</td>
<td>Normal</td>
<td>Normal</td>
<td>Stenosis, mass, fold swelling, LP (J)</td>
<td>Surgery plus R-CHOP</td>
<td>Complete remission</td>
<td>Alive without disease, 12 months</td>
</tr>
<tr>
<td>3</td>
<td>60/F</td>
<td>None</td>
<td>I</td>
<td>J, I, R</td>
<td>Normal</td>
<td>Nodule aggregates (R), LP (I)</td>
<td>Antibiotics ‡</td>
<td>Partial remission</td>
<td>Alive with disease, 20 months</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>64/M</td>
<td>None</td>
<td>II, J</td>
<td>D, J</td>
<td>Multiple small nodules (D)</td>
<td>Normal</td>
<td>Mass, fold swelling, LP (J)</td>
<td>R-CHOP</td>
<td>Partial remission</td>
<td>Alive with disease, 10 months</td>
</tr>
<tr>
<td>5</td>
<td>71/M</td>
<td>Abdominal pain, nausea</td>
<td>IV</td>
<td>D, J</td>
<td>Multiple small nodules (D)</td>
<td>Normal</td>
<td>Stenosis, mass, fold swelling, LP (J)</td>
<td>R-CHOP</td>
<td>Partial remission</td>
<td>Alive with disease, 6 months</td>
</tr>
</tbody>
</table>

EGD, esophagogastroduodenoscopy; DBE, double-balloon enteroscopy; LP, lymphomatous polyposis; R-CHOP, rituximab plus cyclophosphamide, doxorubicin, vincristine, and prednisolone.
D, duodenum; I, ileum; J, jejunum; R, rectum.
* Numerous small polypoid lesions were observed but biopsies failed to reveal lymphoma cells.
** Detected by intraoperative enteroscopy.
† Lansoprazole plus amoxicillin and clarithromycin for 7 days.
‡ Rabeprazole plus amoxicillin, clarithromycin, and metronidazole for 14 days.

the detection and accurate diagnosis of the small-intestinal lesions of this disease.

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Corresponding author

S. Nakamura, M.D.
Department of Medicine and Clinical Science
Graduate School of Medical Sciences
Kyushu University
Maidashi 3–1–1
Higashi-ku
Fukuoka 812-8582
Japan
Fax: +81-92-642-5273
Email: shonaka@intmed2.med.kyushu-u.ac.jp

Figure 2  Double-balloon enteroscopic views of the jejunal in patients with intestinal follicular lymphoma. Numerous polypoid lesions of varying sizes, resembling lymphomatous polyposis, were seen, illustrated by images from patient 4 (a) and patient 5 (b). Patient 5 also showed mass formation (c), and patient 2 had a severe jejunal stenosis due to mass formation with swelling of Kerckring folds (d).

S. Nakamura1, T. Matsumoto1, J. Umeno1, S. Yanai1, Y. Shono1, H. Suekane2, M. Hirahashi3, T. Yao1, M. Lida1
1 Department of Medicine and Clinical Science, Graduate School of Medical Sciences, Kyushu University, Fukuoka, Japan
2 Department of Internal Medicine, Yamaguchi Red Cross Hospital, Yamaguchi, Japan
3 Department of Anatomic Pathology, Graduate School of Medical Sciences, Kyushu University, Fukuoka, Japan.