Endoscopic findings of enteropathy-type T-cell lymphoma

Patient 1 was a 77-year-old man who was admitted because of anorexia and diarrhea. Esophagogastroduodenoscopy revealed edematous mucosa with nodular or mosaic pattern in the duodenum (Fig. 1). Antegrade double balloon endoscopy revealed thickening of the mucosa with loss of folds and a mass with circumferential ulceration in the jejunum (Fig. 2). Biopsy disclosed diffuse infiltrate of small to medium-sized atypical lymphoid cells with CD3+, CD8+, CD20-, CD56+, TIA-1+, and CD103-immunophenotype (Fig. 3). A diagnosis of ETL in stage I was thus made. The patient was treated with two courses of chemotherapy with pirarubicin, cyclophosphamide, vincristine, and prednisolone. However, intestinal perforation occurred, and he underwent immediate laparotomy. The patient died of lymphoma 2 months after surgery. Positive serum antigliadin antibodies and the presence of villous atrophy with intraepithelial T-cells in the small intestine suggested pre-existing celiac disease.

Patient 2 was a 56-year-old man who was admitted with abdominal pain, diarrhea, and body weight loss (7kg). Sigmoidoscopy revealed multiple discrete or punched-out ulcers in the thickened mucosa. After barium meal study, intestinal perforation occurred. During the emergent laparotomy, partial resection of the small intestine was carried out. Histologic examination of the resected intestine suggested a diagnosis of ETL. The patient was treated with four courses of chemotherapy with cyclophosphamide, doxorubicin, vincristine, and prednisolone.
lone. However, he died of lymphoma 6 months after the surgery.

Our experiences suggest diffuse mucosal thickening and edema with ulcerations in the intestine to be characteristic of ETL. In addition, double balloon endoscopy showed a nodular or mosaic mucosal pattern in the small intestine, which may be specific to the disease.

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