Synchronous multiple lymphomatous polyposis and adenocarcinoma in the large bowel

Sir, The occurrence of multiple primary malignancies is well-recognized: most cases have involved two or more carcinomatous, often of the skin, stomach, colon or breast, and most commonly found in the same organ homologously or heterologously. Cases of synchronous carcinoma and a lymphoma have been described, but two separate adenocarcinoma occurring in the presence of lymphomatous polyposis and diffuse lymphoma in the large bowel has not been previously reported.4 We report a case in which two separate adenocarcinomas occurred in the presence of lymphomatous polyposis and diffuse lymphoma in the large bowel. This is novel in several respects. The patient had known risk factors (see box).1,3,4 We report a case in which two separate adenocarcinomas occurred in the presence of lymphomatous polyposis and diffuse lymphoma in the large bowel. This is novel in several respects. The patient had known risk factors (see box).1,3,4 We report a case in which two separate adenocarcinomas occurred in the presence of lymphomatous polyposis and diffuse lymphoma in the large bowel. This is novel in several respects. The patient had known risk factors (see box).1,3,4

A 74-year-old woman presented with a three-month history of pain in the right iliac fossa and weight loss. Examination revealed a palpable fixed caecal mass and an ulcer 6 cm from the anal margin. Contrast radiography additionally revealed numerous small polyps throughout the colon. A computed tomographic (CT) scan demonstrated large paraaortic lymph nodes. A rectal biopsy showed infiltrating adenocarcinoma and a dense, nodular, mucosal lymphoid infiltrate, displacing and infiltrating crypts, with atrophy of the overlying epithelium. It was composed of monotonous small lymphoid cells with indented nuclei resembling centrocytes, and a small proportion of large transformed lymphoid cells and macrophages, consistent with lymphomatous polyposis. The patient underwent chemotherapy. The resected large bowel showed diverticular disease and contained three separate tumour masses: a 3 cm polypoid rectal carcinoma with ulceration, an 8 cm polypoid caecal carcinoma and a 7 cm adjacent ulcerating caecal carcinoma. Numerous small polyps were present in the rectum, colon and the ileal resection margin. Histological examination of both carcinomas revealed Dukes C lesions. The polypoid caecal lymphomatous mass consisted of diffuse sheets of lymphoma cells similar to those in the polyps, with penetration through the bowel wall and spread to adjacent lymph nodes. In some parts of the caecum as well as in the lymph node metastases, the diffuse lymphoma had diffused with the carcinoma. Immunohistochemistry confirmed a B-cell phenotype (CD45+ , CD45RA+ , CD20+ , MB2+, κ+, λ- , CD45RO- , CD43-, CD3- ). The term malignant lymphomatous polyposis1 is now used to describe a specific entity comprising a polypoid mucosal lymphoma of the gastrointestinal tract, regarded as a variant of centrocytic lymphoma and probably identical to mantle zone lymphoma, which may sometimes form into high grade B-cell lymphoma.6 Our patient showed a diffuse low grade lymphomatous mass in the caecum, but no areas of large-cell lymphoma. The lymphoma had involved adjacent mesenteric lymph nodes: both these and the caecal lymphomatomatous mass showed invasion by carcinoma. This might suggest that local factors such as absent immune surveillance in the lymphoma may have caused carcinoma cells to grow there preferentially.

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Previous reports of concurrent lymphoma and carcinoma
- splenic leukaemia with carcinoma1
- leukaemia or lymphoma and coexistent primary malignancy (120 cases)
- lymphoma and adenocarcinoma of the large bowel (separated lesions)3
- lymphoma and adenocarcinoma of large intestine in IgA deficiency4

Manubrio-sternal joint sepsis in rheumatoid arthritis

Sir, Involvement of the manubrio-sternal articulation in rheumatoid arthritis has been documented. Investigators using computed tomography (CT) have noted abnormalities in 50–70% of patients.1,2 It is, however, almost invariably sub-clinical. A 56-year-old man with sero-positive rheumatoid arthritis, developed a large painless, fluctuant swelling over the anterior aspect of his sternum. Investigations revealed a white cell count of 12.5 x10³/l with 93% granulocytes, C-reactive protein 222 mg/l (normal < 10), erythrocyte sedimentation rate 70 mm/h (Westergren); urea, electrolytes and blood sugar were normal. CT scan showed a large fluid-filled cyst extending beneath the sternum in the anterior mediastinum. The bone on either side of the manubrio-sternal joint appeared eroded and ragged. He developed a pyrexia and urine culture grew Staphylococcus aureus. The cystic swelling was incised and several hundred mls of pus aspirated. Culture of the fluid grew S aureus sensitive to flucloxacillin. He was commenced on intravenous flucloxacillin 500 mg qid. Over a two-week period the manubrio-sternal cystic swelling and pyrexia resolved. He was treated for a further four weeks with intravenous flucloxacillin and discharged. Six months later he presented with a further large cystic swelling over his manubrio-sternal joint. The aspirate grew S aureus and he was commenced on intravenous flucloxacillin and fusidic acid for a further six weeks. CT scan at this time showed irregular margins, erosion and destruction of bone on either side of the manubrio-sternal joint (figure). To date he has had no further recurrence.

A 59-year-old woman with sero-positive rheumatoid arthritis complained of pain and swelling over her manubrio-sternal joint. On examination there was a tense, cystic swelling 3–4 cm in diameter over the manubrio-sternal junction. She had a low grade pyrexia of 37.8. White cell count was 13 x10³/l, erythrocyte sedimentation rate was 92 mm/h and C-reactive protein was 93 mg/l, urea and electrolytes, blood sugar and plasma proteins were normal. Urine and blood cultures were sterile. She then developed a hot, painful, swollen elbow joint. The aspirate grew S aureus, sensitive to flucloxacillin. Aspiration of the manubrio-sternal cystic swelling was attempted but fluid was not obtained. CT scan of the manubrio-sternal junction showed erosion and destruction of bone. Intra venous flucloxacillin and fusidic acid were continued for six weeks. Her temperature settled and the manubrio-sternal swelling resolved.

The pathogenesis of manubrio-sternal abnormality in rheumatoid arthritis is not certain; it may relate to primary involvement by the rheumatoid disease process, as both...
Allergic and toxic reaction to alprazolam

Sir,

We report the case of a patient who suffered an alprazolam overdose, and an allergic reaction probably induced by it.

A 19-year-old woman was found unconscious after ingesting 1.2 mg of alprazolam. Six months previously, she had been taking 0.25 mg alprazolam daily and 20 mg fluoxetine daily for two months. One hour later, at the emergency room, a gastric lavage was done, and treatment with fluids was started. Fifteen hours after drug ingestion, the patient’s mental status was characterised by total amnesia of what had happened, and a relative had to relate the story. Alcohol and other drug ingestion was ruled out. The patient then presented a crisis of bronchospasm and larynspasm, with severe dyspnoea and dysphagia.

Physical examination revealed bilateral palpebral and soft palate angioedema and laryngeal stridor. Pulmonary auscultation showed a reduction of the vesicular murmurs and disseminated high-pitched wheezes over both pulmonary fields. Cardiac auscultation and abdominal examination were normal. Molecular oedema with patient mobilisation probably secondary to the fall after taking alprazolam, was observed in the left lower limb.

Laboratory analysis showed: 17.6 x 10^9/l white blood cells, 3.2 x 10^9/1 polymorphonucleocytes, 9% lymphocytes, 6.5% monocytes, 0.1% eosinophils). The remaining cell count, serum electrolytes and urinalysis were normal. Baseline arterial blood gases showed moderate hypoxemia (PaO_2_ = 76 mmHg corrected after oxygen therapy at FiO_2_ of 31%. Chest X-ray and electrocardiogram were normal. IgG, A, M and E levels, complement, Cl inhibitor and protein electrophoresis fell within normal limits. Neither HBV antibodies or antigens nor HIV antibodies were detected.

Successive doses of subcutaneous epinephrine and intramuscular antihistamines, oxygen therapy and inhaled β-adrenergic drugs were administered, with good clinical response. On discharge, eight days later, the patient was asymptomatic. Sensitisation to the most frequent allergens was ruled out through clinical history and skin test. A series of standard prick tests for pollens, house dust mites and molds, latex, foods and hymenoptera poisons were negative. Finally, an in vitro study with alprazolam was conducted on the patient and on three healthy subjects with a negative basophil degranulation test, and a negative histamine release test. In no in vitro study, the patient were conducted, being forbidden by current Spanish legislation.

The loss of consciousness and the transient global amnesia, can be attributed to the sedation and the anesthetic effects of the alprazolam overdose. This reaction occurred with a dose slightly higher than the upper limit of the dose range for the treatment of panic disorders.

The symptoms that occurred 15 h after ingesting the drug suggest an allergic reaction to alprazolam. Other factors (material used for gastric lavage, other medications, foods or substances) may be ruled out by different standard tests. The previous contact of the patient with alprazolam a few months before, supports the idea of a sensitisation. The timing of the clinical manifestations suggests an independence of the toxic reaction, considering the elimination half-life of the drug.

Ethical considerations made confirmation through in vitro tests of our explanation of this clinical picture impossible.

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Chronic myeloid leukaemia and allogenic bone marrow transplantation in a patient with toxic oil syndrome

Sir,

We have observed the development of chronic myeloid leukaemia in a woman who had been affected 10 years earlier by the toxic oil syndrome, produced by the ingestion of adulterated rapeseed oil, and in whom an allogenic bone marrow transplant had been accompanied by severe toxic manifestations.

The toxic oil syndrome is a multisystemic disease in which the basic lesion is endovasculitis involving vessels of all sizes and located anywhere in the organism. The vascular lesion first affects the intima, followed by inflammatory infiltration and cell proliferation producing, in advanced stages, occlusion and occlusion of the vascular lumen, leading to ischaemia and parenchymal atrophy in some organs (liver).

No cases of development of leukaemia in patients affected by the toxic oil syndrome had been previously reported.

The 35-year-old woman whose case we present here, was diagnosed as having toxic oil syndrome 10 years earlier. The only sequel at the time that the leukaemia was detected, was a mild, predominantly sensory, neuromuscular involvement in the upper limbs. After the diagnosis of Ph-positive chronic myeloid leukaemia, she started treatment with interferon α-2b, but no cytogenetic remission was observed in subsequent haematologic studies.

Manubrio-sternal joint sepsis in rheumatoid arthritis.

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