Letters to the Editor

Synchronous multiple lymphomatous polyposis and adenocarcinoma in the large bowel

Sir,

The occurrence of multiple primary malignancies is well-recognised: most cases have involved two or more carcinomata, often of the skin, stomach, colon or breast, and most commonly found in the same organ homolaterally or contralaterally. Cases of synchronous carcinoma and a non-epithelial neoplasm are rarer but still well-documented. Synchronous adenocarcinoma and lymphoma of the large bowel is rarer still and may involve risk factors (see box).^{1–4} We report a case in which two separate adenocarcinomata occurred in the presence of lymphomatous polyposis and diffuse lymphoma in the large bowel. This is novel in several respects: the patient had no known risk factors, the two tumours collided and, as far as we can determine, adenocarcinoma in association with lymphomatous polyposis has not previously been described.

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 7 cm from the anal margin. Contrast radiography additionally revealed numerous small polyps throughout the colon. A computed tomographic (CT) scan demonstrated large para-aortic 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 panproctectomy. 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 lymphoma and a 7 cm adjacent ulcerating caecal carcinoma. Numerous small polyps were present in the rectum, colon and at the ileal resection margin. Histological examination of both carcinomata 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 collided with the carcinoma. Immunohistochemistry confirmed a B-cell phenotype (CD45 +, CD45ra +, CD20 +, MB2 +, κ +, λ –, CD45ro –, CD43 –, CD3 –).

The term malignant lymphomatous polyposis⁵ is now used to describe a specific entity comprising a polypoid mucosal lymphoma of the gastrointestinal tract, regarded as a variant of centrocytic lymphoma^{6,7} and probably identical to mantle zone lymphoma,⁷ which may transform into high grade B-cell lymphoma.⁸ 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 lymphomatous mass showed invasion by carcinoma. This might suggest that local factors such as absent immune surveillance in the lymphoma may have allowed carcinoma cells to grow there preferentially.

Previous reports of concurrent lymphoma and carcinoma

- splenic leukaemia with carcinoma¹
- leukaemia or lymphoma and coexistent primary malignancy (120 cases)²
- lymphoma and adenocarcinoma of the large bowel (separated lesions)³
- lymphoma and adenocarcinoma of large intestine in IgA deficiency⁴

phomatous mass showed invasion by carcinoma. This might suggest that local factors such as absent immune surveillance in the lymphoma may have allowed carcinoma cells to grow there preferentially.

D HOPSTER

PA SMITH

JRG NASH

Department of Pathology

K ELDERS

GJ POSTON

Department of Surgery,

University of Liverpool,

Liverpool, UK

Correspondence to Dr JRG Nash, Department of Pathology, PO Box 147, Liverpool L69 3BX, UK

- 1 Whipham T. Splenic leukaemia with carcinoma. *Trans Pathol Soc Lond* 1878; 29: 313–21.
- 2 Moertal CG, Hagedorn AB. Leukaemia or lymphoma and coexistent primary malignant lesions. A review of the literature and study of 120 cases. *Blood* 1957; 12: 788–803.
- 3 Cornes JS. Multiple primary cancers. Primary malignant lymphomas and carcinomas of the intestinal tract in the same patient. *J Clin Pathol* 1960; 13: 483.
- 4 Mir-Madjlessi SH, Vafai KM, Khademio J, Kamalian M. Coexisting primary malignant lymphoma and adenocarcinoma of the large intestine in an IgA-deficient boy. *Dis Colon Rectum* 1984; 27: 822–44.
- 5 Cornes JS. Multiple lymphomatous polyposis of the gastrointestinal tract. *Cancer* 1961; 14: 249–57.
- 6 O'Briain DS, Kennedy MJ, Daly PA, et al. Multiple lymphomatous polyposis of the gastrointestinal tract. A clinicopathologically distinctive form of non-Hodgkin's lymphoma of B-cell centrocytic type. *Am J Surg Pathol* 1989; 13: 691–9.
- 7 Isaacson PG, MacLennan KA, Subbuswamy SG. Multiple lymphomatous polyposis of the gastrointestinal tract. *Histopathology* 1984; 8: 641–56.
- 8 Harris M, Blewitt RW, Davies VJ, Steward WP. High-grade non-Hodgkin's lymphoma complicating polypoid nodular lymphoid hyperplasia and multiple lymphomatous polyposis of the intestine. *Histopathology* 1989; 15: 339–50.

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 $12.5 \times 10^9/l$ with 93% granulocytes, C-reactive protein 222 mg/l (normal range <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 $13 \times 10^9/l$, 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. Intravenous 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

Figure Erosion and destruction of bone on both sides of the manubrio-sternal joint in case 1.