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Case Report of the Patient with Non-Hodgkin Lymphoma

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ABSTRACT

In Kazakhstan, NHL incidence is 4.6 per 100,000 population. The early stage of the disease (I-II stage) detected in 1/3 patients; process can be disseminated in 2/3 of cases. The forecast is very unfavorable, survival in untreated patients is less than one year. We observed a patient with diffuse large b-cell lymphoma, to research the circumstances and peculiarities of non-Hodgkin's lymphoma. Due to the fact that patient sought medical care too late his condition was initially severe and accompanied by numerous complaints. There were serious disorders of the respiratory and cardiovascular systems. Patient was examined and hospitalized with the diagnosis of primary biliary cirrhosis. On the second day of staying in the gastroenterology department his condition deteriorated sharply and therefore he was transferred to the intensive care unit. Treatment and active resuscitation did not have effect. 02/01/13 At 14:41 p.m. biological death was registered. The cause of death was acute pulmonary and heart failure. In our case, atypical clinical presentation, delays in seeking medical care, and lack of oncological alertness in doctors led to a lack of diagnosis. Therefore, all treatment was not efficient.

KEYWORDS

Non-Hodgkin Lymphoma, Large B-cell Lymphoma, Liver Cirrhosis, Ascites

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INTRODUCTION

Non-Hodgkin's lymphoma (NHL) remains one of the most difficult problems of modern oncology. More than 300,000 new cases of NHL (2.8% of all malignant tumors) are registered every year and 170 000 of them with fatal outcome [5]. The incidence of this form of cancer grows very rapidly, reaching in some countries 6-7% per year [2].

The most common type of NHL is diffuse large b-cell lymphoma, which accounts for about 30-40% of all NHL. This subtype is characterized by an aggressive course [1, 3, 4].

The early stage of the disease (I-II stage) is detected in 1/3 patients; process can be disseminated in 2/3 of cases. The forecast is very unfavorable, survival in untreated patients is less than one year [6].

The aim of the study was to research the circumstances and peculiarities of non-Hodgkin's lymphoma.

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We observed a patient with diffuse large b-cell lymphoma, diffuse form.

CASE HISTORY

Patient L., 42 years old, entered December 27, 2012 with complaints of persistent aching pain, that can not be removed by analgesics, feeling of heaviness in the right upper quadrant, abdominal enlargement, shortness of breath at rest, palpitations, aggravated by the slightest exertion, lack of appetite, constipation for 2-3 days, a significant weight loss (up to 10 kg over the last 2 months), night fever up to 38,8^{0}C, accompanied by night sweats, general weakness.

From Anamnesis: From history: 2,5-3 months ago there were dyspnea on moderate exertion, general weakness, decreased appetite and loss of weight up to 10 kg for 1,5-2 months. Consulted a doctor on a residence month ago, November 24, 2012, due to a significant deterioration: persistent aching pain appeared, can not be removed by analgesics, heaviness in the right upper quadrant, abdominal enlargement, increased shortness of breath, palpitations, weakness, decreased appetite, loss of weight up to 8 kg during the last month. Outpatient examination by ultrasound from 11/25/12 revealed: Ascites abdomen. Cirrhosis

of the liver. Gallbladder edema (Disabled). Reactive pancreatitis. Chronic pyelonephritis of the right kidney. Splenomegaly. Outpatient treatment did not give a positive effect, and patient with a diagnosis of primary biliary cirrhosis was hospitalized to gastroenterological department №1 of Clinical Hospital for further diagnosis.

Since 2007, he is suffering from chronic gastritis, pancreatitis, cholecystitis. In 2008, chronic pyelonephritis of the right kidney was diagnosed. From bad habits: smoking from 15 years, 1.5-2 packs a day (for 27 years), drinking alcohol from 18 years, 2-3 days a week.

On examination: general condition is severe, due to respiratory and cardiac failure, general intoxication. Consciousness is clear. Posture is enforced, lies with raised head end. Shortness of breath at rest. Build is normosthenic. The patient is exhausted, height-173 cm, weight-51.2 kg. Body mass index (BMI) - 17.06 kg / m2. The skin is pale, jaundiced, dry to the touch. Tension is reduced. The subicteric sclerae. Hyperemia of palms. Peripheral lymph nodes are not enlarged, painless. Mild swelling of the feet and legs. In the lungs: weakened vesicular breath, no wheezing. RR-25 per min. Heart sounds are muffled, the rhythm is correct. BP-110/70 mm Hg. Pulse-98 beats per min. Tongue is moist, smooth, with erased papillae, crimson, with imprints of teeth on the sides. The abdomen is significantly increased due to the free fluid in the abdominal cavity. On the front of the abdominal wall expressed venous network. During the superficial palpation, a slight pain in the right upper quadrant and epigastric region was detected. Palpation of the liver and spleen could not take place due to ascites. Stool: constipations up to 2-3 days. Effleurage symptom is weakly positive at right. Urination is free, painless.

Considering the loss of appetite and rapid weight loss (exhaustion), differential diagnosis with malignant tumors of the abdominal cavity was performed, in addition, cause of cirrhosis was refined.

Scheduled survey plan includes: complete blood count; blood chemistry: creatinine, bilirubin, alkaline phosphatase, GGT, total protein, glucose, creatinine, potassium, sodium, thymol test; coagulogram; urinalysis, Nechiporenko sample; ELISA markers of hepatitis B and C; fecal occult blood test, scatology; ECG, EFGDS, ultrasonography and CT scan of the abdominal cavity; consultation of the surgeon and oncologist.

12/28/12 at 15.00, on the second day of staying in the gastroenterologycal department, patient's health sharply deteriorated: increased shortness of breath at rest, palpitations, pressing pain in the chest appeared, arching abdominal pain, nausea, cholemesis, increased general weakness.

Examinated by doctor on duty: general condition remains severe due to respiratory and cardiac failure, ascites, abdominal pain. Facial expression makes pain visible to others. Consciousness is clear. Posture is enforced – patient is sitting with bowed legs. Shortness of breath at rest, mixed type. RR – 30 per min. In the lungs: weakened vesicular breath. Heart sounds are significantly muffled, the rhythm is correct. BP -100/70 mm Hg. Pulse-98 beats per min, the rhythm is correct, weak filling and tension. Tongue is dryish, coated with white bloom. Belly has former size, significantly increased due to ascites. On palpation: moderate pain around the abdomen appeared. Palpation of the liver and spleen could not take place due to ascites. Swelling in the legs remains. Gases depart badly. No stool.

Intervention: Urgently made: 1. Per os-Isoket spray. 2. Intravenous drip: 5% - 200.0 glucose, Potassium chloride 4% - 10.0, 4 units of Insulin. 3. Intravenously Furosemide 40mg on 20.0 saline. 4. One Cleansing enema with Duphalac, after which, imposed solution and gases came out.

Treatment had no effect, therefore patient was examined by resuscitator and transferred to the intensive care unit.

Treatment: Treatment that was conducted in ICU: intravenously streamly - Quamatel 40 mg on 40,0 saline, Vitanime C on 5% – 400,0 glucose, dexamethasone 4 mg, Mildronate 5,0 ml, Furosemide 40 mg, Dopamine 5,0 on 15,0 saline, Ceftriaxone -1,0 gr., Metronidazole 100,0, Heptral 800 mg on 5,0 solution. Intravenous drip: Hepadif 5,0 on 5% - 200,0 glucose, glucose 5% – 200,0+4 units of Insulin + Potassium chloride 4% - 10.0; intramuscularly - Etamsylate 4,0, Vicasolum 3,0.
28/12/12 consultation with the surgeon was held and 29/12/12 Laparocentesis was performed, 500 ml of fluid were evacuated. Drainage tube is left in the abdominal cavity.

29/12/12 consultation with cardiologist, diagnosis: Dismetabolic cardiomyopathy. CHF IIA FC 4.

In the following days, the patient's condition remained severe, positive effect of the therapy was not observed.

02/01/13, at 14:11 p.m. cardiac arrest was recorded on the monitor and active resuscitation was begun:

1. Indirect cardiac massage: 30 chest compressions were made, then the Ambu bag was applied.

2. Atropine 0,1% - 1,0, Epinephrine 0.1% - 1.0, intravenously: Prednisolone-60 mg 3 times through subclavian catheter.

3. Defibrillation was performed twice with an electrical discharge of 200 joules., 250 J., 360 J.

OUTCOME

Active resuscitation lasted for 30 minutes, but had no effect. At 14:41 p.m. biological death was registered.

Cause of death: Acute pulmonary and heart failure.

Primary diagnosis: cirrhosis of the liver, viral (HCV), minimal activity, with portal hypertension, at the decompensation stage, complicated by ascites. Class B according to Child-Pugh. Autoimmune anemia-I st.

Rival: Community-acquired bilateral bottom-lobar pneumonia, course is severe, complicated by right-sided exudative pleurisy, infectious-toxic shock. RF II-III st. IHD. Acute miocardial infarction of rear wall. Infringement of a rhythm by the type of paroxysmal tachycardia.

Anatomopathological diagnosis: Primary disease: Malignant (non-Hodgkin's) lymphoma, diffuse form. Generalization of process that involves all groups of lymph nodes of the right and left lung, pericardium, myocardium, liver, right kidney, spleen, walls of the gastrointestinal tract, pancreas.

Underlying cause of death: Tumor intoxication: pulmonary atelectasis, foci of noncoronary miocardial damage, necrosis of the epithelium of the renal tubules, diapedetic hemorrhage into the parenchyma of internal organs, bleeding in the submucosa and mucosa.

The primary focus of the tumor could not be found, because generalization of the tumor process takes place. It involves all groups of lymph nodes, as well as almost all the internal organs. A complete mismatch of clinical and postmortem diagnoses is noted.

DISCUSSION

This observation shows that the anamnesis of disease in this case is short, with the rapid development of multiple organ failure. According to the literature, general condition deteriorates rapidly when diffuse large b-cell lymphoma takes place.

In the present case: signs of lesion of many internal organs were detected, without symptoms of lesion of the peripheral or regional lymph nodes, it created some difficulties in the diagnosis of lymphoma. The classic version of lymphoma is accompanied by an enlargement of lymph nodes. Syndromes of the disease: heart failure, lesion of a liver, kidney and pancreas.

Considering each highlighted syndrome, diagnosis was made, while all these lesions were a manifestation of the disease - malignant non-Hodgkin's lymphoma, diffuse form. Hypochromic anemia, leucocytosis, lymphopenia, eosinophilia, accelerated ESR are observed in peripheral blood. But in fact, usually peripheral blood does not change much. In some cases there may be a moderate leucocytosis by increasing the number of mature lymphocytes (7.5%) or leucopenia (12%), lymphocytosis (18%), increased erythrocyte sedimentation rate (13.5%). Often in patients with lymphoma eosinophilia is observed. Lymphopenia may develop in the process of generalization.

Lymphomas are diagnosed morphologically, by performing a biopsy of affected lymph nodes or organ. This investigation was not conducted, there are objective reasons: during the palpation, peripheral lymph nodes were not enlarged, intra-abdominal lymph nodes were not detected by ultrasound of the abdomen, thoracic lymph nodes - on radiogram of the chest, there were no local changes in the organs. CT scan of the internal organs is recommended, PET is recommended for the investigation of lymphatic vessels and nodes, also ascetic and pleural fluid should be studied. Condition was severe, so CT scan was not performed. (on the second day due to the deterioration of the condition transferred to the intensive care unit). In our case, there was an opportunity to investigate

the ascitic fluid, which was not realized.

The reason is in lack of the oncological alertness in doctors.

CONCLUSION

Thus, it's seen that the anamnesis of disease in this case is short, with the rapid development of multiple organ failure, the patient sought medical care too late, due to the severity of the condition, CT scans, MRI of the abdomen were not carried out.

But paracentesis was performed, there was an opportunity to investigate the ascitic fluid, which was not realized. **The reason is in a lack of the oncological alertness in doctors.**

Due to the fact that the patient sought medical care too late, necessary investigations were not conducted. All treatment was carried out to no purpose due to the lack of oncological alertness.

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