Metastatic anaplastic large cell lymphoma (ALCL) presenting with small bowel perforation

Novinith Kumar Raja Ram, Siti Fareeda Anuar, Tuan Nur' Azmah Tuan Mat
Department of General Surgery,
Hospital Sultanah Aminah, Jalan Persiaran Abu Bakar Sultan, Johor, Malaysia

Keywords: ALCL; small bowel perforation; lymphoma

Introduction
Lymphoma ranks third in the incidence of small bowel malignancy, with adenocarcinoma being the commonest (1). Anaplastic large cell lymphoma (ALCL) constitutes about two percent of adult non-Hodgkin lymphoma and is a subset of T cell lymphoma histology. It has a bimodal age distribution with regard to incidence with the first peak in adolescence and the second after the sixth decade, with a male predominance. Four cases of primary small bowel ALCL presenting with perforation have previously been reported (1). However, literature regarding metastatic ALCL to the small bowel presenting with perforation is scarce. We report a case of metastatic ALCL which presented as jejunal perforation.

Case report
A 65 year old Malay gentleman presented with fever and sudden onset of abdominal pain, most pronounced over the epigastrium for two days. He had a history of ALK negative anaplastic large cell lymphoma, which was diagnosed 5 months prior to the presentation. He had completed two cycles of chemotherapy with Cyclophosphamide, Doxorubicin, Vincristine and Prednisolone (CHOP). He was later switched to Chlorambucil + Prednisolone due to intolerance. He also suffered from diabetes mellitus and hypertension. Examination revealed tenderness over the epigastric region with peritonism. Computed Tomography (CT) of the abdomen showed fluid in perihepatic, subhepatic and pelvic regions with air pockets within. Patient underwent an emergency laparotomy with a provisional diagnosis of a perforated viscous. Intra operatively, he was found to have a jejunal perforation, approximately 25 cm from duodeno-jejunal flexure with an ulcerative lesion within. There were multiple enlarged mesenteric lymph nodes, largest measuring 3x3 cm. Peritoneal cavity was grossly contaminated with succus entericus. A wedge resection with primary anastomosis and peritoneal lavage was done. Perioperative dissection showed an ulcerative lesion, occupying about 60% of the jejunal lumen. Patient was in intensive care for 48 hours post-operatively with respiratory support. He had an uneventful perioperative recovery and was discharged home on postoperative Day 9.

Histopathological examination revealed ulcerative exudate surrounded by neoplastic lymphoid infiltrates. Hallmark cells were also seen; hence the interpretation of ALCL (ALK negative) of small bowel with clear proximal and distal dissection showed an ulcerative lesion, occupying about 60% of the jejunal lumen. Patient was in intensive care for 48 hours post-operatively with respiratory support. He had an uneventful perioperative recovery and was discharged home on postoperative Day 9.

Histopathological examination revealed ulcerative exudate surrounded by neoplastic lymphoid infiltrates. Hallmark cells were also seen; hence the interpretation of ALCL (ALK negative) of small bowel with clear proximal and distal dissection showed an ulcerative lesion, occupying about 60% of the jejunal lumen. Patient was in intensive care for 48 hours post-operatively with respiratory support. He had an uneventful perioperative recovery and was discharged home on postoperative Day 9.

Histopathological examination revealed ulcerative exudate surrounded by neoplastic lymphoid infiltrates. Hallmark cells were also seen; hence the interpretation of ALCL (ALK negative) of small bowel with clear proximal and distal dissection showed an ulcerative lesion, occupying about 60% of the jejunal lumen. Patient was in intensive care for 48 hours post-operatively with respiratory support. He had an uneventful perioperative recovery and was discharged home on postoperative Day 9.

Histopathological examination revealed ulcerative exudate surrounded by neoplastic lymphoid infiltrates. Hallmark cells were also seen; hence the interpretation of ALCL (ALK negative) of small bowel with clear proximal and distal dissection showed an ulcerative lesion, occupying about 60% of the jejunal lumen. Patient was in intensive care for 48 hours post-operatively with respiratory support. He had an uneventful perioperative recovery and was discharged home on postoperative Day 9.
Learning Points:

- To consider spontaneous hollow viscous perforation as a differential in a patient who presents with acute peritonitis
- In the surgical management of a patient with metastatic small bowel perforation secondary to lymphoma, to perform a procedure that subjects the patient to the least surgical stress, individually tailored according to location of perforation and extent of peritoneal contamination.