

## A giant polypoid mass leading to obstruction in the colon

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**Key words :** polypoid mass, colonoscopy, lymphoma

### Case

A 69-year-old male was admitted to our clinic with the complaints of fatigue and right upper quadrant abdominal pain for a few weeks. His medical history included stage II mantle cell lymphoma (MCL) and stage II prostate cancer. He had received 30 Gy radiotherapy to the neck region and 6 cycles of R-CHOP chemotherapy for MCL and he was in remission for three years. He underwent radical prostatectomy 2 years ago for prostate cancer and was in remission for two years. Physical examination was unremarkable except for abdominal tenderness in the right upper quadrant. The laboratory test results showed; Hb:10.7g/dL (13-17g/dL), WBC:9.4x10<sup>3</sup>/μl (4.3-10.3x10<sup>3</sup>/μl), platelet:343x10<sup>3</sup>/μl (156-373x10<sup>3</sup>/μl), lymphocyte:2.9x10<sup>3</sup>/μl (1.3-3.5x10<sup>3</sup>/

μl), sedimentation:71mm/hour (0-20). Creatinine, ALT, AST, CA19-9, CEA, total and free prostate-specific antigen levels were within normal range. Computed tomography revealed intraabdominal lymphadenopathies and a mass reaching 71-mm thickness and obstructing the lumen within the hepatic flexura of the colon (Figure 1A). Colonoscopy showed a giant polypoid mass at hepatic flexura leading to total obstruction and preventing passage of the scope (Figure 1B). What is the patient's diagnosis?

### Answer

Histopathological investigation of the mass biopsy revealed MCL recurrence (Figure 2). Positron emission tomography showed abnormally high FDG uptake in multiple parts of the abdomen. Chemotherapy was planned for the treatment of the patient.

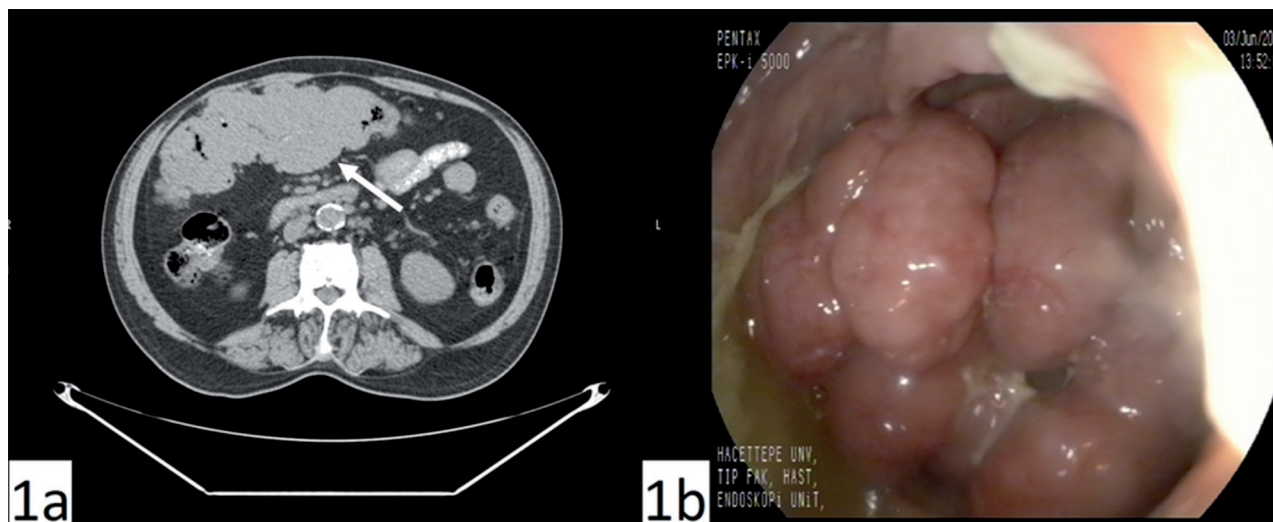


Fig. 1a. — Computed tomography image of the patient showing a giant mass (arrow) within the hepatic flexura of the colon.

Fig. 1b. — Colonoscopic view of the patient showing the obstructive polypoid mass.

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Submission date : 14/10/2016  
Acceptance date : 24/10/2016

Mantle cell lymphoma is an uncommon and aggressive form of B-cell non-Hodgkin lymphomas (NHL) that predominantly affects men over the age of 60. Lymph nodes are the most commonly involved areas and 75% of the patients present with generalized lymphadenopathy. Extranodal involvement including peripheral blood, bone marrow, spleen, liver and the gastrointestinal (GI) tract also occurs frequently. GI involvement of MCL can be seen in any site of the GI tract and colon can be affected in over 80% of cases (1-3). Most of cases with

colonic involvement have normal colonoscopic findings and in these cases evidence of MCL can be detected only with histopathologic examination. Colonic involvement may also present as a nodule, ulcer, wall thickness, polyp, mass, or multiple polyps (3-5). Presentation of MCL with such a giant polypoid mass that lead to colonic obstruction was unusual and to our knowledge has not been reported before. It would be prudent to keep such extraordinary presentations of MCL in mind while following patients with a history of MCL.

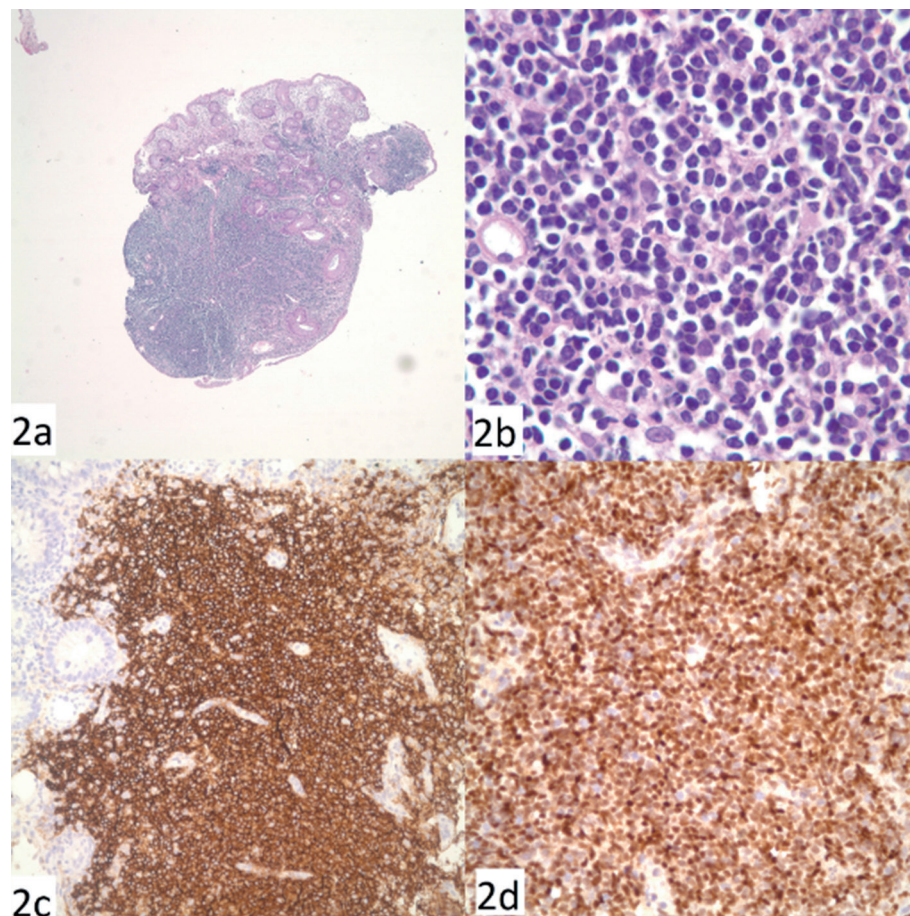


Fig. 2. — Computed tomography image of the patient showing a giant mass (arrow) within the hepatic flexura of the colon. 1b: Colonoscopic view of the patient showing the obstructive polypoid mass.