

原发性小肠淋巴瘤临床病理分析23例

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Clinicopathological features of primary small intestinal lymphoma: analysis of 23 cases

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Abstract

AIM: To summarize the clinicopathologic features of the small intestinal lymphoma.

METHODS: The clinical data, including the initial symptoms or signs, involved locations, histological subtypes, and complications, of 23 patients pathologically diagnosed with small intestinal lymphoma were retrospectively analyzed.

RESULTS: The initial symptoms or signs included abdominal pain (13 cases, 56.5%), abdominal mass (6 cases, 26.1%), melena or hematochezia (2 cases, 8.7%), diarrhea (1 cases, 4.3%), and constipation (1 cases, 4.3%). Five patients had B-symptom. The involved locations were ileocecum (7 cases, 30.4%), jejunum (7 cases, 30.4%), ileum (6 cases, 26.1%), and duodenum (1 cases, 4.3%). Multiple involvements appeared in 2 cases (8.7%). Hodgkin's lymphoma was not found in all the patients. Of the 23 cases, 19 were B-cell origin (82.6%) and 4 were T-cell origin (17.4%). For histological subtypes, 13 cases (56.5%) were diagnosed with diffuse large B cell lymphoma, 6 cases (26.1%) with B-cell MALT lymphoma, 3 cases (13.0%) with diffuse T-cell lymphoma, and 1 cases (4.3%) with enteropathy-associated T cell lymphoma.

CONCLUSION: Abdominal pain is the most common symptom for small intestinal lymphoma, and the most frequently involved location is ileocecum and jejunum. B-cell origin covers a larger percent. Diffuse large B cell non-Hodgkin's lymphoma is commonly occurred in terms of histological classification.

Key Words: Small intestinal lymphoma; Pathological features; Non-Hodgkin's lymphoma

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摘要

目的: 总结小肠淋巴瘤的临床病理特征。

方法: 经病理检查证实的小肠淋巴瘤患者23例, 对临床资料进行系统的回顾分析, 总结其首发症状、好发部位、组织学类型、并发症等临床病理特征。

结果: 首发症状和体征: 腹痛13例(56.5%), 腹部包块6例(26.1%), 黑便/便血2例(8.7%), 腹泻1例(4.3%), 便秘1例(4.3%)。有B症状的5例(21.7%); 肿瘤部位: 回盲部7例(30.4%), 空肠7例(30.4%), 回肠6例(26.1%)、多部位2例(8.7%), 十二指肠1例(4.3%)。均为非霍奇金淋巴瘤, B细胞来源19例(82.6%), T细胞来源4例(17.4%)。组织学类型: 弥漫大B细胞非霍奇金淋巴瘤13例(56.5%); 黏膜相关淋巴组织B细胞性淋巴瘤6例(26.1%), 弥漫T细胞性淋巴瘤3例(13.0%), 肠病相关T细胞非霍奇金淋巴瘤1例(4.3%)。

结论: 小肠淋巴瘤最常见的首发症状和体征是腹痛, 最好发的部位是回盲部和空肠, 大多数为B细胞来源, 最常见的组织学类型是弥漫大B细胞非霍奇金淋巴瘤。

关键词: 小肠淋巴瘤; 病理特征; 非霍奇金淋巴瘤

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0 引言

原发性胃肠道淋巴瘤是最常见的结外非霍奇金淋巴瘤, 约占全部非霍奇金淋巴瘤的4-20%。在原发性胃肠道淋巴瘤中, 肠淋巴瘤约占15-20%, 其中多数为小肠淋巴瘤^[1-5]。

关于原发性胃肠道淋巴瘤或肠淋巴瘤的临床报道较多,而有关原发性小肠淋巴瘤的临床病理特征临床报道相对较少,我院经病理检查证实的原发性小肠淋巴瘤患者23例,对临床资料进行回顾性分析,了解和总结原发性小肠淋巴瘤的临床病理特征。

1 材料和方法

1.1 材料 我院1997-09/2004-12经病理检查证实的原发性小肠淋巴瘤患者23例,男18例,女5例,年龄20-74(中位53)岁。

1.2 方法 总结其首发症状和体征、好发部位、组织学类型、并发症(出血,梗阻,瘘管形成)等临床病理特征。临床资料包括病史、体格检查、B症状(体温 $>38^{\circ}\text{C}$,盗汗,6 mo内体质量下降超过原来体质量的10%)、血常规、尿常规、胸片、小肠气钡灌肠双重造影、B超、CT、内镜检查病理活检,骨髓穿刺活检等。免疫组化检查CD20和CD3。

2 结果

全部23例小肠淋巴瘤均经病理检查证实,均无浅表淋巴结及纵隔和腹膜后淋巴结肿大,没有肝、脾和骨髓等脏器受累。小肠淋巴瘤包括十二指肠、空肠、回肠、回盲部和小肠多部位淋巴瘤。回盲部淋巴瘤定义为病变累及末端回肠和回盲瓣、盲肠或阑尾。

小肠淋巴瘤患者23例,男18例,女5例,年龄20-74(中位53)岁。首发症状和体征:腹痛13例(56.5%),腹部包块6例(26.1%),黑便/便血2例(8.7%),腹泻1例(4.3%),便秘1例(4.3%)。有B症状的5例(21.7%);从首发症状或体征出现到临床确诊所需时间1-22(中位4) mo。需手术处理的并发症:肠梗阻4例,消化道大出血3例,回肠乙状结肠瘘1例。肿瘤部位:回盲部7例(30.4%),空肠7例(30.4%),回肠6例(26.1%)、多部位2例(8.7%),十二指肠1例(4.3%)。均为非霍奇金淋巴瘤, B细胞来源19例(82.6%), T细胞来源4例(17.4%)。组织学类型:弥漫大B细胞非霍奇金淋巴瘤13例(56.5%);黏膜相关淋巴组织B细胞性淋巴瘤6例(26.1%),弥漫T细胞性淋巴瘤3例(13.0%),肠病相关T细胞非霍奇金淋巴瘤1例(4.3%)。

病程中只有1例患者经小肠气钡灌肠双重造影检查发现病变累及全小肠(十二指肠至末端回肠),后经胃镜检查在十二指肠水平段取活检,结肠镜检查在末端回肠取活检,病理检查诊断为弥漫T细胞性非霍奇金淋巴瘤。因病变累及全小肠,无法手术而直接予以化疗。其余22例患者,经反复多次胃肠镜、小肠气钡灌肠双重造影、B超、CT等检查均未能明确诊断。直至术前疑诊为小肠肿瘤或发生需手术处理的并发症时而行剖腹探查,术后病理确诊为小肠非霍奇金淋巴瘤。其中术前疑诊小肠淋巴瘤者2例,小肠和回盲部肿瘤16例,克罗恩病1例,腹膜后肿瘤1例,盆腔肿瘤1例,十二指肠肿瘤1例。

有腹部包块的6例患者(回盲部3例,空肠3例),B超和CT检查均发现了病灶,其中3例回盲部病变术前即准确定位,而3例空肠病变,术前2例定位在小肠,1例疑诊为腹膜后肿瘤,术后才明确定位在空肠。7例回盲部淋巴瘤和2例末端回肠淋巴瘤,结肠镜都发现了病灶,但镜下病理活检均未能明确定性。1例十二指肠淋巴瘤,胃镜检查发现了病变,术前也未能定性;1例术前疑诊小肠克罗恩病患者,行胶囊内镜检查时发生了肠梗阻,经手术治疗病理证实为回肠淋巴瘤。其余的小肠淋巴瘤,小肠气钡灌肠双重造影检查,虽然发现了病灶,但既不好准确定位,也无法定性。

3 讨论

Nakamura *et al*^[5]对原发性胃肠道淋巴瘤455例的临床病理资料进行Cox多变量分析显示,淋巴瘤分期早、患者年轻、B细胞来源和没有B症状是好的总生存期和无事件生存期的独立预后因子。MALToma也是无事件生存期的独立预后因子,但不是总生存期的独立预后因子。Koch *et al*^[6]报道,回盲部淋巴瘤的总生存期和无事件生存期明显高于其它部位的小肠淋巴瘤。Daum *et al*^[7]对原发性肠淋巴瘤56例进行前瞻性、非随机、多中心研究显示, B细胞来源的肠淋巴瘤预后优于T细胞来源的肠淋巴瘤。Ibrahim *et al*^[8]报道原发性肠弥漫大B细胞非霍奇金淋巴瘤的中位总生存期为101 mo, 5 a和10 a总生存期分别为58%和48%。本组资料原发性小肠淋巴瘤大多数是B细胞来源,其中以弥漫大B细胞和黏膜相关淋巴组织B细胞性淋巴瘤较为多见,多数患者没有B症状,回盲部淋巴瘤最为多见,与国外报道[1,9]相近,因此原发性小肠淋巴瘤预后较好。Koh *et al*^[10]报道,1989/1998英国谢菲尔德淋巴瘤协作组对1E期和IIE期的原发性胃肠道非霍奇金淋巴瘤患者71例的临床病理资料进行回顾性分析显示,对原发性小肠淋巴瘤,手术治疗(联合或不联合化疗),术后60%的患者可获得5-10 a的生存。Atalay *et al*^[11]报道,手术联合化疗与单纯手术或化疗相比,可明显提高原发性胃肠道淋巴瘤患者的总生存期。Isomoto *et al*^[12]报道1例46岁男性壶腹部MALToma患者,予以局部放疗,每次1.5G,总量30 G,6 mo后复查胃镜局部肿瘤消失,放疗后4 a复查,患者仍处于完全缓解。

对于原发性小肠淋巴瘤,临床上能够早期诊断对改善预后是非常重要的。原发性小肠淋巴瘤临床表现多样,缺乏特异性。从首发症状或体征出现到明确诊断往往要经历较长的时间。本组资料显示原发性小肠淋巴瘤的首发症状或体征可表现为腹痛、腹部包块、黑便/便血、腹泻和便秘。有B症状的仅占21.7%。因而单从临床表现不易作出小肠淋巴瘤的诊断。小肠处在消化道的中间位置,位于胃和大肠之间,常规的结肠镜和胃镜检查最多只能检查到末端回肠和屈氏韧带附近约20 cm的空肠,对于长约6-7 m的小肠来说,绝大部分小肠均无法检查到;而小肠

气钡灌肠双重造影对于较小的小肠黏膜病变也不易发现,即使发现了病变,有时也不易准确定位,同时也无法定性. Yoshida *et al*^[13]报道1例72岁老年男性患者,间断便血2 a,先后做过大量检查,包括血液学和生化检查,胃镜,结肠镜,CT,核素和血管造影,均未能发现胃肠道出血部位.最后行双气囊小肠镜检查发现扩张的回肠内有几处溃疡瘢痕,活检病理无异常发现,为预防再出血而行回肠部分切除,术后病理显示异常淋巴细胞聚集,以固有肌层为主,免疫组化检查证实肿瘤细胞CD20和BCL2阳性,从而诊断为MALT B细胞淋巴瘤.因而原发性小肠淋巴瘤的临床诊断比较困难. Nomura *et al*^[14]采用多参量(包括临床症状,内镜表现,常规HE染色光学显微镜形态学检查,流式细胞仪检测免疫表型,免疫组化和萃取DNA基因型鉴定)分析的方法可提高MALToma的诊断准确率.

本组资料显示原发性小肠淋巴瘤,中老年患者多见,男性多见.最好发的部位是回盲部和空肠.与国外报道相近^[1,9,15].因此在临床上对于那些原因不明的腹痛、腹部包块、黑便/便血、腹泻和便秘患者,尤其是中老年、男性患者,应该对小肠进行有针对性地检查.结肠镜检查应尽量做到末端回肠,以期发现回盲部和末端回肠病灶并取活检;胃镜检查应尽量做到屈氏韧带附近的空肠,以期发现十二指肠和近端空肠病灶并取活检;小肠气钡灌肠双重造影是临床上最常用的检查方法,可发现大多数的空、回肠病变,但无法取活检,因而无法定性,有时亦无法准确定位,尤其是不容易发现较小的黏膜病变;对于有腹部包块者,B超和CT检查可发现病灶,但也存在不易准确定位和定性的问题,B超或CT引导下细针穿刺活检,有时由于取材少,病理检查也不易定性;胶囊内镜检查可观察到小肠病变,但无法活检,尤其对有肠腔狭窄者,有发生梗阻的危险.新近在临床上应用的双气囊小肠镜可对全小肠进行全面的观察,并可在直视下进行活检,该项检查技术的开展和普及有望提高原发性小肠淋巴瘤的术前确诊率.

4 参考文献

- 1 Lee J, Kim WS, Kim K, Ko YH, Kim JJ, Kim YH, Chun HK, Lee WY, Park JO, Jung CW, Im YH, Lee MH, Kang WK, Park K. Intestinal lymphoma: exploration of the prognostic factors and the optimal treatment. *Leuk Lymphoma* 2004; 45: 339-344
- 2 Radman I, Kovacevic-Metelko J, Aurer I, Nemet D, Zupancic-Salek S, Bogdanic V, Sertic D, Mrcic M, Pulanic R, Gasparovic V, Labar B. Surgical resection in the treatment of primary gastrointestinal non-Hodgkin's lymphoma: retrospective study. *Croat Med J* 2002; 43: 555-560
- 3 Crump M, Gospodarowicz M, Shepherd FA. Lymphoma of the gastrointestinal tract. *Semin Oncol* 1999; 26: 324-337
- 4 Zinzani PL, Magagnoli M, Pagliani G, Bendandi M, Gherlinzoni F, Merla E, Salvucci M, Tura S. Primary intestinal lymphoma: clinical and therapeutic features of 32 patients. *Haematologica* 1997; 82: 305-308
- 5 Nakamura S, Matsumoto T, Iida M, Yao T, Tsuneyoshi M. Primary gastrointestinal lymphoma in Japan: a clinicopathologic analysis of 455 patients with special reference to its time trends. *Cancer* 2003; 97: 2462-2473
- 6 Koch P, del Valle F, Berdel WE, Willich NA, Reers B, Hiddemann W, Grothaus-Pinke B, Reinartz G, Brockmann J, Temmesfeld A, Schmitz R, Rube C, Probst A, Jaenke G, Bodenstern H, Junker A, Pott C, Schultze J, Heinecke A, Parwaresch R, Tiemann M. Primary gastrointestinal non-Hodgkin's lymphoma: I. Anatomic and histologic distribution, clinical features, and survival data of 371 patients registered in the German Multicenter Study GIT NHL 01/92. *J Clin Oncol* 2001; 19: 3861-3873
- 7 Daum S, Ullrich R, Heise W, Dederke B, Foss HD, Stein H, Thiel E, Zeitz M, Riecken EO. Intestinal non-Hodgkin's lymphoma: a multicenter prospective clinical study from the German Study Group on Intestinal non-Hodgkin's Lymphoma. *J Clin Oncol* 2003; 21: 2740-2746
- 8 Ibrahim EM, Ezzat AA, El-Weshi AN, Martin JM, Khafaga YM, Al Rabih W, Ajarim DS, Al-Foudeh MO, Zucca E. Primary intestinal diffuse large B-cell non-Hodgkin's lymphoma: clinical features, management, and prognosis of 66 patients. *Ann Oncol* 2001; 12: 53-58
- 9 Al-Shemmari SH, Sajjani KP, Ameen RM, Ragheb AM. Primary gastrointestinal non-Hodgkin's lymphoma: treatment outcome. *Clin Lymphoma* 2003; 4: 99-103
- 10 Koh PK, Horsman JM, Radstone CR, Hancock H, Goepel JR, Hancock BW. Localised extranodal non-Hodgkin's lymphoma of the gastrointestinal tract: Sheffield Lymphoma Group experience (1989-1998). *Int J Oncol* 2001; 18: 743-748
- 11 Atalay C, Kanlioz M, Demir S, Pak I, Altinok M. Primary gastrointestinal tract lymphomas. *Acta Chir Belg* 2003; 103: 616-620
- 12 Isomoto H, Kamihira S, Matsuo E, Tawara M, Mizuta Y, Hayashi T, Maeda T, Kohno S, Tomonaga M. A case of mucosa-associated lymphoid tissue lymphoma of the ampulla of Vater: successful treatment with radiation therapy. *Eur J Gastroenterol Hepatol* 2003; 15: 1037-1041
- 13 Yoshida N, Wakabayashi N, Nomura K, Konishi H, Yamamoto H, Mitsufuji S, Kataoka K, Taniwaki M, Yamagishi H, Okanoue T. Ileal mucosa-associated lymphoid tissue lymphoma showing several ulcer scars detected using double-balloon endoscopy. *Endoscopy* 2004; 36: 1022-1024
- 14 Nomura E, Takagi S, Ichinohasama R, Kikuchi T, Shiraki M, Oomori S, Yokoyama H, Utsunomiya K, Negoro K, Aihara H, Takahashi S, Kinouchi Y, Shimosegawa T. Multiparameter analysis for discreet differential diagnosis of mucosa-associated lymphoid tissue lymphoma in the intestine. *In Vivo* 2004; 18: 437-441
- 15 Kohno S, Ohshima K, Yoneda S, Kodama T, Shirakusa T, Kikuchi M. Clinicopathological analysis of 143 primary malignant lymphomas in the small and large intestines based on the new WHO classification. *Histopathology* 2003; 43: 135-143