A 62-year-old Caucasian male presented for evaluation of heme-occult positive stool discovered during routine screening. He denied melena, hematochezia or any other GI symptoms. On laboratory studies he was not anemic. His past medical history was significant for localized prostate carcinoma treated with radical prostatectomy followed by radiation treatment for positive margin three years earlier. At colonoscopy he had internal hemorrhoids and a 2 mm rectal nodule which was not biopsied. Nine months later, the patient underwent follow-up flexible
A CASE TO REMEMBER

Primary Low-grade Lymphoma of the Rectum

Repeat flexible sigmoidoscopy a month later demonstrated clusters of small, 1–2 mm whitish nodules with red halo at the rectosigmoid junction (Figure 2). Biopsies of several of these nodules again showed follicular B cell lymphoma. The patient underwent rectal endoscopic ultrasound which was negative. Bone marrow aspiration and biopsy did not demonstrate involvement of lymphoma. Computed tomographic scans with contrast of the chest, abdomen and pelvis showed mesenteric and aorto-caval lymph nodes less than 1 cm in diameter, and two pleural-based nodules in the left lung. Gallium-67 and bone scans were unremarkable. A whole-body FDG-PET showed no rectal uptake, but did highlight a 1 cm left lung nodule. The lung lesion was biopsied with findings of pleural fibrosis, chronic inflammation and mesothelial cell hyperplasia but no evidence of malignancy. His hematologic parameters and other laboratory findings, including lactate dehydrogenase, albumin and serum electrophoresis were normal. An ELISA test for HIV was non-reactive. The patient received four weeks therapy with Rituximab. A follow-up colonoscopy seven months later revealed endoscopic resolution, but residual lymphoma on histology.

DISCUSSION

Lymphomas comprise 1%–4% of all malignant neoplasms in the GI tract (1), and primary lymphomas of the colon account for less than 0.2% of all malignant (continued on page 103)
colonic neoplasms. In adults only 10%–20% of the primary GI lymphomas occur in the colon, and of these only 20% are located in the rectum (1,2). Previous cases of primary rectal lymphoma have presented at more advanced stages and have been associated with GI symptoms. In one study, all patients with rectal lesions had symptoms related to distal bowel obstruction, and all patients complained of increasing constipation and tenesmus (3).

Very little is known about the prognosis of primary GI lymphomas. In one series of patients with primary large bowel lymphoma treated with surgery followed by chemotherapy, the International Prognostic Index and other putative predictors were not significant (4).

This patient is the first instance we are aware of with an asymptomatic primary follicular lymphoma of the rectum. His presentation provided a rare opportunity to describe the early history and macroscopic appearance of lymphoma presenting in an unusual location.

References