Retroperitoneal Hodgkin Lymphoma with Giant Renal Cyst: Case Report

H. Lachhab, H. Moudlige, C. Waffar, A. Moataz, M. Dakir, A. Debbagh, and R. Aboutaieb

ABSTRACT

Detection of Hodgkin’s lymphoma at earlier stages increases the chances of successful chemotherapy treatment. Retroperitoneal localization makes the diagnosis difficult, which can delay treatment. We report here the case of a 65-year-old patient presenting right lumbar pain for 2 years, who was admitted for surgical exploration of a fluid retroperitoneal mass, after an inconclusive CT-guided biopsy and a surgical biopsy showing reactive lymph node tissue remodelled without tumor element. After operating the patient, the pre-cellar lymph node dissection concluded with classic Hodgkin lymphoma.

Keywords: Hodgkin’s lymphoma, lymph node, renal cyst, retroperitoneal.

I. INTRODUCTION

Approximately 50% of the population over 50 years carrier a kidney cyst [1]. Most benign renal cysts are asymptomatic and require no treatment. However, cases of huge renal cysts have been very rarely reported [2]. Hodgkin lymphoma is a rare B-cell malignant neoplasm affecting approximately 9000 new patients annually, most patients with Hodgkin lymphoma present with supradiaphragmatic lymphadenopathy, retroperitoneal and inguinal lymphadenopathy occur less frequently [3].

II. CASE PRESENTATION

A 65-year-old woman hypertensive under treatment with a history of unconvincing CT-guided biopsy of a right retroperitoneal mass and a surgical biopsy that showed reactive lymph node tissue remodelled without tumor element one year before her admission, presented to our hospital with progressively increasing pain and fullness in the right lumbar region. On clinical examination, she had a blood pressure of 120/70 mmHg, a pulse rate of 82 beats/minute, with a mass in the right lumbar fossa of 10 cm long axis and firm consistency, mobile with respect to the superficial plane and slightly mobile with respect to the deep plane and painless on palpation. There was no hepatomegaly, or splenomegaly and no palpable lymph nodes. Biological examinations were normal.

Fig. 1. Right retroperitoneal solidocystic mass.

Submitted: March 10, 2021
Published: March 31, 2021
ISSN: 2593-8339
DOI: 10.24018/ejmed.2021.3.2.764

H. Lachhab*
Department of Urology, UHC Ibn Rochd, Casablanca, Morocco.
(e-mail: lachhabhoussame@gmail.com)
H. Moudlige
Department of Urology, UHC Ibn Rochd, Casablanca, Morocco.
C. Waffar
Department of Urology, UHC Ibn Rochd, Casablanca, Morocco.
A. Moataz
Department of Urology, UHC Ibn Rochd, Casablanca, Morocco.
M. Dakir
Department of Urology, UHC Ibn Rochd, Casablanca, Morocco.
A. Debbagh
Department of Urology, UHC Ibn Rochd, Casablanca, Morocco.
R. Aboutaieb
Department of Urology, UHC Ibn Rochd, Casablanca, Morocco.

*Corresponding Author
No deep adenopathy was found. The patient had surgery with extraction of the mass with precave lymph node dissection (Fig. 2).

![Extracted mass](image)

Fig. 2. Extracted mass.

The anatomopathological study had concluded in a remodelled renal cyst unspecified with lesions of chronic pyelonephritis, with classic Hodgkin's lymphoma in the lymph node dissection (Fig. 3).

![CD15 and CD30](image)

Fig. 3. Node expressing CD15 and CD30 (cHL).

The patient was referred to oncologists for chemotherapy.

III. DISCUSSION

Over 90% of cases of Hodgkin lymphoma (HL) are of classical Hodgkin lymphoma (cHL), which behaves as an aggressive neoplasm. HL is most commonly diagnosed in the 20-34y age group, accounting for 31% of new cases but can be seen across the age spectrum from adolescents to the elderly. Painless lymphadenopathy enlarging over months is a common mode of presentation. The three commonest sites of disease presentation - mediastinal involvement or left neck nodal enlargement or right neck nodal enlargement are each seen in about 60% of patients (not mutually exclusive). Other sites include splenic, axillary, abdominal, hilar or inguino-femoral in descending order of frequency [4]. Due to the uncommon anatomical location and the lack of symptoms in many of them for a long time, the diagnosis is usually late and the management of this patient is difficult, a definitive diagnosis is critical and requires that the treating physician provide the pathologist with an adequate pathologic specimen showing Reed-Sternberg cells [3]. Chemotherapy and radiation are the mainstays of cHL treatment. Advances in understanding the biology of the disease and improvement in modalities of chemotherapy and radiotherapy have improved survival across the board in every stage of cHL [4].

There are varying results in interpretation of complex cysts, and this is heavily dependent on interobserver variability. Bosniak classification is a valuable tool for the clinician. Computed tomography remains the gold standard. Percutaneous biopsy of these complex lesions would appear to be well tolerated and adequate for diagnosis [5].

IV. CONCLUSION

This case is reported to highlight the atypical presentation of HL and its association with a giant renal cyst which inclines a physician to think about an uncommon site of this lymphoma.

ACKNOWLEDGMENT

We acknowledge the contribution of all the working in urology department, the nursing staff, the staff of the radiology department and oncologists.

REFERENCES

[1] C. Lanchon, G. Fiard, et J.A. Long, Prise en charge des lésions kystiques du rein: revue de la littérature. Progrès en urologie, vol. 25, no 12, p. 675-682, oct 2015.

[2] O. Riyach, M. Ahsaini, K. Tazi, et al, A huge renal cyst mimicking ascites: a case report. BMC research notes, vol. 7, no 1, p. 1-4, 2014.

[3] SM. Ansell, Hodgkin lymphoma: diagnosis and treatment. In : Mayo Clinic Proceedings, Elsevier, p. 1574-1583, 2015.

[4] S. Shanbhag, R. Ambinder, Hodgkin lymphoma: A review and update on recent progress. CA: a cancer journal for clinicians, vol. 68, no 2, p. 116-132, 2018.

[5] B.B. Mcguire, J.M. Fitzpatrick, The diagnosis and management of complex renal cysts. Current opinion in urology, vol. 20, no 5, p. 349-354, 2010.