Hepatosplenic T-cell lymphoma in a 47-year-old Crohn’s disease patient on thiopurine monotherapy

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Abstract
Hepatosplenic T-cell lymphoma (HSTCL) is a rare non-Hodgkin lymphoma with a high mortality rate. Higher incidence is reported in patients with inflammatory bowel disease, specifically in male patients that are younger than 35 years, and have been treated with thiopurine and tumor necrosis factor (TNF)-alpha inhibitor combination therapy for over 2 years. In this case report we describe a 47-year-old patient with Crohn’s disease (CD) who developed HSTCL after having been treated with thiopurine monotherapy for 14 years. To our best knowledge, only eleven cases exist of patients with CD who developed HSTCL while on thiopurine monotherapy. We report the first patient with CD, older than 35 years, who developed HSTCL while on thiopurine monotherapy. This emphasizes that HSTCL risk is not limited to young men receiving both thiopurines and TNF-alpha inhibitors.

Key words: Hepatosplenic T-cell lymphoma; Thiopurine; Crohn’s disease; Immunosuppression

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Case report

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monotherapy who developed HSTCL at a relatively old age. This emphasizes that HSTCL may develop at all ages, even when the patient is solely on thiopurine monotherapy.

van de Meeberg MM, Derikx LAAP, Sinnige HAM, Nooijen P, Schipper DL, Nissen LHC. Hepatosplenic T-cell lymphoma in a 47-year-old Crohn’s disease patient on thiopurine monotherapy. World J Gastroenterol 2016; 22(47): 10465-10470. Available from: URL: http://www.wjgnet.com/1007-9327/full/v22/i47/10465.htm DOI: http://dx.doi.org/10.3748/wjg.v22.i47.10465

INTRODUCTION

Hepatosplenic T-cell lymphoma (HSTCL) is a rare subtype (1%) of peripheral T-cell non-Hodgkin lymphomas[1]. It is an extranodal and systemic neoplasm deriving from cytotoxic T-cells, usually with a gamma-delta (γδ)-T-cell receptor type[2]. These atypical lymphocytes display global infiltration in the splenic red pulp and in the intrasinusoidal space in the liver and bone marrow[3]. As a consequence, patients present with hepatomegaly (77%), splenomegaly (96%), constitutional symptoms (70%), anemia (85%), thrombocytopenia (89%), leukopenia (72%) and liver enzyme abnormalities (46%), in the absence of lymphadenopathy[3]. HSTCL mainly affects male[4] adults with a median age of 20 to 35 years[1,3]. HSTCL has a rapidly progressive course with a mean overall survival less than 16 mo, regardless of the available treatment modalities (chemotherapy, splenectomy, bone marrow or stem cell transplantation)[3].

The incidence of the highly lethal HSTCL is very low in the general population[11]. However, at least 10% of HSTCL arises in inflammatory bowel disease (IBD) patients treated with immunomodulatory therapy (thiopurines and/or tumor necrosis factor (TNF)-α inhibitors)[3]. This results in an increased HSTCL risk in IBD patients compared to the general population, although the absolute risk remains low[1,5]. Especially men younger than 35 years with Crohn’s disease (CD) who are treated with thiopurines and TNF-α inhibitor combination therapy for at least two years are at increased risk[4]. The estimated absolute risk to develop HSTCL in IBD patients treated with combination therapy is 1:22000 in general and 1:3534 for men younger than 35 years old. By contrast, IBD patients on thiopurine monotherapy had an estimated absolute risk of 1:45000 and 1:7404 in general IBD patients and men younger than 35 years old, respectively[4,6]. IBD patients with HSTCL have a poor prognosis with a median survival of seven to eight months[7,8].

In this case report, we present a 47-year-old male CD patient on thiopurine monotherapy. To our best knowledge, this is the first case report describing an IBD patient on thiopurine monotherapy who developed HSTCL at an age older than 35 years.

CASE REPORT

A 47-year-old Caucasian man with CD presented at our hospital with painless icterus, weight loss and malaise, without fever. He had a 33-year history of penetrating CD in the colon (Montreal Classification L2, B3 + P) and was treated with thiopurine monotherapy at presentation. Initial CD treatment had consisted of budesonide and mesalamine which was followed by azathioprine 150-200 mg per day for 14 years. Subsequently, he received infliximab at the age of 33 (three doses, remission induction therapy) and 36 (maintenance therapy for one-and-a-half years, discontinued due to neurologic side-effects). During his course of CD, he underwent both right and left hemicolectomy (at the age of 18 and 30 years, respectively) and received a permanent ileostomy at the age of 41 due to active perianal fistulating disease in the three years before. CD had been in remission in the five years preceding presentation at our hospital.

Physical examination of our patient revealed hepatosplenomegaly in the absence of lymphadenopathy, which was confirmed by computed tomography and positron emission tomography (Figure 1). Laboratory testing indicated anemia, thrombocytopenia and liver test abnormalities (Table 1A). Imaging did neither reveal dilated bile ducts nor other (obstructive) abnormalities. Furthermore, viral causes of hepatitis, including Epstein-Barr virus, were excluded by serology. Based on these results, we suspected an hematological malignancy and performed a liver and bone marrow biopsy. Liver biopsy showed sinusoidal and portal infiltration of atypical lymphocytes (Figure 2). Immunophenotyping of both biopsies confirmed a T-cell population with the surface proteins listed in Table 1B. Based on these biopsies, γδ-HSTCL was diagnosed[1].

Following the diagnosis of HSTCL, high dose corticosteroids (125 mg per day) were administered, followed by chemotherapy (CHOP regimen; cyclophosphamide, hydroxydoxorubicin, vincristine and prednisone). Despite this treatment, both clinical and biochemical parameters rapidly deteriorated and the patient died 21 d post-diagnosis due to massive esophageal bleeding, secondary to therapy-induced mucositis.

DISCUSSION

In this case report, we presented a male CD patient who developed HSTCL at the age of 47 years and after having been on thiopurine monotherapy during 14 years. Remarkably, this rare malignancy developed at an age older than 35, which is in contrast with previous cases in patients on thiopurine monotherapy. As HSTCL is very rare, and controlled cohort studies are lacking, this case report may contribute to the assessment of HSTCL risk and its relation with immunosuppressive therapies[27].
IBD patients, especially CD patients, are twice more likely to develop any lymphoma, regardless of immunosuppressive treatment [9,10]. The risk to develop HSTCL is also increased in auto-immune disorders like rheumatoid arthritis [11,12], specifically in those patients, treated with TNF-α inhibitors, and in immunocompromised patients with, among others, renal or heart transplant [3].

In IBD patients, thiopurine treatment is associated with a significantly increased overall risk (rate ratio of 1.41) of developing cancer [13], specifically non-melanoma skin cancer, urinary tract cancers and lymphoproliferative disorders (multivariate adjusted hazard ratio of 5.28) [10,14].

More specifically, thiopurines promote development of lymphomas: a recent meta-analysis found an overall standard incidence ratio for lymphoma of 5.7 in IBD patients receiving thiopurines, but not in patients formerly treated with thiopurines or patients who had never used these drugs [4]. The excess risk can be reversed by thiopurine withdrawal. Thiopurine cytotoxicity is mediated by the incorporation of 6-thioguanine during DNA replication in targeted cells, instead of guanine, which ultimately leads to apoptosis [10].

Figure 1 Positron emission tomography showing hepatosplenomegaly with increased metabolic activity in liver, spleen and bone marrow. Left: Coronal plane; Right: Sagittal plane.

Table 1 Results of our patient

| Analysis (Unit)                  | Results | Reference value | CD 2 and 3 | CD 4 and 5 | CD 7 | CD 8 | CD 16 | CD 56 | CD 107 T-cell receptor | TIA | Typical HSTCL 
|--------------------------------|---------|-----------------|------------|------------|------|------|-------|-------|-------------------------|-----|-----------------------|
| White blood cell count (× 10^9/L) | 4.6     | 4.0-10.0        | +          | -          | +    | -    | +/−   | +    | +                      | -   | +                     |
| Platelet count (× 10^9/L)       | 42      | 150-400         |            |            |      |      |       |      |                         |     |                       |
| Hemoglobin (mmol/L)             | 7.7     | 8.5-11.0        |            |            |      |      |       |      |                         |     |                       |
| Bilirubin (µmol/L)              | 175     | 0-17            |            |            |      |      |       |      |                         |     |                       |
| ALP (IU/L)                      | 265     | 0-125           |            |            |      |      |       |      |                         |     |                       |
| GGT (IU/L)                      | 154     | 0-45            |            |            |      |      |       |      |                         |     |                       |
| ASAT (IU/L)                     | 250     | 0-34            |            |            |      |      |       |      |                         |     |                       |
| ALAT (IU/L)                     | 437     | 0-44            |            |            |      |      |       |      |                         |     |                       |
| LDH (IU/L)                      | 701     | 0-247           |            |            |      |      |       |      |                         |     |                       |

ALP: Alkaline phosphatase; ASAT: Aspartate transaminase; ALAT: Alanine transaminase; GGT: γ-glutamyltransferase; LDH: Lactate dehydrogenase; TIA: T-cell restricted intracellular antigen.

Table 2 Number of Crohn’s disease cases with hepatosplenic T-cell lymphoma [7,15]

| Age      | Combination therapy | Monotherapy | Total |
|----------|---------------------|-------------|-------|
| > 35 year| 7                   | 0           | 7     |
| < 35 year| 20                  | 11          | 31    |
| Total    | 27                  | 11          | 38    |

Previous studies showed a higher absolute risk of developing HSTCL in patients receiving both thiopurines and TNF-α inhibitors, compared to patients on thiopurine monotherapy [4-6]. Furthermore, a review including 25 IBD patients with HSTCL reported an increased HSTCL risk in those on thiopurine monotherapy compared to patients using TNF-α inhibitor monotherapy [11].

Duration of immunosuppressive therapy may also influence the risk of developing HSTCL. For example, more than 80% of HSTCL cases occur in the first two years after initiation of combination therapy [12]. Median time from initiation of thiopurines to HSTCL development did not significantly differ between patients on thiopurine monotherapy and combination therapy (5.5 years vs 6 years, P = 0.39) [4].

A review of the literature revealed 38 cases of γδ-HSTCL in patients with CD, including 27 patients on combination therapy and 11 on thiopurine monotherapy (Tables 2 and 3) [7,15]. In contrast to these previous cases, our patient developed HSTCL after a longer period of thiopurine treatment (14 years vs a mean time of 5 years in the previously reported cases) and at an older age (47 years). HSTCL in general mainly affects men with a median age of 20 to 35 years [1,3,4]. Only 7 CD cases are known to develop γδ-HSTCL below the age of 35 [4,5]. Finally,
and a history of cancer. Given the prolonged clinical remission in our case, thiopurine withdrawal could have been considered to reduce HSTCL risk, although the extensive, relapsing disease course including surgery called for prolonged therapy [17].

This case report presents the first IBD patient on thiopurine monotherapy for an extended period of time, who developed a \( \gamma \delta \)-HSTCL at an age older than 35 years. This highlights the clinical relevance of knowledge and awareness of HSTCL risk in patients with CD on immunomodulatory therapies.

COMMENTS

Case characteristics

A 47-year-old male with Crohn disease with painless icterus, weight loss

Figure 2  Liver biopsy showing hepatosplenic T-cell lymphoma. Left: Hematoxylin and eosin staining (magnification \( \times 100 \)) showing intrasinusoidal and portal infiltration of atypical lymphocytes. Right: CD3 staining (magnification \( \times 100 \)) showing neoplastic cells (appearing in brown colour).

Table 3  Cases of \( \gamma \delta \)-hepatosplenic T-cell lymphoma in patients with Crohn's disease on thiopurine monotherapy

| Index       | Age, sex | Years of thiopurine treatment (type) | Presentation                                  | Treatment                      | Survival (mo) |
|-------------|----------|--------------------------------------|-----------------------------------------------|--------------------------------|---------------|
| Index case  | 47, M    | 14 (AZT)                             | HSM, icterus, anemia, thrombocytopenia        | Ch. (CHOP)                     | < 1           |
| Selvaraj et al [7] 2013 (AERS 6751796) | 18, M    | < 1 (AZT, 6MP)                       | NS                                            | NS                            | 7             |
| Selvaraj et al [7] 2013 (AERS 7554658) | 13, M    | NS (6MP)                             | NS                                            | NS                            | NS            |
| Fowler et al [18] 2010 | 19, M    | 6 (AZT)                             | SM, leucocytopenia                            | Ch. (NS) + splenectomy         | 4             |
| Fowler et al [18] 2010 | 22, M    | 8 (6MP)                             | SM, night sweats, fever, abdominal tenderness | Ch. (NS)                       | Survival      |
| Ochenrider et al [19] 2010 | 18, M    | 5 (6MP)                             | Fever, night sweats, SM, anemia, thrombocytopenia | Ch. (Pentostatin, ICE) + auto-SCT | 7             |
| Humphreys et al [15] 2008 | 27, F    | 5 (AZT)                             | Fever, nights sweats, pancytopenia, HSM      | Interferon-\( \alpha \) + auto-SCT | > 31          |
| Zeidan et al [20] 2007 | 31, M    | 6 (6MP)                             | Chills, SM, fever, pancytopenia              | Ch. (CHOP, cytarabine, ESHAP)  | 7             |
| Falchook et al [21] 2006 | NS       | NS (6MP)                             | SM                                            | Ch. (NS)                       | NS            |
| Mittal et al [22] 2006 | 18, M    | 6 (AZT)                             | Fever, pancytopenia, HSM                     | Ch. (IV, ESHAP, alemtuzumab)   | NS            |
| Navarro et al [23] 2003 | 35, M    | 5.6 (AZT)                            | Fever, night sweats, HSM, anemia, thrombocytopenia | fludarabine + allo-SCT         | NS            |
| Lémann et al [24] 1998 | NS       | 4 (AZT)                             | NS                                            | Ch. (NS) + splenectomy         | NS            |

Received one single gift infliximab 51 mo before presentation, therefore considered as TNF-\( \alpha \) inhibitor naive. AERS: Adverse Event Reporting System; AZT: Azathioprine; Ch.: Chemotherapy; CHOP: Cyclophosphamide, hydroxydoxorubicin, vincristine and prednisone; ESHAP: Etoposide, methylprednisolone, cytarabine, cisplatin; ICE: Ifosphamide, carboplatin, etoposide; IVE: Ifosphamide, carboplatin and etoposide; NS: Not specified; (H)SM: (hepato)splenomegaly; SCT: Stem cell transplantation; 6MP: 6-mercaptopurine.
and malaise.

**Clinical diagnosis**
Hepatosplenic lymphoma in the absence of lymphadenopathy and fever.

**Differential diagnosis**
Bile duct abnormalities, toxic hepatitis, viral hepatitis, liver cirrhosis.

**Laboratory diagnosis**
Anemia, thrombocytopenia and liver test abnormalities.

**Imaging diagnosis**
Hepatosplenic lymphoma, with increased metabolic activity in liver, spleen and bone marrow.

**Pathological diagnosis**
Hepatosplenic T-cell lymphoma (HSTCL).

**Treatment**
Chemotherapy.

**Related reports**
There are only 38 known cases of HSTCL in Crohn’s disease of which eleven were using thiopurine monotherapy. This is the first patient with CD, older than 35 years, to develop HSTCL while on thiopurine monotherapy.

**Term explanation**
HSTCL is a rare and lethal lymphoma with an increased risk by using thiopurines monotherapy or thiopurine TNF-α inhibitors combination therapy.

**Experiences and lessons**
Authors are emphasizing that HSTCL risk is not limited to young males receiving both thiopurines and tumor necrosis factor-α inhibitors.

**Peer-review**
The literature is described well, the authors report in detail information regarding the other patients affected from this rare condition. The review of the literature pertaining to HSTCL in inflammatory bowel disease is through.

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