To the Editor: A 50-year-old man was admitted to Peking Union Medical College Hospital with recurrent abdominal pain, vomiting, and melena. In the past 2 years, he had visited several hospitals for abdominal discomfort and was diagnosed as ileus or subileus. Normal mucosa was shown in both gastroscopy and colonoscopy. Three months before admission, the patient started suffering from recurrent hematemesis and melena. Physical examination only showed abdominal tenderness, without lymphadenopathy. His hemoglobin was 94 g/L. The lymphocyte count, platelet count, liver function, tumor markers, and erythrocyte sedimentation rate (ESR) were normal. Antinuclear antibodies, anticytoplasmic antibodies, and anti-saccharomyces cerevisiae antibody were undetectable. Small-bowel barium enema showed multiple ulcerations and stenosis in the jejunum and proximal hold-up [Figure 1a]. Computed tomography (CT) confirmed the presence of multiple jejunal strictures, prestenotic dilation, and bowel wall thickening [Figure 1b]. The 18F-fluorodeoxyglucose positron emission tomography-CT (PET-CT) suggested intestinal inflammations, the diagnosis of CMUSE was questioned when the ulcerations were localized to the mucosa and submucosa instead of transmural inflammations, the diagnosis of CMUSE was questioned when the patient encountered intestinal perforation. Ultimately, our patient was diagnosed as MALT lymphoma, which partly explains the symptoms temporarily improved by glucocorticoids. In spite of this, the macroscopic presentation in this case was an unusual pattern. According to the clinicopathological analysis of 143 primary intestinal lymphomas,\(^1\) tumorous type was the most common pattern (86.7%). Saito et al\(^3\) reviewed colonoscopy features of MALT lymphoma, confirming that the main appearance was solitary or multiple, sessile, and semipedunculated protrusions

MALT lymphoma comprises about 5% of all non-Hodgkin’s lymphoma. Although gastrointestinal tract is frequently involved, small intestine is a relatively uncommon site of origin, and only 9% involves jejunum.\(^1\) Multiple superficial ulcers, causing significant stenosis, normal ESR, and good response to glucocorticoids, were typical characteristics of CMUSE.\(^2\) However, since the ulcerations were localized to the mucosa and submucosa instead of transmural inflammations, the diagnosis of CMUSE was questioned when the patient encountered intestinal perforation. Ultimately, our patient was diagnosed as MALT lymphoma, which partly explains the symptoms temporarily improved by glucocorticoids. In spite of this, the macroscopic presentation in this case was an unusual pattern. According to the clinicopathological analysis of 143 primary intestinal lymphomas,\(^1\) tumorous type was the most common pattern (86.7%). Saito et al\(^3\) reviewed colonoscopy features of MALT lymphoma, confirming that the main appearance was solitary or multiple, sessile, and semipedunculated protrusions.
covered with seemingly normal mucosa, instead of skip-pattern stenosis and superficial ulcerations in our case.

Findings on PET in our patient indicated inflammation rather than malignancy. MALT lymphoma, as a clinically indolent subtype of lymphoma, might have variable FDG-avidity on PET-CT.\(^4\) In a prospective study,\(^5\) PET failed to visualize all the biopsy-confirmed MALT lymphoma; therefore, double-balloon enteroscopy, capsule endoscopy, radiographic imaging, and pathological study would be critical in early diagnosis of small-intestinal lymphoma.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**

There are no conflicts of interest.

**REFERENCES**

1. Kohno S, Ohshima K, Yoneda S, Kodama T, Shirakusa T, Kikuchi M, et al. Clinicopathological analysis of 143 primary malignant lymphomas in the small and large intestines based on the new WHO classification. Histopathology 2003;43:135-43. doi: 10.1046/j.1365-2559.2003.01659.x.

2. Kohoutová D, Bártová J, Tachecí I, Rejchrt S, Repák R, Kopáčová M, et al. Cryptogenic multifocal ulcerous stenosing enteritis: A review of the literature. Gastroenterol Res Pract 2013;2013:918031. doi: 10.1155/2013/918031.

3. Saito T, Toyoda H, Yamaguchi M, Nakamura T, Nakamura S, Mukai K, et al. Ileocolonic lymphomas: A series of 16 cases. Endoscopy 2005;37:466-9. doi: 10.1055/s-2005-861093.

4. Treglia G, Zucca E, Sadeghi R, Cavalli F, Giovanella L, Ceriani L, et al. Detection rate of fluorine-18-fluorodeoxyglucose positron emission tomography in patients with marginal zone lymphoma of MALT type: A meta-analysis. Hematol Oncol 2015;33:113-24. doi: 10.1002/hon.2152.

5. Hoffmann M, Kletter K, Diemling M, Becherer A, Pfeffel F, Petkov V, et al. Positron emission tomography with fluorine-18-2-fluoro-2-deoxy-D-glucose (F18-FDG) does not visualize extranodal B-cell lymphoma of the mucosa-associated lymphoid tissue (MALT)-type. Ann Oncol 1999;10:1185-9. doi: 10.1023/A:1008312726163.

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**Figure 1:** A 50-year-old man with lymphoma of mucosal-associated lymphoid tissue. (a) Multiple intestinal stenosis in small-bowel barium enema; (b) multiple jejunal strictures and bowel wall thickening in computed tomography; (c) perforation area with local pus and debris accumulation; (d) multiple intestinal strictures with significant bowel wall thickening; (e) histopathological finding showed infiltrated atypical lymphocytes (H & E staining, original magnification, ×150); (f) immunohistochemical examination demonstrated strongly positive stained with CD20 (original magnification ×150).