Case Report

Precursor T-lymphoblastic lymphoma presenting as primary renal lymphoma with acute renal failure

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Abstract

We report a case of acute renal failure (ARF) and bilateral nephromegaly in a patient with a history of Crohn’s disease and treatment with azathioprine. Kidney biopsy revealed diffuse renal infiltration by precursor T-cell lymphoblastic lymphoma (T-LBL). At the time of diagnosis, no extrarenal manifestations of the lymphoma were detectable and therefore the lymphoma was categorized as primary renal lymphoma (PRL). Thus far, precursor T-LBL presenting as PRL has not been described before. We emphasize that in patients with ARF and bilateral renal enlargement, renal lymphoma is an important differential diagnostic consideration.

Keywords: acute renal failure; bilateral nephromegaly; precursor T-lymphoblastic lymphoma; (primary) renal lymphoma

Background

Renal involvement of systemic lymphoma is a frequent feature with a prevalence of up to 50% in autopsy studies [1]. Primary involvement of the kidney, however, is very rare (1%) [2]. We report a case of precursor T-cell lymphoblastic lymphoma (T-LBL) presenting as primary renal lymphoma (PRL) with acute renal failure (ARF) and bilateral nephromegaly in a patient with history of Crohn’s disease and prior treatment with azathioprine.

Case report

A 23-year-old man presented at the emergency department with ARF. The patient had a medical history of Crohn’s disease for which he had been treated with prednisone and azathioprine until 2006, followed by a laparoscopic ileocaecal resection. Four months before presentation, he was admitted elsewhere because of chest pain, for which acetylcysteine and esomeprazole were started. At that time, serum creatinine levels were within normal limits. At the current consultation, serum creatinine level was 548 µmol/L. He experienced chest pain which was continuously present during the day, and not related to exercise. No radiation of the pain nor dyspnoea were present. In the past 4 months, he had lost 3 kg of body weight. Physical examination revealed a blood pressure of 150/80 mmHg, but otherwise normal vital signs. Except for an erythema on the malar eminences, no abnormalities were noted, especially no oedema, no pericardial friction rub, no lymphadenopathy, nor hepatosplenomegaly. Further laboratory values showed haemoglobin 7.9 mmol/L, white blood cell count 13.4 × 10^9/L, 68% neutrophils, trombocytes 330 × 10^9/L, 4.4 g/L and C-reactive protein 45.5 mg/L. Serology of human immunodeficiency virus, hepatitis B virus (HBV) and hepatitis C virus (HCV) was negative. Moreover, normal C3 and C4 and negative results of anti-double strain DNA, anti-nuclear antibody, anti-nuclear cytoplasmatic antibody and anti-GBM antibody were found. Urinalysis showed microscopic haematuria (3+1) and proteinuria (1+), and urine microscopic examination showed >20 red blood cells/high-power field but no red blood cell casts. A 24-h urine collection measurement showed 230 mg of protein. Renal ultrasound showed bilateral nephromegaly of 15, respectively, 14.6 cm in length without evidence of obstruction. At this stage, a kidney biopsy was performed which showed interstitial infiltration of medium-sized atypical lymphoid cells by light microscopy (Figure 1). Immunohistochemical stains of these atypical lymphocytes were strongly positive for CD3, TdT, Ki67 and CD99 and negative for CD20 and Epstein–Barr virus (EBV). The morphology and the immunohistochemical marker profile were consistent with the WHO classification of precursor T-lymphoblastic leukaemia/lymphoma. Additional molecular diagnostic analysis supported the diagnosis of malignant T-lineage lymphoma. The tubuli and glomeruli did not show apparent histopathological abnormalities. Total body computerized tomography, a bone marrow biopsy and a spinal fluid aspiration were performed to stage the lymphoma. Apart from diffusely enlarged kidneys, these investigations were negative: neither lymphadenopathy nor pericardial effusion was seen.

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on these results, the lymphoma was classified as PRL and the patient started immediately with remission-induction chemotherapy receiving prednisolone, cyclophosphamide, daunorubicin, vincristin, L-asparaginase and intrathecal methotrexate for induction. After completion of the consolidation phase, kidney function improved to a serum creatinine level of 74 μmol/L. Recently, the patient finished his almost 2 years of maintenance treatment. At re-evaluation, no evidence of renal or extrarenal lymphoma was present and kidney function remained normal.

**Discussion**

Most reported cases of PRL are of B-cell lineage and only a few case reports on T-cell PRL have been published [3,4]. To our knowledge, a precursor T-LBL presenting as a PRL has not been described before. A precursor T-LBL is a highly aggressive neoplasm of T-cell lineage, arising from precursor T lymphoblasts. Precursor T-LBL is differentiated from T-cell acute lymphoblastic leukaemia by bone marrow biopsy or aspiration, and the diagnosis precursor T-LBL is established when <25% blasts are present. In our patient, no blasts were present in the bone marrow.

Since the kidneys do not contain lymphoid tissue, controversy exists whether PRL should be considered as a distinct disease entity. Some have postulated that lymphoma can arise from potential lymphoid tissue in the renal hilum [4] or capsule [5]. Others suggest chronic inflammation as an initiator for lymphoma [6]. For this reason, the diagnosis of PRL should only be made in the presence of a biopsy-proven lymphomatous renal infiltration, a
non-obstructive nephromegaly, and in the absence of extra-
renal lymphoma [7]. Furthermore, some authors also stipulate
improvement of renal failure after chemotherapy [8].

Lymphoma may cause ARF by multiple mechanisms. A
direct effect may result from ureteral obstruction, the com-
pression of renal arteries, veins and tubules and/or bilateral
parenchymal infiltration, as seen in the present case. PRL
may indirectly lead to ARF by causing hypercalcaemia and/
or haemolysis. Treatment-related effects include tumour
lysis syndrome, nephrotoxicity of chemotherapeutic agents
and radiation nephritis.

A role of immunosuppressive agents in the develop-
ment of lymphoproliferative disease, predominantly
EBV-associated B-cell lymphomas, has been known for
many years. Of note, we describe a case of T-cell lymph-
oma without an EBV association. A meta-analysis by
Kandiel et al. revealed a 4-fold increased risk of lymph-
oma in patients with inflammatory bowel disease, treated
with azathioprine [9]. However, independently of the
use of immunosuppressive agents, patients with Crohn’s
disease itself seem to have no substantially increased risk
to develop a malignant lymphoma [10].

The prognosis of primary renal T-cell lymphoma is dif-
ficult to estimate as PRL only represents a minor fraction of
the total number of primary extranodal lymphomas. Only
two other cases with ARF have been described in the liter-
ature. One patient died within 13 months after initial presen-
tation [4] the other was disease-free 17 months post-diagnosis
[3]. In general, adult patients with precursor T-LBL have a
poor prognosis, despite the significant progress that has
been made with the introduction of more aggressive treat-
ment protocols.

In conclusion, we report a case of primary renal T-cell
lymphoma presenting with ARF and bilateral nephrome-
galy in a patient with a history of Crohn’s disease and
treatment with azathioprine. Renal biopsy was diagnostic
of diffuse precursor T-LBL. In patients with ARF and
bilateral renal enlargement, renal lymphoma is an impor-
tant differential diagnostic consideration.

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