Atypical gastrointestinal plasmacytomas presenting with gastrointestinal bleeding in a patient with multiple myeloma

Multipl myelom'lu hastada gastrointestinal kanama ile prezente olan atipik gastrointestinal plazmositom lezyonları

To the Editor,

Gastric plasmacytomas are unusual and rare forms of extramedullary plasmacytomas (EMPs), and constitute 2-5% of all EMPs. Gastric plasmacytoma lesions may be nodular, infiltrative, ulcerative, or polypoid form (1-3). We present unusual gastric plasmacytoma lesions on gastroscopy in a multiple myeloma patient who admitted to our hospital with melena.

A 77-year-old male patient admitted to our hospital with dark-colored, saucy and foul-smelling defecation. His history revealed that he had been followed with a diagnosis of multiple myeloma for about one year and that he had used melphalan and prednisolone treatments. One year before, on his bone marrow aspiration examination, plasma cell levels were 37%, IgA level was high, and serum lambda monoclonal antibody was high.

On physical examination, his blood pressure was 100/60 mmHg and pulse rate was 85/min, and conjunctivas were pale. Systolic murmur was found on all cardiac foci. On his back left side, we found a soft tissue swelling of about 10 cm in diameter long, while on the front chest wall, a lesion of about 2 cm in diameter long found. Melena was present on rectal examination.

On laboratory examination, hemoglobin was 7.6 g/dl, hematocrit 23%, thrombocyte count 91,000/mm^3, and white blood cell count 3,100/mm^3. Serum creatinine was 2.0 mg/dl, calcium 9.1 mg/dl and potassium 4.8 mEq/L; liver enzymes and serum bilirubin levels were all normal.

On upper gastrointestinal endoscopy, which was performed for melena, we found 8-10 lesions on the corpus, with the largest 2 cm in diameter wide, which was swollen and presented an ulcerated plaque-like lesion seen on its center (Figures 1, 2). On the bulbus, two lesions were found measuring about 1.5 and 2 cm in diameter wide, and visible vessels were seen on the center of one of them (Figure 3). Biopsies were done from all these lesions.

Pathology results from these lesions were reported as follows: on mucosal tissue samples, tumoral structure was seen to be formed of plasmacytoid cells, infiltrating the muscularis mucosa and immunohistochemically expressing lambda (+), kappa (-), CEA (-), and cytokeratin (-). The patient was accepted as plasma cell myeloma (multiple myeloma infiltration) (Figure 4).

In addition, the result of the biopsy taken from the soft tissue on his back left side was reported as plasmacytoma.

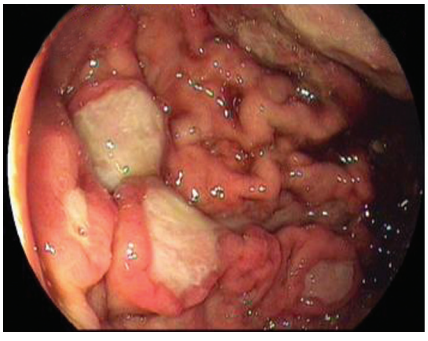

Figure 1. Plasmacytoma lesions on corpus

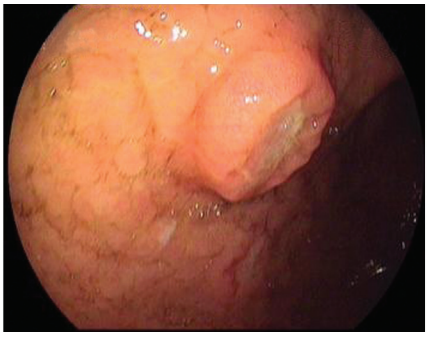

Figure 2. Plaque like lesion on corpus

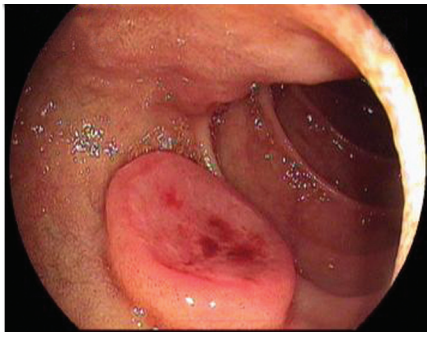

Figure 3. Plaque like lesion on bulbus

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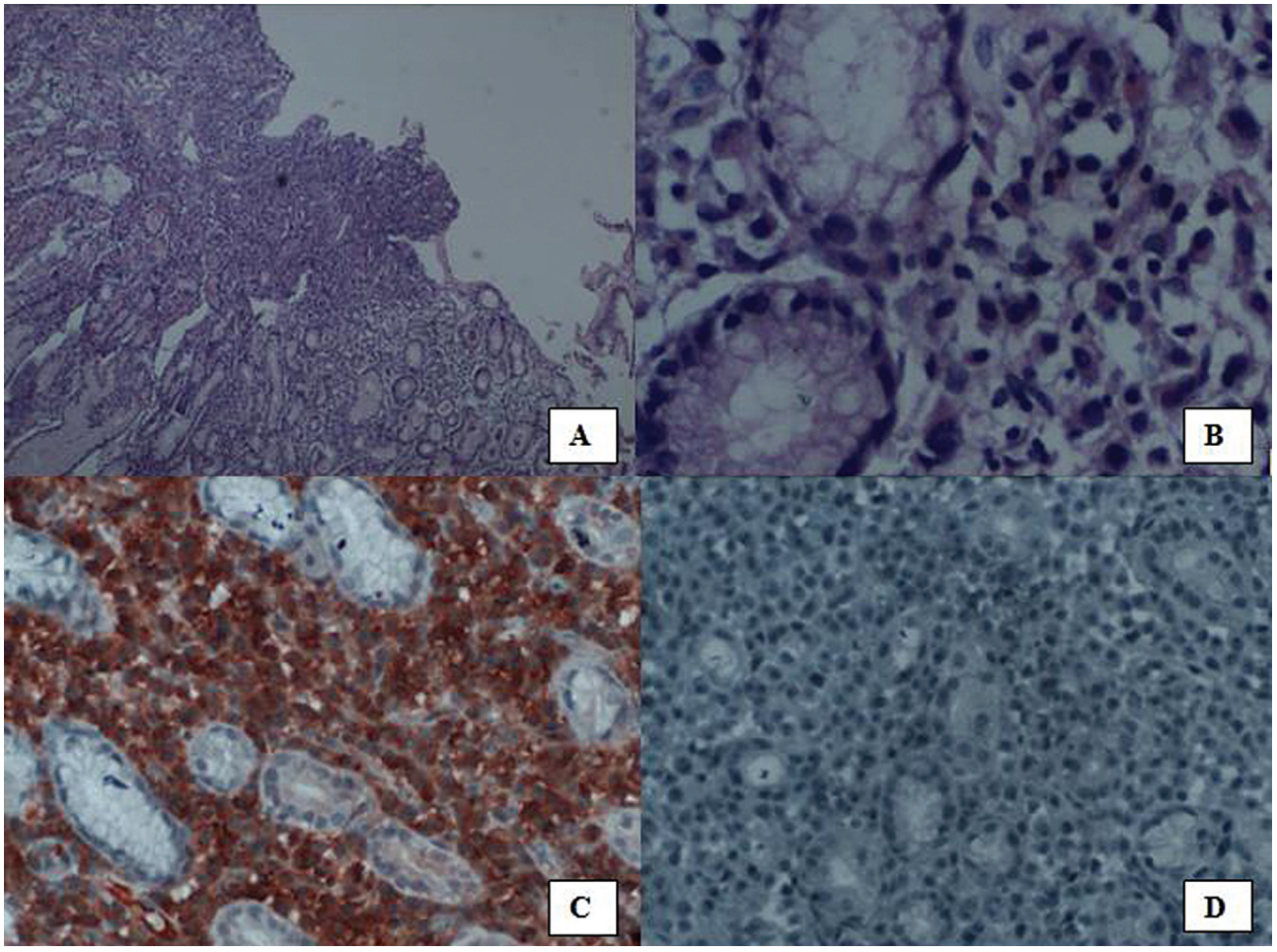

Figure 4. A. Tumoral infiltration seen eroding mucosal surface (H&E x 40), **B.** Plasmocytoid cells surrounding mucosal glands (H&E x 200), **C.** Immunhistochemically lambda positive (H&E x 100), **D.** Kappa negative (H&E x 100).

With these results, it was understood that the lesions on the stomach and duodenum were plasmacytoma infiltrations. The patient was followed with cessation of oral feeding, erythrocyte transfusions, two doses of intravenous omeprazole daily, and other supportive care. The patient was stable for gastrointestinal bleeding, and was then referred to the hemato-oncology clinic for the skin involvement of the plasmacytoma.

Multiple myeloma is a plasma cell neoplasm that results in monoclonal gammopathy, bone marrow insufficiency, renal failure, and hypercalcemia. In 20% of cases, extramedullary involvement may be seen; however, this involvement is generally seen in the upper respiratory tract, oropharynx, nasopharynx, nasal cavity, and larynx.

Ten percent of all EMPs are seen in the gastrointestinal tract. Small intestinal involvement is common, but the stomach, colon and esophagus may also be involved (1). Gastric plasmacytomas are generally presented with epigastric pain, nausea, weight loss, and anorexia, but gastrointestinal bleeding is seen rarely. Many gastrointestinal plasmacytoma lesions in the literature were reported as large, ulcerative and deeply infiltrative tumors.

The lesions on the bulbus seen in our case have not been reported previously in the literature, and were large plaque- or disc-like lesions. The disc-like lesion typically does not fit nodular, infiltrative, ulcerative, and polypoid forms.

For treatment, subtotal or total gastrectomy and/or radiotherapy may be performed (1). Some Helicobacter pylori (HP)-positive stage 1 primary gastric plasmacytoma cases are reported to be completely regressed after HP eradication (4). Furthermore, eradication therapy should be considered as a potential first-line therapy for gastric plasmacytoma associated with HP infection, before aggressive treatments such as surgical resection or radiotherapy (5).

REFERENCES

1. Maskin LP, Diaz MF, Hlavnicka A, et al. Gastrointestinal bleeding secondary to multiple gastric plasmacytoma. Am J Clin Oncol 2008; 31: 100-1.
2. Chim CS, Wong WM, Nicholis J, et al. Hemorrhagic gastric plasmacytoma as the primary presentation in multiple myeloma. J Clin Oncol 2002; 20: 344-7.
3. Hamilton JW, McCluggage WG, Jones F, et al. Extramedullary gastric plasmacytoma. Ulster Med J 1999; 68: 103-5.
4. Papadaki HA, Skordilis P, Minadakis G, et al. Complete regression of primary gastric plasmacytoma following Helicobacter pylori eradication. Ann Hematol 2003; 82: 589-92.
5. Stasi R, Evangelista ML, Brunetti M, et al. Primary gastric plasmacytoma and Helicobacter pylori infection. J Clin Oncol 2009; 27: 150-3.

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Ileocolic intussusception due to a gastrointestinal stromal tumor

Gastrointestinal stromal tümöre bağlı ileokolik invajinasyon

To the Editor,

Intussusception, defined as the invagination of a part of the gastrointestinal tract into an adjacent part, is extremely rare in the stomach; the small bowel, ileocecal junction and colon are more commonly involved (1-3). Intussusception is uncommon in adults compared to the pediatric population. In children, 90% of the cases are idiopathic, whereas in adults, 70–95% of cases of intussusception have a specific identifiable cause. This cause is a benign or malignant neoplasm in about 65% of the cases (4,5).

A 64-year-old woman presented to our clinic with abdominal pain, nausea, an inability to defecate, and gradually increasing vomiting. Except for leukocytosis and minimal uremia, the laboratory results were normal. An upright plain abdominal X-ray revealed small bowel obstruction with marked small bowel air–fluid levels. At laparotomy, the small bowel was dilated, and the ileum was invaginated into the colon (Figure 1). When the ileum was reduced, 25 cm of bowel was seen to be devitalized. Furthermore, an approximately 3 x 3 cm solid mass was palpated 6–7 cm proximal to the ileocecal valve, extending toward the lumen. Ile-

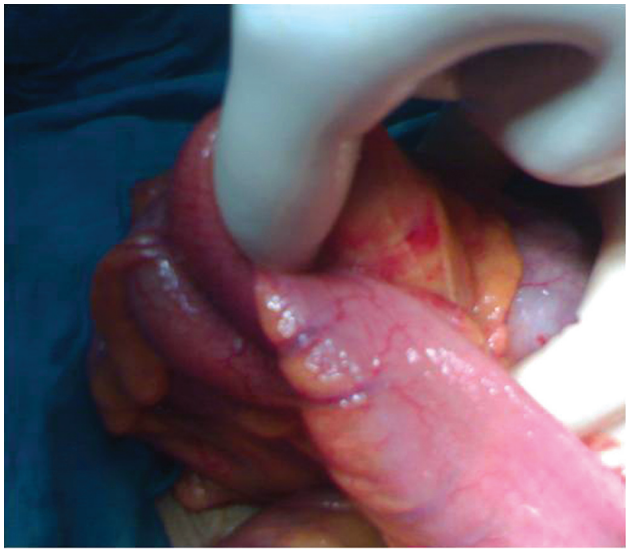

Figure 1. The view of the invaginated segments.

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