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Colonic Plasmacytoma Revealing Kahler's Disease: A Case Report

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Summary: Case Report

Plasmacytoma is defined as a malignant differentiation of B lymphocytes with production of serum immunoglobulins. Plasmacytoma can affect most organs either as a secondary location of a multiple mye1oma or as a primary location called extramedullary plasmacytoma. We report a rare case of colonic plasmacytoma revealing Kahler's disease.

Keywords: Colonic plasmacytoma, kahler's disease, intestinal occlusion.

INTRODUCTION

Plasmacytoma is a monoclonal proliferation of malignant plasma cells that may develop in isolation, corresponding to solitary medullary or extramedullary plasmacytoma, or as part of multiple myeloma [1].

Secondary sites of Kahler's disease most commonly involve the respiratory tract in around 75% of cases. In contrast, the gastrointestinal tract is involved in only 5-10% of cases [2], with colonic involvement being extremely rare [3]. We report a rare case of colonic plasmacytoma revealing Kahler disease.

OBSERVATION

A 65-year-old patient with no specific pathological history presented to the emergency department with abdominal pain in the IDF and right flank, associated with cessation of bowel movements and gas and vomiting, which had been progressing for 5 days. The patient also had asthenia and anorexia associated with significant weight loss. On clinical examination, the patient was in poor general condition; the abdomen was distended and tympanic; the lymph nodes were free; on rectal examination, the rectal ampulla was empty; the rest of the clinical examination was unremarkable.

The ASP carried out had objectified NHA with a predominance of bowel, the patient had then benefited from an abdominal CT scan demonstrating distension of the bowel upstream of a circumferential and irregular thickening 33mm thick at the level of the ileo-caecal junction associated with some mesenteric adenopathy at the level of the IDF (Fig 1).

The patient benefited from a carcinological right hemicolectomy with ileo-colic anastomosis. Histological examination of the resection specimen objective plasmacytic infiltration of less than 10%, with infiltration by large blast cells with an appearance of plasmoblasts or immunoblasts (Fig 2).

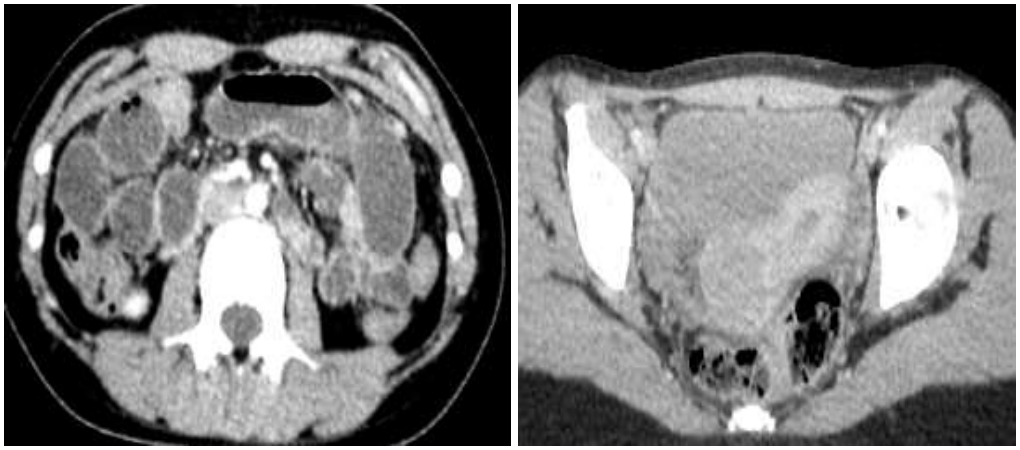

Figure 1: Abdominal-pelvic CT image showing hydroaeric distension of the ileal ansae upstream of irregular thickening of the ileo-caecal junction

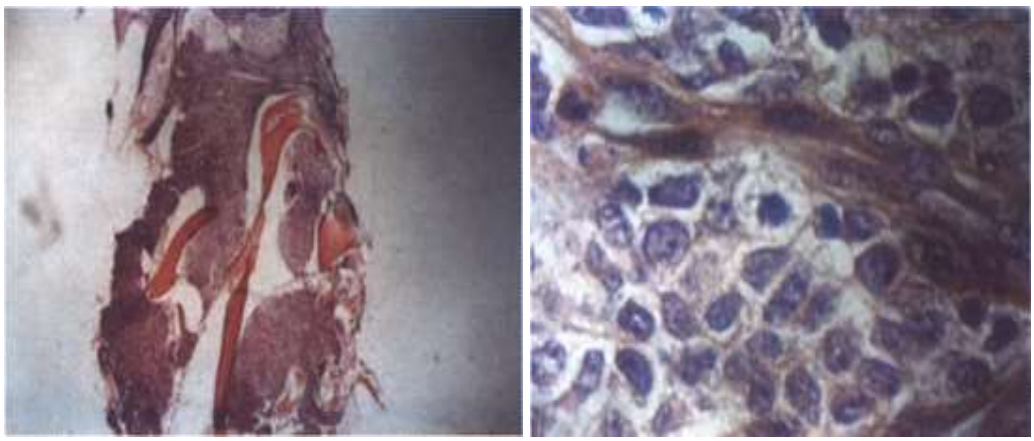

Figure 2: Hemalun-eosin colonic biopsy, magnification x 10 Dense focal plasma cell infiltration of the chorion dissociating the gland (left) and x 40 immature plasmoblastic or immunoblastic cells & the bone marrow biopsy

DISCUSSION

The digestive sites of Kahler disease [3] involve, in decreasing order of frequency, the stomach, jejunum, ileum, colon, rectum, duodenum and oesophagus. Patients may present with several digestive tract sites [4]. However, colonic involvement is exceptional.

Intestinal and colorectal involvement usually leads to symptoms of occlusion, as in the case of our patient, or digestive haemorrhage. Intestinal invagination and ileocolic fistula have also been described [5, 6]. However, colonic localisation may be asymptomatic.

Digestive plasmacytomas are most often polyploid and appear as adenocarcinomas. Endoscopic polypectomy followed by radiotherapy appears to be the logical treatment. The case report presents an ulcerative form of colonic plasmacytoma not suitable for endoscopic polypectomy.

Colonoscopy has a great place in reducing morbidity, mortality and the cost of medical care when endoscopic polypectomy is possible without laparotomy.

All lesions apart from those that are sessile and large can be completely resected endoscopically [3]. In general, colonic plasmacytoma progresses slowly, but there is a strong tendency for local relapse [2, 7].

Surgical excision supplemented by radiotherapy has been the recommended treatment for localised plasmacytoma [3, 8, 9].

CONCLUSION

The colonic plasmacytoma of Kahler disease is exceptional; it is most often polyploid and symptomatic. However, it can also be asymptomatic, in which case colonoscopy, in conjunction with biopsies, is of vital importance in making the diagnosis.

There is no established treatment protocol: radiotherapy alone or major surgery combined with radiotherapy and/or chemotherapy, or endoscopic polypectomy supplemented by adjuvant treatment. Only multicentre, comparative studies and prolonged follow-up will be able to determine the advantages of each of these therapeutic approaches.

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