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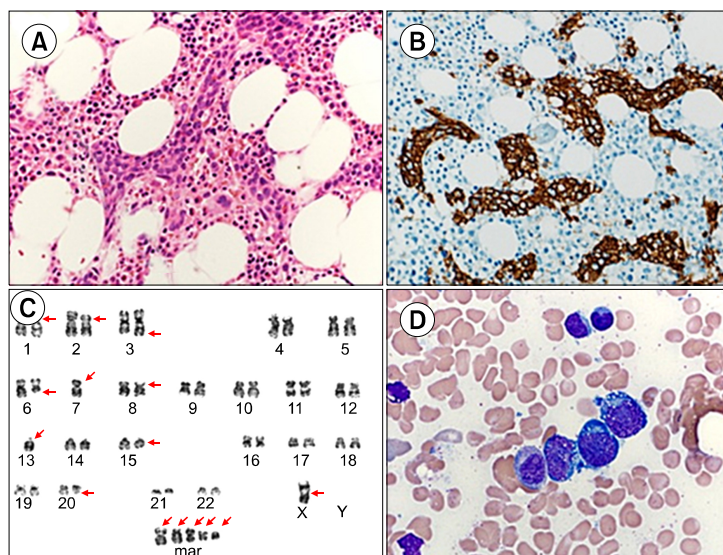
Relapsed intravascular large B-cell lymphoma

Kyoung Il Jo¹, Rojin Park¹, Jong Ho Won²

Departments of ¹Laboratory Medicine, ²Internal Medicine, Soonchunhyang University Seoul Hospital, Seoul, Korea

Correspondence to Rojin Park, M.D. Ph.D., Department of Laboratory Medicine, Soonchunhyang University Seoul Hospital, 59, Daesagwan-ro, Yongsan-gu, Seoul 140-887, Korea, E-mail: rpark@schmc.ac.kr

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A 44-year-old woman presented with myalgia and fever. Initial laboratory results were: White blood cell (WBC) count, $7.8 \times 10^9/L$; hemoglobin, 11.3 g/dL; platelet count, $42 \times 10^9/L$; and lactate dehydrogenase, 619 IU/L. Peripheral blood cell morphology showed leukoerythroblastic features (nRBC, 8/100 WBCs). Abdominal computed tomography (CT) indicated hepatosplenomegaly. Bone marrow biopsy showed focal large cell aggregates with prominent nucleoli in capillaries (A, H&E stain, $\times 400$; B, CD20 stain, $\times 400$). These cells were positive for CD5 and CD20 and negative for CD10, CD56, CD117, CD34, TDT, and CD3. Chromosomal study showed a complex karyotype (C, 48,-X,add(X)(p11.2),add(1)(p12),add(2)(p11.2),add(3)(q27),del(6)(q21)-7,add(8)(p21),-13,del(15)(q11.2q15),del(20)(q13.3),+mar1,+mar2,+mar3,+mar4,+mar5[cp3]/46,XX[17]). She was diagnosed with intravascular large B-cell lymphoma and treated with rituximab, cyclophosphamide, adriamycin, vincristine, and prednisolone (R-CHOP) combination chemotherapy. Three months after auto-peripheral blood stem cell transplantation, she was readmitted due to coughing, sputum, and myalgia. Bone marrow analysis showed an intravascular large B-cell lymphoma recurrence with normal karyotype (D, Wright-Giemsa stain, $\times 1,000$). In a BCL6 dual-color, break-apart probe (Vysis/Abbott Molecular, Des Plaines, IL, USA) initial diagnostic specimen FISH study, 9.8% (49/500) of the cells had a 2-green 1-fusion abnormal signal pattern, suggesting 3q27 rearrangement, while no abnormal signal patterns were observed, although abnormal lymphoid cells comprised 6.8% of the bone marrow at relapse.