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# Lymphosarcoma of the Stomach A Case Report.

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## SUMMARY

Lymphosarcoma of the stomach is rare. This article deals with a case which was probably primary.

## CASE REPORT

Mr J.C. 31 year old African (I.P. No: 23573/74) was admitted on 8th November, 1974 to Kitwe Central Hospital, Lusaka with the following complaints.

(1) Pain in the upper central abdomen with loss of appetite and weight for 2½ years.

(2) Swelling in the right supraclavicular fossa for 6 weeks. He had been attending different hospitals with the pain in abdomen since May, 1972. The pain was burning in nature with substernal radiation. Examination of the abdomen did not show any abnormality except for a slight tenderness in the epigastrium. The lump in the right supraclavicular fossa was a hard, mobile, non-tender, discrete lymph node (2 x 2 cms). There were two more just palpable nodes of the same features in the vicinity. No other group of lymph nodes was palpable. The chest was clinically and radiologically normal.

**Investigations**

1. Blood – Haemoglobin 13 G%, ESR 15mm, Total White-blood Cell count 5200, P. 24, L58, E 18. Sickling negative.
2. Urine – and stool microscopy normal.
3. Faecal Occult blood: negative.
4. Gastric acid studies – Basal Acid output: NIL Augumented acid output (histonine stumulated Nil.
5. Barium meal – Giant rugae with irregular filling defects on the greater curvature (Fig. 1).
6. Biopsy of the right supraclavicular lymphnode was done on 15th November, 1974 and the reports is as follows:

"The normal structure of the lymphnode has been completely destroyed and replaced by round cells of lymphocytic variety with mitotic figures. Diagnosis:- lymphosarcoma.

In the light of the biopsy report, the provisional diagnosis of carcinoma of the stomach was changed to lymphosarcoma of the stomach and laparotomy was done on 10th December, 1974. The operative findings were the following. The body of the stomach was found thickened and tumour infiltrates with which Irregular small masses were felt. On gastrotomy these were found to be the thickened giant mucosal rugae (Fig. 2) around three giant ulcer craters, two of which 6cms in diameter and the third 3cms. in diameter. The entire gastric mucosa was found hypertrophied with giant rugae. The lymphnodes in the omentum and mesentry were enlarged and firm. Liver looked pale. A high partial gastrectomy was done. One of the mesentric lymphnodes was also taken for biopsy. The post-operative period was uneventful and he was discharged on 5th January, 1975.

**Biopsy Report**

1. Partial gastrectomy specimen:- When cut, the walls of 3 gastric ulcers are thickened and homoge-

FIG. I

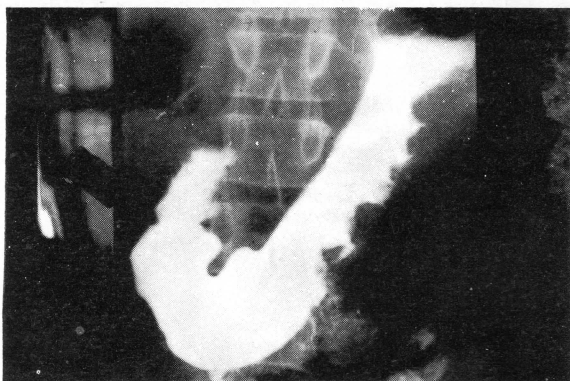
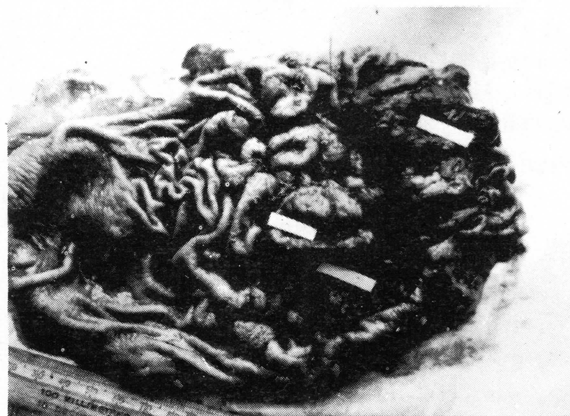


FIG. II



nous white. Underneath the ulcer are masses consisting of closely packed cells, most of them resembling mature lympocytes. Occasional areas show mitotic figures and hyperchromatism.
Diagnosis:- Lymphosarcoma stomach.
2. Lymphnode from the mesentry:- Sinus cattarrh only; no evidence of lymphosarcomatosis.

## DISCUSSION

Lymphosarcoma of the stomach is a rare, forming 1 to 5% of the total gastric neoplasms (Allen et al 1954, Azopardi and Menzies (1960). The pancity of lympoid tissue in the stomach accounts for the rarity of this condition (Ackerman 1964). Lymphosarcomatosis (Ackerman 1964). From the history of two and half years of gastric symptoms and a very short duration of the swelling in the neck, it is possible that this case was a primary lymposarcoma of the stomach.

Due to vague symptomatology, a precise preoperative diagnosis is difficult. Clinical features sugges-carcinoma of the stomach. In 80% of cases radiological studies are in favour malignancy of the stomach (Loehr et al 1969).

Grossly it has many patterns. They are (1) giant convolutions resembling cerebral convolutions (2) ulcerative growth (3) lobulated mass with areas of superficial or deep ulcerations (4) polypoidal masses (5) infiltrating plaques (6) hypertrophic gastritis (Ackerman 1964). In its gross appearance it can not be distinguished from gastric carcinoma and the sure means of diagnosis is histopatholgy (Kline and Goldstein 1973).

The possiblity of cure rests with the early surgical removal of the primary lesion and the involved lymph nodes where possible, followed by post-operative irradiation or chemotherapy (Ellis and Lannigan 1963). Since gastric lymphomas are easily resectable and do not often disseminate after removal, the prognosis is good (Loehr et al 1969).

## SUMMARY

A case of lymphosarcoma of the stomach which was diagnosed pre-operatively by biopsy of a supraclavicular lymph node is presented a brief review of the literature is given.

## ACKNOWLEDGEMENTS

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