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Case Report

Hodgkin Lymphoma with an Atypical Lymphadenopathy: A Case Report

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1. Introduction

Hodgkin lymphoma (HL) is characterized as a heterogenous group of malignant B cells with extra medullary proliferation. This lymphoma can be subcategorized but still retain the same classical presentation being cervical, supraclavicular, or mediastinal lymphadenopathy and B symptoms: fevers, night sweats, or unintended weight loss. However, in rare cases this classical presentation and lymph node involvement is not see. We present a case of Hodgkin lymphoma with an atypical presentation[1].

Case Report

A 40-year-old female with history of systemic lupus erythematosus on anifrolumab, left vertebral artery occlusion on aspirin complicated by a transient ischemic attack, nonalcoholic steatohepatitis, fibromyalgia, bipolar mood disorder, chronic pain disorder, migraines, and chronic anemia requiring IV iron and blood transfusions who was admitted to the complex care unit following a history of failure to thrive and severe weakness. Prior to this recent history, she had no significant cancer history, was up to date on all cancer screenings, and had no significant family history[2].

The patient reports that she was in her usual state of health until six-months ago when she developed weakness, nausea, vomiting, and night sweats. Additionally, she lost over 60 pounds in the past six months[3].

Prior to hospitalization, she underwent imaging as an outpatient which demonstrated mild retroperitoneal pelvic lymphadenopathy and splenomegaly as seen on CT imaging. There were no significant findings in her thoracic cavity. She underwent a biopsy of the retroperitoneal lymph nodes which demonstrated changes consistent with reactive processes only. Cytometry on that specimen showed no signs of lymphoproliferative disease. Due to the inconclusive finding, a bone marrow biopsy was conducted which showed normocellular bone marrow with polytypic plasmacytosis and maturing trilineage hematopoiesis. There were no signs of lymphoproliferative disease.

She continued to be closely monitored and had a repeat chest, abdomen, and pelvis CT scan showing a new mass-like density within the porta hepatis along with the persisting retroperitoneal lymphadenopathy. A PET scan illustrated hypermetabolic activity in the portacaval lymph nodes at that time[4].

On the day of presentation, she was unable to rise from her bed and required her partner to carry her from her room to the ambulance. While admitted, her ESR and CRP were significantly elevated, and remained elevated throughout the duration of her hospitalization. Her labs were otherwise within normal limits compared to her baseline. She had a negative hemophagocytic lymphohistiocystosis and viral panel. She underwent a biopsy of the portacaval lymph nodes; this biopsy was found to have numerous scattered large malignant cells with large bi- or multinucleated cells. Additionally, cytometry was positive for CD30, CD15 and Pax5. Following this finding, her Epstein Barr Virus DNA quantitative was 68,562. These biopsy findings are consistent with Hodgkin Lymphoma. She was subsequently initiated on a bleomycin, Adriamycin, vinblastine, and dacarbazine regiment.

Discussion

We presented a case of HL with atypical initial lymph node involvement. About 9000 patients are annually diagnosed with HL with most patients demonstrating the classical "B" symptoms

and specific patterns of lymphadenopathy. 60-80% of patients will present with cervical or supraclavicular lymphadenopathy, mediastinal lymphadenopathy is seen in 50-60% of patients on initial presentation and <10% will have infra-diaphragmatic lymphadenopathy.

Thus, physicians tend to direct their focus on supradiaphragmatic lymph nodes when they suspect HL.

As seen in this case, it is important to continue to search for other possible sites for affected lymph nodes if the initial biopsies are benign and the patient continues to demonstrate symptoms.

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