

AMSER Case of the Month

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79 y/o male presenting with recurrent melena and anemia



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Patient Presentation

- CC: recurrent melena
- HPI: Pt is a 79 y/o male admitted for three month hx of recurrent melena. ROS + for abdominal pain, shortness of breath, and early satiety; - N/V or weight loss. Was hospitalized earlier in the month: CT abd w/o contrast showed wall thickening in RLQ small bowel. Colonoscopy and EGD were negative.
- PMHx: recurrent GI bleeds from AVMs, colonic polyps (tubular adenomas), congenital midgut malrotation, CAD s/p CABG, PVD on Plavix
- Vitals: T 97.5°F, BP 101/67, HR 70, RR 24, SpO2 100%
- Physical exam: abdomen is distended and soft to light palpation, there is fullness in RLQ and tenderness in the RLQ to deep palpation

Pertinent Labs and Procedures

- WBC 8.48
- Hb 8.3, MCV 77.8, Hct 30.2, plt 335
- ALT 11, AST 13, ALP 72, total bilirubin 0.3
- Guaiac positive stool in ED
- Capsule endoscopy showed fresh blood as capsule passed through ileocecal valve, in area where endoscopic clip was previously placed d/t AVM. No mass in terminal ileum visualized.

What Imaging Should We Order?

Select the applicable ACR Appropriateness Criteria

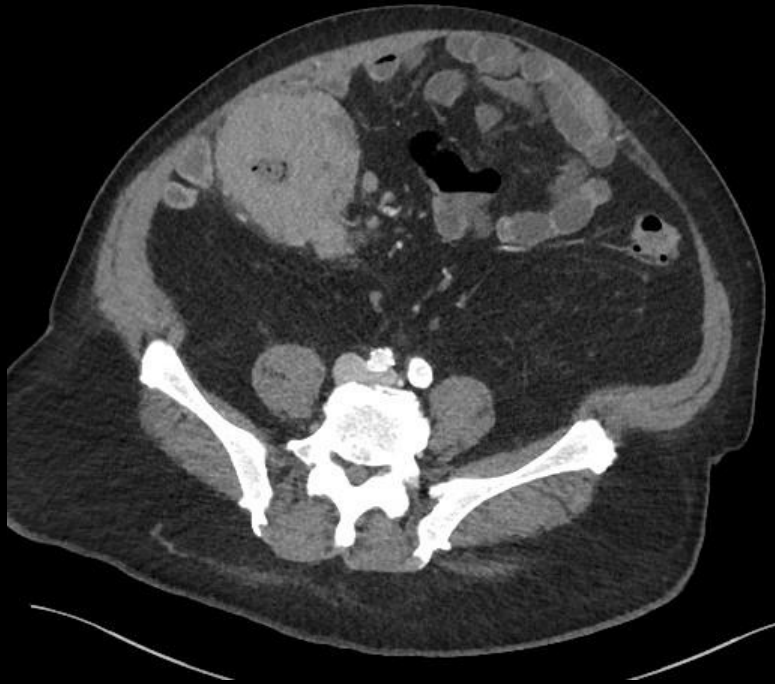
Variant: 5 Lower gastrointestinal tract bleeding. Obscure (nonlocalized) recurrent bleeding in a hemodynamically stable patient (assumes a prior negative adequate colonoscopy and upper gastrointestinal endoscopy). Next procedure or intervention.

Procedure	Appropriateness Category
Capsule endoscopy	Usually Appropriate
CT enterography abdomen and pelvis with IV contrast	Usually Appropriate
RBC scan abdomen and pelvis	May Be Appropriate
RBC scan with SPECT or SPECT/CT abdomen and pelvis	May Be Appropriate
Push enteroscopy	May Be Appropriate
Transcatheter arteriography/embolization	May Be Appropriate (Disagreement)
MR enterography	May Be Appropriate
Surgery	Usually Not Appropriate
Fluoroscopy small bowel follow-through	Usually Not Appropriate

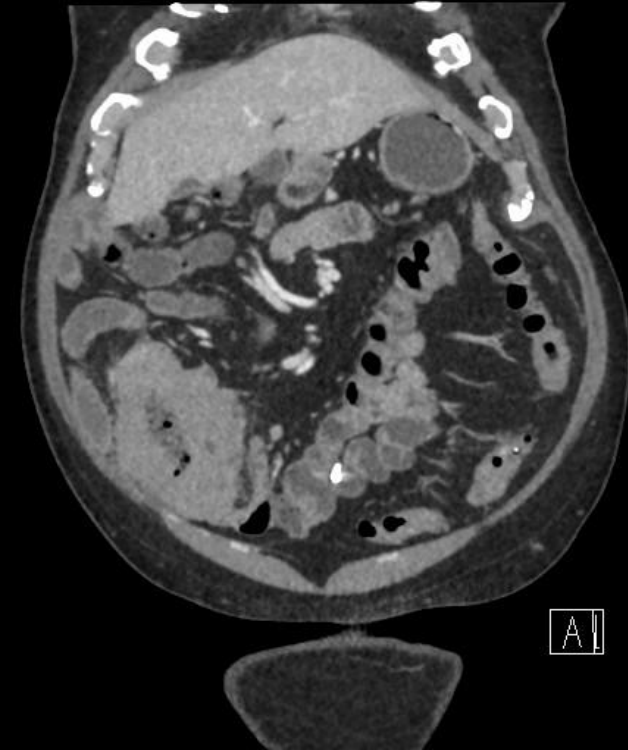
This imaging modality was ordered by the GI consulting team

Findings (unlabeled)

CT enterography with IV
contrast

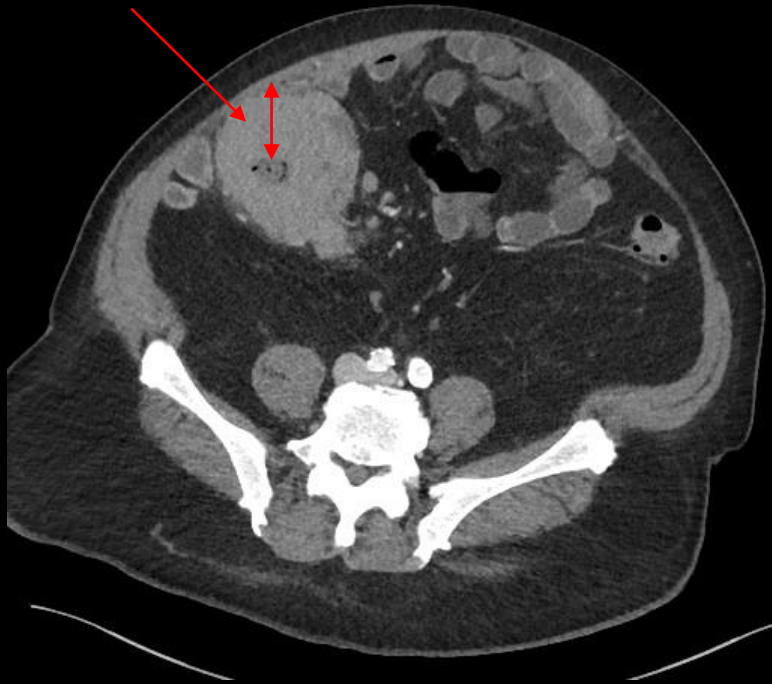


CT enterography with IV contrast



Findings (labeled)

Thickening of terminal ileum wall due to homogenously enhancing soft tissue mass



CT enterography with IV contrast

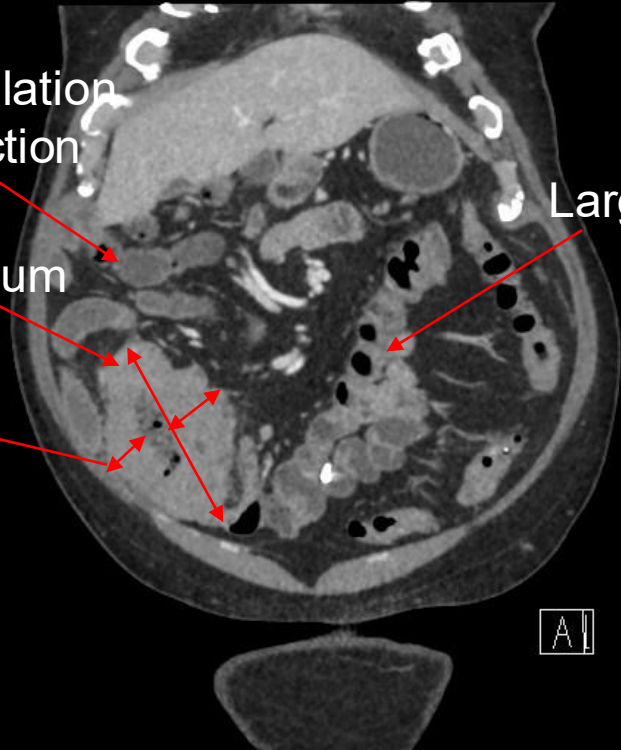
CT enterography with IV contrast

Small bowel, no dilation to suggest obstruction

12.3 cm long terminal ileum mass

Terminal ileum wall thickening

Large bowel



Due to patient's congenital midgut malrotation, the majority of his small intestine is in the right hemiabdomen and his large bowel is in the left hemiabdomen

Findings: (unlabeled)

DWI MRI



ADC MRI



Findings: (labeled)

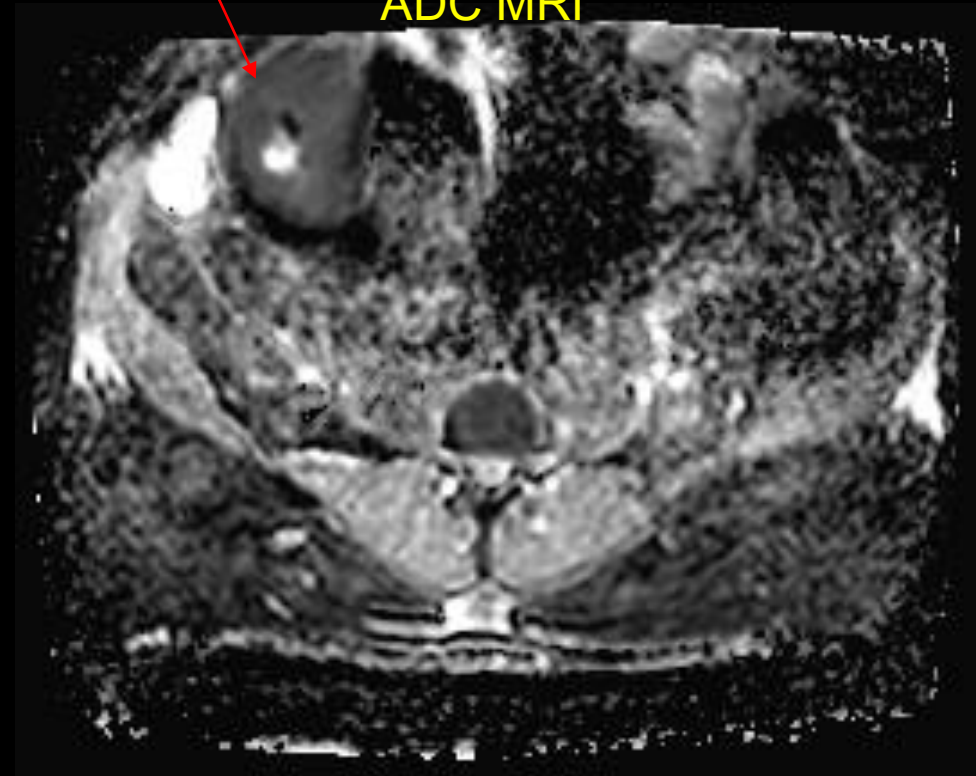
Hyperintense signal in terminal ileum mass

DWI MRI



Low ADC signal within the mass

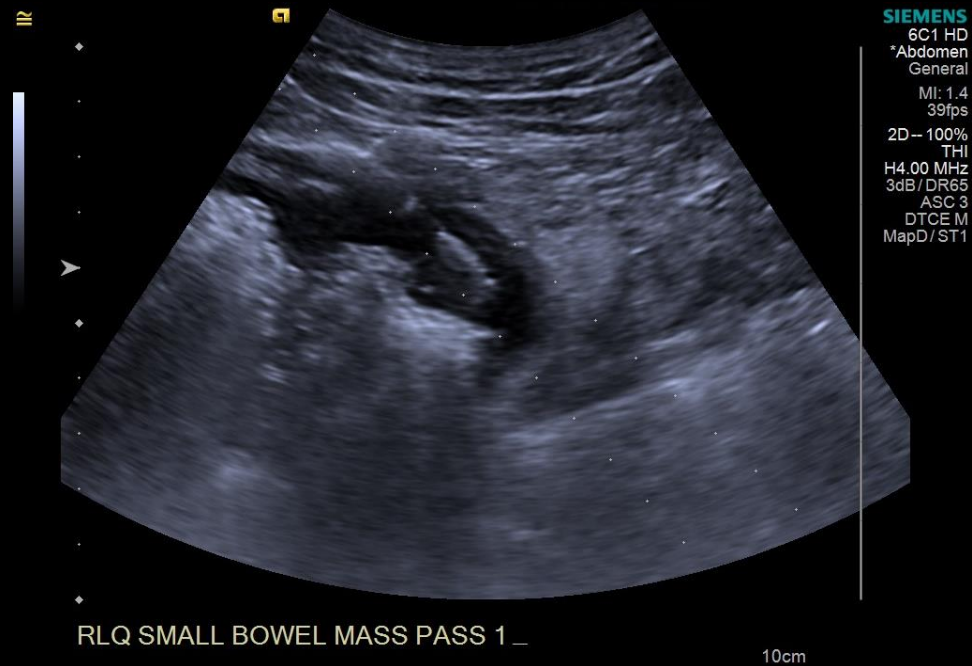
ADC MRI



Terminal ileum mass shows true restricted diffusion as demonstrated by high DWI signal and low ADC signal, indicating a highly cellular mass

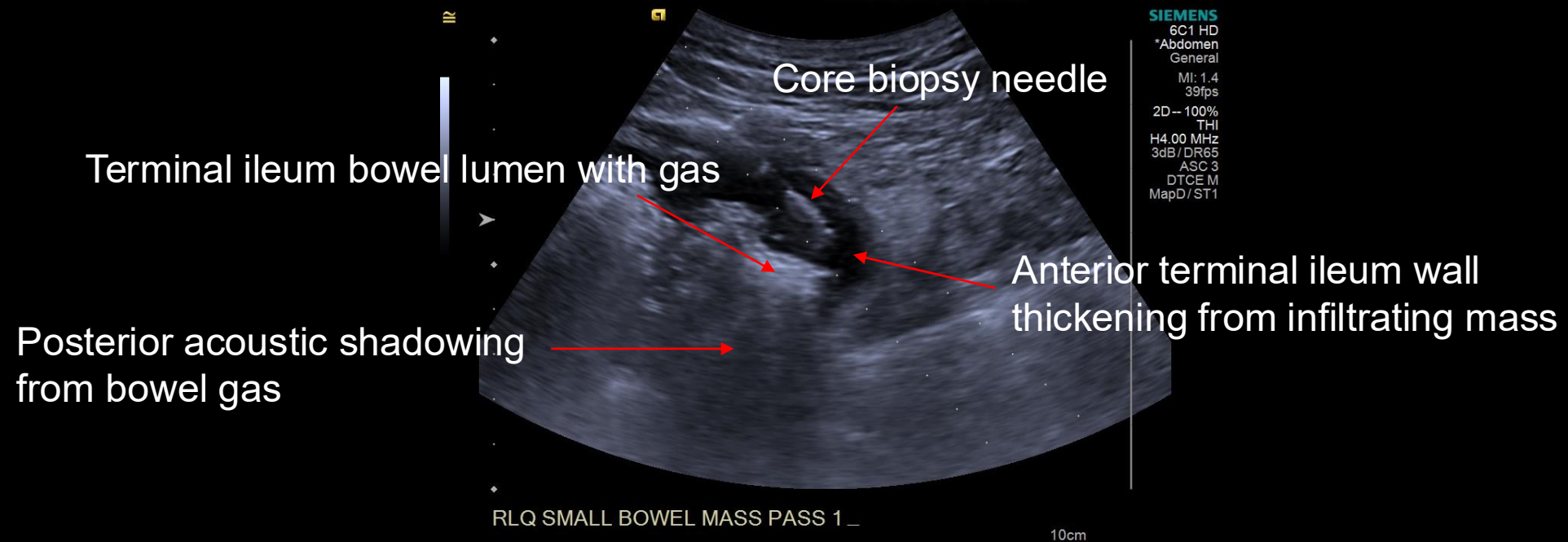
Findings: (unlabeled)

RLQ US guided percutaneous
biopsy of small bowel mass



Findings: (labeled)

RLQ US guided percutaneous
biopsy of small bowel mass



Hospital Course

- Patient's hospital course was c/b bowel perforation, and he underwent surgical resection of the perforated ileal mass and a subtotal colectomy
- Biopsy of ileal mass confirmed diffuse large B cell lymphoma
- Immunohistochemistry: +CD10, +CD19, +CD20, +CD45
- FISH: c-MYC and BCL2 rearrangement (aggressive double-hit phenotype)
- PET-CT for staging did not show any hypermetabolic lesions, no concern for metastatic spread
- Patient received modified Ann Arbor stage IE and IPI score 3, suggesting poor prognosis
- Patient received 5 cycles of R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone)

Final Dx:

Diffuse large B cell lymphoma

Discussion

Epidemiology:

- Diffuse large B cell lymphoma (DLBCL) is the most common type of non-Hodgkin lymphoma¹
- Median age of diagnosis is in mid-60s¹
- 30-40% present with extranodal disease, with DLBCL representing the most common primary lymphoma of the GI tract²
- Risk factors: autoimmune disease, family history, and viral infection (EBV, HBV, HCV)¹
- DLBCL is associated with greater risk of bowel perforation than other GI lymphomas³
- High-grade B cell lymphoma subtype (double hit MYC and BCL2/BCL6 rearrangement as seen in this patient) confers a poorer prognosis⁴

Discussion

Radiographic findings in DLBCL:

- Homogenous gastric/intestinal wall thickening⁵
- Aneurysmal bowel wall dilation d/t mass infiltrating muscularis propria⁵
- May cause bowel wall necrosis or bowel obstruction

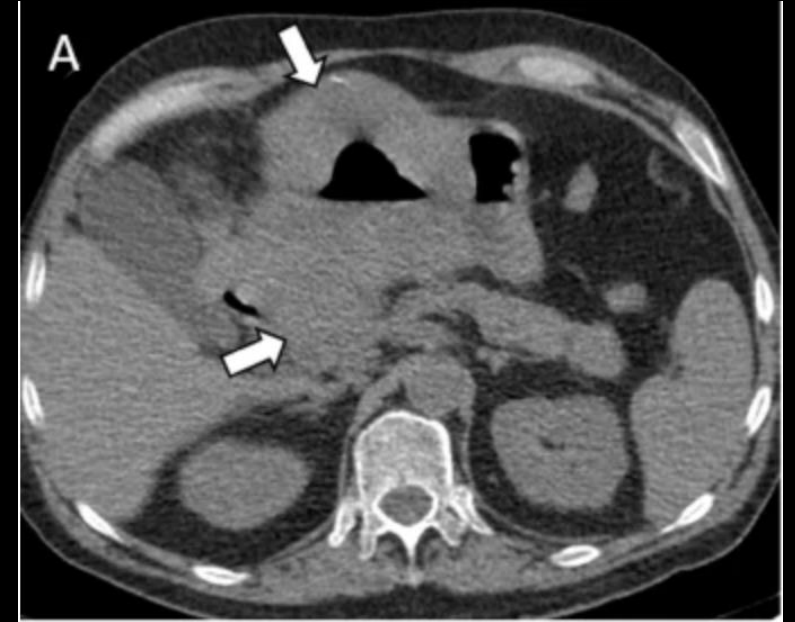


Figure 1. Non-contrast CT for a patient with DLBCL in the stomach. White arrows show gastric wall thickening.⁵

Discussion

Diagnosis:

- Excisional or core needle biopsy needed to confirm diagnosis
- Immunohistochemistry shows pan B-cell marker expression: CD10, CD19, CD20¹
- FISH shows MYC, BCL2 and/or BCL6 rearrangements¹
- PET-CT for staging

Treatment:

- R-CHOP is first line treatment for early-stage disease; more aggressive subtypes may benefit from other combinations of immunochemotherapy⁶

References:

- 1. Berhan A, Almaw A, Damtie S, Solomon Y. Diffuse large B cell lymphoma (DLBCL): epidemiology, pathophysiology, risk stratification, advancement in diagnostic approaches and prospects: narrative review. *Discov Oncol*. 2025;16:184. doi:10.1007/s12672-025-01958-w
- 2. Howell JM, Auer-Grzesiak I, Zhang J, Andrews CN, Stewart D, Urbanski SJ. Increasing incidence rates, distribution and histological characteristics of primary gastrointestinal non-Hodgkin lymphoma in a North American population. *Can J Gastroenterol*. 2012;26(7):452-456. doi:10.1155/2012/480160
- 3. Vaidya R, Habermann TM, Donohue JH, et al. Bowel perforation in intestinal lymphoma: incidence and clinical features. *Ann Oncol*. 2013;24(9):2439-2443. doi:10.1093/annonc/mdt188
- 4. Sehn LH, Salles G. Diffuse Large B-Cell Lymphoma. *N Engl J Med*. 2021;384(9):842-858. doi:10.1056/NEJMr2027612
- 5. Hanafy AK, Morani AC, Menias CO, et al. Hematologic malignancies of the gastrointestinal luminal tract. *Abdom Radiol*. 2020;45(10):3007-3027. doi:10.1007/s00261-019-02278-8
- 6. Chong EA, Tomasulo EB, Barta SK. 2026 Update on the Management of Diffuse Large B-Cell Lymphoma. *Am J Hematol*. 2026;101(4):832-863. doi:10.1002/ajh.70229