

## **Case study**

### **Mandibular Non-Hodgkin's Lymphoma mimicking as Dentoalveolar abscess - a rare case report**

#### **Abstract**

Mandible remains a site of swelling for number of diseases including infection, cyst, and tumors. A few rare lesions without any pathognomic and radiological features may cause diagnostic predicament. Diffuse large B-cell lymphoma, a rare form of extranodal non-Hodgkin's lymphoma accounts for 0.1 – 0.2% of cases in oral cavity, and occasionally appears in the mandible. We report a case of diffuse large B-cell lymphoma in a 77-year-old male patient. The patient presented with firm, mild painful swelling on the left lower face with history of non-healing extraction socket and enlarged left submandibular lymph nodes leading to a provisional diagnosis of chronic dental infection or dentoalveolar abscess. Incisional biopsy from the lesion and immunohistochemistry study confirmed the diagnosis of diffuse large B-cell lymphoma of left mandible.

**Keys word:** Diffuse large B-cell lymphoma, immunohistochemistry and mandible.

#### **Introduction**

Lymphomas are a diverse group of neoplasm affecting the lympho-reticular system. It is divided into Hodgkin's disease and Non-Hodgkin's disease. Hodgkin's type commonly presented as nodal disease, often involving cervical, axillary and inguinal nodes. Whereas non-Hodgkin's disease has extra-nodal presentation and can occur in stomach, salivary glands and rarely in oral cavity and jaw [1]. Primary non-Hodgkin's lymphomas (NHL) of

bone are quite rare, but among jaw lesions, they more frequently arise in the maxilla than in the mandible [1].

NHL of bone formerly referred to as reticulum cell sarcoma of bone, represents 7% of primary bone tumors and 5% of all primary extranodal NHL [2,3]. The most common histologic type is diffuse large B-cell lymphoma (DLBCL) accounting for approximately 30% of all NHL [4]. Most of DLBCL arises in lymph nodes. However, 40% of these malignancies arise in extranodal sites; most commonly the gastrointestinal tract, skin, and Waldeyer's ring [5]. Lymphomas arising within the oral cavity accounts for less than 5% of all oral malignancies and approximately 85% of the lesions involve the tonsils and palate [6]. Here, we reported a case of primary DLBCL of the mandible, presenting as diffuse swelling on the left side body of the mandible.

### **Case report**

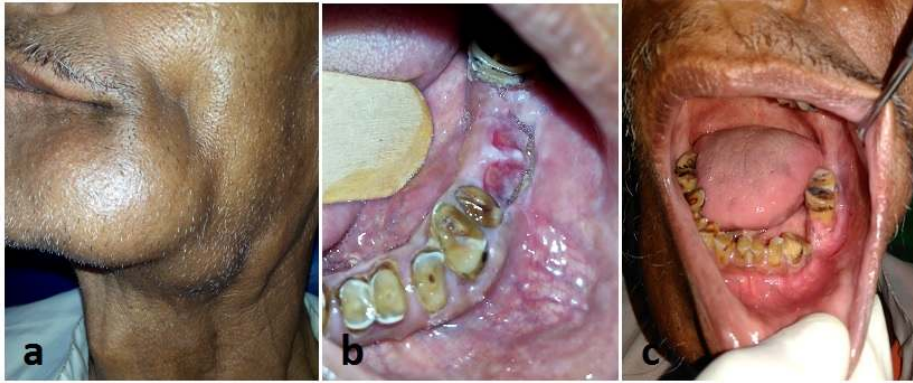
A 77-year old male patient presented with firm, mild painful swelling on the left lower face with a duration of two months. The swelling was gradual in onset and increases to present size with facial asymmetry. The patient had past history of loosening of left side tooth with extraction of 36 mobile teeth and received antibiotics for one month without any significant clinical improvement.

Extraoral examination revealed a solitary swelling extending from left parasymphysis region to body of mandible measuring about 2.5×2cm in size, firm to hard in consistency with smooth surface with normal overlying skin and a mobile left submandibular lymphadenopathy of size approximately 1x1cm (figure-1a). Intra oral examination showed the swelling was extended from 32 to 37 tooth regions obliterating the buccal vestibule,

44 with non-healing 36 socket region and lateral expansion of the buccal cortical plate (figure-  
45 1b). Patient had history of smoking (10years), poor oral hygiene, generalized attrition, and  
46 calculus deposit. Orthopantogram showed radiolucency with irregular destruction of bone  
47 extending 32-37 tooth regions (figure-2a).

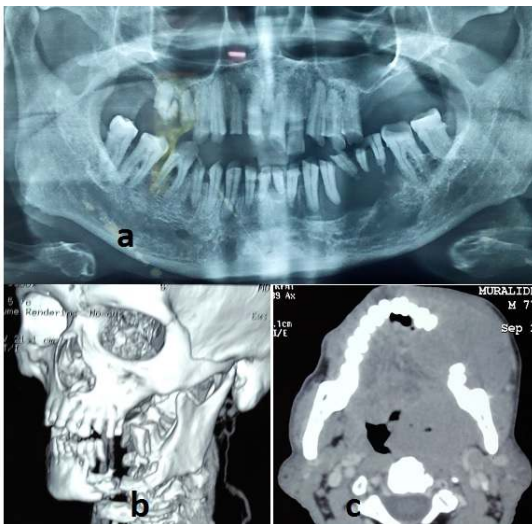
48 Indurated non-healing extraction socket, smoking history and atypical clinical finding raised  
49 a suspicion of malignancy. Incisional biopsy from the lesion was performed which showed  
50 diffuse sheets of round to oval tumor cells with scanty cytoplasm, vesicular nuclei with prominent  
51 nucleoli revealing features of round cell tumor possibly NHL with differential diagnosis of other  
52 round cell tumors (poorly differentiated squamous cell carcinoma, small cell osteosarcoma,  
53 neuroblastoma, Ewing sarcoma) (figure-3a). Immunohistochemistry study showed positivity  
54 for LCA, CD20, and negative for CK, S100, HMB 45, Vimentin with a high proliferative index  
55 (MIB1 = 60%) confirming the diagnosis of DLBCL (figure-3b, -3c).

56 Due to communication breach, the patient reported after 2months and contrast enhanced  
57 CT (CECT) scan showed complete destruction of both buccal and lingual cortical plates with  
58 enlargement of the ulcerative growth (figure-2b, -2c). Serum lactate dehydrogenase (LDH),  
59 CECT scan of thorax, abdomen and pelvis, and bone marrow biopsy were found to be  
60 normal and diagnosed as NHL of mandibular primary with clinical stage I disease. The  
61 patient was treated with radical chemotherapy followed by radiotherapy. The patient had  
62 received six cycles of chemotherapy with R-CHOP regimen (Rituximab, Cyclophosphamide,  
63 doxorubicin, vincristine and Prednisolone) under proper dose schedule, followed by  
64 involved field radiotherapy (IFRT) of 40 GY in 20 fractions. The patient was disease free with  
65 normal healthy oral mucosa (figure-1c) after one year of follow-up.



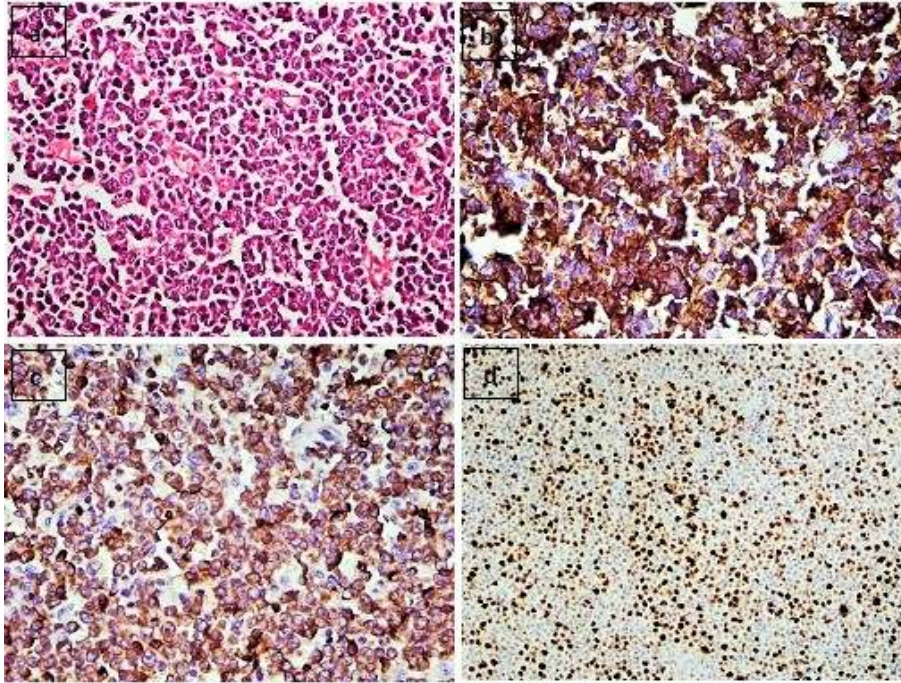
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67 Figure-1: Showing a) Swelling over left side body of the mandible, b) Non-healing socket  
 68 with respect to 35-36 tooth regions with swelling of the left vestibule, and, c) Post-  
 69 treatment normal healthy mucosa.



70

71 Figure-2: a) Orthopantomogram showing ill-defined radiolucency extending from the 32 -37  
 72 tooth regions, b) and c) CECT scan showing bicortical bone destruction with extension of the  
 73 lesion.



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75 Figure-3: Showing a) histopathology (H & E stain 400X): Diffuse sheets of round to oval  
 76 tumor cells with the scanty cytoplasm, vesicular nuclei with prominent nucleoli  
 77 Immunohistochemistry study showing b) CD20 positive, c) BCL-2 positive, d) MIB1 (60%)

## 78 Discussion

79 NHL is broadly classified into two groups: B-cell lymphoma and T-cell lymphoma. According  
 80 to WHO classification (2001), DLBCL is a special entity placed under the mature peripheral B-  
 81 cell neoplasm group [7].

82 Extra nodal presentation is seen in 40% of the NHL [8] and 2-3% of these found as oral  
 83 cavity and jaw primary. Majority presents in the age group of 6th and 7th decades of life and  
 84 commonly seen in the maxilla [9]. Present case was found at the age of 77 years with a  
 85 diagnosis of DLBCL at a rare site of location as mandible primary. To our knowledge, there  
 86 are only a few cases were reported.

87 DLBCL is a high-grade B-cell NHL, but the present case is without any significant  
88 aggressiveness of the tumor presenting as stage I disease. Due to uncommon incidence and  
89 non-specific symptoms, primary NHL of the mandible or jaw is often misdiagnosed for a  
90 dental infection [10,11]. Biopsy is commonly performed after poor response to antibiotic  
91 treatment, non-healing ulcer or extraction socket.

92 WHO diagnostic criteria for primary lymphoma of the bone is a primary focus in a single  
93 bone with no evidence of distant soft tissue or lymph node involvement. According to Coley  
94 (1950), the criteria for diagnosis of bone primary is lymphoma presenting in an osseous site  
95 with no evidence of disease elsewhere for at least 6 months after diagnosis [10].

96 Parrington et al. have discussed a case of primary lymphoma of the mandible presenting  
97 after tooth extraction [12]. Leva Djavonmardi et al. have reviewed 16 cases of NHL of the  
98 jaws and found that diagnosis was usually difficult and often misleading and delayed before  
99 the first bone biopsy [13]. The present case also misdiagnosed and treated as dento-alveolar  
100 abscess. Gusenbauer et al. emphasized that malignant lymphoma must be considered in the  
101 differential diagnosis of unexplained dental pain and swelling of the mandible [14]. In non-  
102 healing extraction socket with irregular bone destruction NHL is one of the differential  
103 diagnosis.

104 Bone swelling is the frequent clinical presentation in jaw lymphoma, often associated with  
105 teeth mobility, pain and neurological disturbance as in the present case. Histopathology  
106 usually shows sheets of chronic inflammatory cells, especially lymphocytes, mimicking an  
107 inflammatory lesion. Careful examination by a skillful pathologist is necessary. In DLBCL  
108 careful microscopic examination showed presence of particular types of large cancerous

lymphocytes spread diffusely throughout the biopsy specimen, cells are spread about rather than in clusters and should be confirmed by immunohistochemistry study.

Localized low-grade lymphomas are treated with radiotherapy, while aggressive chemotherapy is used for diffuse high-grade ones. A combination of chemotherapy and radiotherapy is used to treat the patients with localized high-grade lymphomas. Surgical approach is limited to obtain a specimen sufficient for a complete histological examination [15]. As DLBCL is an aggressive, rapidly growing neoplasm, a combination of chemotherapy and radiotherapy would be the most appropriate choice and this chemo-radiotherapy was adopted in our case with disease free for one year follow-up. The prognosis is excellent in localized disease, whereas in disseminated disease, it is less favorable [9].

## **Conclusion**

Lymphoma of the mandible being a rare disease and may be considered in the differential diagnosis of long-standing, unhealed extraction wound. Early diagnosis and treatment for such disease results in improved survival outcome. With the rising incidence of extra-nodal lymphomas, clinician may not take laxity on any oro-facial swellings at their face values; on the contrary the histopathology consideration may be given priority to plan an appropriate treatment to yield improving results.

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