Successfully cured primary esophageal lymphoma in a patient with acquired immune deficiency syndrome (AIDS)

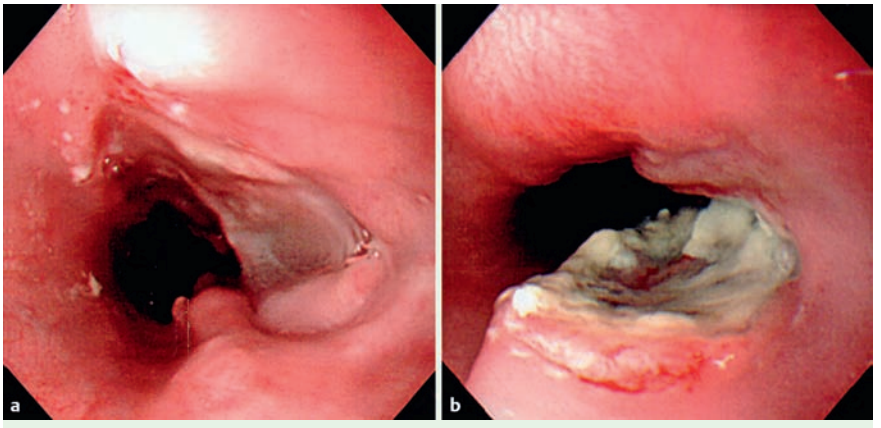

Fig. 1 Esophagogastroduodenoscopy showing ulcerative masses in: **a** upper esophagus; and **b** mid-esophagus.

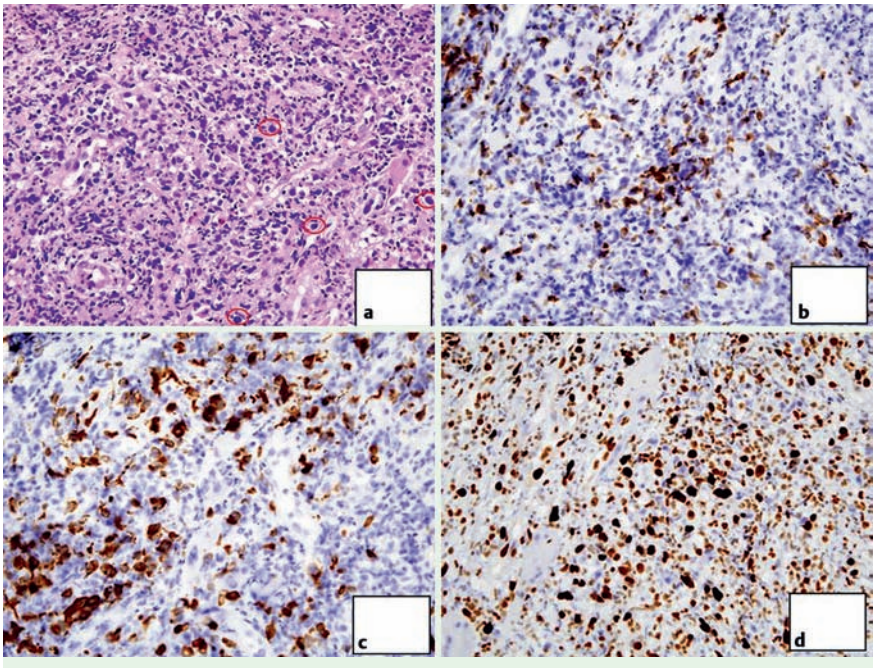

Fig. 2 Photomicrographs (× 400) of the endoscopic biopsy from the upper esophagus. **a** Multiple atypical large lymphoid cells (within the red circles) infiltrating the esophageal mucosa (hematoxylin and eosin [H&E] stain). **b** The large lymphoid cells stained negatively for the T-cell marker CD3. **c** However, the large lymphoid cells were strongly positive for the B-cell marker CD79a. **d** The large lymphoid cells stained strongly for Mib-1, reflecting a high proliferation index.

The esophagus is an infrequent site for primary presentation of human immunodeficiency virus (HIV)-associated extranodal non-Hodgkin's lymphoma (NHL) [1]. Although rare, this disease should be suspected in patients with acquired immunodeficiency syndrome (AIDS) who have recurrent esophageal symptoms and esophageal ulcerations or a mass not responding to antiviral or antifungal therapy [2]. Endoscopy is essential to pathologic diagnosis, serving as a useful tool for differential diagnosis of esophageal diseases seen in AIDS patients. We report a completely healed case of esophageal NHL in an HIV-seropositive patient.

A 39-year-old man diagnosed as having AIDS 6 years ago presented with odynophagia and dysphagia since 2 months for both solids and liquids. Esophagogastroduodenoscopy (EGD) revealed two lesions (**Fig. 1**): the lesion in the upper esophagus showed mild inflammatory changes around an ulcer with a dirty base, whereas the mid-esophageal lesion, which was protruding into the lumen, consisted of an ulcer with irregular margins and a whitish layer on the top.

Pathologic examination confirmed these lesions as NHL of diffuse large B-cell type (**Fig. 2**).

There was no notable abnormality in the thorax, abdomen, or pelvis, except for suspected mild wall thickening in the upper and mid-esophagus on computed tomography. Bone marrow biopsy showed normocellular marrow and normal karyotype, resulting in a definitive diagnosis of primary malignant lymphoma confined to the esophagus. Combination chemotherapy with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) was administered every 3 weeks, in conjunction with highly active antiretroviral therapy (HAART) (zidovudine, lamivudine, and indinavir). After 6 cycles of chemotherapy, the patient has been in a state of complete remission for nearly 3 years. A follow-up EGD 4 years after diagnosis (**Fig. 3**) showed completely healed lesions with a minute persistent deformity.

The endoscopic findings of HIV-seropositive primary esophageal lymphoma are variable, with no proven pathognomonic features. Histologic diagnosis is challenging; therefore, repeated endoscopic biopsies followed by empirical therapy and follow-up examinations are important and required for confirmation of diagnosis [3].

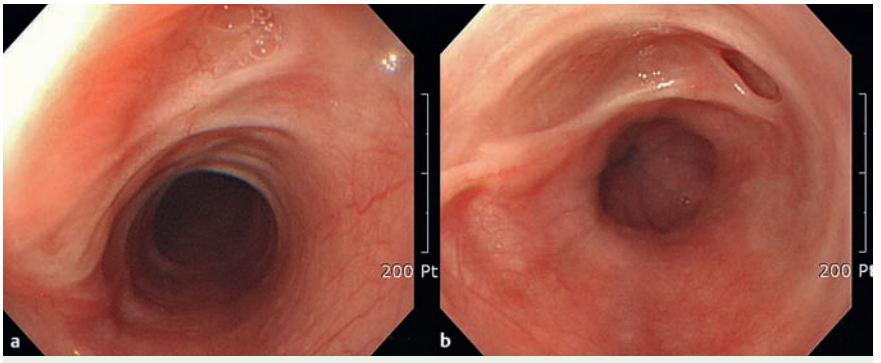

Fig. 3 After intensive chemotherapy targeted at the non-Hodgkin's lymphoma in the esophagus, endoscopic examination showed complete healing of the previously ulcerated and elevated lesions, with slight diverticular changes in the mid-esophageal lesion: **a** upper esophagus; and **b** mid-esophagus.

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Bibliography
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