

# MALToma of the Transverse colon, Ascending colon and Caecum: A Case Report

Case Report

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## ABSTRACT

### BACKGROUND

The stomach is the most common site formucosa – associated lymphoid tissue [MALT] lymphoma (MALToma). MALToma of the colon is a rare occurrence. It is on this background that we report this case.

### METHODS

The case records a patient with a MALT lymphoma and a review of the literature on the subject using google, Medline and PubMed search as well as available literature on the subject were utilized.

### RESULT

We herein report a case of a 40-year-old male with mucosa – associated lymphoid tissue [MALT] lymphoma of the transverse colon, ascending colon and caecum. He presented with severe abdominal pains and a centrally located huge abdominal mass for which a surgical resection was done. Histologically the tumour was diagnosed as colonic maltoma because of the presence of lymphoepithelial lesions made up of wide proliferation of atypical lymphocytes which are infiltrating and destroying mucosal glands. Lymph nodes of the transverse mesocolon were involved. Patient was referred for surgical oncologic follow-up and chemotherapy post-operatively.

### CONCLUSION

Colonic MALToma is a very uncommon diagnosis in our environment and adequate surgical resection with adjuvant chemotherapy in cases with lymph node involvement is strongly advocated.

**Keywords:** Mucosa-associated lymphoid tissue lymphoma; MALToma; colon.

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## INTRODUCTION

MALT lymphomas occur in a variety of extranodal organs of which the gastrointestinal (GI) tract is the most common. The stomach is the most common site for GI MALT lymphomas [1]. On the other hand colonic maltoma is very rare and only a few cases have been reported over the years [2, 3].

In this report we describe a case of colonic MALToma in a 40 year old male with lymph node involvement.

## CASE REPORT

A 40-year- old male was referred to the surgical outpatients' clinic of Federal Medical Centre, Yenagoa in 2011 with a 3 month history of central abdominal mass, frequent, non-mucoid, watery and occasionally bloody stools. There was a one week history of severe colicky abdominal pains with some weight loss.

On examination, he was in severe painful distress, pale and dehydrated. His pulse rate was 88beats/ minute, blood pressure 110/70 mmHg and temperature 37.4°Celsius. His chest was clear. His abdomen was full with an umbilical hernial defect 4cm wide with visible peristalsis. There was a centrally located, hard, tender and mobile intra-abdominal mass about 14cm x 7cm in dimensions. Liver and spleen were not palpably enlarged. Bowel