Unusual manifestations of type II cryoglobulinaemia associated with Waldenström’s macroglobulinaemia

P Blanco, J-F Viallard, J Rivel, B Leng, J-L Pellegrin

Abstract

Cryoglobulinaemia in association with Waldenström’s macroglobulinaemia is relatively common, ranging from 8% to 18% of cases; however, < 5% have symptoms or complications. We describe a patient with a history of cutaneous, peri- toneal, and fallopian tube vasculitis related to type II cryoglobulinaemia associated with Waldenström’s macroglobulinaemia. Cytotoxic treatment was initiated (cyclophosphamide, vincristine, and prednisone) and had a good initial response. However, after the third course of chemotherapy, the patient presented with septic shock and died. Even though cryoglobulinaemia is a model of systemic vasculitis, peritoneal and fallopian tube vasculitis associated with type II cryoglobulinaemia has not been described previously.

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Keywords: cryoglobulinaemia; Waldenström’s macroglobulinaemia; peritoneum; fallopian tube

First described in 1944,1 Waldenström’s macroglobulinaemia is thought to be a lymphoproliferative disease characterised by a clonal proliferation of B cells or lymphoplasmacytic cells in the bone marrow and/or lymph nodes, and monoclonal IgM in the plasma. Cryoglobulinaemia in association with Waldenström’s macroglobulinaemia is relatively common, ranging from 8% to 18% of cases.2 However, < 5% of patients have symptoms or complications. Its main clinical manifestations are systemic vasculitis, arthralgias, myalgias, vascular purpura, glomerulonephritis, peripheral neuropathy, and cardiac involvement1; gastrointestinal symptoms induced by cryoglobulinaemia are unusual and peritoneal involvement has never been described. Here, we report a patient presenting with cutaneous, peritoneal, and fallopian tube vasculitis related to mixed cryoglobulinaemia associated with Waldenström’s macroglobulinaemia.

Case report

A 57 year old white woman was referred to hospital because of a two week history of intermittent fever, fatigue, 5 kg weight loss, several nodular purpuric cutaneous lesions, arthralgias of her ankles, wrists, metacarpophalangeal joints and shoulders, abdominal pain with diarrhoea and vomiting. On physical examination, she was pale and pyrexial (39°C). There was a palpable nodular purpura of the legs and no arthritis. A splenomegaly was present with a diffuse abdominal tenderness but no contracture. There was no peripheral lymphadenopathy and neurological examination was normal. Routine haematological tests revealed: haemoglobin, 99 g/litre; white blood cell count, 4.4 × 10⁹/litre; platelets, 289 × 10⁹/litre, erythrocyte sedimentation rate, 107 mm in the first hour; and C reactive protein, 107 mg/litre (normal, < 10). Results of blood chemical tests were unremarkable (serum electrolytes, urea, creatinine). Serum protein was 50 g/litre and immunoelectrophoresis disclosed an IgM κ paraprotein. Bence-Jones protein was detected in the urine and serum immunoglobulin values were as follows: IgG, 0.24 g/litre; IgM, 1.09 g/litre; IgA, 0.28 g/litre. Immunological studies (antinuclear antibodies, antineutrophil cytoplasm antibodies) were negative except for the presence of rheumatoid factors. C4 concentrations were dramatically low (0.07 g/litre; normal range, 0.2–0.4 g/litre). Serological tests for virus infection were negative (Epstein-Barr virus, cytomegalovirus, hepatitis B and C virus, human immunodeficiency virus 1 and 2). There was a mixed cryoglobulinaemia (35 mg/litre) with an IgM monoclonal component. The IgM was an autoantibody with rheumatoid factor activity. Culture of blood and urine specimens yielded no microorganism. A bone marrow aspirate demonstrated infiltration with lymphocytoid plasma cells and mature plasma cells. Chest and abdominal computed tomography (CT) disclosed mediastinal, paratracheal, and retroperitoneal lymphadenopathies and a splenomegaly. In addition, there was an irregular nodular mass (7 × 8 cm) involving the peritoneum, ovaries, and fallopian tubes. The ovarian mass was resected and biopsies of the peritoneum and fallopian tubes were performed. They revealed leucocytoclastic vasculitis with fibrinoid necrosis (figs 1 and 2). Pathological study of the ovarian mass revealed a benign tumour.

The patient was diagnosed as having Waldenström’s macroglobulinaemia with mixed cryoglobulinaemia and systemic vasculitis (peritoneal, fallopian tubes, and cutaneous). Cytotoxic treatment was initiated (cyclophosphamide, vincristine, and prednisone) resulting in a good initial response. Abdominal symptoms decreased, and arthralgias and purpura of the legs were absent after two courses of
III cryoglobulinaemia is mainly noted as the cause of clinical disease in several series, type I and II cryoglobulins are more commonly associated with immunoproliferative disorders. Cryoglobulinaemia in association with Waldenström's macroglobulinaemia occurs in 8–18% of patients, and consists of either monoclonal IgM (type I) or mixed immunoglobulin complexes in which monoclonal IgM behaves as an antibody against polyclonal IgG (type II), as in our case. Fewer than 5% of cases of cryoglobulinaemia associated with Waldenström's macroglobulinaemia are symptomatic; they usually involve type I cryoglobulins and cryoglobulinaemia might have an unfavourable role regarding the prognosis of the disease.7 Patients with symptomatic cryoglobulinaemia have many different manifestations of vasculitis, including renal involvement with rapidly progressive glomerulonephritis, purpura, leg ulcers, polyarthralgia, Raynaud's phenomenon, liver involvement, and peripheral neuropathy. To our knowledge, vasculitis involving the peritoneum and the fallopian tubes secondary to type II cryoglobulinaemia has not yet been described.

Peritoneal or mesenteric vasculitis has been reported in association with periarteritis nodosa, rheumatoid arthritis, Henoch-Schoenlein purpura, Wegener's granulomatosis, systemic lupus erythematosus, and Churg-Strauss syndrome, but never in mixed cryoglobulinaemia. Typical features include diffuse non-specific abdominal pain progressing on occasion to gastrointestinal haemorrhage, perforation, or more rarely infarction. By contrast, isolated cases of ovarian or fallopian tube necrotising vasculitis have been reported both in association with periarteritis nodosa, and as a rare finding in routine gynaecological surgery, especially when this involves the cervix, uterus, or oviduct.10 We think that the ascites with slightly increased peritoneal enhancement, and possibly the abdominal pain that occurred in our patient, might be ascribed to the concurrent peritoneal serositis. This notion was strengthened by the simultaneous relief of clinical symptoms and resolution of ascites after treatment.

The pathological appearance of cryoglobulinaemia is a widespread vasculitis involving small and medium sized vessels usually resulting in ischaemia of the skin, nerve, and renal tissue. The cause of this vasculitis remains unclear. Cryoglobulins are thought to form complexes that activate inflammatory effectors and complement factors to induce vascular lesions characterised by neutrophil infiltration, deposition of immune complexes, and necrosis of the vessel wall.11

In conclusion, our case suggests that cryoglobulinaemia could be taken into consideration among the aetiologies of peritoneal and fallopian tube vasculitis. Clinicians should be aware of this uncommon complication, particularly in patients with associated lymphoid malignancy.

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