Immunocytological diagnosis of primary cerebral non-Hodgkin’s lymphoma

A P Lai, A S Wierzbicki, P M Norman

Abstract
Four men with primary cerebral non-Hodgkin's lymphoma diagnosed by immunocytological analysis of cerebrospinal fluid (CSF) presented with cranial nerve palsies. All had CSF lymphocytoses and low CSF glucose. The cell phenotypes were two T cell tumours, one B cell, and one null. A review of 13 previously recorded cases of immunocytologically diagnosed CNS non-Hodgkin’s lymphoma showed that there were 10 B cell, two T cell, and one null tumour. Overall (17 cases) the cell phenotype distribution was 65% B cell, 24% T cell, and 11% null. High CSF lymphocyte counts were found in 94%, proteinosis in 85%, and low CSF glucose in 87%.

In contrast to the B cell tumours, all of the T cell tumours were diagnosed by CSF cytology before being visualised radiologically. It is suggested that all CSF lymphocytes (>5 x 10^6/ml) should be immunohistochemically typed to permit earlier diagnosis of CNS non-Hodgkin’s lymphoma.

Central nervous system non-Hodgkin’s lymphoma is a rare form of neoplasia whose incidence has risen from 1% to 2.6% of cerebral tumours over the past five years. We present a series of four cases acquired over three years. These comprised 6% of all tumours diagnosed by cerebrospinal fluid (CSF) cytology.

Case histories
All the patients had been previously healthy and the clinical details of the four cases are summarised below.

Case 1
A 61 year old man presented with multifocal neuropathy, diplopia, a left sixth nerve palsy and headaches and had signs of papilloedema. Computed tomographic brain scanning showed a left optic nerve and corpus striatum tumour.

Case 2
A 66 year old man presented with multiple bulbar palsy. A computed tomogram showed a right cavernous sinus tumour, and three months later, a left ileopsoas tumour.

Case 3
A 17 year old boy presented with an acute confusional state, diplopia, and a left seventh nerve palsy. A computed tomogram showed no radiological abnormality.

Case 4
A 64 year old man presented with bilateral sixth nerve palsies and a right seventh nerve palsy. No radiological abnormality was detected.

Methods
Cerebrospinal fluid was obtained by lumbar puncture and two CSF cytopin preparations were prepared and stained by the Romanovsky method and the remainder were stained by standard immunocytochemical techniques after a provisional diagnosis had been made. The antibodies used in the lymphoma panel were anti-Ig, anti-HLA-DR, anti-CD3, anti-CD5, anti-CD10, anti-CD19, anti-CD25, and anti-CD45. Two separate positive specimens were required for a diagnosis to be made.

Results
The CSF biochemical and cytological findings are shown in Table 1. CSF biochemical showed pronounced proteinosis (19.4–51.0 g/l; reference limit 10 g/l), and a reduced glucose concentration (0.2–1.9 mmol/l; reference limits 4.5–6.5 mmol/l) in all four cases. All the CSF specimens were hypercellular (230–830 x 10^6/ml; reference limit 3 x 10^6/ml) and showed a predominance (>80%) of abnormal large malignant lymphoid cells. Results of CSF and blood serology and immunoblots were unremarkable in all cases. In two cases the diagnosis was confirmed by biopsy of the tumour deposit (cases 1 and 2) and in the others by biopsy of later secondary deposits. Histological analysis confirmed the cytological findings of two T cell lymphomas, one B cell and one with null staining on two occasions.

Discussion
The incidence of primary cerebral non-Hodgkin’s lymphoma is increasing; 25% of cases show meningeal infiltration at necropsy, and some cases have been diagnosed as a result of this by CSF cytology.

Meningitis is the commonest presentation of CNS non-Hodgkin’s lymphoma, but all our four patients presented with cranial nerve...
The four cases described here were large cell, of which one had a cleaved nuclear pattern. Overall, this changes the distribution of immunological subtypes in cytologically diagnosed CNS-non-Hodgkin’s lymphoma to 65% B cell (11 cases), 24% T cell (four cases), and 11% null (two cases). The four cases of T cell CNS-non-Hodgkin’s lymphoma had no radiologically visible tumour deposits at the time of diagnosis. The clinical importance of this finding is unclear as few cases of T cell CNS-non-Hodgkin’s lymphoma have been described.3

This study shows that cytological diagnosis of some lymphomas is possible before tumour deposits are detected radiologically. CSF cytology, however, is a specialised investigation and false positive results can occur with reactive processes, though the use of multiple sampling and immunohistochemical techniques increases the diagnostic reliability.7 We suggest that all unexplained persistent CSF lymphocytes should be viewed as suspicious and that efforts should be made to immunotype the cells present as earlier diagnosis would improve the prognosis of primary cerebral lymphoma.

We thank Dr R O Barnard for neuropathological advice and Mrs L Duddridge for secretarial assistance.
Primary squamous cell carcinoma of the terminal ileum

C C Platt, N Y Haboubi, P F Schofield

Abstract
A case of squamous cell carcinoma of the terminal ileum with no underlying duplication or inflammatory disorder is described. The neoplasm seemed to have originated from the surface epithelium, invading the wall and metastasising to the regional lymph nodes. The 65 year old patient was free of disease three years after having had the tumour removed.

Previous reports of squamous carcinoma of the small intestine have been associated with intestinal duplication or metastatic disease from distant sites.

Pathology
The resected specimen consisted of 40 cm of small intestine, the appendix, and 10 cm of large bowel with the associated mesentery. There was a fungating tumour sparing the terminal 5 cm of ileum but affecting the mucosa of the next 5 cm and spreading through the thickness of the wall into the mesentery. Focal areas of calcification were identified on cut section.

Paraffin wax sections showed the tumour to be a moderately differentiated keratinising squamous cell carcinoma arising from the surface epithelium. Intercellular bridges and keratinous cysts and pearls were prominent (figure). The tumour had infiltrated the wall and extended into the mesentery and paraintestinal lymph nodes. There was evidence of vascular invasion, but none of glandular differentiation or adenomatous change in any part of the tumour.

Mucin stains and Gremelius argyrophil stains were negative. Electron microscopical examination showed features typical of squamous cell differentiation. The neoplastic cells contained well formed tonofilaments, while microvilli, glycocalyeal bodies; mucinous granules were absent.

Discussion
The spread of tumour into the small bowel as a result of secondary squamous carcinoma has been well documented.1-3 Primary malignant tumours, however, are rare and the squamous carcinomas have so far been reported in cases of duplication.4

In the colon squamous cell differentiation is seen in about 0·05% of adenocarcinoma1 and in 0·4% of adenoma.6 The pathogenesis of squamous cell carcinoma of the colon is unknown but in some cases it has been associated with carcinoma