LETTER TO THE EDITOR

Response to the case report ‘oral presentation of diffuse large B-cell lymphoma: a rare entity’

We read with interest the case report by Hindocha and Nilsson on the oral presentation of diffuse large B-cell lymphoma (DLBCL) and would like to add to this with a case report of an uncommon variant of DLBCL which presented to us at the Department of Oral and Maxillofacial Surgery, the Royal London Dental Hospital.

A 76-year-old male was referred to us by his general dental practitioner (GDP) regarding a persistent fluctuant swelling in the left side of the hard palate. The patient reported that the swelling had been present for approximately three months at the time of presentation and was painful to touch with no associated bleeding, discharge or paraesthesia in the region. There was no recent history of dental treatment or surgery and no signs of infection. The patient suffers from essential hypertension and is under investigation for type 2 diabetes mellitus. He is an ex-smoker, having quit in 1990, and consumes approximately 10 units of alcohol each week.

Examination revealed no palpable extraoral masses in the head and neck region. Intraorally, there was a semi-fluctuant mass in the left side of the posterior hard palate measuring approximately 3 cm in diameter and the overlying mucosa was normal and mildly tender to touch. The teeth in the upper left quadrant were restored with no tenderness or obvious associated pathology.

A sectional DPT excluded a dental cause and revealed no associated abnormalities. An urgent MRI head was then organised along with an incisional biopsy of the lesion under local anaesthetic.

The MRI head confirmed a homogenous and mildly enhancing submucosal solid lesion causing focal erosion of the hard palate with parenchymal texture suggestive of a lymphoproliferative process (Fig. 1).

Histopathological analysis of the biopsy sample confirmed DLBCL (germinat centre cell type). DLBCL is the most common subset of non-Hodgkin

Figure 1 MRI head demonstrating the size and location of the palatal lesion.

Figure 2 PET-CT showing intense uptake in biopsy proven lymphomatous tissue arising from the left palate extending into the posterior left nasal cavity.
lymphoma (NHL), making up approximately 25% of all cases². Whilst the incidence of palatal lesions remains unclear, it has been reported that primary lymphomas of the oral cavity account for 2% of all extranodal lymphomas³.

Fluorescence in situ hybridisation (FISH) analysis revealed concurrent MYC and BCL2 oncogene rearrangement, known as double-hit lymphoma (DHL). DHL is an uncommon subset of DLBCL estimated to occur in between 5% and 12% of cases⁴. It is an aggressive form of lymphoma and portends a poor prognosis²⁴. In the latest WHO classification system, this is described as high-grade B-cell lymphoma (HGBL) with MYC and BCL2 translocations⁵.

Following the histopathological findings, an immediate haemato-oncology referral was made, the patient was seen the following week and several further investigations were arranged including a PET-CT (Fig. 2). Treatment involving chemo-immunotherapy was also discussed which commenced the following week.

We hope that this case raises further awareness of a sub-type of malignant lymphoma and draws attention to a possible clinical presentation that should be managed with high suspicion and referred appropriately by both general practitioners and those working in secondary/tertiary care.

Conflicts of Interest

Dr. Grossman, Dr. Dungarwalla and Dr. Jones have nothing to disclose.

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References