Not All Biopsies Are Made Equal, A Case of Lymphocyte Depleted Hodgkin Lymphoma
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INTRODUCTION

A 27-year-old male presented with sudden onset dyspnea and chest pain. The patient also reported six months of generalized weakness, 40 lbs weight loss, and had become bed bound. On presentation, the patient was cachectic, dyspneic, and tachycardic. The patient underwent emergent pericardiocentesis with pericardial drain placement for a large pericardial effusion (Figure D) with tamponade physiology.

Labs were notable for neutrophil predominant leukocytosis 28k/uL, CRP 158mg/L, elevated INR, Hepatitis C antibody positive, and lactic acidosis. Computed Tomography of chest/abdomen/pelvis revealed diffuse bulky lymphadenopathy and multiple splenic and hepatic lesions measuring up to 2.6 cm (Figure B, C, D). He was transferred to the Cardiac Intensive Care Unit (CICU) and treated for suspected distributive shock with vasopressors and empiric antibiotics. Flow cytometry, fine needle aspiration (FNA) and core lymph node biopsies were obtained. Over his CICU course, he continued to deteriorate clinically with increasing vasopressor requirements (max doses of three pressors), worsened liver function, increasing leukocytosis, and renal failure requiring continuous renal replacement therapy (CRRT).

Initial core biopsy, FNA biopsy, and pericardial fluid cytology results returned with no evidence of malignancy. He developed respiratory failure requiring intubation, and a bronchoscopy revealed a large endobronchial mass (Figure A).

He also underwent excisional lymph node biopsy which showed preliminary lymphoma, although final pathology results would be needed for final diagnosis. Given his overall clinical course and preliminary biopsy results, a risk/benefit discussion with the patient’s family resulted in chemotherapy with full dose Adriamycin, Vinblastine, and Dacarbazine due to the patient’s hepatic dysfunction.

Over the next seven days, the patient’s clinical condition improved with a dramatic decrease in his pressor requirements, improved leukocytosis and respiratory status. His final excisional lymph node biopsy revealed LDHL, with CD30 (+), CD20 (-), PAXS (+). However, the patient developed multi-organ-system-failure with worsening shock and passed away.

REFERENCES