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Letter to the Editor

Antineutrophil cytoplasmic antibody-associated vasculitis in diffuse large B cell lymphoma

Vasculitis asociada al anticuerpo citoplasma antineutrófilo en el linfoma difuso de células grandes B

Dear Editor:

A 70-year-old Japanese woman with a 57-year history of hepatitis C virus presented with nausea, abdominal pain, and renal dysfunction. Physical examination revealed splenomegaly. Blood examination revealed elevated levels of C reactive protein (2.7 mg/dL), serum creatinine (2.46 mg/dL), blood urea nitrogen (22 mg/dL), and uric acid (7.8 mg/dL). Test for myeloperoxidase-antineutrophil cytoplasmic antibody (MPO-ANCA) was positive (71.2 U/mL). Urinalysis showed proteinuria (0.56 g/gCr) and microhematuria (>100 red blood cells/high-power field). ^{18}F-fluorodeoxyglucose-positron emission tomography/computed tomography (FDG-PET-CT) revealed FDG accumulation in the cervical, thoracic, and abdominal lymph nodes and spleen (Fig. 1A). Abdominal computed tomography revealed splenomegaly with a low-density area (Fig. 1B). Renal biopsy specimen showed crescentic glomerulonephritis (Fig. 1C). Abdominal paraaortic

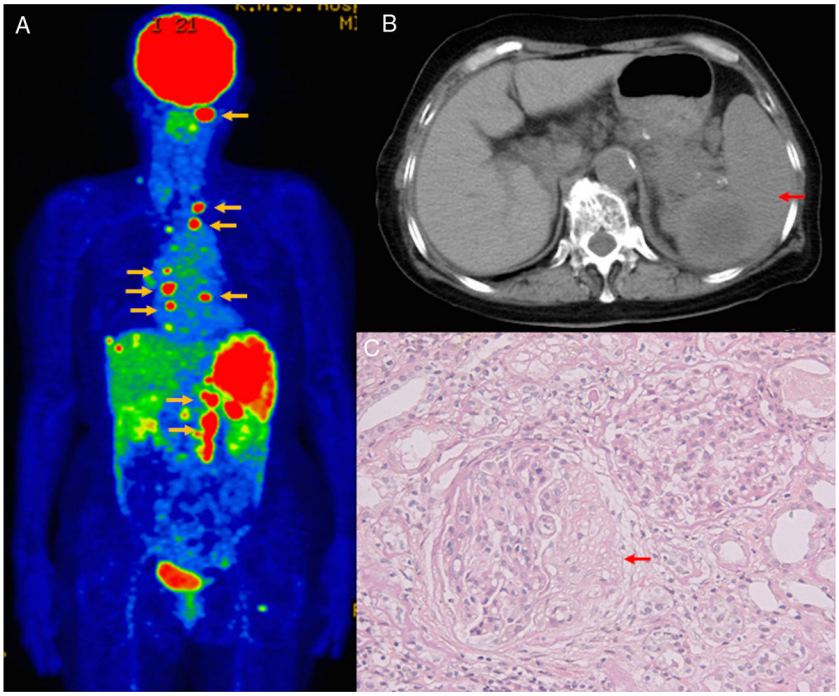

Fig. 1 – Findings of ^{18}F-fluorodeoxyglucose-positron emission tomography/computed tomography (FDG-PET-CT), abdominal enhanced CT, and renal biopsy. (A) FDG-PET-CT shows FDG accumulation in the cervical, thoracic, and abdominal lymph nodes (yellow arrows) and spleen, indicating widespread lymphadenopathy and splenomegaly. (B) Abdominal enhanced CT shows splenomegaly (red arrow) with a low-density area. (C) Renal biopsy specimen reveals crescentic glomerulonephritis with fibrocellular crescent (arrow, Periodic acid-Schiff stain).

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lymph node biopsy revealed diffuse large B cell lymphoma (DLBCL). Based on these findings, the patient was diagnosed with ANCA-associated vasculitis (AAV) and DLBCL with suspected splenic DLBCL. Treatment with R-CHOP regimen was initiated, and her renal function improved. However, no remission was noted for the DLBCL. The patient died 4 months later.

Although malignant lymphomas are occasionally complicated by autoimmune diseases,[1] complication with AAV is notably rare.[2] There have been recent reports of ANCA-positive cases with B-cell lymphomas, especially intravascular lymphoma.[3–6] These cases, have included proven[3,4] or unproven[5–7] AAV. Moreover, an ANCA-positive case with splenic malignant lymphoma without proven AAV, as in this case, has been reported.[7] Like the above cases with intravascular lymphoma and/or embolic damage,[5] vascular damage caused by B cell lymphomas appeared to predispose the patient to ANCA. There have been reports of successful R-CHOP therapy, including rituximab, for both lymphoma and AAV.[3–5] Recently, the RAVE[8] and RITUXVAS[9] trials demonstrated that rituximab is effective for AAV, especially renal AAV. This is the first case of DLBCL-related AAV with biopsy-proven crescentic glomerulonephritis, and although R-CHOP did not provide lymphoma remission, renal function improved. Thus, rituximab could be effective for improving renal function in AAV. Clinicians should consider the possibility of AAV occurring as a complication in DLBCL.

Informed consent was obtained from the patient for the publication of this article.

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