中文題目：多發性骨髓瘤併骨髓外質漿細胞瘤，合併大腸腺癌；案例報告及文獻回顧

英文題目：Multiple myeloma with plasmacytoma, coexistence with colon adenocarcinoma ; A Case Report and Review of Literature

作　　者：陳康盈[1]，劉益昌[1,2]

服務單位：[1] 高雄醫學大學附設醫院內科部; [2] 高雄醫學大學附設醫院血液腫瘤內科

Introduction:

Multiple myeloma (MM) is a neoplastic proliferation of monoclonal plasma cells. Although it is usually restricted to the bone marrow, extramedullary plasmacytoma (EMP) can occur and accounts for approximately 3% of all plasma cell neoplasms. It has been reported that most of the EMPs are located in the head and neck region, while only about 4% are of gastrointestinal origin. The incidence of EMPs is 7% to 18% at MM diagnosis. In this case report, we present a male patient who was diagnosed as MM with EMPs of neck lymph node and colonic plasmacytomas coexisting with colon adenocarcinoma. The initial presentations were supraclavicular mass, dyspnea, and sternal pain.

Case report:

A 78 years old man with hypertension, chronic kidney disease presented to our hematologist outpatient department due to enlarged right supraclavicular mass, sternal pain and dyspnea on exertion for a month. After admission, laboratory test showed normocytic anemia (hemoglobin 7.0 g/dL), thrombocytopenia (87000/ μ L); elevated creatinine level, hypercalcemia (ionized Ca+ 5.58 mg/dL), elevated IgA (3060 mg/dl) and free λ light chain level (>12400 mg/dL). Serum and urine immunofixation electrophoresis revealed monoclonal IgA lambda gammopathy. Bone marrow aspiration and biopsy confirmed plasma cell myeloma, with plasmablastic morphology . Cytogenetic study revealed multiple chromosome abnormalities. DSS stage III and ISS stage III was confirmed after staging workup. Bone marrow study confirmed plasma cell myeloma. In addition, CT of abdomen was done for highly suspicion of occult intra-abdominal malignancy related supraclavicular lymph node, and sigmoid colon cancer with regional metastatic lymph nodes was reported (radiological staging: cT4aN2aM0, stage IIIC). Adenocarcinoma was proven by biopsy via colonfiberscopy. Patient underwent anterior resection and end-to-end colo-colostomy for sigmoid colon cancer, and resection of supracalvicular mass at the same time. The pathology of supraclavicular mass showed plasma cell myeloma with plasmablastic morphology, consistent with bone marrow findings. Unexpectedly, the pathological characteristics of resected colon revealed sigmoid colon cancer, adenocarcinoma grade 2, pT2N0 without regional lymph nodes involvement, collided with many plasma cells with plasmablastic morphology, which was positive for CD138 and lambda light chain restriction. Therefore the pictures suggest a stage I sigmoid colon cancer, surrounded by myeloma cells with EMD, rather than advanced stage colon cancer. After the surgery,

the patient received first-line therapy with VTD (bortezomib + thalidomide + dexamethasone) for multiple myeloma, and close followup for stage I sigmoid colon cancer.

Conclusion:

We here report a case with EMPs at the diagnosis of MM, coexisting with colon adenocarcinoma, which was initially thought to have regional metastatic lymph nodes invasion, but turned out to be colloid with plasma cell. In review of literature, most of the EMPs of Gastrointestinal plasmacytomas are isolated and concurrent with second caner have never been reported in the literature. Here we present this unusual case to highlight the importance of considering this entity in the patient with concurrent extramedullary plasmacytoma and gastrointestinal cancer before the pathological characteristic was report. This may aid in the recognition of this rare disease, thus avoiding misdiagnosis and inadequate treatment.