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CYTOMEGALOVIRUS OESOPHAGITIS IN A PATIENT WITH NON-HODGKIN’S LYMPHOMA

Cytomegalovirus (CMV) infection is frequent in immunocompromised patients, especially in AIDS, organ transplantation and rarely in Hodgkin’s disease and Non-Hodgkin’s lymphoma (NHL). We present a case of NHL with CMV oesophagitis, which has rarely been documented in literature. Apart from fungal and herpes simplex infections, as the common differential diagnosis for oesophagitis in patients of lymphoma, CMV should be considered an important etiologic agent. Early diagnosis and prompt treatment of CMV oesophagitis with gancyclovir can avert significant morbidity and avoid unacceptable treatment delays.

Key words: Cytomegalovirus, non-Hodgkin’s lymphoma, oesophagitis

Cell-mediated immunity is altered in patients of lymphoma. Cytomegalovirus (CMV) infections are less common and not frequently reported in patients of Hodgkin’s disease (HD) and Non-Hodgkin’s lymphoma (NHL).[1] Among CMV infections in patients of lymphoma, CMV pneumonias are the most common. We report a case of oesophageal CMV in a case of NHL, which was treated successfully with gancyclovir.

Case Report

A 50-year-old male patient, HIV seronegative, symptomatic with fever for 8 months and significant weight loss, was found to have mediastinal, retroperitoneal, para-aortic, left axillary and right supraclavicular lymphadenopathy. Biopsy of the right supraclavicular lymph node was consistent with the diagnosis of T cell rich, B cell high-grade NHL. Subsequent to three cycles of chemotherapy, the patient developed non-neutropenic fever, associated with severe dysphagia, persistent retrosternal pain and reduced oral intake. Oesophagoscopic examination revealed extensive superficial ulceration with erythematous nodules. Cytologic examination of oesophageal brushings showed squamous cells with large intra-nuclear basophilic inclusions with a distinct halo around it. These inclusion bodies in epithelial cells were diagnostic of CMV (Figure).

CMV DNA positivity in blood by hybrid capture assay confirmed the diagnosis of CMV oesophagitis. Gancyclovir in a dose of 5 mg/kg was given per oral for 21 days, following which the patient showed symptomatic relief, with resolution of oesophageal lesions on upper gastrointestinal endoscopic examination and negative CMV DNA assay.

Discussion

CMV is a herpes virus, which causes a latent, asymptomatic infection. Symptomatic CMV infection occurs with suppression of cellular immunity. Both reactivation and primary infections are common in organ transplantation and AIDS. CMV is the most common viral pathogen complicating organ transplantation. Kidney, liver, heart and bone marrow transplant recipients are at very high risk of CMV infections. CMV is an important pathogen in AIDS, almost universal in these patients. Cell-mediated immunity is altered in patients of lymphoma. CMV infections are less common and not frequently reported in patients of HD and NHL. Among CMV infections in patients of lymphoma, CMV pneumonias[1] are the most common.

CMV retinitis[2,3] and encephalitis have been reported in patients of HD and NHL. Only few case reports have documented gastrointestinal CMV infections in lymphoma patients.[4,5] CMV enterocolitis causing fatal gastrointestinal haemorrhage, intestinal perforation, CMV gastritis and CMV infection of jejunum has been reported. CMV oesophagitis in patients of lymphoma is rarely reported in literature. Apart from fungal and herpes simplex infections, as the common differential diagnosis for oesophagitis in patients of lymphoma, CMV should also be considered an important etiologic agent. Early diagnosis and prompt treatment of CMV oesophagitis with gancyclovir can avert significant morbidity and avoid unacceptable treatment delays.
HYDATID CYST OF MEDIASTINUM

We report a case of hydatid cyst of the mediastinum in a 32-year-old female patient who was admitted with chest pain. CT scan reported posterior mediastinal mass towards the right side. Surgical exploration revealed a loculated cyst in posterior mediastinum on the right side, adherent to the overlying lung and underlying bone. Posterolateral thoracotomy was performed for cyst aspiration and excision. The patient was discharged on albendazole.

Key words: Hydatid cyst, hydatid disease, mediastinal cyst, mediastinal echinococcosis

Hydatid disease caused by *Echinococcus granulosus*, *E. multilocularis* and *E. oligarthrus* is an uncommon parasitic disease. The disease poses a serious problem in India, where it is endemic. The primary hosts for the infecting organism are the members of the Canidae family, usually dogs, wolves and coyotes. The intermediate hosts are sheep, cattle and deer. Humans enter the cycle through infected canine faeces. Liver and lungs are the most common sites of infection, but it can also be seen elsewhere in the body. Extrapulmonary location of the disease in the thorax is very rare. Intrathoracic extrapulmonary locations are generally the mediastinum, pleura, pericardium and chest wall. We report a case of posterior mediastinal mass, which was provisionally diagnosed as bronchogenic cyst and later confirmed to be hydatid cyst of the posterior mediastinum.

Case Report

A 30-year-old lady was admitted to the cardiovascuothoracic surgery (CTVS) department with complaints of chest pain for the past 6 months. Pain started at the back radiating to the right lateral side of the chest below the nipple. Pain was constant and had a pinprick quality in nature without any change for the last six months. There was no history of trauma, fever, syncope, haemoptysis, haematemesis and dyspnoea on exertion. Laboratory tests were normal except for mild leucocytosis. CT scan of thorax showed a well-defined lobulated cystic lesion 6.2 × 4 × 4.2 cm in size at the right posterior mediastinum (Figure). The mass lesion was compressing the posterior segment of the upper lobe of the right lung; otherwise, the lung appeared normal. Abdominal ultrasonography (US) revealed a normal liver, spleen and gall bladder. A preoperative diagnosis of bronchogenic cyst was made. Posterolateral thoracotomy was performed and the lung retracted. The cyst was found adherent to the lung. The fluid aspirating from the cyst was straw-coloured and contained some particulate matter. Hence, it was sent for microscopy to the Microbiology Department. Total cyst excision was performed, and the postoperative stay of the patient in the hospital was uneventful. Microscopy of the aspirated cystic fluid showed hooklets of *Echinococcus*.