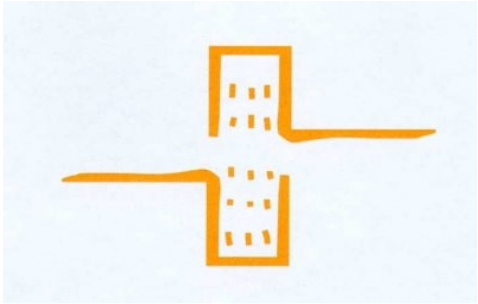
LINFOMA TIPO BURKITT PRIMARIO DE OVARIO

Gómez Alarcón A, Quesada Villar J, Parras Onrubia F, Quesada Fernández MN, Troncoso Saleh AC, Sánchez Pastrana JJ, Cerrillos Morales C, Hernández Aznar JF, Pagan Muñoz I

Servicio de Obstetricia y Ginecología del Hospital Virgen del Castillo (Yecla), España.



Caso clínico

Paciente de **13 años** sin antecedentes personales ni ginecológicos de interés que consulta por **dolor en hipogastrio** y fosa iliaca derecha y **cuadro sincopal**.

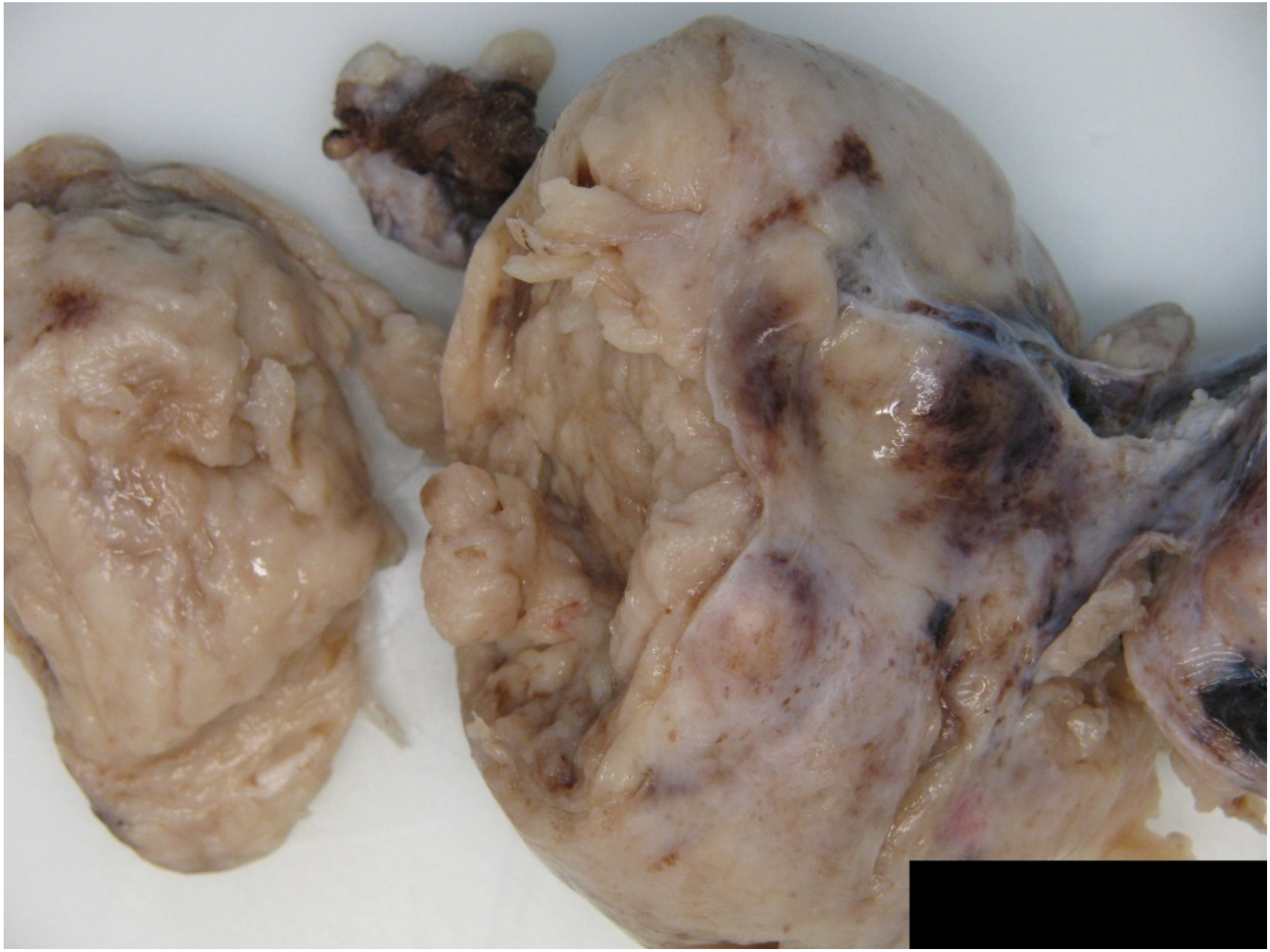
Exploración física

- Intensa palidez y obnubilación.
- H[illegible]n marcada.
- [illegible] Taquicardia con tonos apagados.
- Palpación a[illegible]agudo con defensa involuntaria y ausencia de peristalsis.
- Ecografía Fast: Masa s[illegible]m localizada en hipogastrio y pelvis menor.

LAPAROTOMÍA URGENTE

Pruebas complemen[illegible]

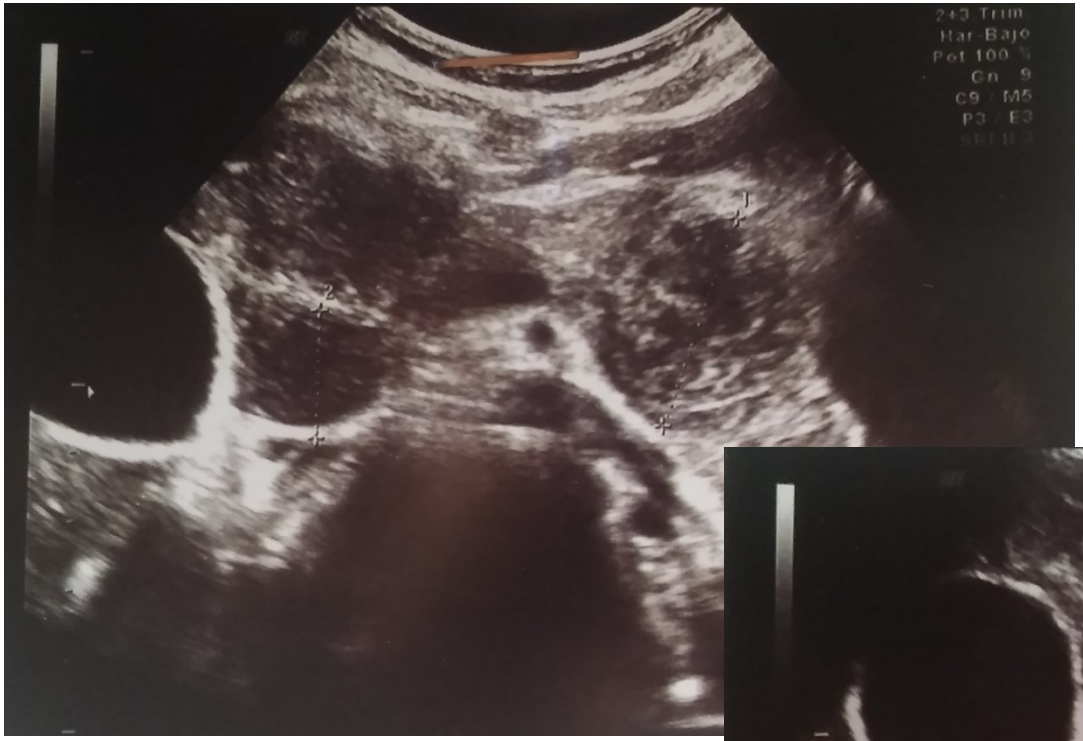
- Analítica de urgencias:
  - Hb 6,7gr/dl, Hto 20%, 25160 leucocitos (70% N,
  - Glucemia 215 mg/dl
  - Test de gestación negativo
- Ecografía abdominal: Masa en hipogastrio de 10cm y abundante líquido libre.

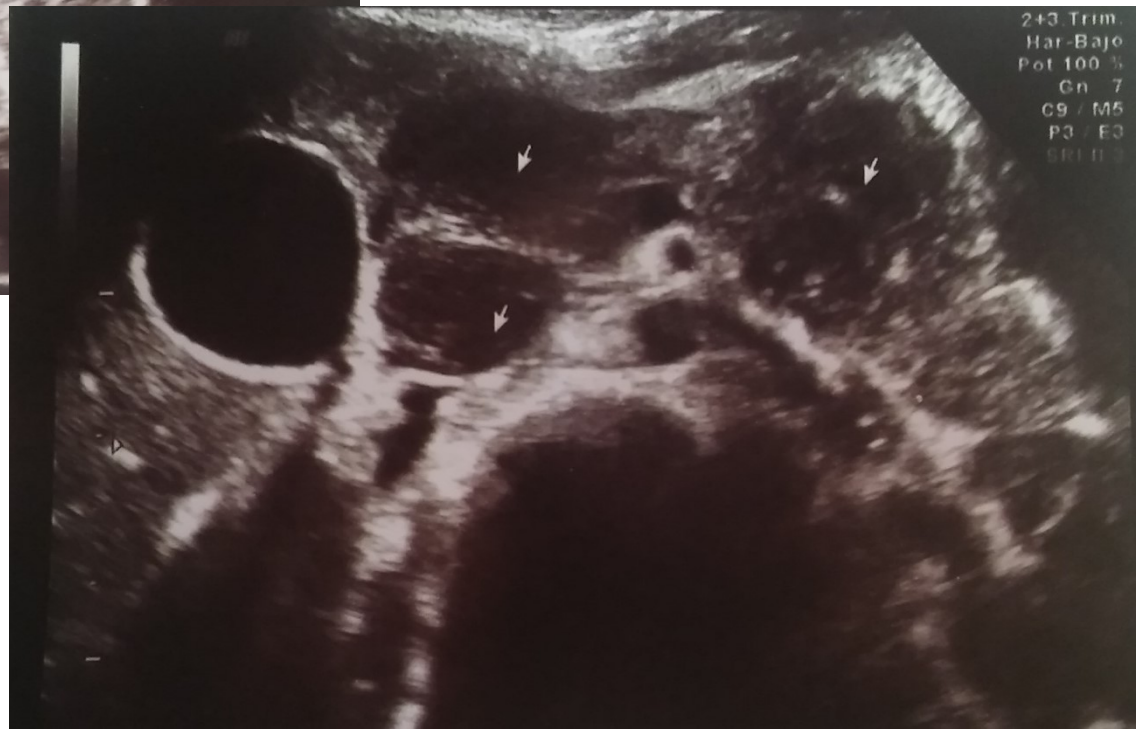


21 días después…

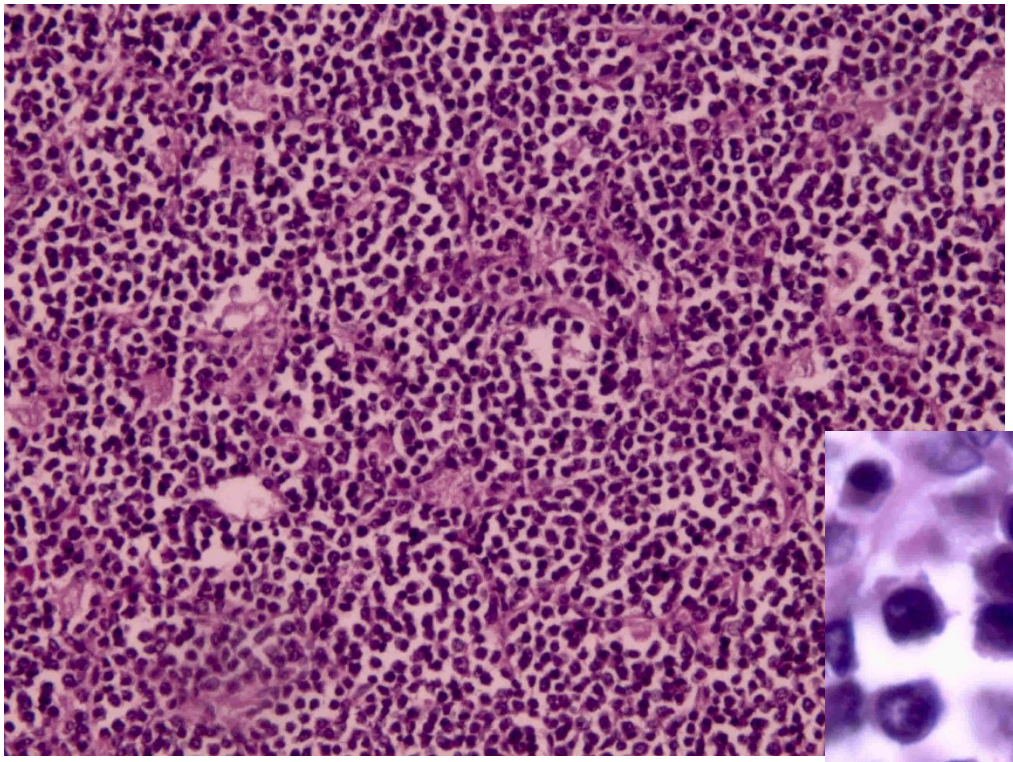
- Ingreso por **epigastralgia, vómitos,** astenia e intolerancia alimentaria.
- EF:
  - **REG, palidez** cutánea, afebril.
  - Hematoma en pared abdominal derecha y zona subumbilical, que abomba la pared abdominal. Múltiples nódulos pequeños a lo largo de toda la incisión de laparotomía previa.
- Analitica al ingreso:
  - Hb 11gr/dl, Hto 35%, 14470 leucos (57%N), plaquetas 172000
  - Bioquímica**: GPT 823, amilasa 237, FA 1169**, resto normal
  - PCR 1,69
- Rx tórax normal

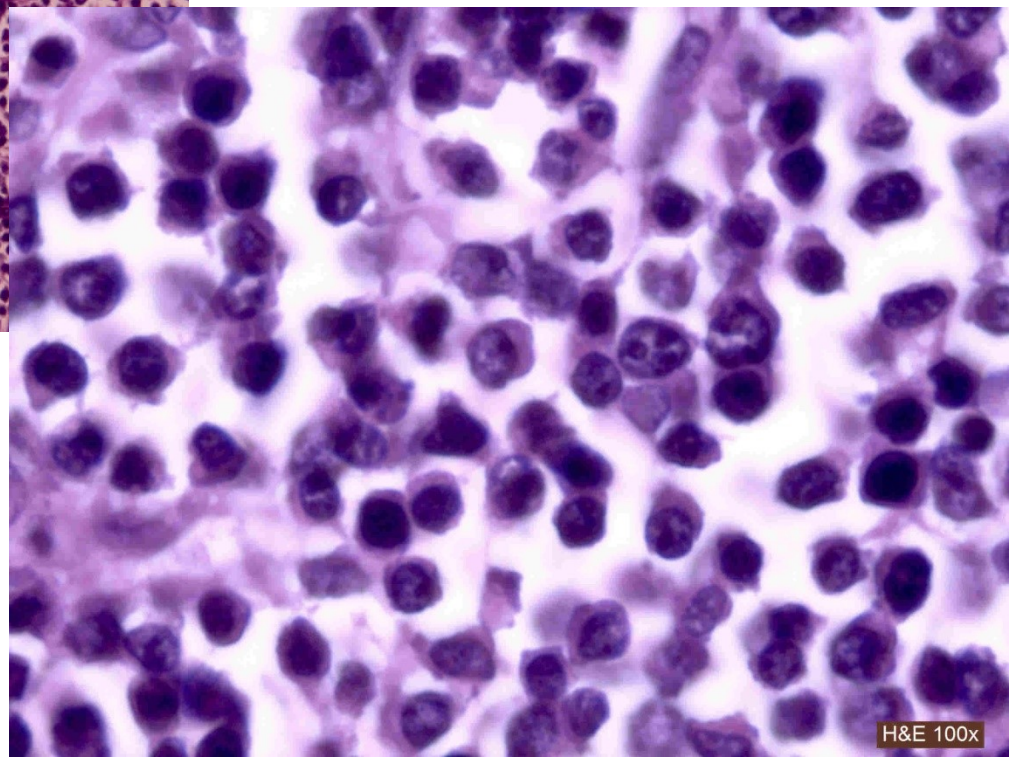
Ecografía ginecológica

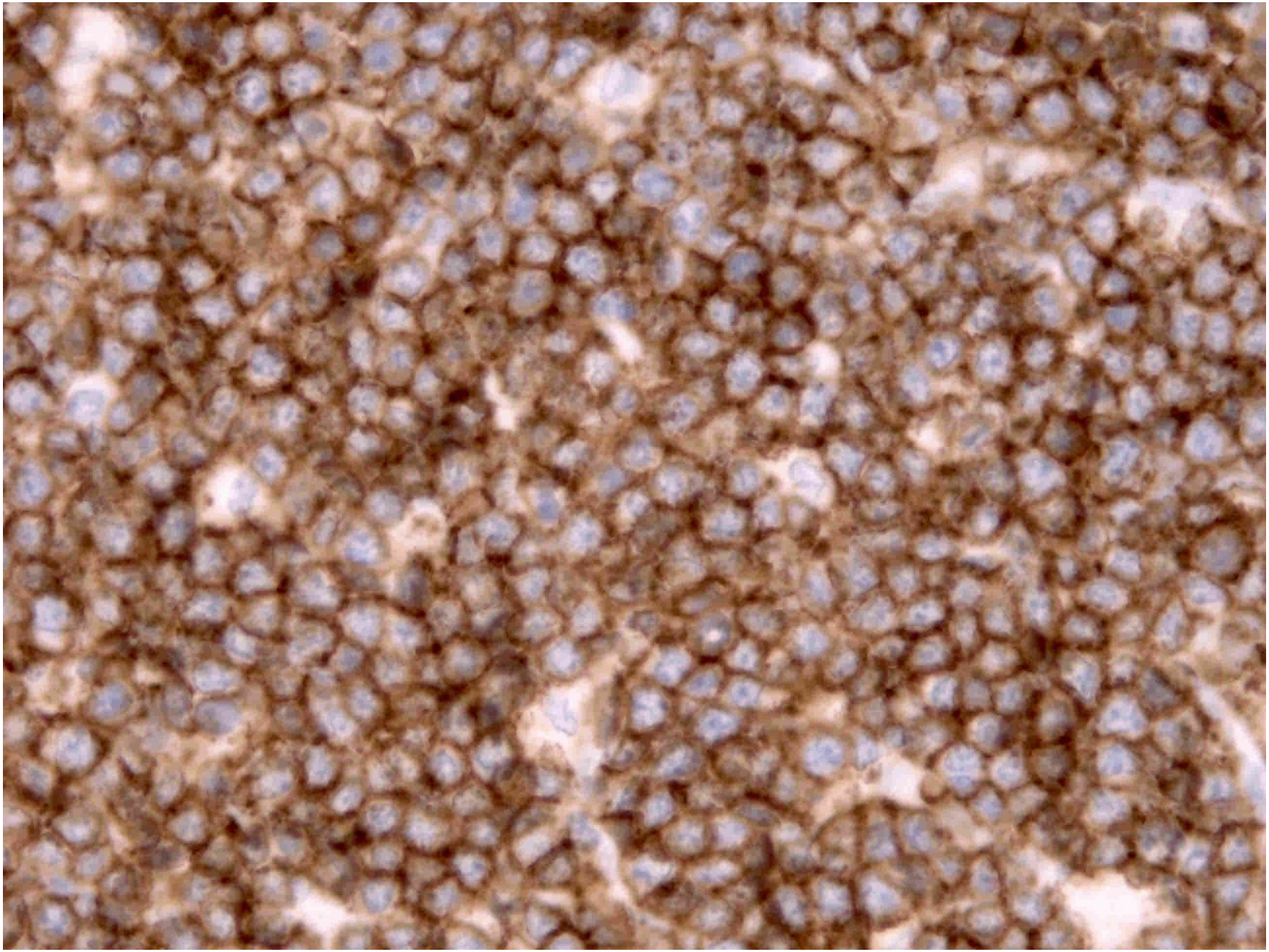


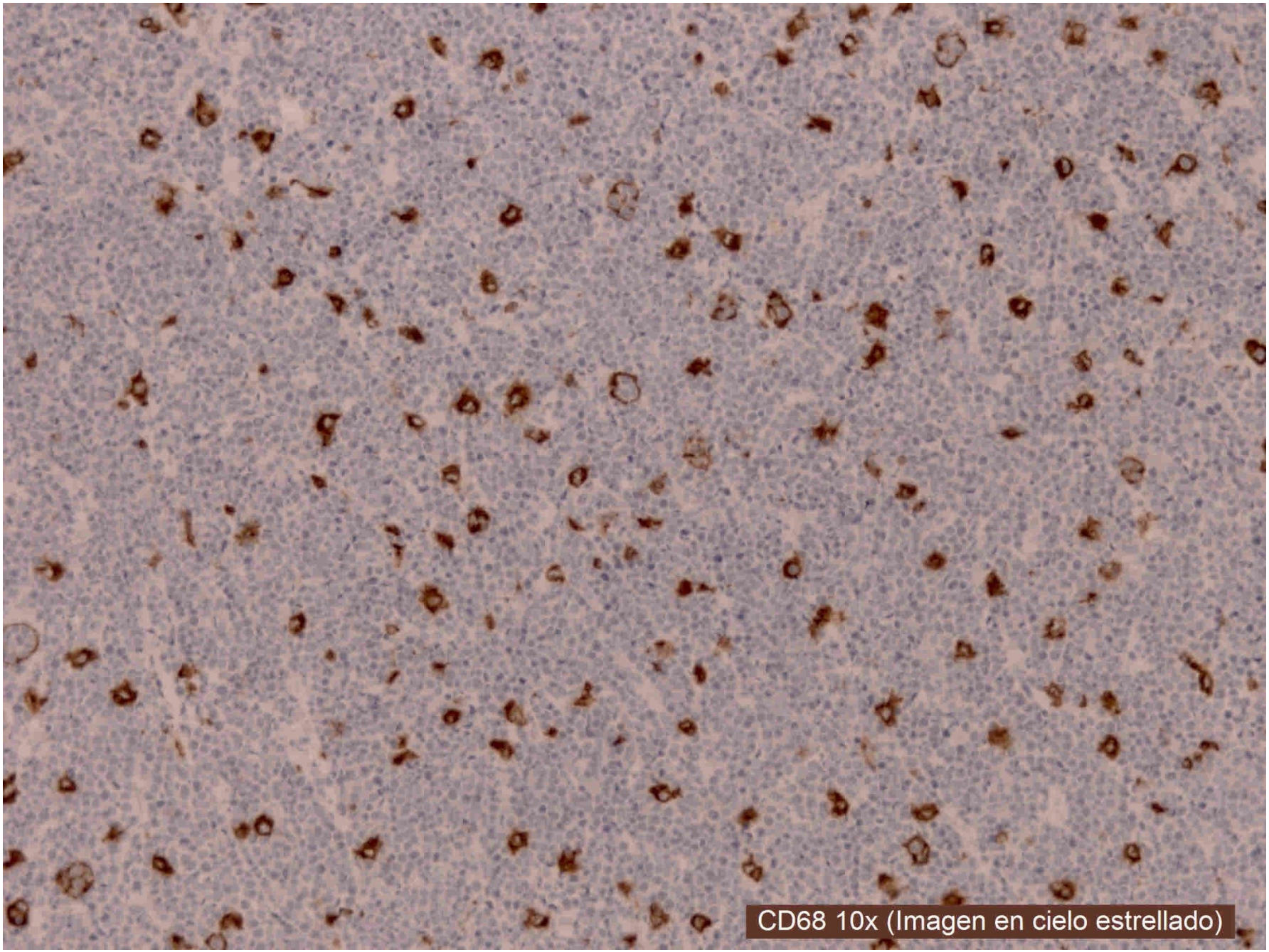


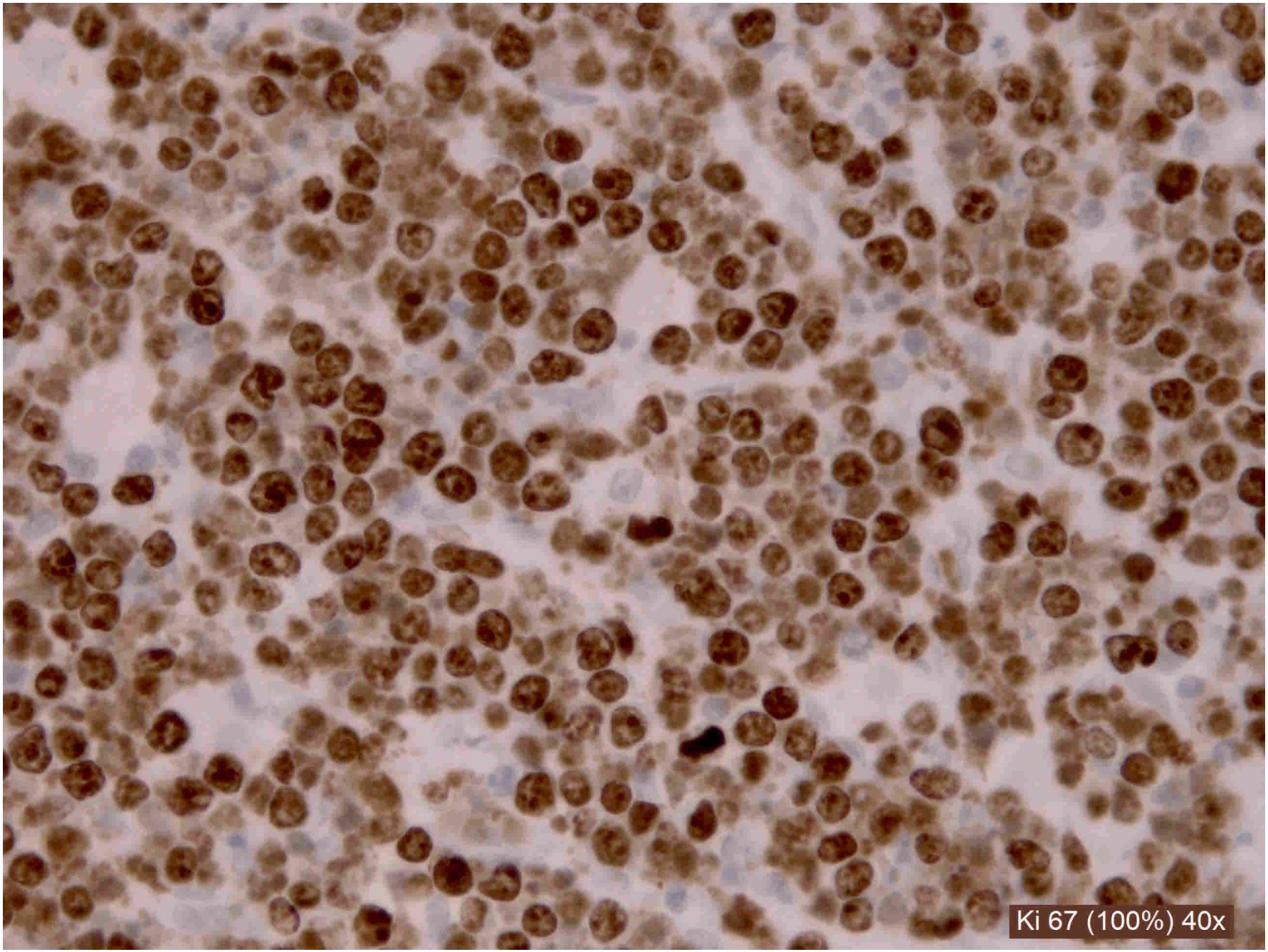
Anatomía patológica








CD68 10x (Imagen en cielo estrellado)

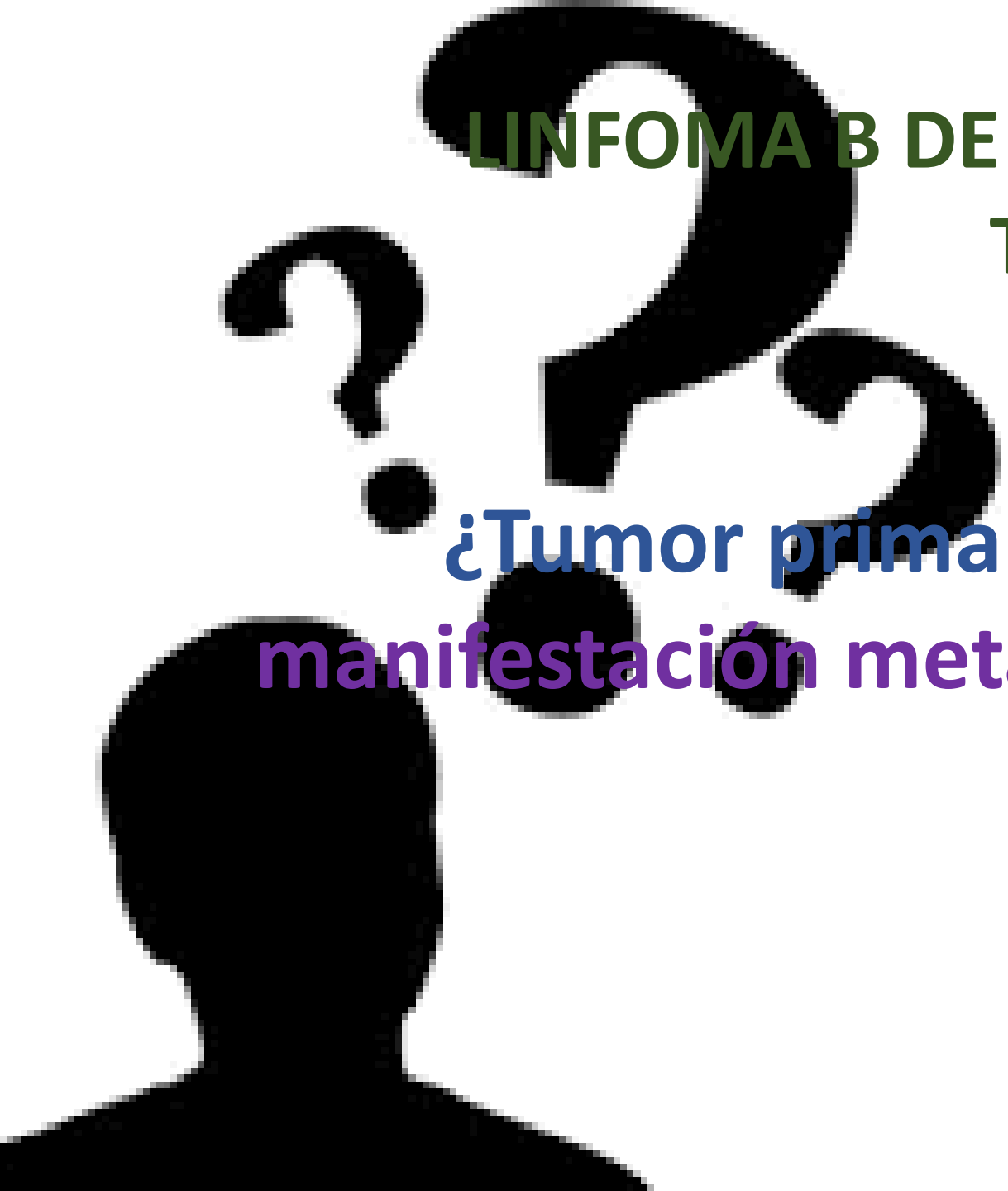

Ki 67 (100%) 40x

+ CD20

Falta de expresión de Bcl-2

Presencia de un punto de ruptura en la región Myc

Ki 67+++ en practicamente el 100% de las células neoplásicas



LINFOMA B DE ALTO GRADO TIPO BURKITT

¿Tumor primario o manifestación metastásica?

British Journal of Obstetrics and Gynaecology
April 1988, Vol. 95, pp. 386–390

Malignant lymphoma presenting as an ovarian tumour: a clinicopathological analysis of 34 cases

H. FOX, F. A. LANGLEY, A. D. T. GOVAN, A. SHIRLEY HILL, M. H. BENNETT

posed the following criteria for the diagnosis of a primary ovarian lymphoma:

(i) At the time of diagnosis the lymphoma is clinically confined to the ovary and full investigation fails to reveal evidence of lymphoma elsewhere. A lymphoma can still, however, be considered as primary if spread has occurred to immediately adjacent lymph nodes or if there has been direct spread to infiltrate immediately adjacent structures.

(ii) The peripheral blood and bone marrow should not contain any abnormal cells.

(iii) If further lymphomatous lesions occur at sites remote from the ovary then at least several months should have elapsed between the appearance of the ovarian and extra-ovarian lesions.

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Burkitt's Lymphoma of the Ovary: Case Report and Review of the Literature

Adi Shacham-Abulafia[a, c] Ran Nagar[b, d] Ram Eitan[b, d] Hanoch Levavi[b, d]
Gad Sabah[b, d] Liat Vidal[a, c] Ofer Shpilberg[a, c] Pia Raanani[a, c]

Table 1. Clinical characteristics of the 17 patients with primary Burkitt's lymphoma of the ovary

Patient No. [ref.]	Age	Duration of symptoms	B symptoms	Ovarian involvement	Ann Arbor stage/ FIGO stage	Pleural effusion or ascites	CA-125 U/ml	LDH IU/ml	Surgery	Frozen section	Chemotherapy protocol	Survival
1 [9]	27	NA	NA	NA	IV/3	NA	NA	NA	yes	NA	NA	4 m
2 [19]	11	NA	NA	NA	IV/3	no	NA	720	not done	NA	cyclophosphamide	10 m (incomplete response)
3 [19]	27	NA	NA	NA	IV/3	yes	NA	4,775	not done	NA	MOPP	4 m (incomplete response)
4 [19]	21	NA	NA	NA	IV/4	no	NA	1,400	not done	NA	cyclophosphamide	10 m (incomplete response)
5 [19]	2	NA	NA	NA	IV/4	NA	NA	NA	not done	NA	cyclophosphamide	46 m (relapse)
6 [4]	62	NA	NA	unilateral	IE/1	no	NA	NA	not done	NA	NA + RT	11.7 y (alive)
7 [20]	24	NA	NA	bilateral	IV/1	yes	327	2,180	yes	a small round blue cell tumor	cyclophosphamide, doxorubicin, vincristine, L-asparaginase, prednisone + DHAP + IT MTX) + ABMT	35 d after ABMT
8 [21]	25	NA	no	bilateral	IV/1	yes	450	14,497	yes	suspicious of malignancy	CHOP + dose-intensified R-CHOP	30 m (alive)
9 [18]	50	2 w	no	bilateral	IV/2	no	NA	normal	yes	an ovarian malignancy of sex cord-stromal origin	NA	NA
10 [22]	20	acute[1]	no	bilateral	IV/1	yes	NA	2,362	yes	NA	BFM 1986 protocol	36 m (alive)
11 [23]	28	6 w	no	bilateral	IV/1	yes	1,111	905	not done	NA	NA	NA (dramatic response at 6 w)
12 [24]	30	acute[1]	no	bilateral	IV/2	NA	77	normal	yes	NA	CODOX-M-IVAC-R	NA
13 [25]	34	4 w	no	bilateral	IV/3	yes	125	1,375	yes	NA	NA	1 m
14 [26]	21	NA	yes (fever)	bilateral	IV/1	yes	565	517	yes	NA	cisplatin (into abdominal cavity)	1 d
15 [27]	13	acute	yes (fever)	bilateral	IV/1	no	112	2,280	not done	NA	LMB 89 protocol	NA: CR at 6 m
16 [13]	31	NA	NA	unilateral	II/2	NA	NA	elevated	yes	NA	CHOP	14.67 m (relapse)
17 (present case)	39	4 w	yes (night sweats)	bilateral	IV/3	yes	134.4	1,483	yes	granulosa cell tumor	R-Hyper-CVAD + GMALL-B-ALL/NHL 2002	6 m (alive)

ABMT = Autologous bone marrow transplantation; CHOP = cyclophosphamide, vincristine, doxorubicin, prednisone; CODOX-M-IVAC-R = cyclophosphamide, vincristine, doxorubicin, methotrexate/ifosfamide, etoposide, high-dose cytarabine; CR = complete remission; d = days; DHAP = dexamethasone, cytarabine, cisplatin; IT MTX = intrathecal methotrexate; m = months; MOPP = mustargen, oncovin, procarbazine, prednisone; NA = not available; R = rituximab; R-Hyper CVAD/MTX – ARA-C =– rituximab, hyperfractionated cyclophosphamide, vincristine, doxorubicin, dexamethasone/high-dose methotraxate, cytarabine; RT = radiotherapy; w = weeks; y = years. Normal CA-125 values: <35 U/ml. In patient 10, Ann Arbor stage IV was defined as IE by the authors.

[1] Abdominal pain, suspected as ovarian torsion.


LINFOMA TIPO BURKITT PRIMARIO DE OVARIO

La paciente fue tratada con una combinación adyuvante de agentes quimioterapéuticos entre los que incluyen doxorrubicina, vincristina, citarabina, genoxal y dexametasona sin efectos secundarios importantes. +/- combinación con anticuerpo anti-CD20 (Rituximab).

Así como metotrexate intratecal

Actualmente se encuentra libre de enfermedad, con ciclos regulares

Es necesario que los ginecólogos conozcan el linfoma primario de ovario para realizar un adecuado diagnostico y por tanto un correcto abordaje terapéutico