**CASE REPORT**

**NK/T cell lymphoma of the lung: a case report and review of literature**

P Laohaburanakit, K A Hardin

Primary pulmonary lymphoma is rare. Most cases are of B cell origin and commonly arise from bronchial mucosa associated lymphoid tissue (MALT). Non-B cell lymphomas—that is, T cell and natural killer (NK) cell lymphomas—involving the lung parenchyma are uncommonly reported. NK/T lymphoma is aggressive and delay in establishing the diagnosis can result in a fatal outcome.

**CASE REPORT**

A 72 year old female non-smoker presented with shortness of breath (SOB), productive cough, and intermittent fever for 3 months. She was treated with azithromycin for community acquired pneumonia without improvement. The chest radiograph showed multiple areas of consolidation in the right lung. Initial laboratory findings revealed normal complete blood count and an unremarkable chemistry panel. A computed tomographic (CT) scan of the chest showed bilateral areas of consolidation with cavitation in the right upper lobe and diffusely distributed small nodules. No mediastinal or hilar adenopathy was noted (fig 1). Antibiotic coverage was modified to intravenous doxycycline and cefotaxime. A bronchoscopy with transbronchial biopsy (TBB) was performed. The bronchoalveolar lavage (BAL) fluid revealed 240 white blood cells (WBC)/ml with 80% lymphocytes, and the TBB showed lymphocytic inflammation. Cultures from the BAL fluid subsequently grew group B Streptococcus and parainfluenza virus, which were believed to be responsible for the lymphocytic inflammation. She improved and was discharged home only to return to the hospital 2 weeks later with worsening SOB.

A repeat CT scan of the chest showed increasing consolidation in both lungs without adenopathy and a new right sided pleural effusion. Thoracentesis was performed which also revealed a lymphocytic exudate. Cultures and cytological examination of the pleural fluid were negative. The patient underwent a repeat bronchoscopy with TBB which again indicated lymphocytic infiltration. Gram stain and special stains for atypical organisms including mycobacteria, fungi, and Pneumocystis carinii were negative. The BAL fluid cultures were negative. Flow cytometry of the BAL fluid indicated that more than 80% of the lymphocytes were T cells (CD3+) with a CD4 to CD8 ratio of 0.3.

At this point a clinical suspicion for a T cell lymphoproliferative disorder was raised. A positron emission tomographic (PET) scan was obtained in an attempt to identify the extent of the disease and an alternative site for tissue sampling. The PET scan revealed an isolated intense hypermetabolic uptake in the right middle and lower lung regions without other identifiable adenopathy. An open lung...
biopsy was recommended to the patient which she declined. A CT guided transbronchial needle biopsy of the right perihilar area was therefore undertaken which revealed CD3+, CD20−, and CD56+ cells indicating that the cells were of T and NK cell lineages. The new finding of CD56+ lymphocytes increased the likelihood of an atypical lymphoproliferative process involving NK cells, but it cannot be considered pathognomonic for a malignant process. T cell receptor (TCR) gene rearrangement was attempted but was unsuccessful due to paucity of viable cells. The patient’s clinical condition deteriorated. She refused further evaluation and developed progressive respiratory failure and died.

Post mortem examination showed multiple masses in both lungs, hilar and mediastinal lymphadenopathy. On microscopic examination the lung tissues and enlarged lymph nodes contained uniform, round, small cells with a high nucleus to cytoplasm ratio supportive of a malignant process. The cells were angiocentric and angioinvasive (fig 2). Special staining for leucocyte common antigen (LCA) was positive (fig 3A). The cells stained positive for CD3 and CD56 but negative for CD20 (fig 3B). As CD3 is a T cell marker, CD56 is an NK cell marker, and CD20 is a B cell marker, the immunocytochemistry showed that the malignant lymphoma cells were of T and NK lineages. TCR gene rearrangement could not be done because of the lack of viable cells at post mortem examination. Based on the neoplastic morphology and the destructive nature of the CD3+ CD56+ lymphocytes, the pathological diagnosis was primary T cell lymphoma of the lung with the possibility of NK cell overlap.

DISCUSSION
Apart from HIV related lymphoproliferative disorders, primary lymphoma of the lung is rare. While extranodal manifestations of non-Hodgkin’s lymphoma (NHL) are not uncommon, isolated involvement of the lung is found in only 3–4% of cases. Most cases reported are B cell lymphoma. The true incidence of pulmonary lymphomas other than B cell type is unknown. Tamura and co-workers reported 24 cases of primary pulmonary lymphoma, only one of which was T cell in origin. Since 1990 only 13 cases of non-B cell pulmonary lymphoma have been reported. Most of these reports are not in English. Eleven of the 13 cases are reviewed here. The clinical characteristics of these cases are summarised in table 1.

The patients were usually elderly, with a female to male ratio of approximately 2:1. Most of the cases presented with cough and dyspnoea. Only three patients were asymptomatic and were diagnosed after incidental discovery of an abnormal chest radiograph. The most common radiographic finding was bilateral diffuse nodular lesions. Mass-like consolidation, cryptogenic organising pneumonia (COP)-like lesions, hilar adenopathy, and pleural effusion were also reported. These radiographic features are also associated with bronchial MALT lymphoma and cannot be used to differentiate between non-B cell and B cell malignancy of the lung.

TBB was non-diagnostic in nine of the 11 cases. Transbronchial needle aspiration (TBNB) was obtained in one case, which was also non-diagnostic. Limited flow cytometry on BAL fluid (CD4/CD8 subpopulation analysis only) was done in two cases. An open lung biopsy (OLB) or lobectomy was eventually required in nine cases. The other two cases were diagnosed by an endobronchial biopsy of a well visualised mass, and by a cervical lymph node excisional biopsy. Immunocytochemistry of the surgical biopsy specimens showed T cell markers in all cases. None of the cases reported simultaneous NK cell markers on the tumour cells. Genotypic assessment—that is, TCR gene rearrangement—was not reported in any of the cases.

Treatment consisted of CHOP (cyclophosphamide, adriamycin, vincristine and prednisone) based chemotherapy in eight patients with varying success. Four patients subsequently died and four were still living by the time the reports were published. Boon et al and Hanawa et al reported dramatic clinical and radiographic response to systemic corticosteroid alone without chemotherapy. In one case corticosteroid was used as a temporary measure until the patient could tolerate OLB.

Surgical resection was performed on three patients. In two cases the tumours were focal and the lobectomy led to cure. The pathology and immunocytochemistry of the third patient showed mixed T cell lymphoma and squamous cell carcinoma of the lung. Adjuvant chemotherapy for lym-
phoma was given after surgery. Despite the combined treatments, the patient died.

NK/T cell lymphoma of the lung is an unusual diagnosis and warrants high clinical suspicion. In conclusion, lymphoma of the lung is extremely rare and is a transbronchial needle aspiration (TBNA) or Wang needle aspiration may have a role in obtaining a clinical specimen for TCR gene rearrangement when thoracic lymphadenopathy is present. However, one third of all T cell lymphomas and virtually all NK cell tumours arise at extranodal sites. As shown in table 1, most cases of pulmonary T cell lymphoma presented with isolated lung parenchymal lesions without thoracic lymphadenopathy. Only one of the 11 cases reported hilar adenopathy. In our case, hilar and mediastinal adenopathy was not detected by CT scan or PET scan but was present at post mortem examination. This could be explained by the fact that the lymph nodes were adjacent to the mass-like parenchymal lesion which might have obscured the presence of distinct lymphadenopathy.

Table 1 Summary of reported cases of primary pulmonary T cell lymphoma since 1990

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age</th>
<th>Sex</th>
<th>Presentation</th>
<th>Radiographic findings</th>
<th>Diagnostic intervention</th>
<th>Treatment and outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asano</td>
<td>75</td>
<td>F</td>
<td>Dyspnoea</td>
<td>Multiple nodules, hilar adenopathy</td>
<td>Cervical lymph node biopsy</td>
<td>Chemotherapy with complete remission, alive*</td>
</tr>
<tr>
<td>Maehara</td>
<td>70</td>
<td>F</td>
<td>Productive cough, fever</td>
<td>L pleural effusion, LLL mass</td>
<td>Endobronchial biopsy</td>
<td>Chemotherapy, alive*</td>
</tr>
<tr>
<td>Boon</td>
<td>63</td>
<td>M</td>
<td>Fever</td>
<td>COP-like</td>
<td>OLB</td>
<td>Chemotherapy, died</td>
</tr>
<tr>
<td>Fujisawa</td>
<td>69</td>
<td>F</td>
<td>Abnormal CXR</td>
<td>Multiple lung nodules</td>
<td>Lobectomy</td>
<td>Chemotherapy, alive*</td>
</tr>
<tr>
<td>Hanada</td>
<td>42</td>
<td>M</td>
<td>Abnormal CXR</td>
<td>Multiple lung nodules</td>
<td>OLB</td>
<td>Chemotherapy, CNS relapse and died</td>
</tr>
<tr>
<td>Maejima</td>
<td>29</td>
<td>M</td>
<td>Dyspnoea</td>
<td>Multiple lung nodules</td>
<td>OLB</td>
<td>Chemotherapy, alive*</td>
</tr>
<tr>
<td>Sasaki</td>
<td>65</td>
<td>F</td>
<td>Abnormal CXR</td>
<td>RML, RLL infiltrates</td>
<td>RML and RLL lobectomy</td>
<td>Lobectomy with residual disease, alive*</td>
</tr>
<tr>
<td>Hanawa</td>
<td>52</td>
<td>M</td>
<td>Recurrent infiltrates</td>
<td>COP-like</td>
<td>OLB</td>
<td>Systemic corticosteroid, alive*</td>
</tr>
<tr>
<td>Karakus</td>
<td>48</td>
<td>F</td>
<td>Cough, dyspnoea</td>
<td>Multiple lung nodules</td>
<td>OLB</td>
<td>Chemotherapy with partial remission, alive*</td>
</tr>
<tr>
<td>Kawashima</td>
<td>74</td>
<td>F</td>
<td>Cough, haemoptysis</td>
<td>RLL mass</td>
<td>Lobectomy</td>
<td>Chemotherapy, alive*</td>
</tr>
<tr>
<td>DeTorres</td>
<td>68</td>
<td>F</td>
<td>Fever, weight loss</td>
<td>Multiple lung nodules</td>
<td>OLB</td>
<td>Lobectomy and chemotherapy, died</td>
</tr>
</tbody>
</table>

*At the time the report was published.

F, female; M, male; LLL, left lower lobe; RML, right middle lobe; RLL, right lower lobe; COP, cryptogenic organising pneumonia; OLB, open lung biopsy; CXR, chest x ray; CNS, central nervous system

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molecular analyses. TBB, transthoracic needle biopsy, and TBNA are generally insufficient and early open lung biopsy or video assisted thoracoscopic lung biopsy should be considered. In view of its extreme rarity, there is no recommended treatment at present. CHOP based chemotherapy and surgical resection have been reported in the literature. The response to chemotherapy is variable. Surgical resection may offer a cure in a patient whose tumour is localised. Systemic corticosteroids may be tried as a temporary measure to stabilise the patient sufficiently to undergo surgical biopsy.

ACKNOWLEDGEMENTS
The authors thank Kanokwan I Katagiri PhD for her assistance with translation of the Japanese case reports.

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Received 30 March 2004
Accepted 13 September 2004

REFERENCES

LUNG ALERT

Implication of ANCA status in Churg-Strauss syndrome

muş in patients with ANCA who were not initially ANCA negative were not retested.

The authors hypothesise the presence of two phenotypes of Churg-Strauss syndrome on the basis of the ANCA status. They conclude that the latter reflects the underlying pathophysiology of the disease, with the presence of ANCA favouring the likelihood of a vasculitis affecting certain organs. Further work is required to determine what effect these findings might have on treatment.

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