

■ Srce kao sijelo posttransplantacijskog limfoproliferativnog poremećaja

The heart as a site of posttransplant lymphoproliferative disease involvement

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Uvod: Posttransplantacijski limfoproliferativni poremećaj (PTLD) komplikacija je transplantacije organa, a najčešće (80 %) je udružen s (re)infekcijom Epstein-Barr virusom i javlja se rano poslije transplantacije.^{1,2} EBV-negativni PTLD pojavljuje se kasnije. Najveći rizik razvitka PTLD je u prvih godinu dana od transplantacije, a najrjeđi (1-3%) je kod transplantacije bubrega i jetre. PTLD u obliku limfomske infiltracije srca, koliko je poznato, do sada nije opisan, a primarni limfomi srca su iznimno rijetki (0,5-1%) stoga prikazujemo ovaj slučaj.

Prikaz slučaja: Hospitalizirali smo 31-godišnjaka zbog srčane tamponade. Pacijentu je prije sedam godina transplantirana jetra zbog sekundarne bilijske ciroze. Dva tjedna prije prijema javlja se tupu bol u prsištu, pojačani umor i zaduha uz generaliziranu limfadenopatiju. Odmah po prijemu ehokardiografski je verificirana infiltrativna masa lijevog atrija i ventrikula, desnog atrija te oba septuma uz obilni perikardijalni izljev. Odmah se učini perikardiocenteza i citološka punkcija uvećanog limfnog čvora na vratu. Citološki se opisuje B velikostanični non-Hodgkinov limfoma dok se u izljevu ne nađe limfomskih stanica. Po punkciji empirijski je liječen kortikosteroidom kroz 4 dana (deksametazon 40 mg/dnevno) i modificirana je imunosupresija. Na terapiju je nastupio odličan klinički odgovor te regresija limfadenopatije i mase u desnom atriju. Serološka analiza na EBV je bila negativna. Primio je dva ciklusa rituksimaba te treći po CHOP-R protokolu, sve bez komplikacija. Šest mjeseci kasnije učinjenim PET CT-om nije nađeno znakova relapsa limfoma, a ehokardiografski je vidljiva značajna regresija svih promjena. Nalazom 20 mjeseci po završenom liječenju verificirana je potpuna regresija bolesti u srcu.

Rasprava: PTLD često je agresivna i brzoprogresivna, potencijalno smrtonosna bolest. Difuzni B-veliko stanični limfom zbog pridružene tamponade u našeg pacijenta je zahtijevao neodgodivo liječenje stoga nismo učinili dodatne slikovne, niti patohistološke analize. Izvrstan odgovor na kemoterapiju kao i potpuna regresija govore u prilog činjenici da je brzo liječenje u ovom slučaju bilo presudno. PTLD srca koliko je nama poznato nije do sada opisivano nakon transplantacije jetre, a brzi dokaz bolesti i odlučno liječenje u našem slučaju rezultirali su potpunim oporavkom.

Introduction: Posttransplant lymphoproliferative disease (PTLD) is a complication of organ transplantation and mainly (80%) is associated with EBV (re)infection, usually with early-onset.^{1,2} EBV-negative PTLD is mainly late-onset. The highest risk of developing PTLD is within the first year after transplantation and appears the rarest (1-3%) in kidney and liver transplants. PTLD as heart infiltration for so far was not described and the primary heart lymphoma are extremely rare (0.5-1%) so we represent this case report.

Case report: We admitted a 31-year-old male for cardiac tamponade. Seven years ago patient underwent OLT due to secondary biliary cirrhosis. Two weeks before admission he developed dull chest pain, fatigues, shortness of breath and generalized lymphadenopathy. After admission, echocardiography showed infiltrative mass of the left atrium and ventricle, the right atrium and both septa with abundant pericardial effusion. Pericardiocentesis and FNA of enlarged lymph node in the neck were done. Cytology described giant B non-Hodgkin's lymphoma while in an effusion lymphoma cells weren't find. Patient was empirically treated for 4 days with corticosteroid (dexamethasone 40 mg/day) and the immunosuppressive therapy was modified. Clinical status improved dramatically, with regression of the lymph nodes and the heart chamber mass on echocardiography. Serological analysis of EBV was negative. He received 2 cycles of rituximab and one per CHOP-R protocol, without the complications. Six months later PET CT showed no signs of relapse of lymphoma, and echocardiographically was seen significant regression of all changes. Findings 20 months after completion of treatment verified complete regression of disease in the heart.

Discussion: PTLD is often aggressive, rapidly progressive and potentially life threatening disease. Diffuse large B-cell lymphoma with associated tamponade in our patient required immediate treatment, therefore we did not do additional image or histopathological analysis. An excellent response to chemotherapy and complete regression testifies the fact that the rapid treatment in this case was crucial. PTLD in heart after liver transplantation has not been described, to our knowledge, and a quick and decisive evidence of disease treatment in our case resulted in a complete recovery.

LITERATURE

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