



Clinical Image

Diffuse Large B Cell Lymphoma with Marked Imaging Response after R CHOP

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Image Case Presentation:

A 67-year-old man with a history of arterial hypertension, dyslipidemia and type II diabetes, who presented to the emergency department with productive cough, asthenia, dyspnea and unquantified weight loss. Chest radiography revealed extensive opacification of the left hemithorax, with mediastinal shift to the contralateral side. Chest computed tomography revealed a large left perihilar mediastinal mass (11 × 7 × 13 cm), causing narrowing of the left main bronchus, occlusion of the left lower lobar bronchus and compression of the pulmonary artery, associated with loculated pleural effusion and multiple supra- and infradiaphragmatic lymphadenopathies (Figures 1A, B). Bronchoscopic biopsy confirmed diffuse large B-cell lymphoma (DLBCL), GCB subtype, stage IV, bulky disease, with R-IPI 3–4 and CNS-IPI 4. Emergent R-CHOP chemotherapy was initiated, with good clinical and laboratory tolerance. After the first cycle, the patient showed significant symptomatic improvement and imaging reduction of the mediastinal mass to 8 × 3.8 cm (Figure 2A, B), along with decreased pleural effusion. Reassessment bronchoscopy demonstrated bronchial patency without the need for endobronchial stenting. The patient remained clinically stable and was discharged home.

Diffuse large B-cell lymphoma (DLBCL) is the most common histological subtype of non-Hodgkin lymphoma, with incidence increasing with age [1,2]. Approximately 50% of cases occur in individuals over 65 years old [2]. It may arise de novo or through transformation or progression of indolent lymphomas [2,3]. R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine and prednisone) is currently the first-line treatment for DLBCL [2]. Despite its biological heterogeneity, it remains potentially curable with multi-agent immunochemotherapy [2,3].

Keywords: B Cell Lymphoma, R-CHOP, DLBCL, Radiography

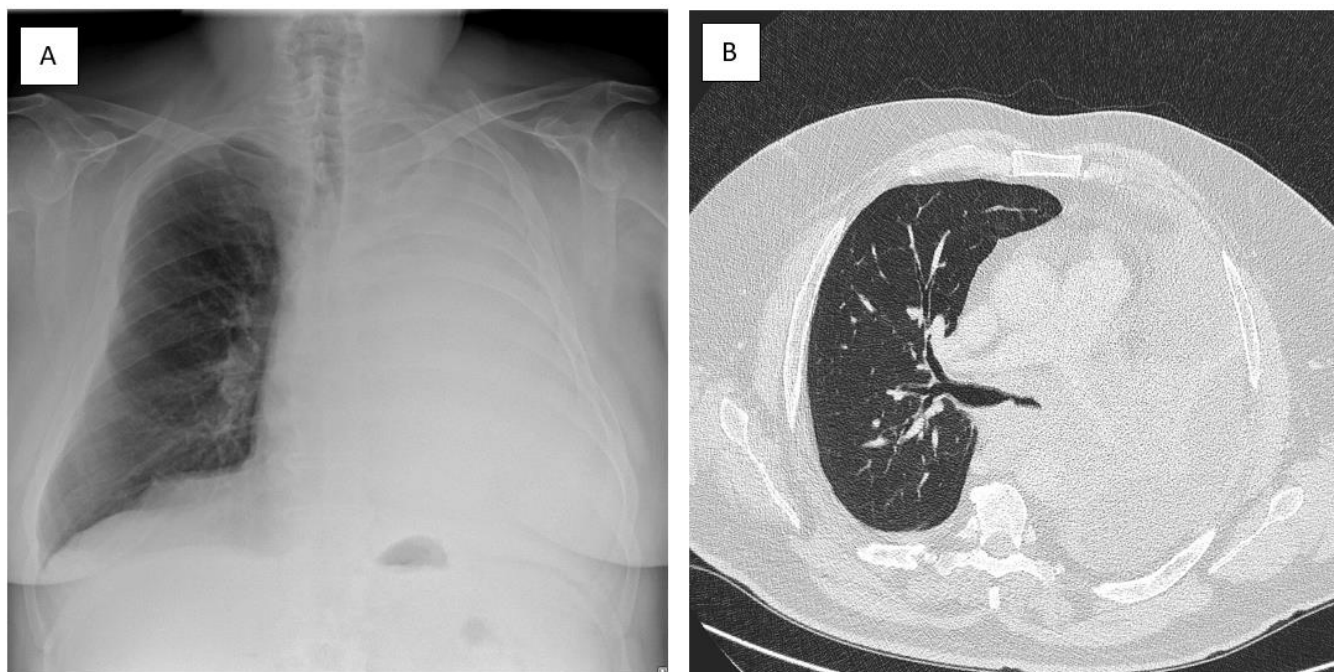


Figure 1: A) Pre-treatment chest radiography showing extensive opacification of the left hemithorax with contralateral (right) mediastinal shift and reduced left lung volume; B) Pre-treatment chest computed tomography demonstrating a large left perihilar mediastinal mass (11 × 7 × 13 cm) causing narrowing of the left main bronchus, occlusion of the left lower lobar bronchus and compression of the pulmonary artery, associated with loculated pleural effusion and multiple supra- and infradiaphragmatic lymphadenopathies.

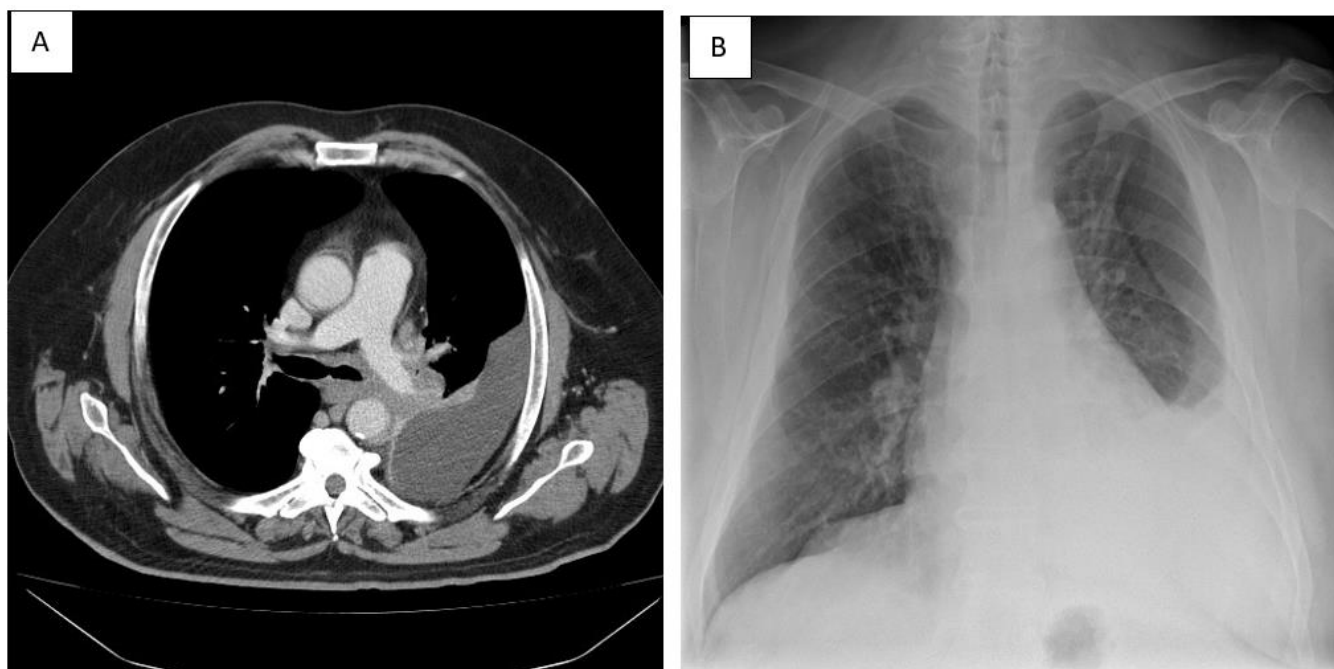


Figure 2: A) Post-treatment chest radiography after R-CHOP showing partial re-expansion of the left lung, with marked reduction of the previous opacification and reappearance of the left cardiac and diaphragmatic contours, as well as regression of the rightward mediastinal shift with recentring of mediastinal structures; B) Post-treatment chest computed tomography demonstrating reduction of the mediastinal mass to 8 × 3.8 cm, along with decreased pleural effusion.

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