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Diffuse Large B-Cell Lymphoma Masquerading as Advanced Ovarian Carcinoma: A Case Report of Bilateral Adnexal Involvement with Peritoneal Carcinomatosis

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Abstract

Background

Ovarian and adnexal involvement by non-Hodgkin lymphoma is uncommon and may clinically and radiologically mimic advanced epithelial ovarian malignancy. This diagnostic overlap can lead to inappropriate assumptions regarding the primary site and delay initiation of lymphoma-directed therapy. We report an unusual presentation of diffuse large B-cell lymphoma (DLBCL) involving the bilateral adnexa, associated with extensive intra-abdominal disease, malignant ascites and pleural effusion

Methods

A 50-year-old postmenopausal woman with no significant previous comorbidities presented with progressively worsening abdominal pain, abdominal fullness, dyspnea and low-grade fever for one month. Clinical examination revealed ascites and bilateral pleural effusions. Computed tomography of the abdomen and pelvis demonstrated heterogeneous solid masses in both adnexa, measuring $5.3 \times 3.0 \times 5.2$ cm on the right and $4.8 \times 4.3 \times 5.1$ cm on the left, with multiple enlarged para-aortic, common, external and iliac lymph nodes, diffuse omental thickening and caking, and moderate ascites with radiological

features of peritoneal carcinomatosis. Pleural-based nodules and bilateral pleural effusions were also identified. Pleural and peritoneal fluid cytology demonstrated malignant cells. Omental biopsy showed diffuse infiltration by atypical lymphoid cells. Immunohistochemistry was positive for CD20, PAX5, BCL2, MUM1, BCL6 and c-MYC, while CD3, CD10, TdT and cyclin D1 were negative. The Ki-67 proliferation index was approximately 90%, supporting a diagnosis of high-grade B-cell non-Hodgkin lymphoma, consistent with DLBCL of activated B-cell phenotype. The patient was diagnosed with stage IV disease and a high-risk prognostic score. She received six cycles of R-CHOP chemotherapy after management of malignant pleural effusion and ascites. Treatment was complicated by a moderate rituximab-associated infusion reaction, severe community-acquired pneumonia requiring intensive care admission, and febrile neutropenia. Follow-up computed tomography demonstrated no evidence of residual primary disease, consistent with complete remission.

Conclusion

DLBCL involving the ovaries or adnexa can closely mimic advanced ovarian carcinoma, particularly when accompanied by ascites, omental caking, elevated CA-125 and peritoneal disease. Tissue diagnosis with appropriate

immunohistochemistry is essential because treatment differs substantially from epithelial ovarian cancer. This case emphasizes the importance of considering lymphoma in the differential diagnosis of bilateral adnexal masses with extensive nodal and serosal disease.

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