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# A Dramatic Presentation of Plasmablastic lymphoma In Untreated HIV

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## INTRODUCTION

Human immunodeficiency virus (HIV) is associated with many malignancies including non-Hodgkin Lymphoma, Kaposi sarcoma and cervical cancer<sup>1</sup>. People with HIV have a risk ratio for AIDS-defining malignancy of 14 compared to otherwise similar people without HIV<sup>1</sup>. The following case details a novel presentation of a rare HIV-associated malignancy (HIVAM), plasmablastic lymphoma.

## CASE REPORT

A 29 y/o male presented to the hospital with diarrhea for one year and new right upper quadrant abdominal pain associated with hematochezia. A CT scan of the abdomen and pelvis revealed a thickened cecal wall and prominent lymphadenopathy, suggestive of malignancy or infection. HIV antibody was positive, with a viral load of 1.3 million/ml. CD4 count of 51/cc. An RPR was positive, and a treponemal antibody test confirmed the diagnosis of syphilis. Cytomegalovirus PCR [of what] and stool studies for shigella toxin were positive. Infectious colitis was suspected. Pertinent negatives included Quantiferon Gold; PCR for Gonorrhea, Chlamydia, and Pneumocystis jirovecii; and serology for Blastomyces, Histoplasma, and Mycoplasma.

Therapy with piperacillin/tazobactam was initiated to treat syphilis and shigellosis, along with ganciclovir for CMV. HIV was treated with a highly active anti-retroviral (HAART) regimen of emtricitabine-tenofovir, dolutegravir, ritonavir and darunavir. However, on day five of HAART therapy, the patient developed sustained fevers to ~104 F. HAART therapy was held while the patients was treated empirically with azithromycin and ethambutol for Mycobacterial avium complex infection unmasked by immune reconstitution.

During this period, the patient suddenly developed sustained hypotension and profuse hematochezia. Hemorrhagic shock was confirmed by a hemoglobin concentration of 5.6g/dL, down from 9.6g/dL twelve hours prior. He underwent fluid resuscitation and then emergent laparotomy that revealed a hemorrhaging mass in the cecum requiring hemicolectomy. Pathology of the mass was diagnostic of plasmablastic lymphoma and a CT-PET scan showed widespread metastases (Figure 1). Therapy with etoposide, prednisone, vincristine, cyclophosphamide and doxorubicin (EPOCH) was initiated. Six months later, a CT PET demonstrated nearly complete remission (Figure 2) and the HIV viral load was undetectable.

## PET SCAN IMAGES

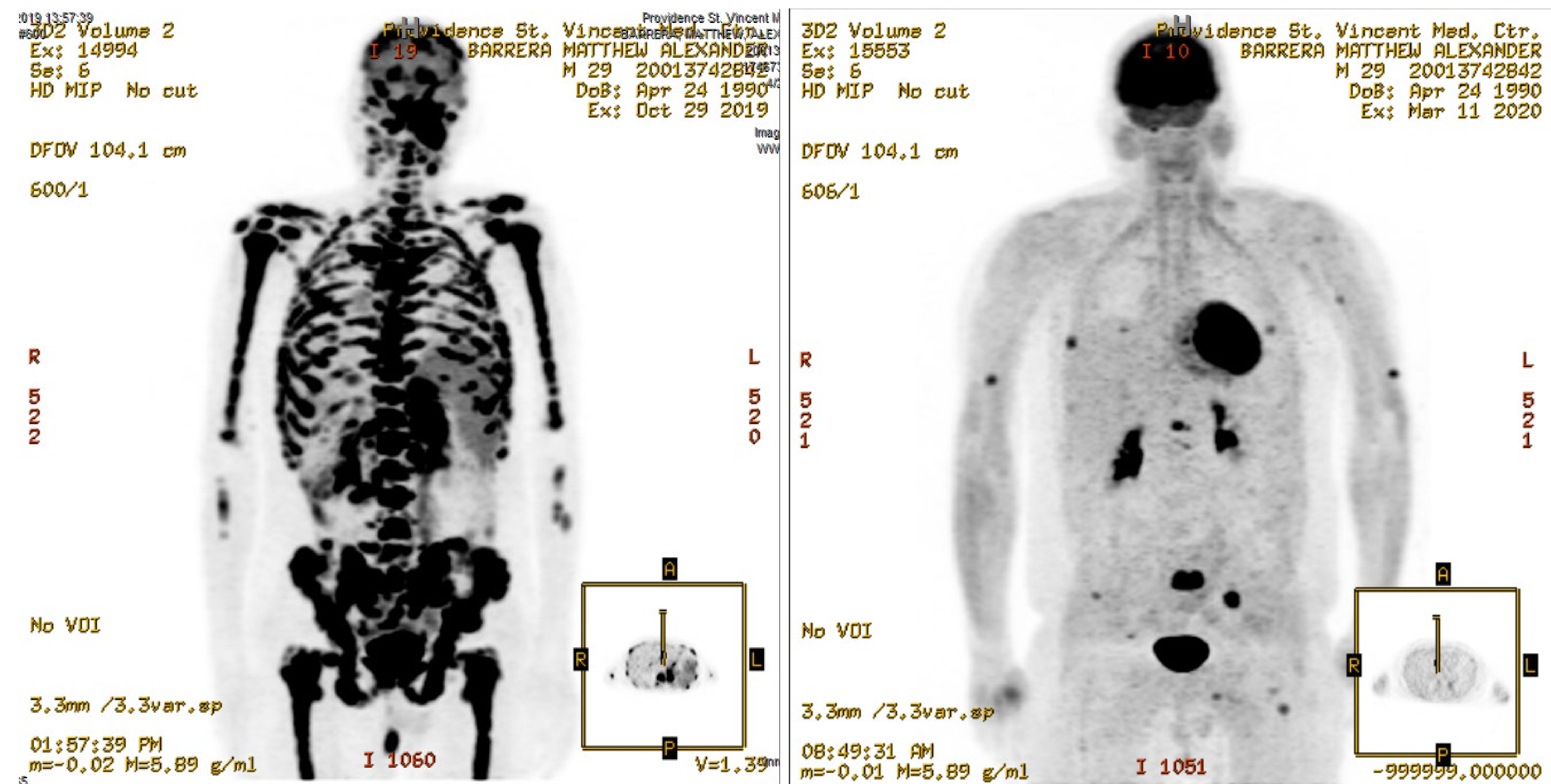


Figure 1

Figure 2

## DISCUSSION

HIVAM often manifests with indolent "B" symptoms, skin lesions, internal mass effects, and less commonly acute symptoms such as, in the case of CNS lymphoma, seizures<sup>2</sup>. Plasmablastic lymphoma is a rare, aggressive, AIDS-defining illness<sup>3</sup>. EPOCH remains standard of care, though survival rates are poor<sup>4</sup>. HAART is an essential component of treatment that should be continued during chemotherapy because an undetectable viral load is associated with increased survival<sup>5</sup>. This is the first report of plasmablastic lymphoma presenting with hemorrhagic shock, and it illustrates that both the variety and the clinical presentation of HIV-associated malignancies are broad.

## REFERENCES

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