

Diffuse gastric plasmacytoma involvement in multiple myeloma



Fig. 1 Endoscopic view of multiple red, polypoid nodules on the posterior wall of the gastric body.

Involvement of the gastrointestinal tract in multiple myeloma is rare. It is an aggressive biological sign and is associated with a poor prognosis [1,2].

A 64-year-old woman with a history of multiple myeloma, diagnosed 3 years earlier, experienced persistent epigastric pain for 1 month. The multiple myeloma was classified as an IgG-k type, stage IIIA according to the Durie–Salmon classification system. The patient had undergone several cycles of chemotherapy with vin-

cristine, doxorubicin, and dexamethasone, followed by high doses of melphalan and lenalidomide.

Based on the symptoms, the patient underwent upper endoscopy, which revealed multiple polypoid red nodules (● **Fig. 1**) extending from the fundus to the antrum of the stomach. Immunohistochemical analysis of biopsies from the lesions showed infiltration of the gastric mucosa by CD138-positive, CD56-positive, monoclonal IgG-k-type plasma cells (● **Fig. 2**), in accordance with the patient's multiple myeloma classification. Because of the diffuse involvement of the stomach by plasmacytomas and her clinical condition, neither total gastrectomy nor radiation could be done. The patient died 3 months later.

The endoscopic picture of plasmacytomas in the gastrointestinal tract includes the nodular, ulcerative, polypoid, and infiltrative types, with the nodular being the most commonly seen [3,4]. The small bowel is the gastrointestinal site most commonly affected, followed by the stomach, colon, and esophagus, in order of frequency of involvement [3].

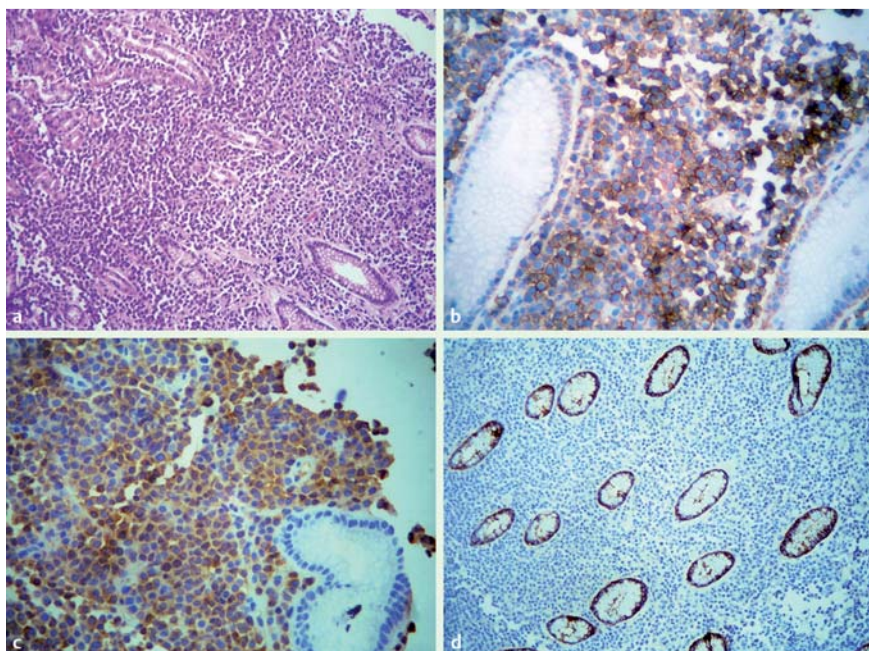


Fig. 2 Pathological analysis of the stomach biopsies performed during upper endoscopy. **a** Hematoxylin and eosin stain, $\times 200$ magnification, **b** Immunohistochemical stain for CD138, $\times 200$. **c** Immunohistochemical stain for kappa chain, $\times 200$. **d** Cytokeratin AE1/AE3 stain, $\times 100$.

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