

## ***Images in Clinical Oncology***

### **POST TRANSPLANT LYMPHOPROLIFERATIVE DISEASE (PTLD) IN A RENAL TRANSPLANT RECIPIENT**



Fig:1 Chest X-ray showing cannon ball/nodular secondaries

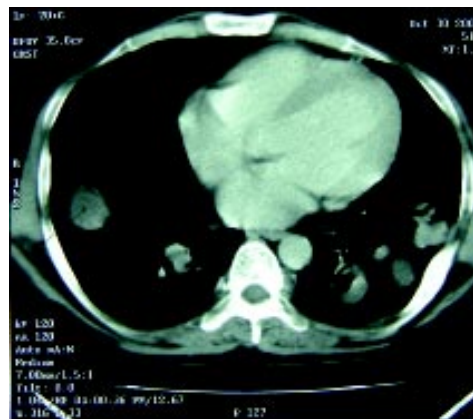


Fig:2 CECT of chest showing pleural based nodules



Fig:3 CECT of abdomen showing diffuse thickening of the bowel

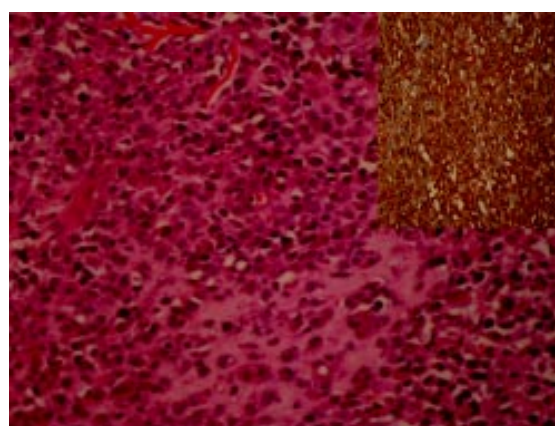


Fig:4 H & E stain showing tumor cells composed of atypical lymphoid cells with occasional mitotic figures (200X) which are reactive to CD 3-T cell marker (inset)

Mr. PK, a 41 years old nondiabetic and non hypertensive male underwent renal transplant at another hospital in 1997 for end stage renal disease. He was on immunosuppressive agents initially on cyclosporin and then on azathioprim and prednisolone. He became symptomatic in September, 2007 with bodyache, myalgia dyspnoea, and had episodes of recurrent sub acute intestinal obstruction. Chest X-ray (fig 1) was suggestive of multiple bilateral nodular lesions. CECT was suggestive of multiple pleural based nodules (fig 2) and abnormal thickening of bowel with dilatation of distal jejunal and ileal segments (fig 3). Serum creatinine was 1.6 mg%, albumin 3gm%. CT guided biopsy from pleural based mass was suggestive of non Hodgkin's Lymphoma with large areas of necrosis (fig 4), immunohistochemistry revealed CD 3 positivity (inset) and CD20 negativity. Bone marrow was not involved. A final diagnosis of post transplant lymphoproliferative disorder (T-cell NHL) was made.

About 1 to 3% of Renal transplant recipients develop Post transplant lymphoproliferative diseases (PTLD). It ranges from early disease, EBV-negative large cell lymphoma, to Burkitt's/atypical Burkitt's lymphoma or T cell variants. T-cell variants have poor prognosis with sepsis as main cause of death.

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