

## Rare Case of T-cell Lymphoma of Tongue in a Young Female

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Primary non-Hodgkin lymphomas of the oral cavity are extremely rare. They account for 3-5% of all malignant lesions of the oral cavity. Only a very few cases have been reported in literature of which T cell lymphomas are even lesser in comparison to B cell lymphomas. In this article we describe a case of 24-year-old female who presented with a smooth surfaced lesion on the tip of tongue. PTCL was diagnosed after histopathological examination and immunohistochemistry.

**Keywords:** Non-Hodgkin Lymphoma; Oral Cavity; Peripheral T-cell Lymphoma; Tongue**Introduction**

Extranodal lymphomas account for 20–30% of non-Hodgkin lymphoma (NHL) [1]. NHL accounts for 3-5% of all malignant lesions of the oral cavity. The commonly affected areas include the Waldeyer's ring including tonsils (55%), soft palate (30%), tongue (2%), buccal floor (2%), retromolar area (2%) and others (9%) [2]. 1% of all lymphomas are oral cavity lymphomas of which diffuse large B-cell lymphoma is the most common type [3]. Oral T-cell lymphomas are extremely rare, and only a few cases have been reported in literature [4]. Most patients are asymptomatic, and few of them present with swelling causing pain and discomfort mimicking benign orodental conditions. The overlying lingual mucosa may or may not be involved. Hence histopathological examination is extremely essential for accurate diagnosis.

**Case Report**

A 24-year-old newly married female visited our OPD with complaints of swelling in the tip of tongue. She noticed it about 1.5 months back. She had visited a dentist who just gave her anti-inflammatories and oral gels. The swelling did not regress nor

progress in size. She completed all her wedding festivities and then visited us as her swelling did not subside. She did not have pain, fever, loss of weight or appetite, no difficulty in swallowing nor speaking. The swelling was about 1x1cm and was smooth surfaced. There was no ulceration or bleeding. They already had done an MRI with contrast which revealed a relatively well defined 2.2x1.3x1 cm homogeneously enhancing lesion which was suggestive of neoplastic etiology or vascular malformation. There was no significant cervical lymphadenopathy. Rest of the oral cavity was normal. A complete pre-anesthetic evaluation was done including a CT Chest which were all normal. The patient was then taken up for surgery. Coblation excision of the entire lesion was done leaving clear margins and the specimen was sent for histopathological examination. Histopathological examination revealed a diffuse infiltrate of small lymphoid cells with scanty cytoplasm, irregular hyperchromatic nucleus and inconspicuous nucleoli. There were admixed few epithelioid histiocytes, eosinophils and rare multinucleated giant cells. Areas of necrosis were noted. The overlying mucosa was not involved. Immunohistochemistry done was conclusive of a T Cell Non-Hodgkin's Lymphoma. A whole body PET

scan was done which did not show any significant lesion anywhere else in the body. The patient was categorized as Stage I as postoperative PET-CT scan was normal. The final diagnosis was peripheral T-cell lymphoma (PTCL). The patient then went to Cancer Institute for further follow ups.

**Figure 1:** Pre operative photo showing the lesion.

**Figure 2:** Post operative photo showing the operated site.

## Discussion

About 20-30% of NHLs arise from extranodal sites [1]. Gastro-intestinal tract is the most common extranodal region after which is the head and neck region. Lymphomas are the third most common malignant lesion seen in the oral cavity and account for 3-5% of the oral cavity malignancies [5]. B Cell Lymphomas are the most common type of primary NHL [3]. Most commonly involved sites are tonsils followed by palate, tongue, buccal mucosa and retromolar area [2]. Only a very small number of PTCLs of oral cavity have been reported till date [4]. Lavanya Karanam., *et al.* reported a similar case of T cell lymphoma at the base of tongue [14]. Madana., *et al.* [15] and Swetha Narla., *et al.* [16] each reported a case of T cell lymphoma presenting at the lateral border of tongue. Etiological factors of primary lymphomas of the oral cavity is still a dilemma. Risk factors associated with NHL are Primary or acquired immunodeficiency, autoimmune disease (Sjogren's syndrome, Coeliac disease, treatment with immunosuppressant drugs), infective agents such as herpetic virus, hepatitis C virus, Helicobacter pylori, exposure to chemical agents, hereditary factors, etc [6-8]. It is usually seen over the sixth decade of life [9]. The commonly noticed symptoms are pain, swelling and discomfort. Oral NHLs may mimic benign oro dental conditions and hence could be misdiagnosed [10]. Oral cavity lymphomas are quite sensitive to both chemotherapy and radiotherapy. Prognosis is totally dependent on the stage of the tumor, the aggressiveness of the cell type and the response to treatment [11]. Went., *et al.* reported that Ki67 is prognostically relevant [12]. New prognostic predictive scores include age >60 years, high LDH, poor performance status and Ki-67 >80% which are associated with poor prognosis. Wolvius., *et al.* reported median survival of 34 months with no difference in prognosis between patients with bone and soft tissue lymphoma [13].

## Conclusion

NHL of the oral cavity is not a common disease and most of the cases reported are B-cell NHLs [1]. T Cell Lymphomas are extremely rare with only very few cases reported in the literature [4]. We have reported this case in view of the rarity of the disease, rarity of the site and presentation and the young age of the patient.

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