CASE REPORT
A 68-year-old male presented to an urgent care facility complaining of dizziness, lightheadedness, new onset left, lower-extremity weakness, as well as urinary urgency and decreased urine output. He was sent to the Emergency Department to be evaluated for stroke. An MRI of the brain revealed acute and subacute lacunar infarctions. Given his urinary retention, a Foley catheter was placed. He underwent CT of his abdomen and pelvis, which showed evidence of locally, advanced prostate cancer, with subsequent PSA measuring 441 ng/mL.

Additionally, the CT revealed an 8.6 x 3.4 x 7.9 cm soft tissue density mesenteric mass within the left hemiabdomen (Figure 1). There was mild mass effect on the normal-appearing adjacent small bowel loops, but the mesenteric vasculature traversed the mass without distortion. Though nodal metastatic disease may be seen in prostate cancer, the location and imaging appearance of the mass were thought to be most consistent with primary lymphoma.

The patient underwent image-guided, percutaneous biopsy. Histologic examination demonstrated lymphoid tissue fragments consisting of small- to medium-sized lymphocytes with oval to irregular nuclei, dense chromatin, and a moderate amount of cytoplasm. A small subset displayed a centroblast-like appearance. By immunohistochemistry, the diagnosis was confirmed to be primary low-grade follicular lymphoma (Figure 2).

DISCUSSION
Mesenteric lymphoma is the most common malignant neoplasm affecting the mesentery. Most mesenteric lymphomas are Non-Hodgkin’s Lymphomas (NHL), and approximately 30-50% of patients with NHL have mesenteric nodal disease. Bulky retroperitoneal adenopathy will often accompany primary mesenteric disease and can be a clue to the diagnosis.

A common finding on Computed Tomography (CT) imaging of mesenteric lymphoma is termed the “sandwich sign” (Figure 1). The sandwich sign appears as multiple rounded, mildly enhancing masses encasing mesenteric vessels. The mesenteric fat and tubular vascular structures serve as the “filling,” and the homogeneous soft tissue masses serve as the “sandwich bun.” The bulky adenopathy of lympho-
Figure 2a. Hematoxylin and eosin stain demonstrates small- to medium-sized lymphocytes with oval to irregular nuclei, dense chromatin, and a moderate amount of cytoplasm. b. Immunohistochemical staining showed these cells to be CD20 positive, CD10 positive, Bcl-2 positive, and Bcl-6 positive.

Mesenteric lymphoma is unique, which makes the sandwich sign specific to mesenteric lymphoma. Mesenteric lymphoma is typically asymptomatic until large, enveloping fat, bowel and vessels without causing significant clinical symptoms. Other CT appearances of mesenteric lymphoma include: a large, lobulated and “cakelike” heterogeneous mass displacing small bowel and containing areas of necrosis (low attenuation); or, ill-defined infiltration of mesenteric fat. Mesenteric lymphoma can occasionally invade the bowel serosa and muscularis propria, which can result in GI bleeding. Bowel perforation, however, is rare.

References

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Disclosures
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