中文題目：巨大後腹腔腫瘤以自發性腫瘤溶解症候群表現:病例報告

英文題目：Spontaneous tumor lysis syndrome in a case with huge retroperitoneal tumor: A case report

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Introduction

Tumor lysis syndrome is an oncologic emergency caused by massive tumor cell death after cytotoxic anti-cancer treatment. However, tumor lysis syndrome can also occur spontaneously in tumors with large tumor burden and high proliferative rate. Here, we report a case of spontaneous tumor lysis syndrome in a patient with plasmablastic lymphoma patient with initial presentation of a huge retroperitoneum mass.

Case presentation

A 28-year-old man, with medical history of amphetamine abuse, HIV (human immunodeficiency virus) infection and AIDS (acquired immunodeficiency syndrome), under HARRT (highly active antiretroviral therapy), presented to our emergent department due to progressive abdominal distension and epigastralgia for 1 month. Laboratory study showed microcytic anemia (MCV: 72.2 fl, Hb: 9.2 g/dL), elevated liver enzymes (GOT: 113 IU/L, GPT: 61 IU/L), extreme high level of amylase and lipase (amylase: 1081 U/L, lipase > 400 U/L), and impaired renal function (Cr: 1.72 mg/dL, eGFR: 52.49 ml/min). Contrast enhanced-abdominal CT disclosed a large relatively well-defined, lobulated, hyperdense mass in the right retroperitoneum encasing the right adrenal gland, right kidney, right ureter, prostate, seminal vesicle and posterior wall of the urinary bladder. Compression on the pancreas and duodenum, causing mild dilatation of common bile duct were also found. CT-guided biopsy was done immediately after admission. Pathology disclosed plasmablastic lymphoma with positive for Epstein-Barr virus-encoded RNA (EBER). However, 5 days after admission, persistent abdominal pain with rapid worsening of renal function (Cr: 5.31mg/dL), metabolic acidosis (pH: 7.347, HCO3-: 14.8 mmol/L), hyperkalemia (K: 5.3 mmol/L), hyperphosphatemia (P: 7.2 mg/dL), hyperuricemia (UA > 21 mg/dL), and lactetamia (lactate: 2.8 mmol/L) were found. Tumor lysis syndrome was impressed. In addition, obstructive jaundice (total bilirubin: 5.6 mg/dL, directed type bilirubin: 3.2 mg/dL) and obstructive uropathy leading to anuria were also found. Bilateral percutaneous nephrostomy with antegrade ureteric stenting were done. Aggressive intravenous fluid supplement with hypouricemic agents, including allopurinol and rasburicase were done. The electrolyte imbalances were corrected gradually few days later. Endoscopic Retrograde Cholangio-Pancreatography with Endoscopic Retrograde Biliary Drainage was performed as well.

For lymphoma treatment, methylprednisolone was prescribed initially, followed by chemotherapy with modified COP (cyclophosphamide + vincristine + methylprednisolone). He was gradually recovered from anuria and obstructive jaundice. Further chemotherapy with modified DA-EPOCH (dose-adjusted Etoposide + Vincristine + Cyclophosphamide+ Doxorubicin + methylprednisolone) was performed for this patient later.