

Is bendamustine plus rituximab a suitable option for rituximab-refractory duodenal-type follicular lymphoma?

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To the Editor,

Duodenal follicular lymphoma (DFL) is a specific variant of FL, predominantly localized in the second portion of the duodenum and often represents an incidental finding, even if some cases can present with abdominal pain. Overall prognosis is excellent, with high progression-free survival (PFS) and overall survival (OS) (1).

Watch&wait, rituximab or radiotherapy (RT) should represent a suitable first-line therapy with long-term efficacy (1-4). However, a small proportion of rituximab-refractory patients exists. Here we would like to report a rituximab-refractory DFL successfully treated with rituximab and bendamustine (BR).

A 67-year-old man was referred to our Hospital because of abdominal pain, with normal blood cell count. Endoscopic findings included whitish nodular lesions in the second portion of the duodenum with granular aspects. Helicobacter Pylori evaluation was negative. Neoplastic cells infiltrated the lamina propria outside of the follicles, histological diagnosis according to WHO 2016 classification was DFL (CD20+, BCL2+, CD10+, BCL6+, MIB1 10-20%). Bone marrow biopsy demonstrated normal cellularity without lymphoid infiltrates. Computed tomography (CT) scan showed a localized thickening of duodenal walls, confirmed by 18F-FDG PET. Ann Arbor staging was IA, FLIPI score was 1.

The patient signed informed consent according to the Declaration of Helsinki and received intravenous weekly rituximab for a total of 4 administrations. Esophagogastroduodenoscopy performed 4 weeks after last administration showed both endoscopic and histological DFL persistence. It is unusual to find a rituximab-refractory DFL; however, given that DFL has some biological similarities with MALT lymphoma, we

tried to administer BR regimen (4 cycles of bendamustine 90mg/m² and rituximab 375mg/m² every 28 days). CT scan after 4th cycle demonstrated a complete disappearance of duodenal wall thickening, without enlarged lymph nodes, esophagogastroduodenoscopy was negative for DFL. Treatment tolerance was excellent. The patient started endoscopic follow-up; at last evaluation after 18 months he was still in CR.

Rituximab or RT could be a reasonable treatment option for localized FL, including DFL (1-4). RT alone demonstrated long-term local disease control, but 4/21 patients relapsed outside the irradiated area (4). BR could represent a suitable regimen for both follicular and MALT lymphoma (5). In our knowledge, it is the first report of BR use in DFL.

In conclusion, we suggest DFL has significant differences compared to nodal FL and multiple similarities with MALT lymphoma, arguing a common origin (1). There is a limited proportion of rituximab-refractory cases in which BR regimen could represent a suitable treatment choice.

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