

13º Encontro do Núcleo de Especialidades  
Sociedade Brasileira de Patologia  
23.jun.12

Dra. Sheila Ap. Coelho Siqueira

Dr. Ariel Barreto Nogueira

- Identificação:

- Masculino, 56 anos, pardo, casado, natural de Barra do Mendes-BA e procedente de Carapicuíba-SP. Operador de injetoras. Ateu.

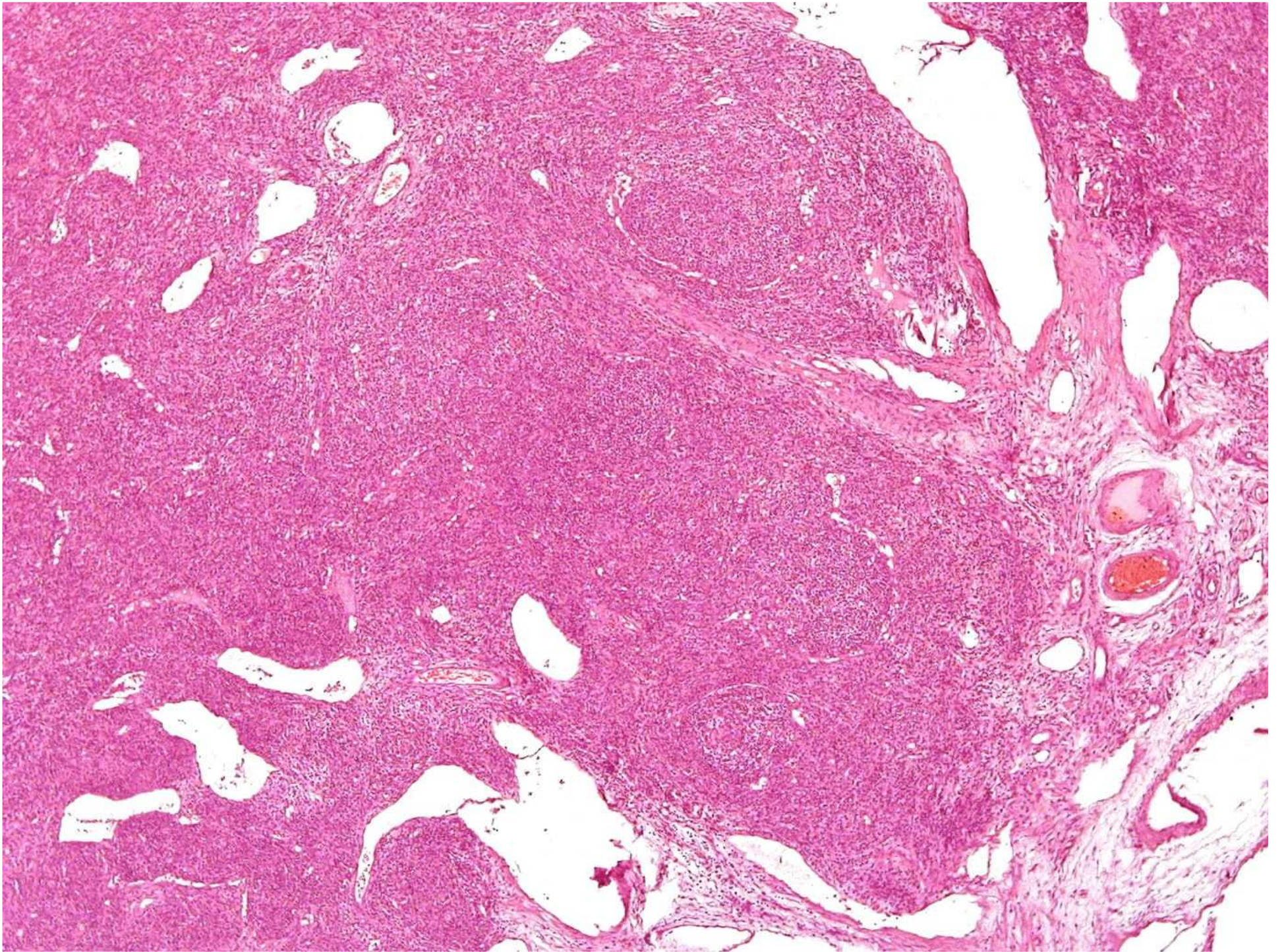
- Queixa e duração:

- Nódulo inguinal há 5 meses

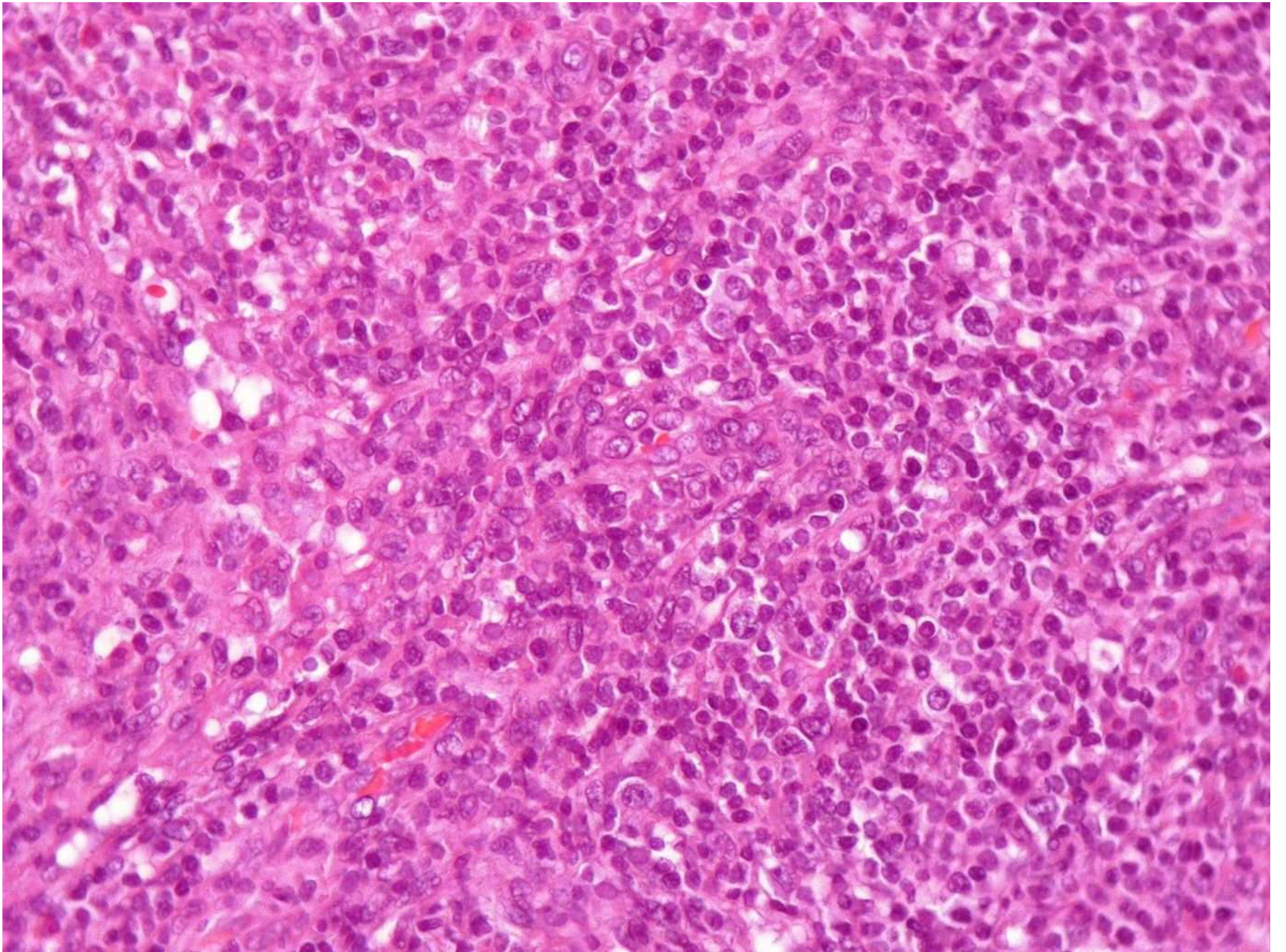
- Antecedentes Pessoais: negava HAS, DM, IM, AVC prévios. Tabagista 20 anos/maço, DPOC. Ex-etilista há 1 ano.
- Antecedentes Familiares: sem antecedentes relevantes
- Exame físico:
  - REG, palidez cutânea
  - Adenomegalia submentoniana até 1,5cm, móvel, indolor; cervical anterior bilateral até 1,5cm; supraclavicular bilateral até 2cm; axilar até 3cm; inguinal bilateral até 3cm.
  - Flácido, RHA+, baço a 2cm RCD indolor, fígado a 2cm RCD, discretamente doloroso.

Linfonodo inguinal – revisão externa  
Março/2011

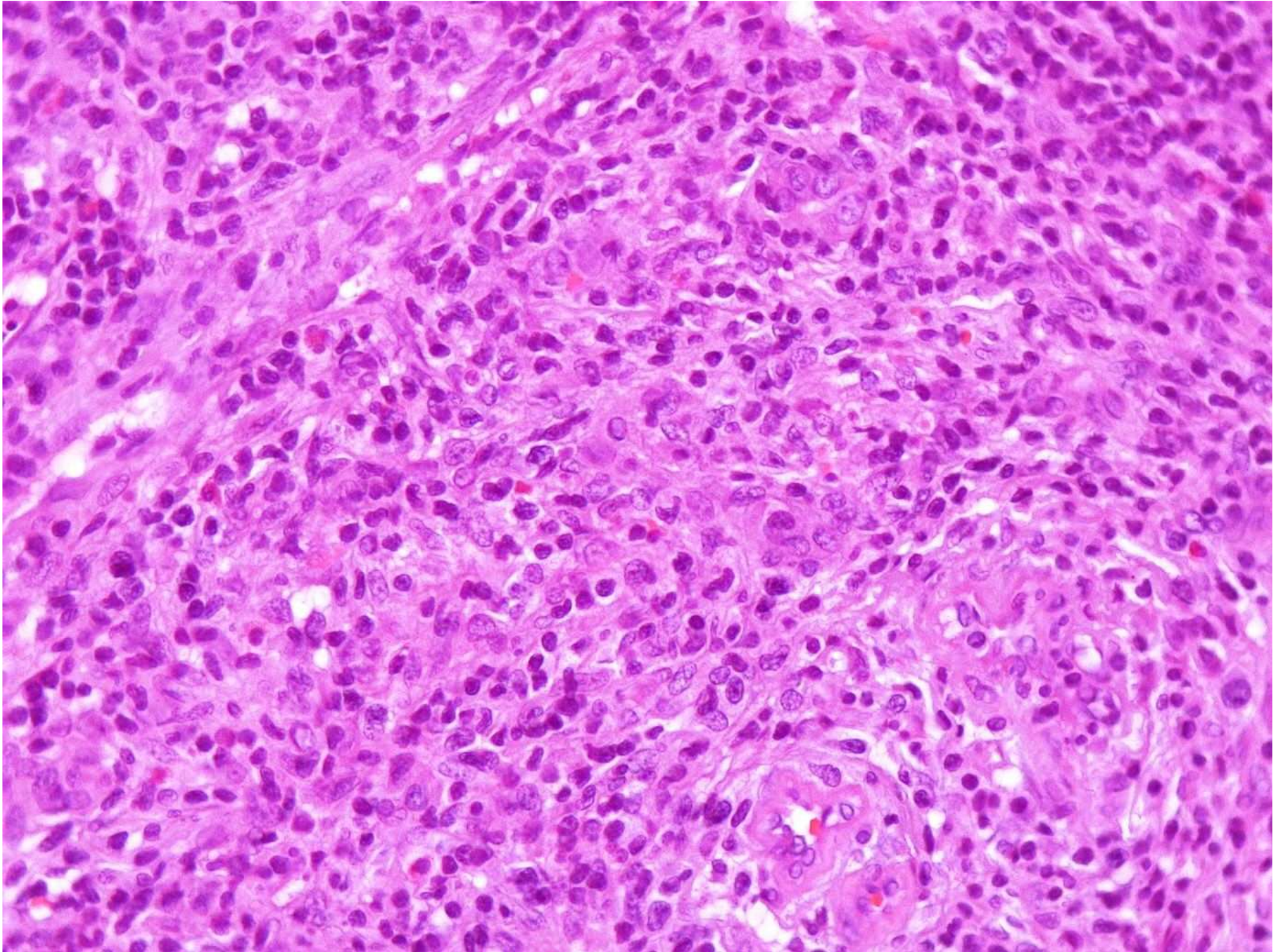




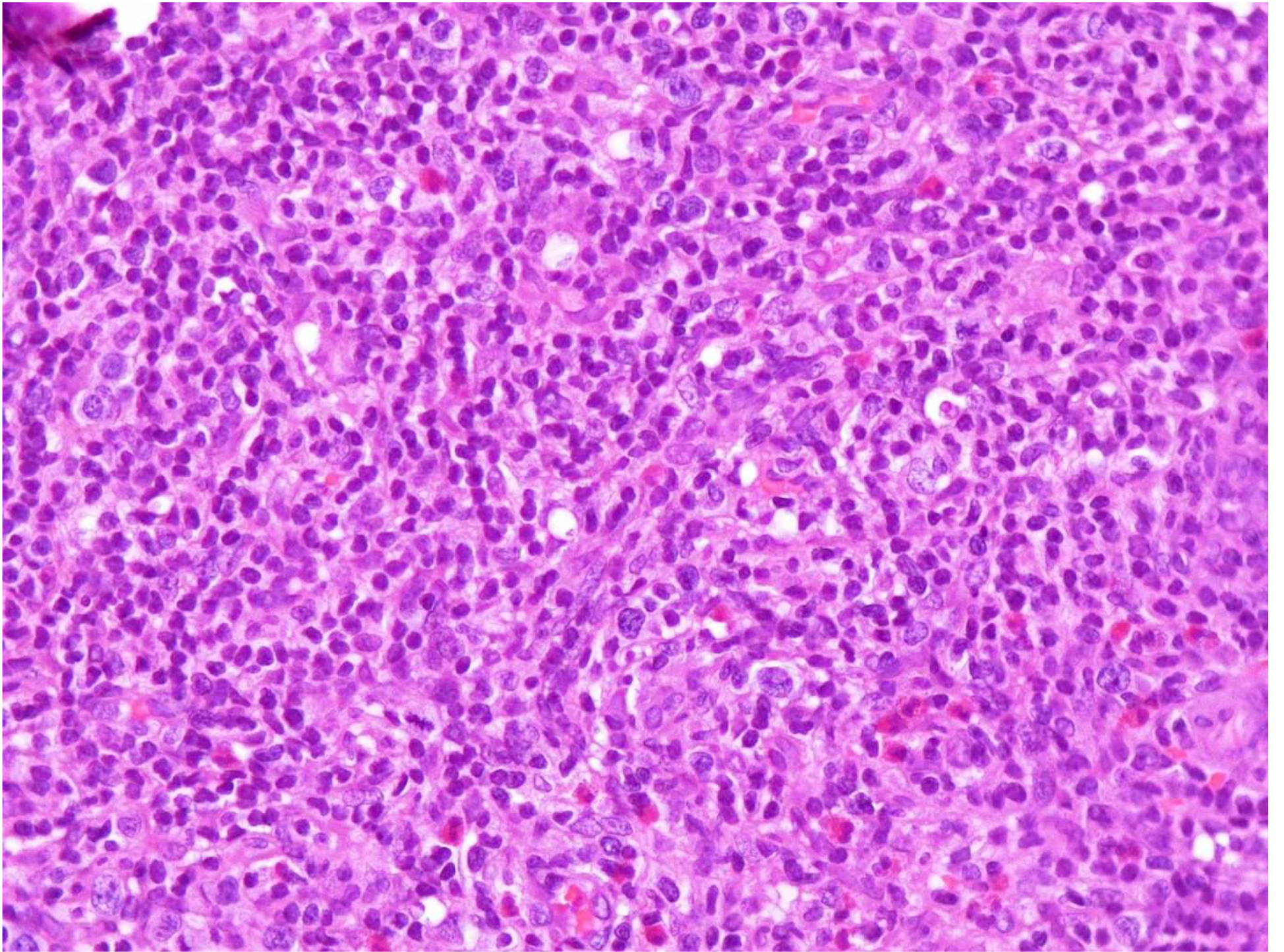












- Hemograma (abril 2011)

- Hb 11,6
- VCM 88,9
- Leucócitos 11710
- Neutrófilos 4400
- Eosinófilos 500
- Linfócitos 5400
- Monócitos 1300
- Plaquetas 120000



Mielograma (28/04/11):

MORFOLOGIA: predomínio de células maduras, algumas com núcleo convoluto de aspecto cerebriforme e 1 nucléolo evidente. Visualizados número aumentado de linfócitos grandes granulares.

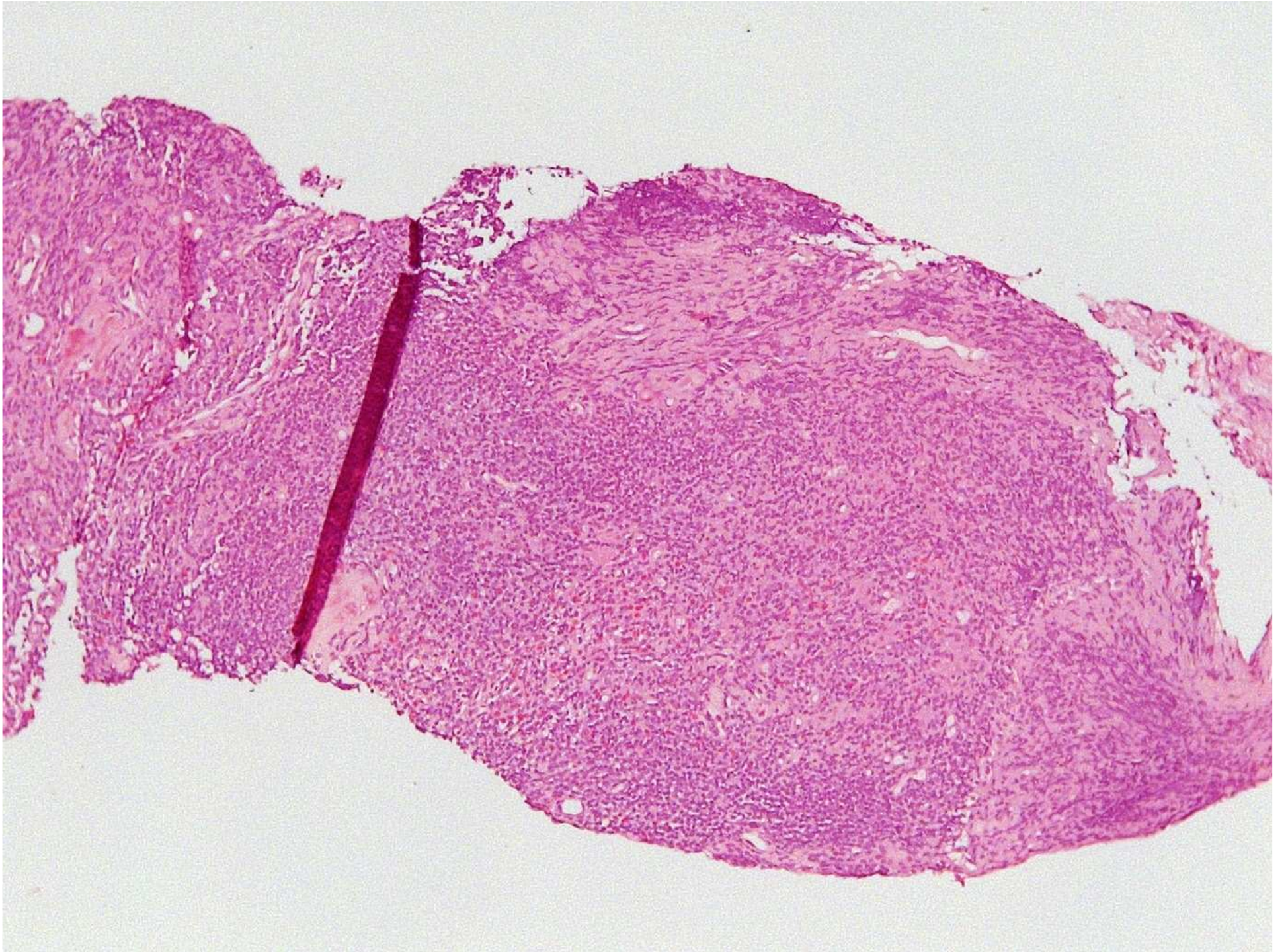
Presença de 11% de células CD3-/CD4+++ /CD26+++ que podem corresponder a população linfóide T clonal.

CONCLUSÃO: O conjunto dos achados morfológicos e imunofenotípicos admitem possibilidade de linfoproliferação T em fase circulante, porém necessita confirmação por citogenética ou pesquisa de clonalidade T por biologia molecular.

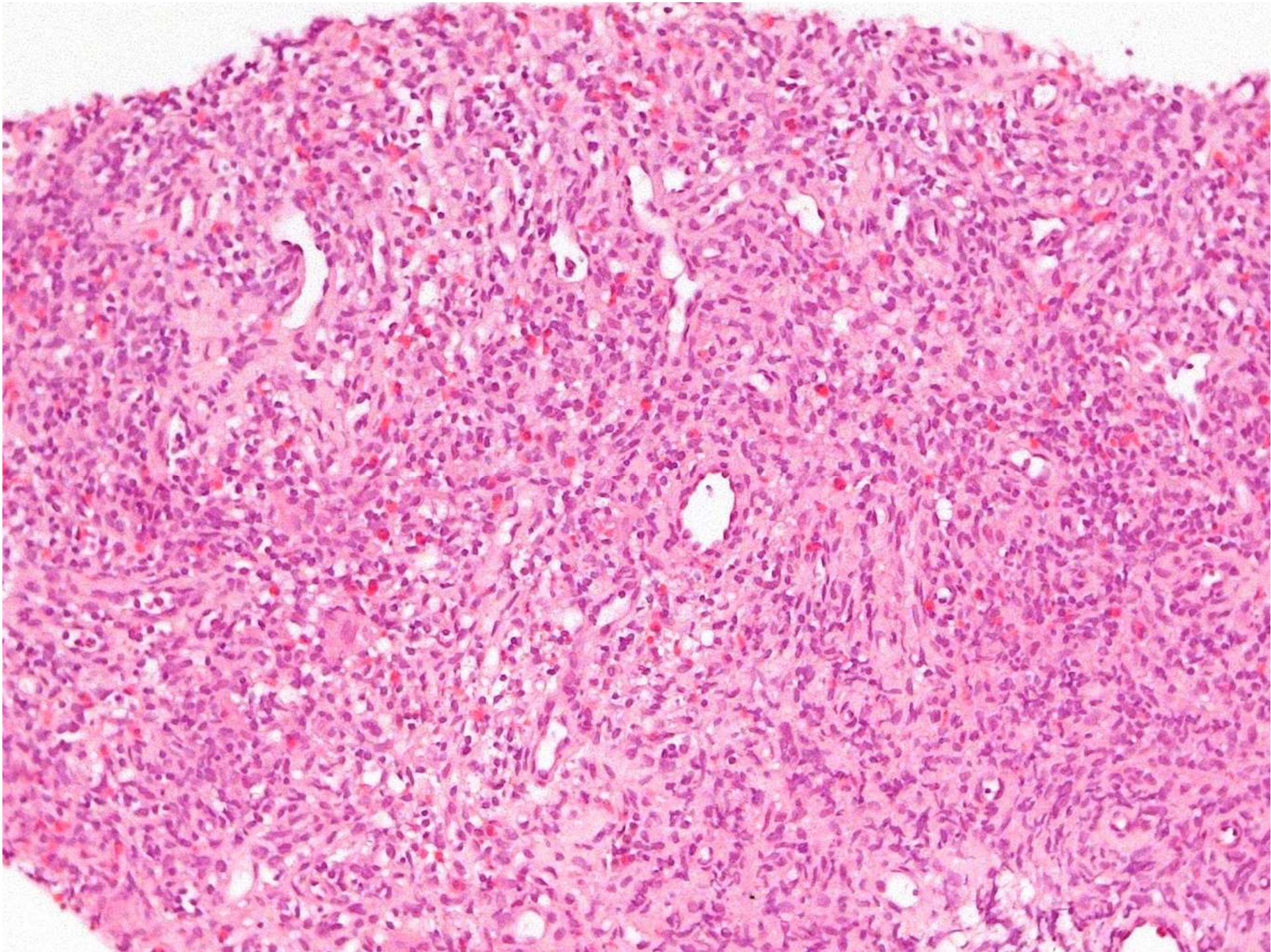
- *Pesquisa de clonalidade T (09/05/11): O rearranjo clonal do TCR sugere diagnóstico de doença linfoproliferativa T, entretanto, há necessidade de correlação com outros exames laboratoriais e achados clínicos para a elucidação diagnóstica.*

Linfonodo axilar direito  
Junho/2011

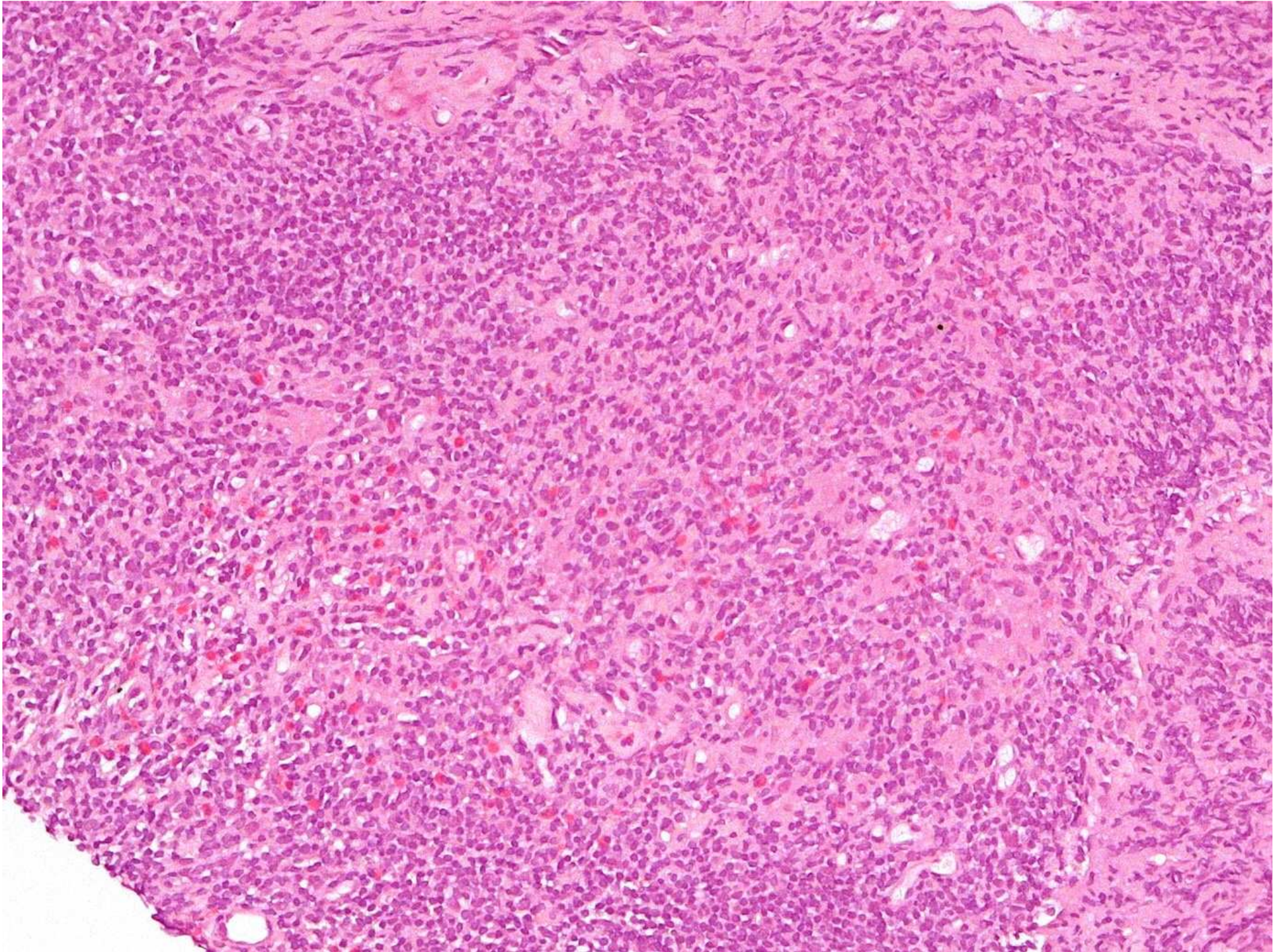




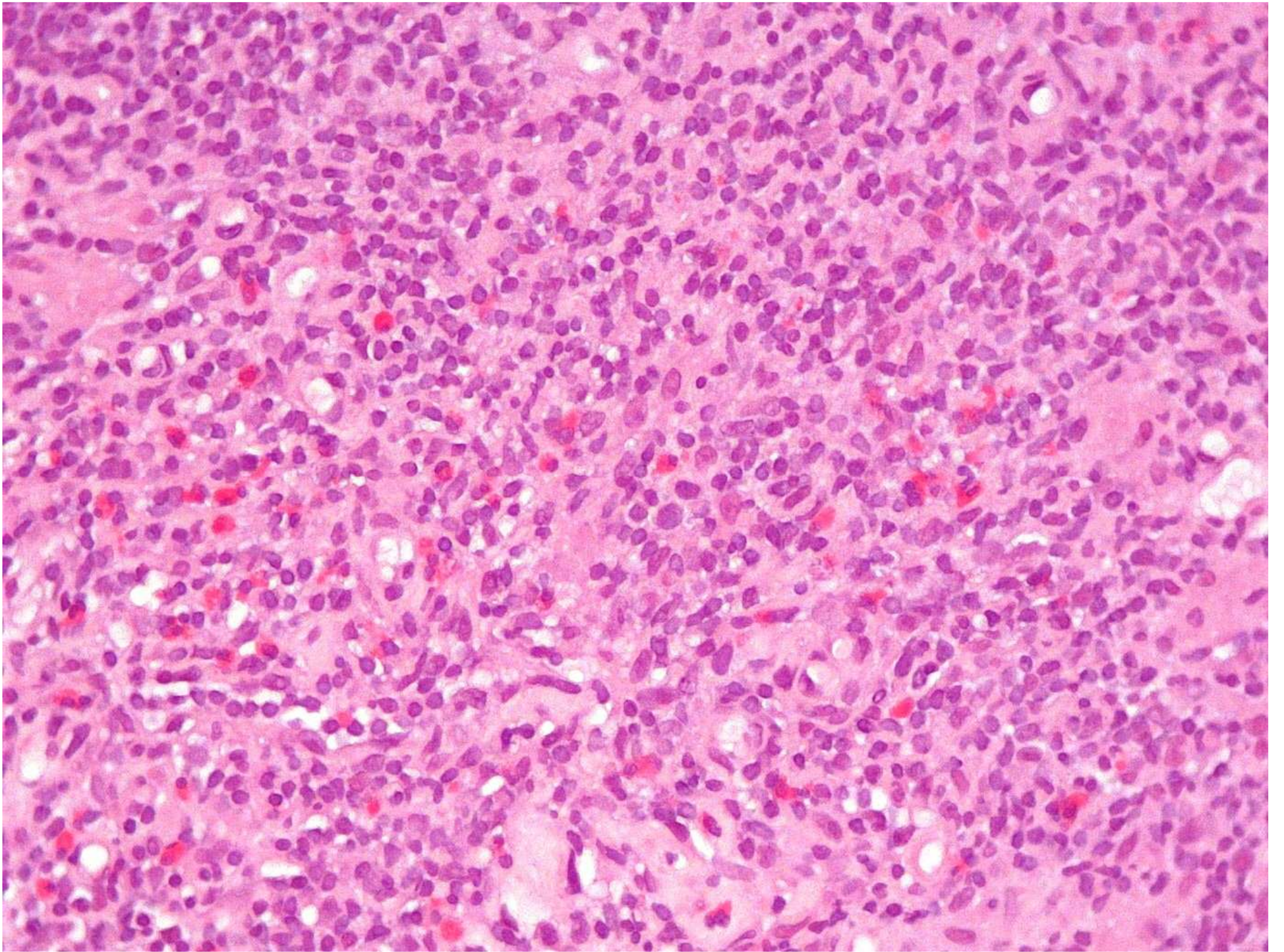






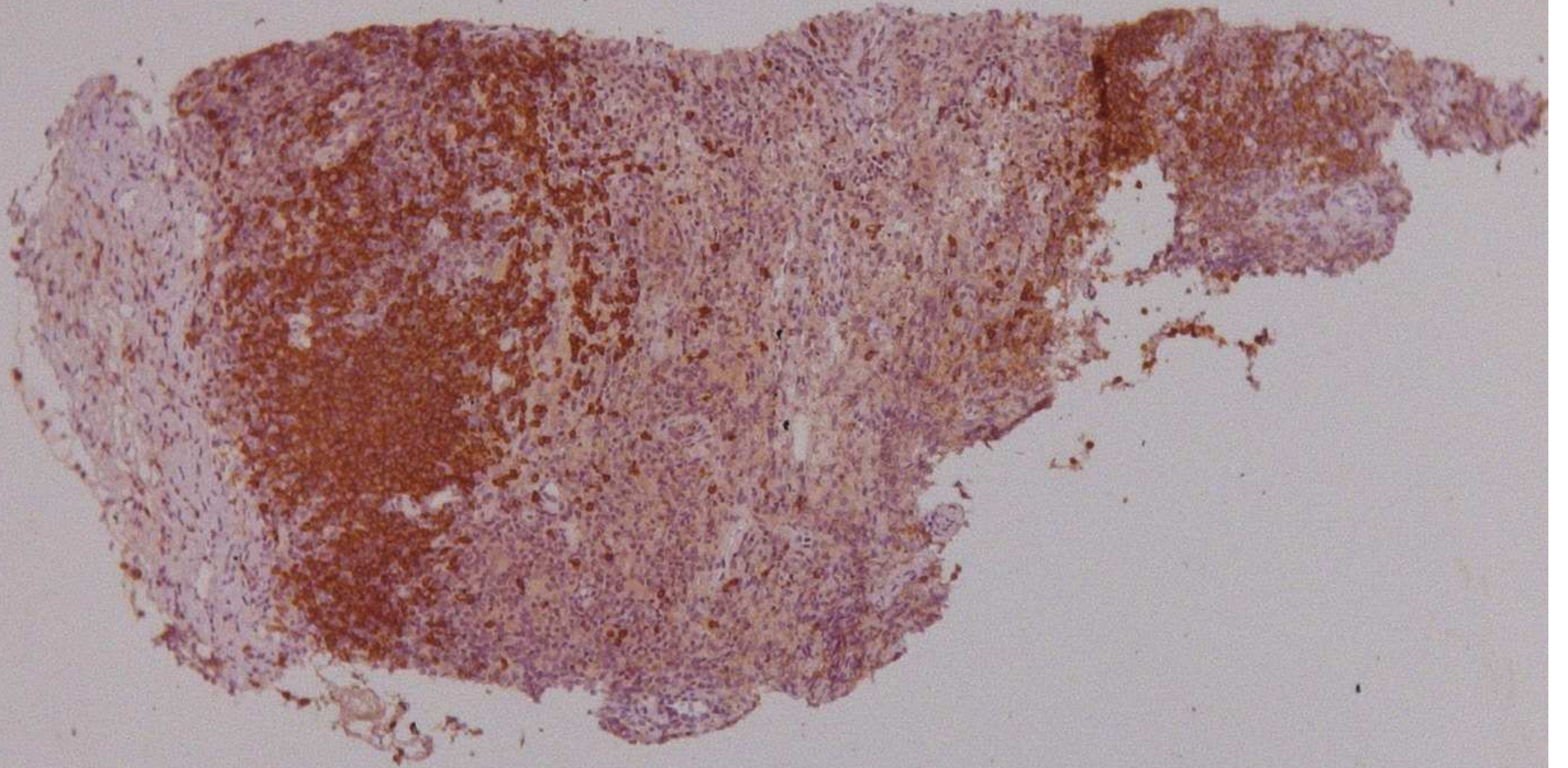






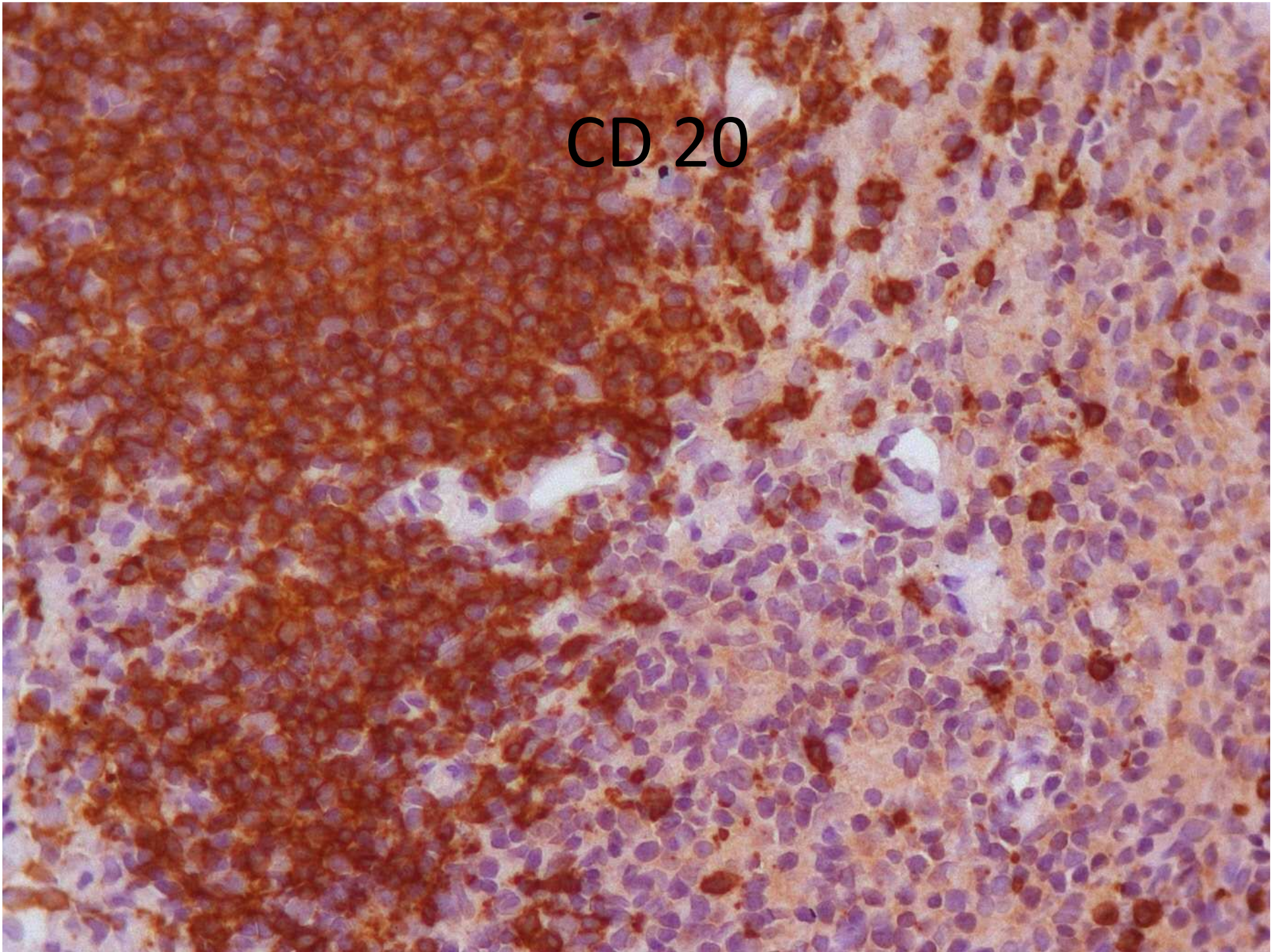


CD 20



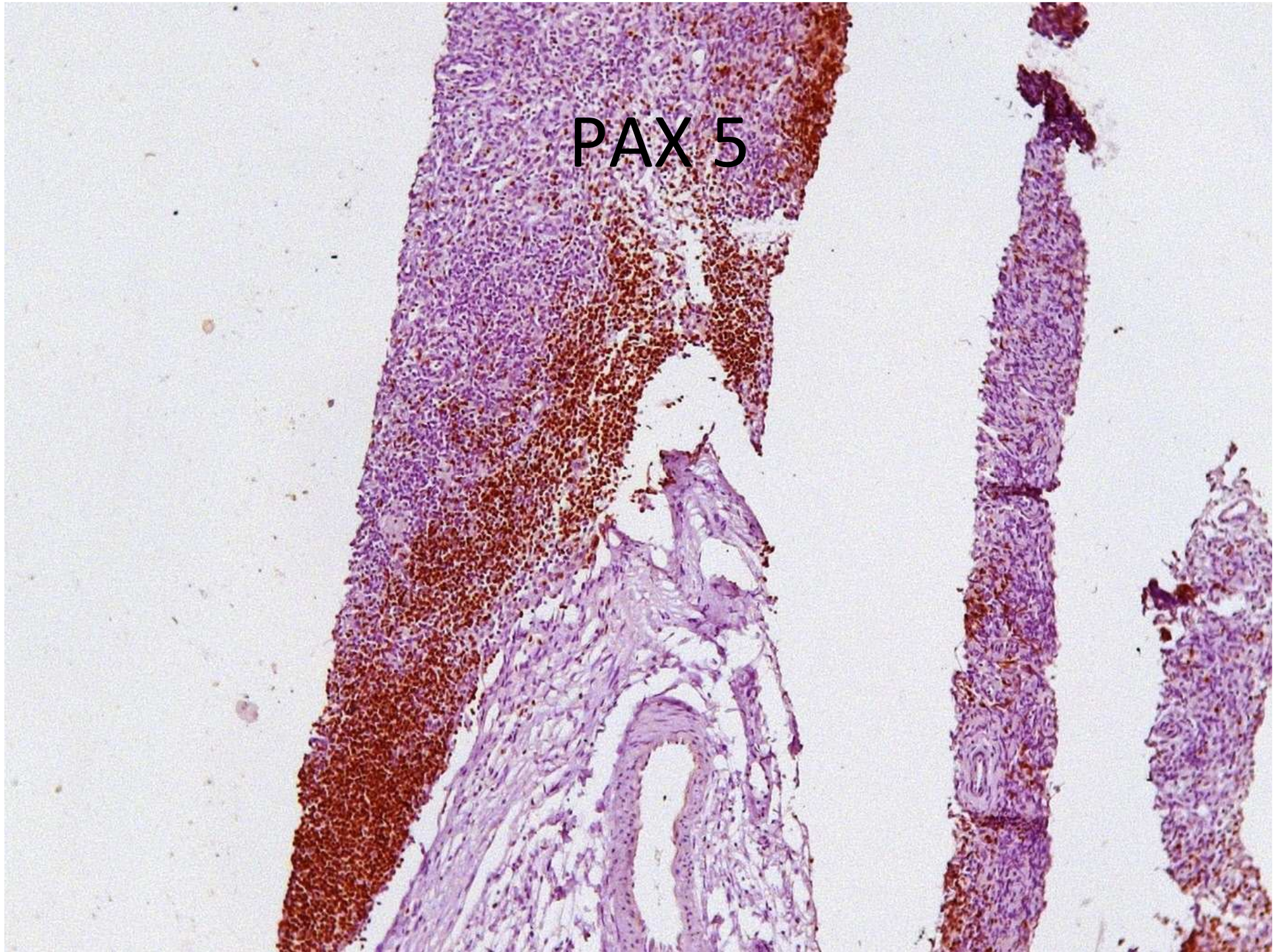


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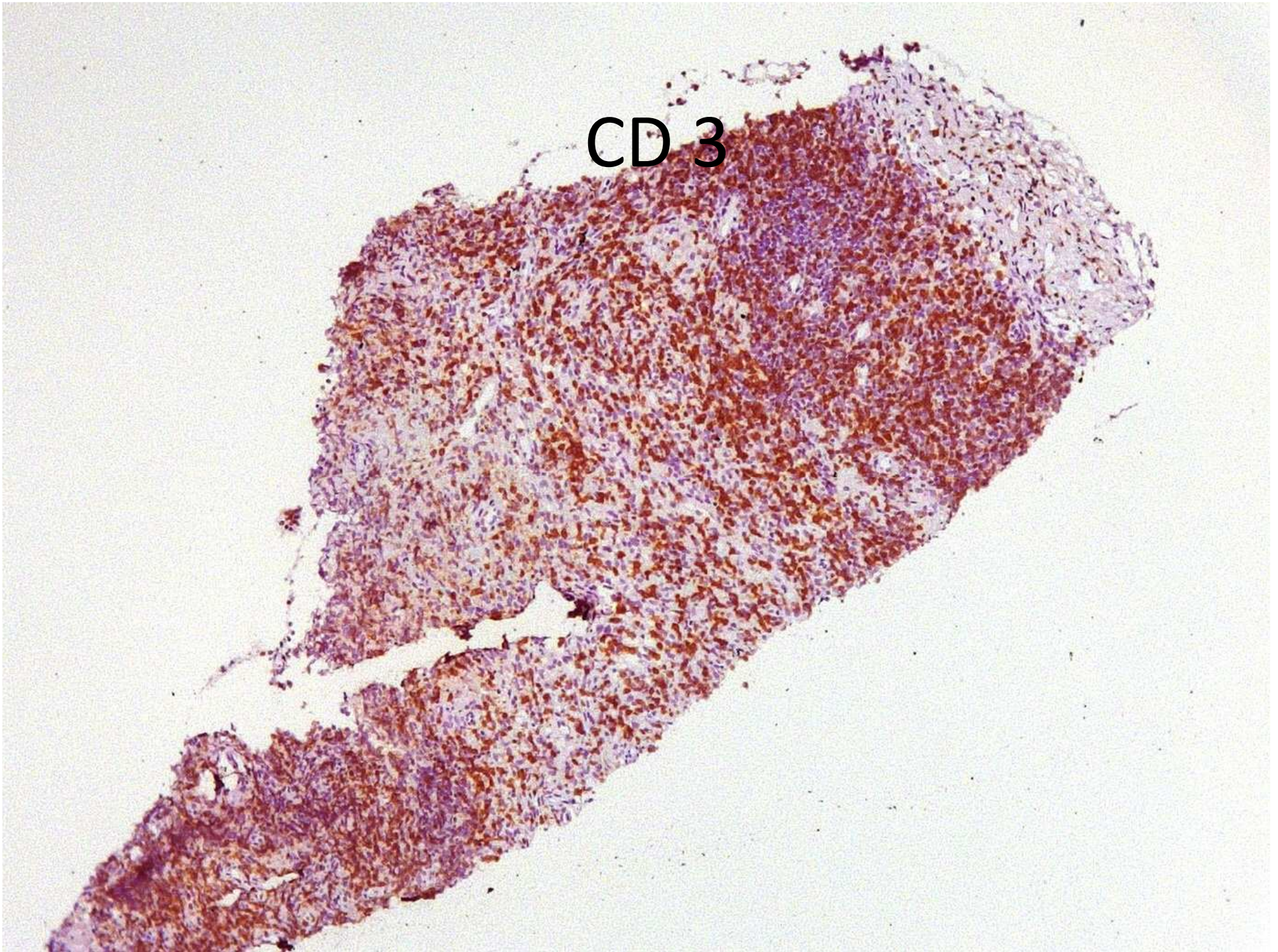


PAX 5



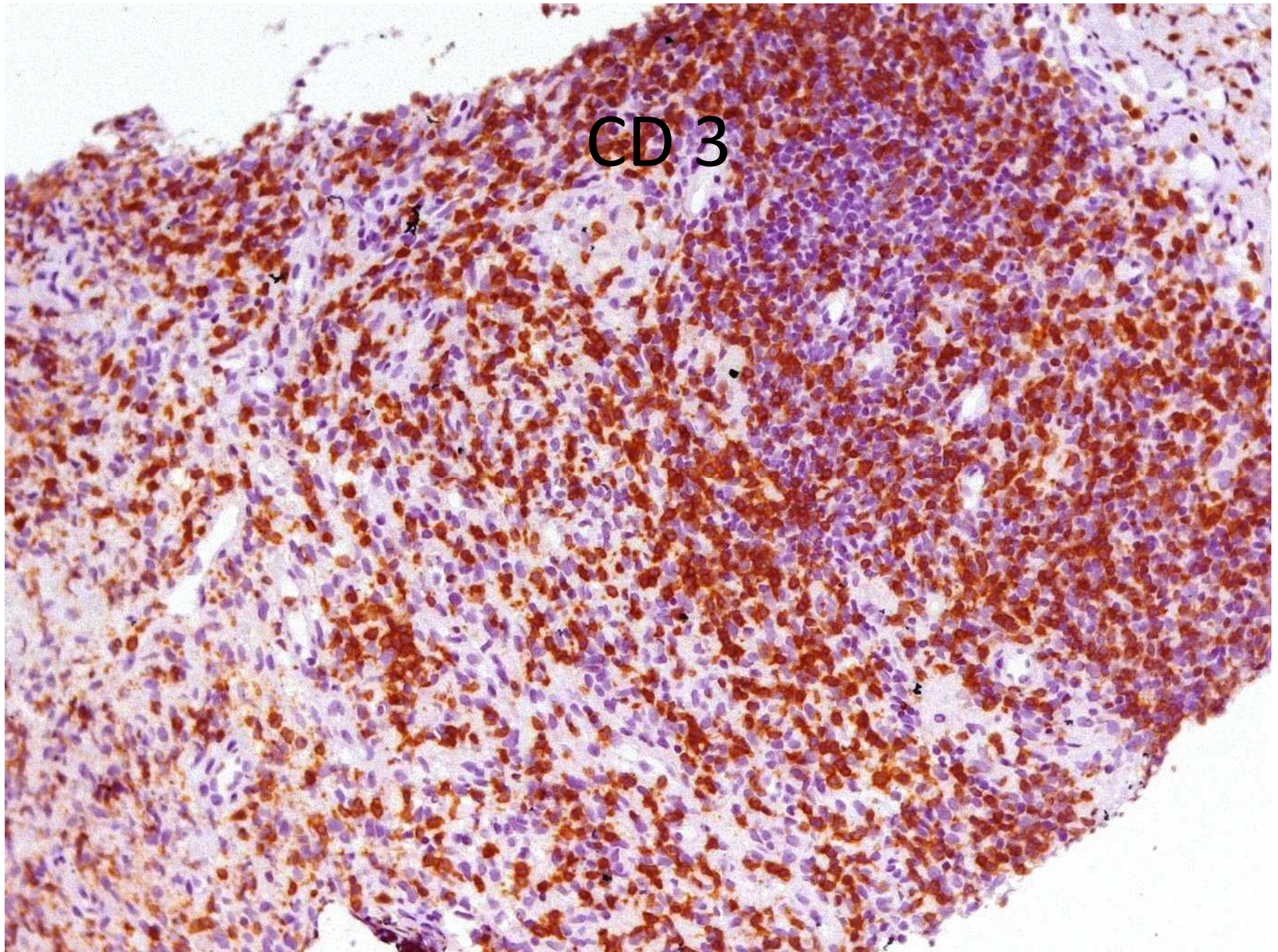


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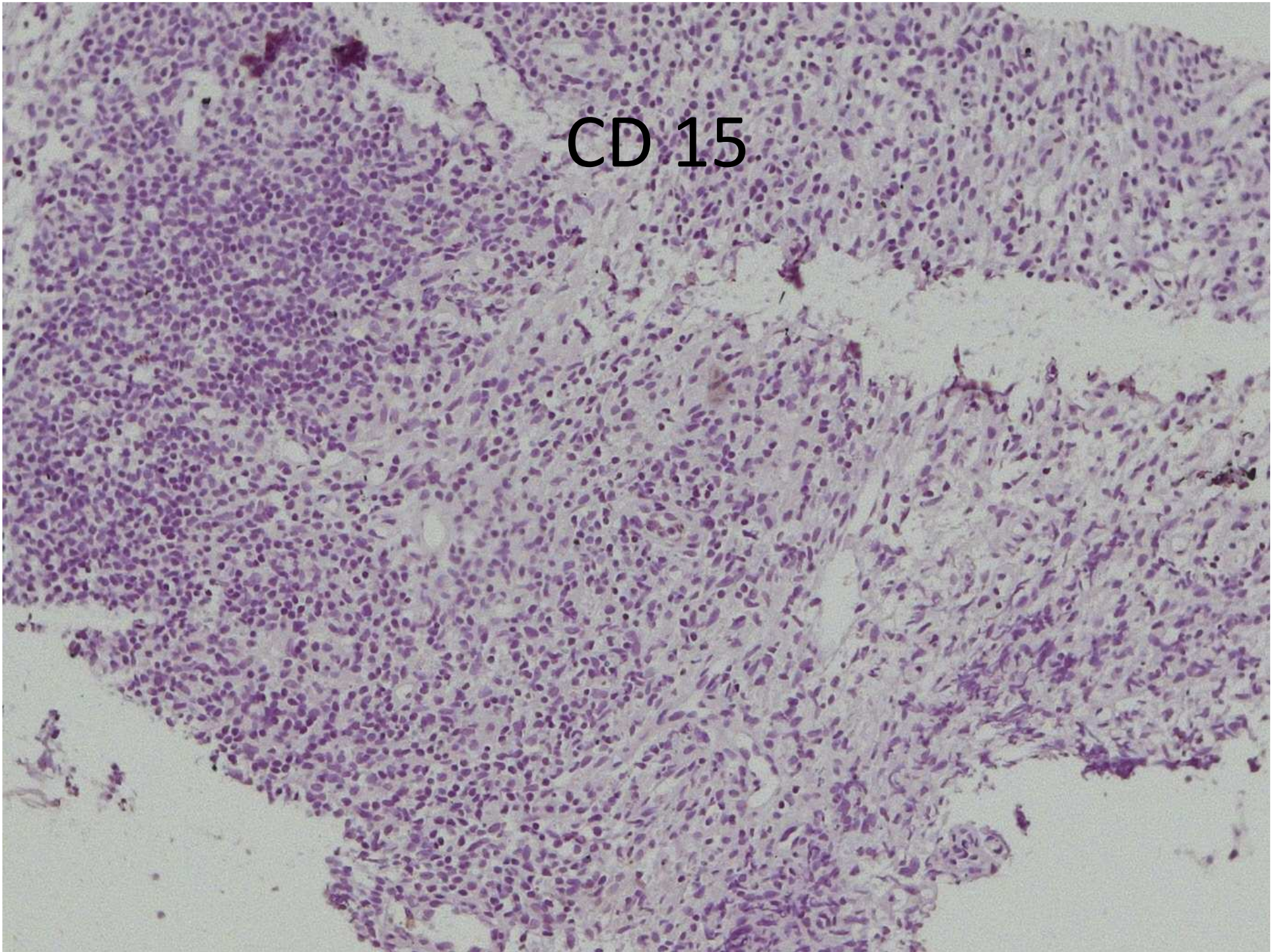


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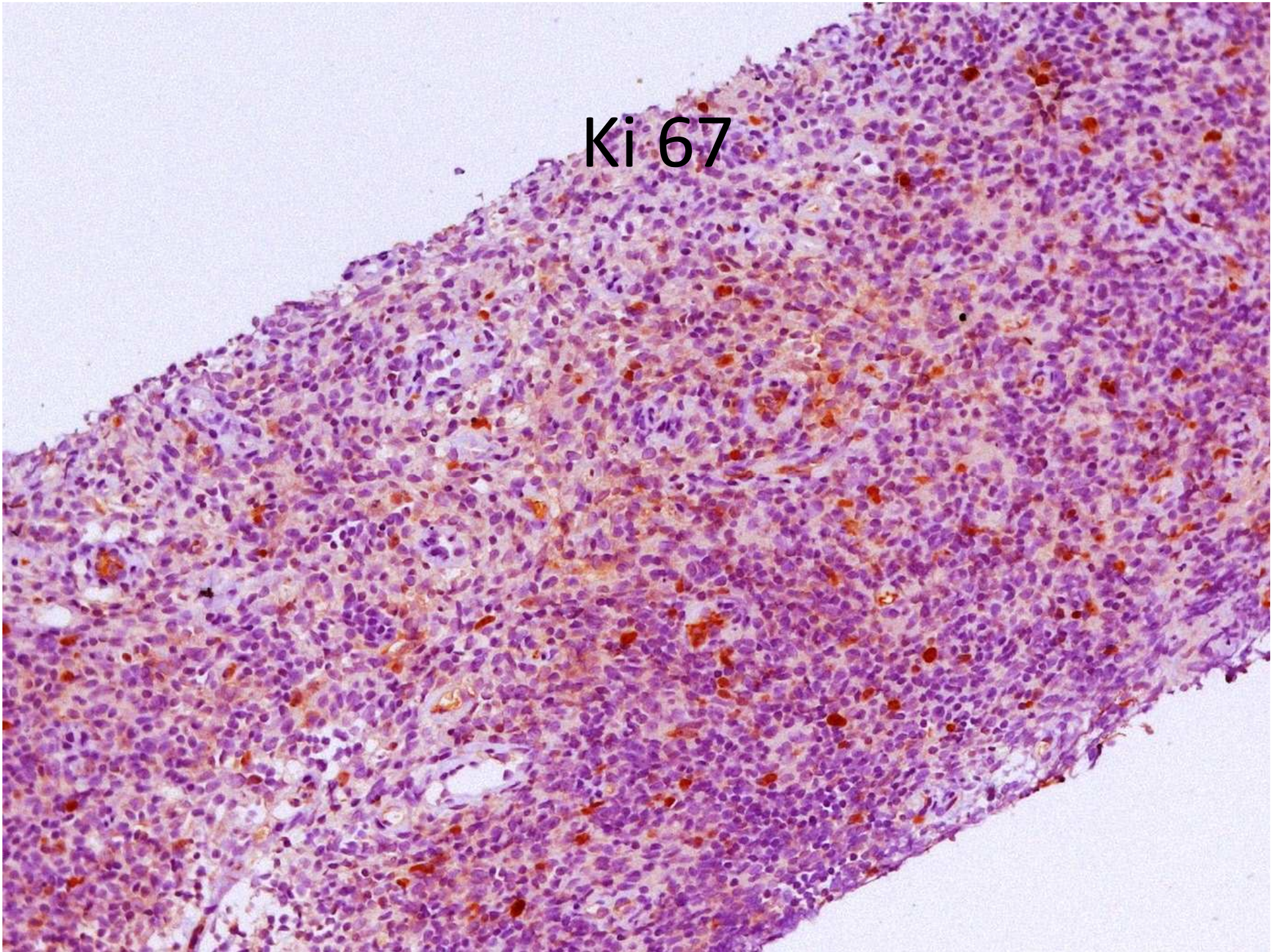


CD 15



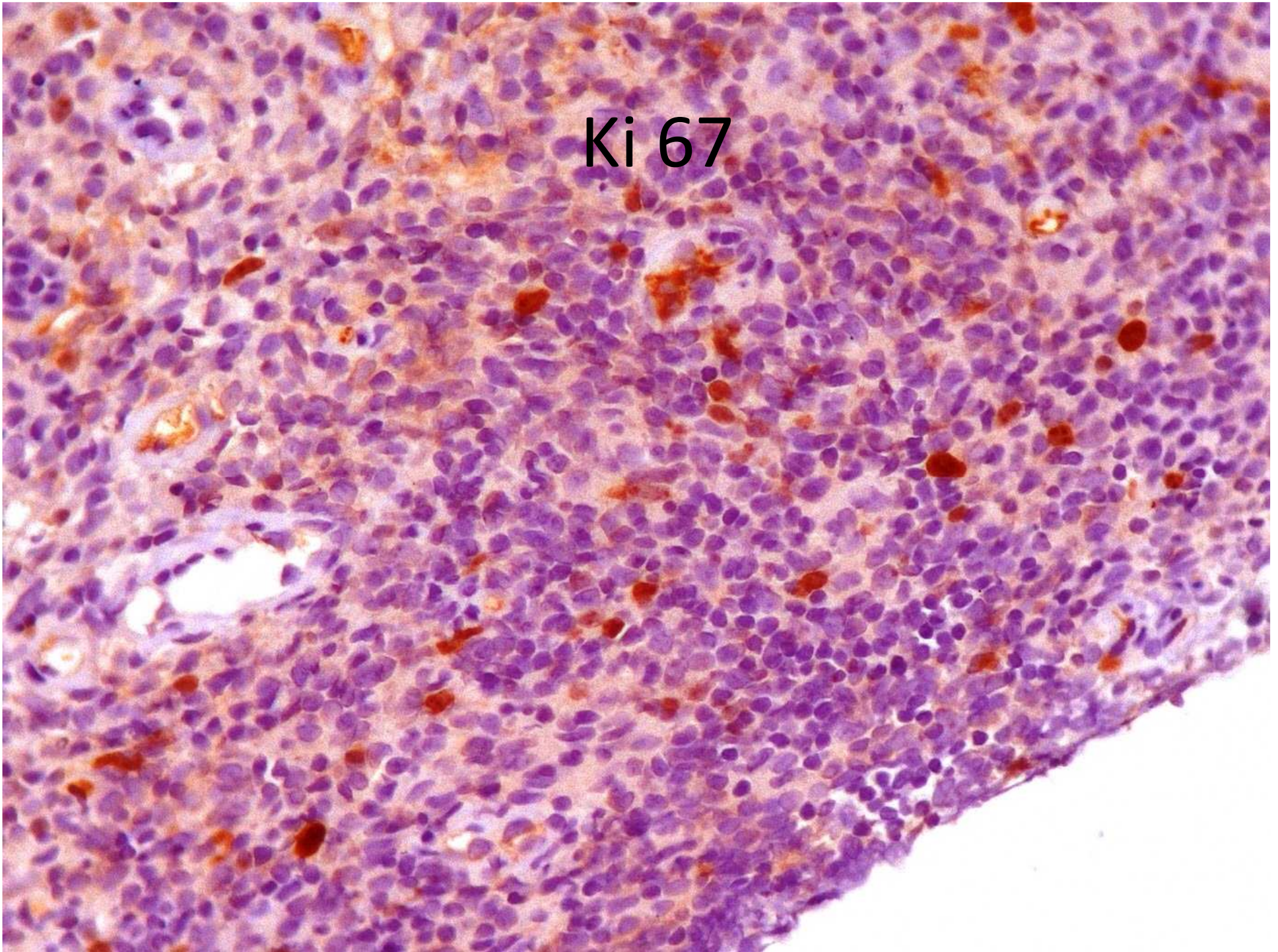


Ki 67





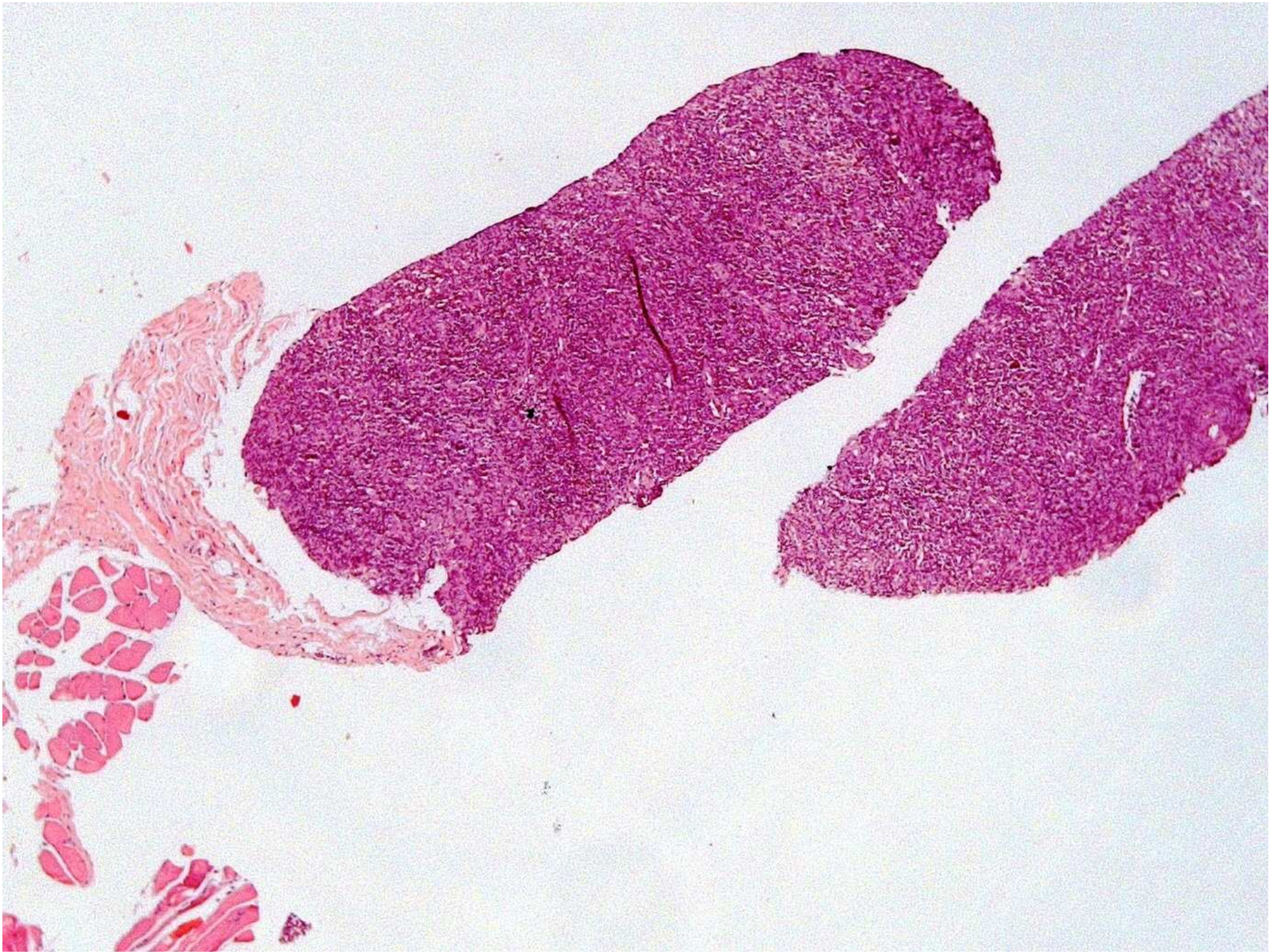
Ki 67



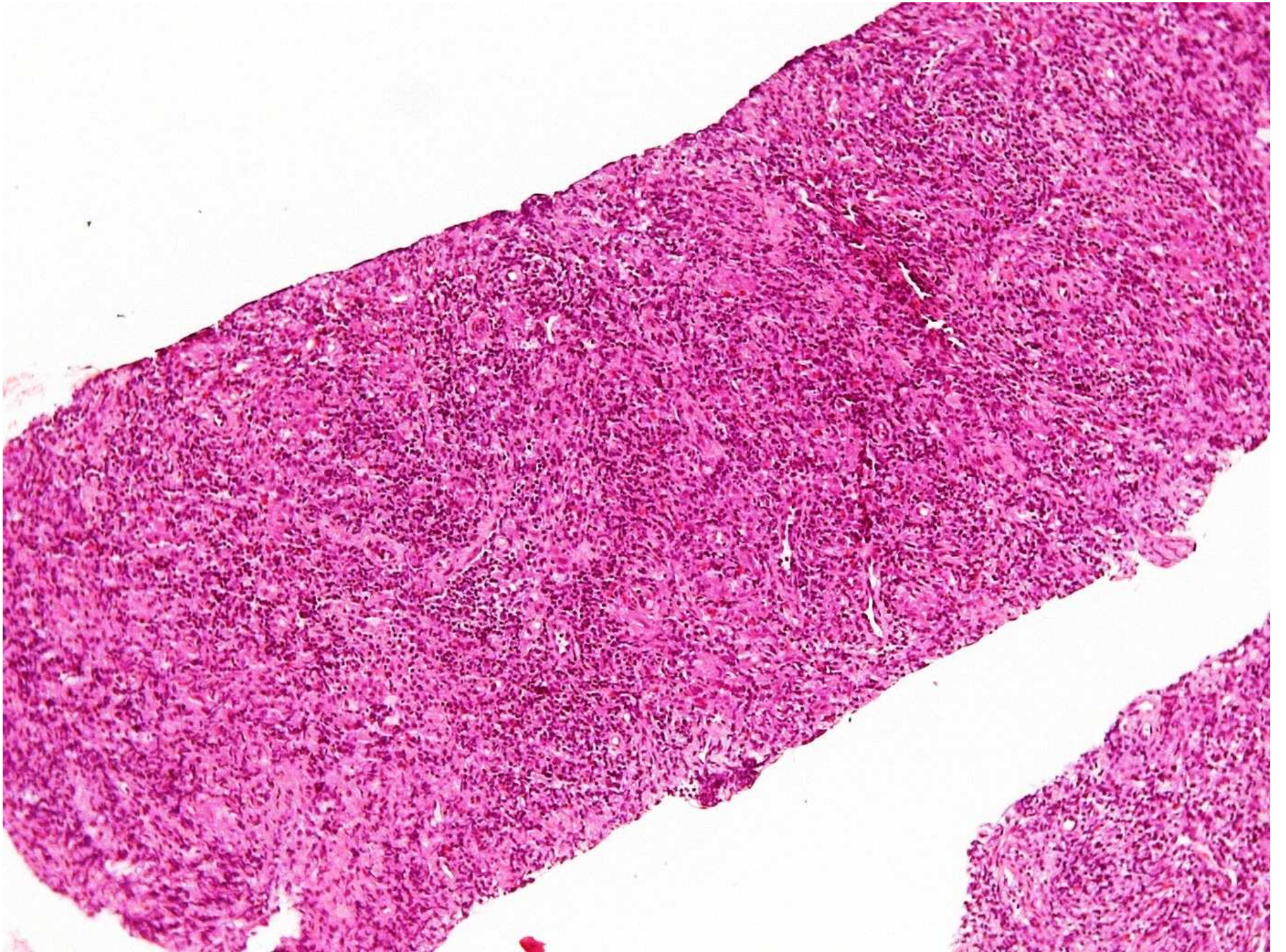
- *Pesquisa de clonalidade T (09/05/11): O rearranjo clonal do TCR sugere diagnóstico de doença linfoproliferativa T, entretanto, há necessidade de correlação com outros exames laboratoriais e achados clínicos para a elucidação diagnóstica.*
- *Pesquisa de clonalidade T (04/08/11): Presença de população monoclonal para o gene gama do receptor de célula T. OBS: O rearranjo clonal do TCR sugere o diagnóstico de doença linfoproliferativa T, entretanto, há necessidade de correlação com outros exames laboratoriais, e achados clínicos para a completa elucidação diagnóstica.*

Linfonodo cervical – nivel II  
Agosto/2011

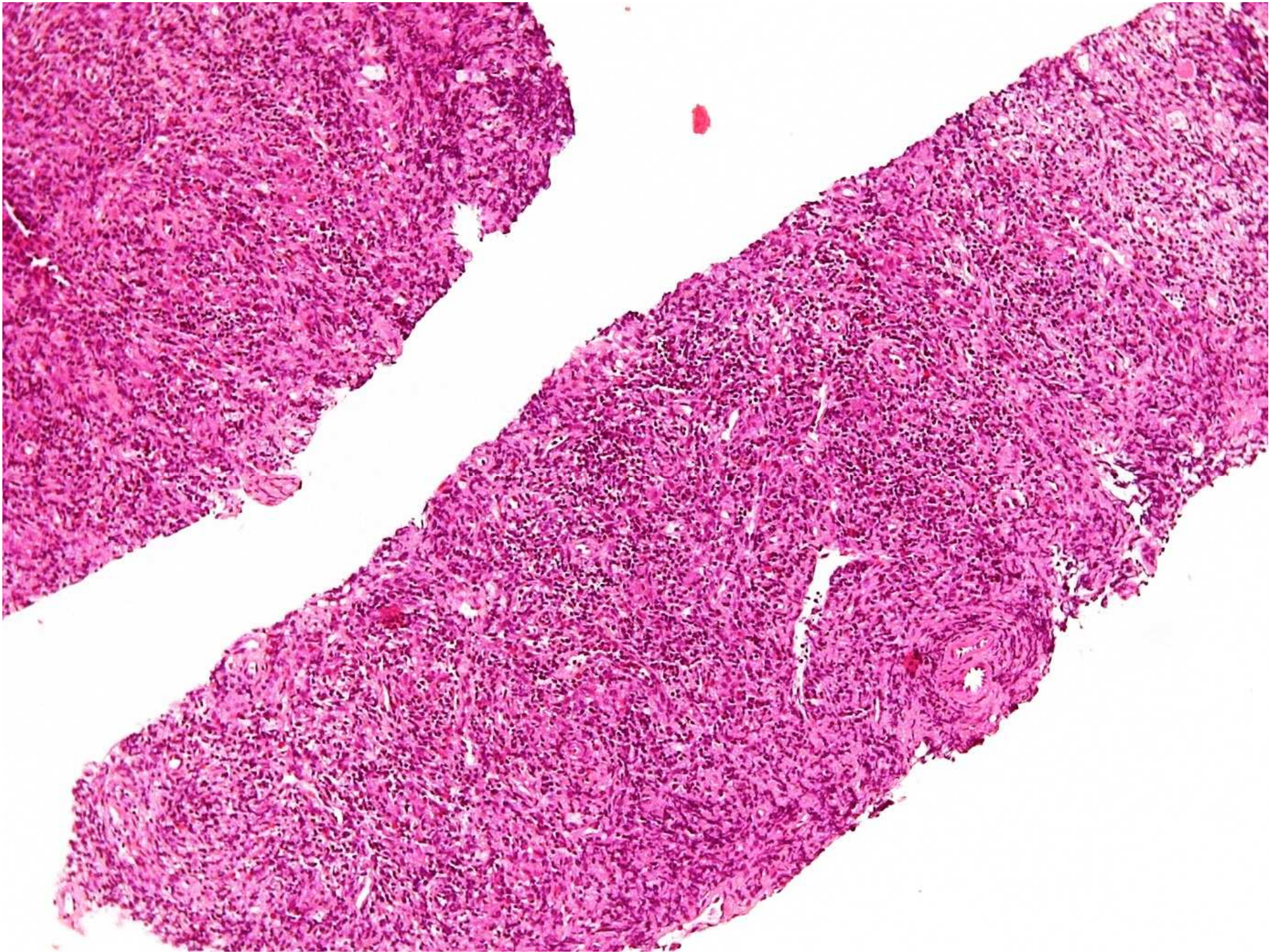




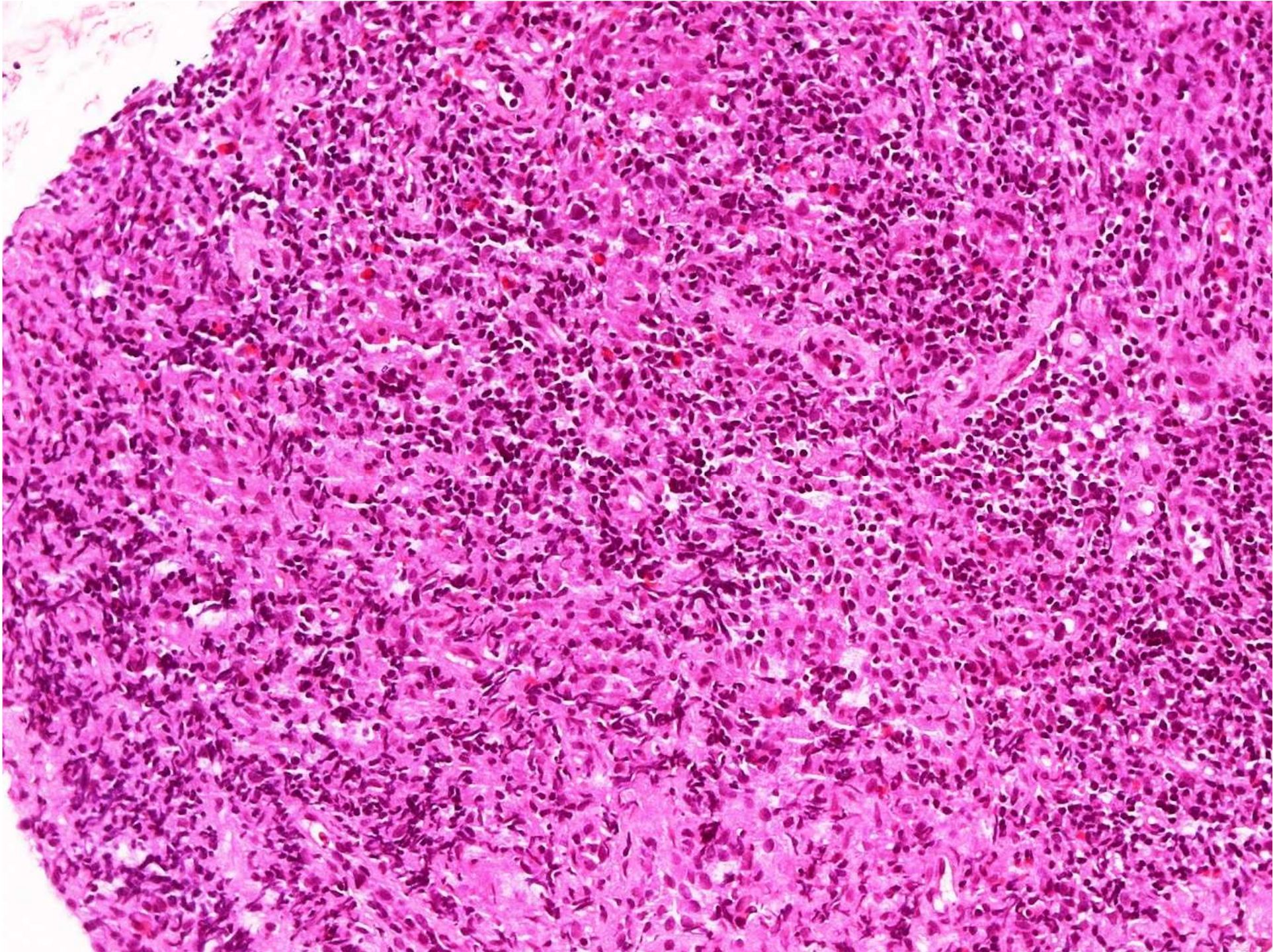




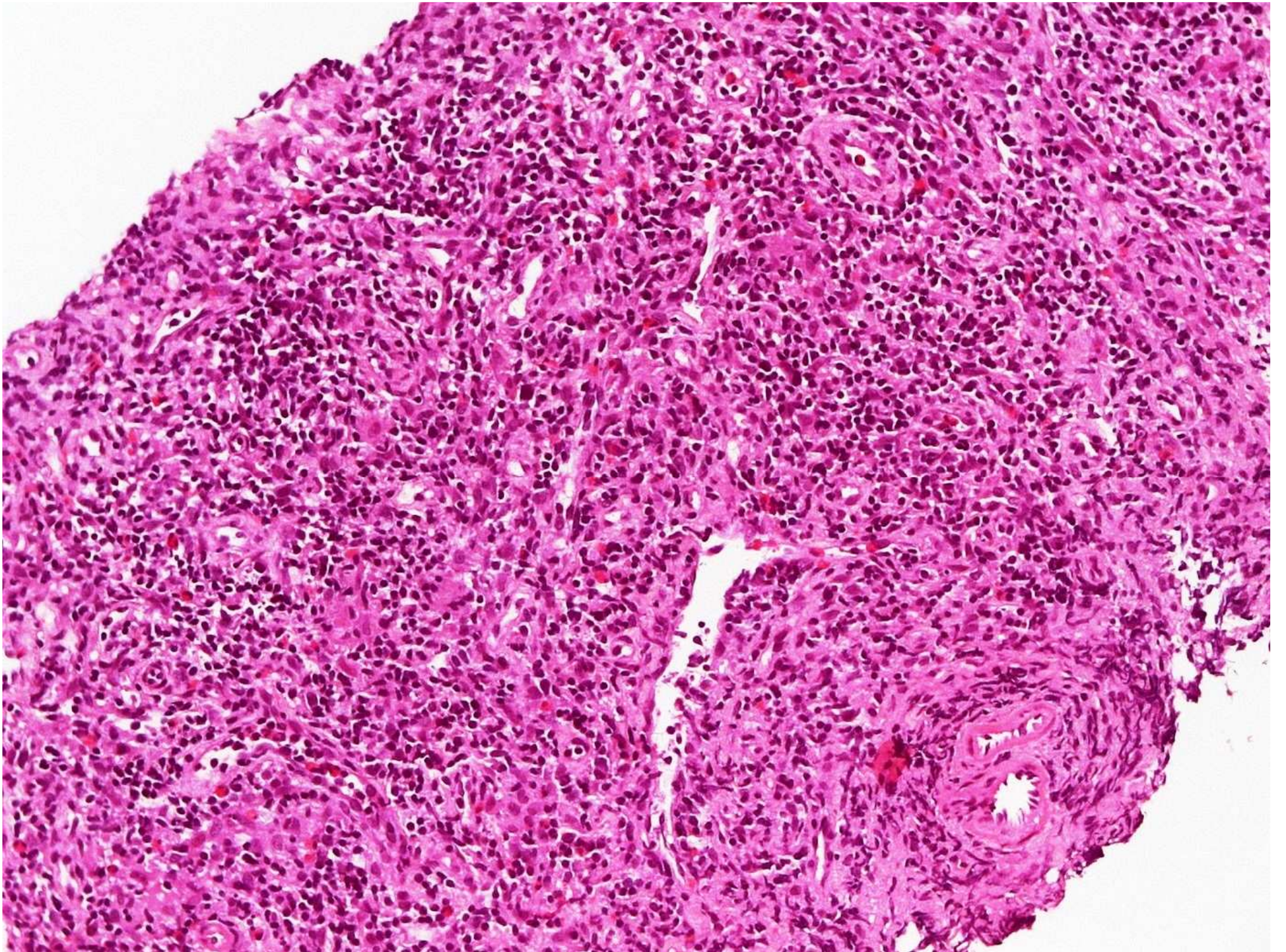




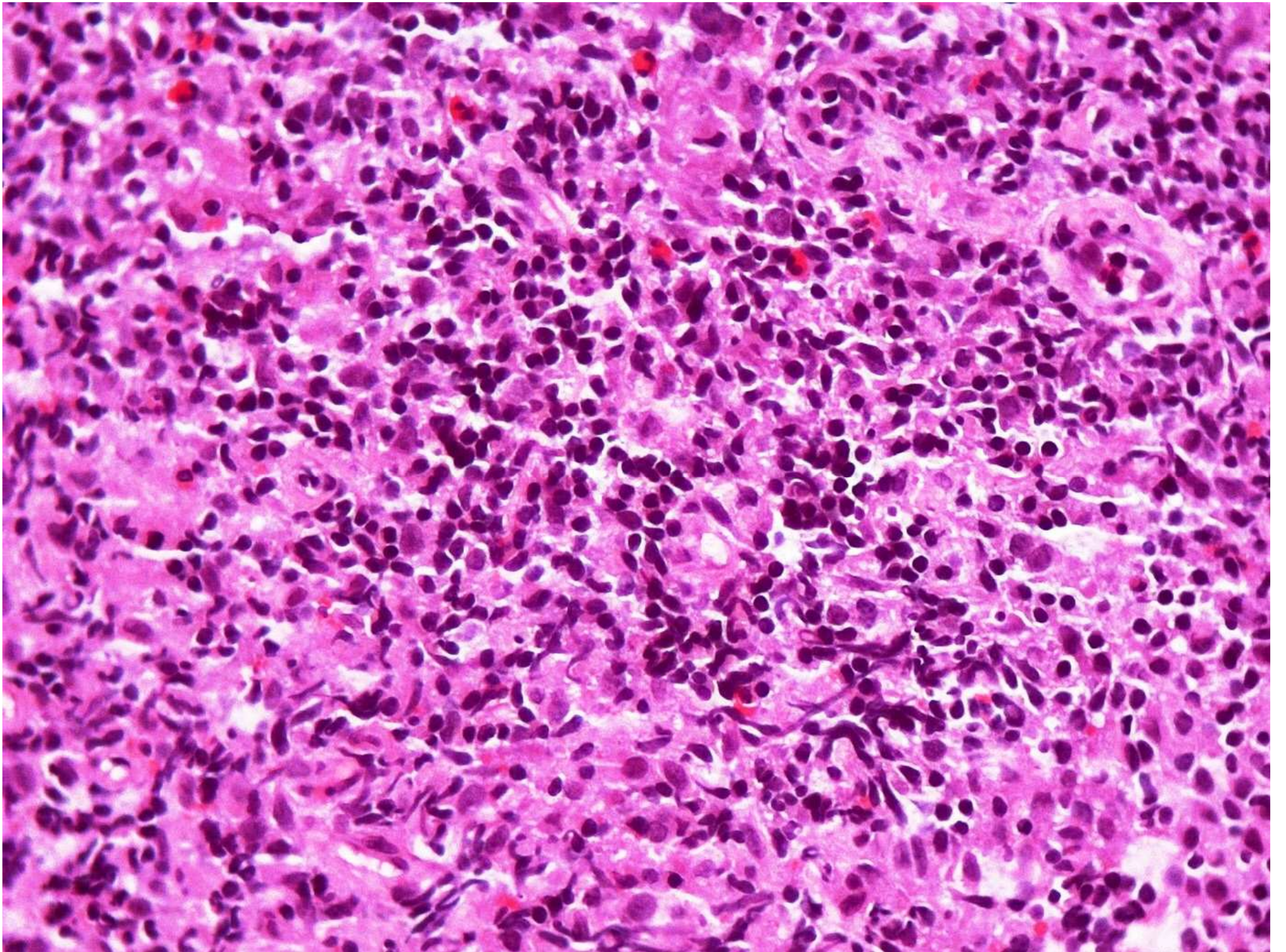




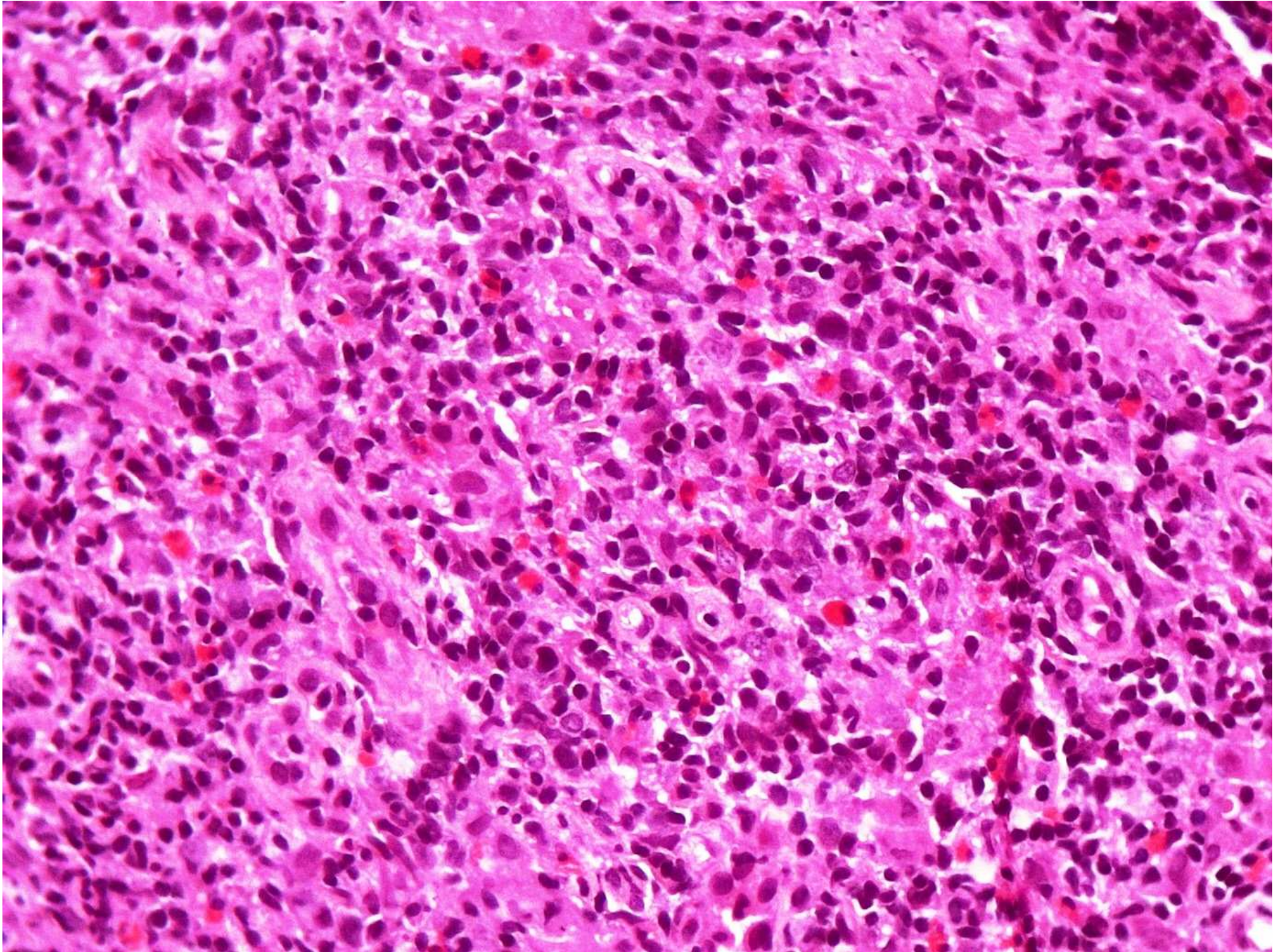




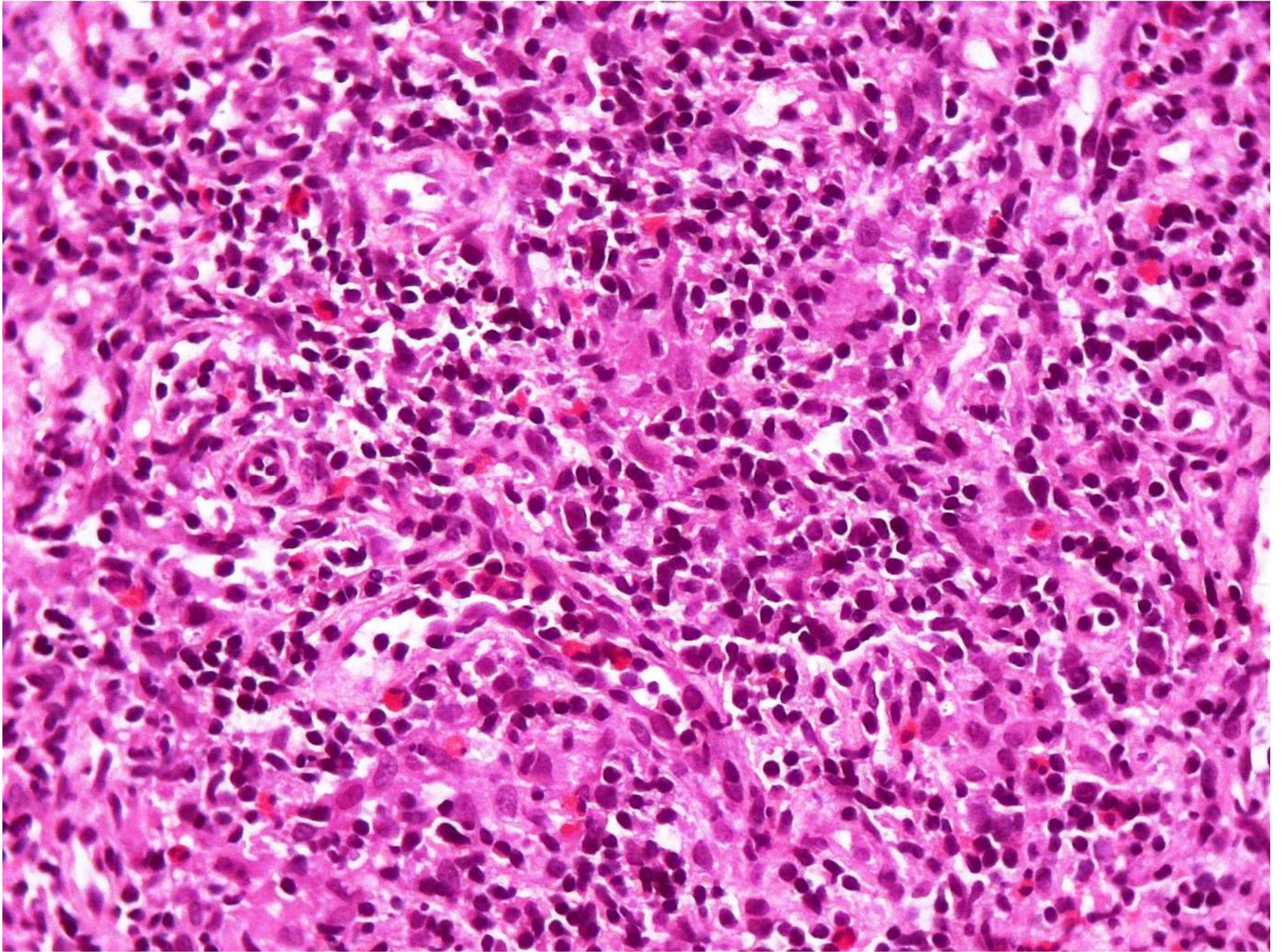












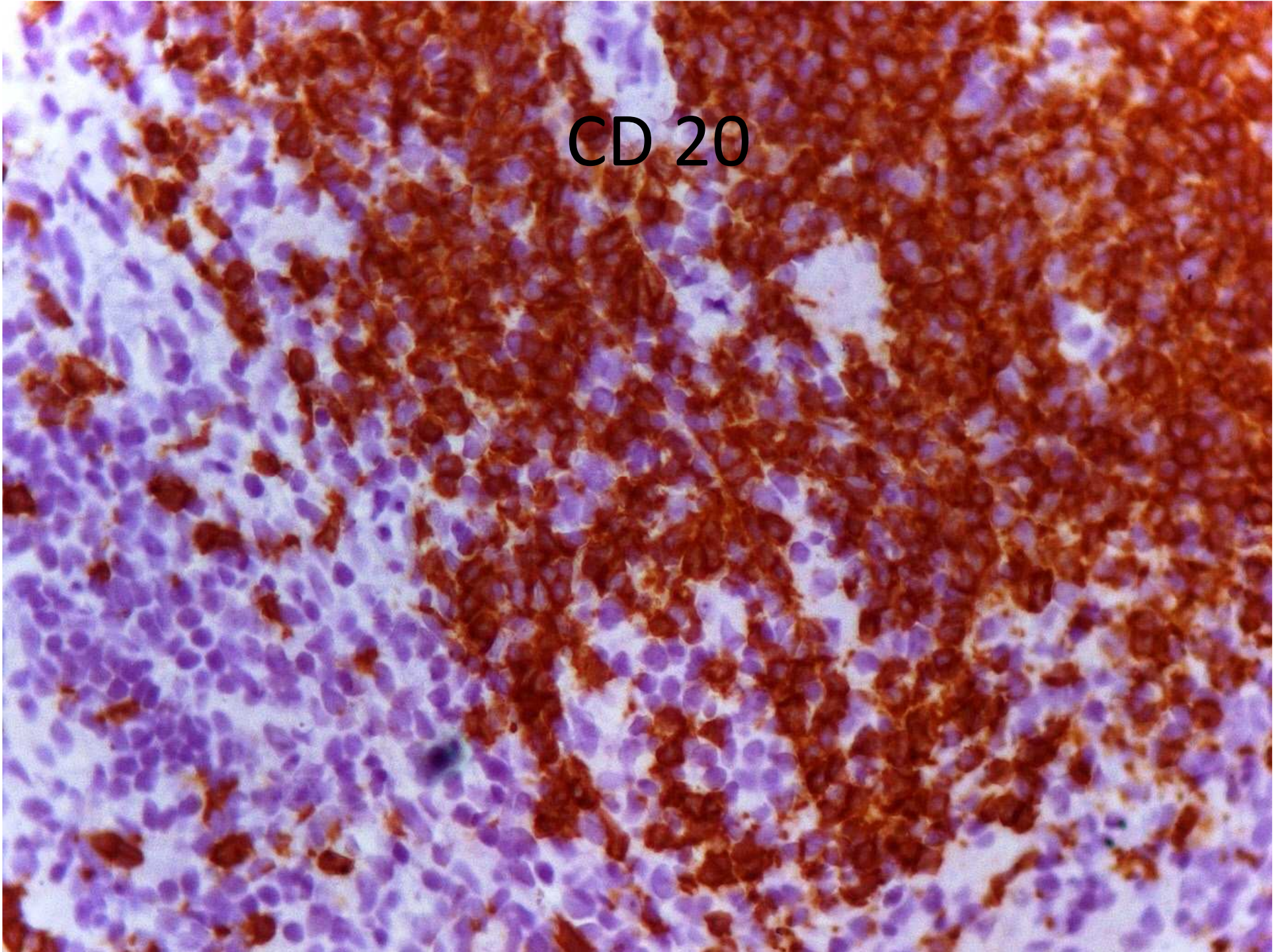


CD 20



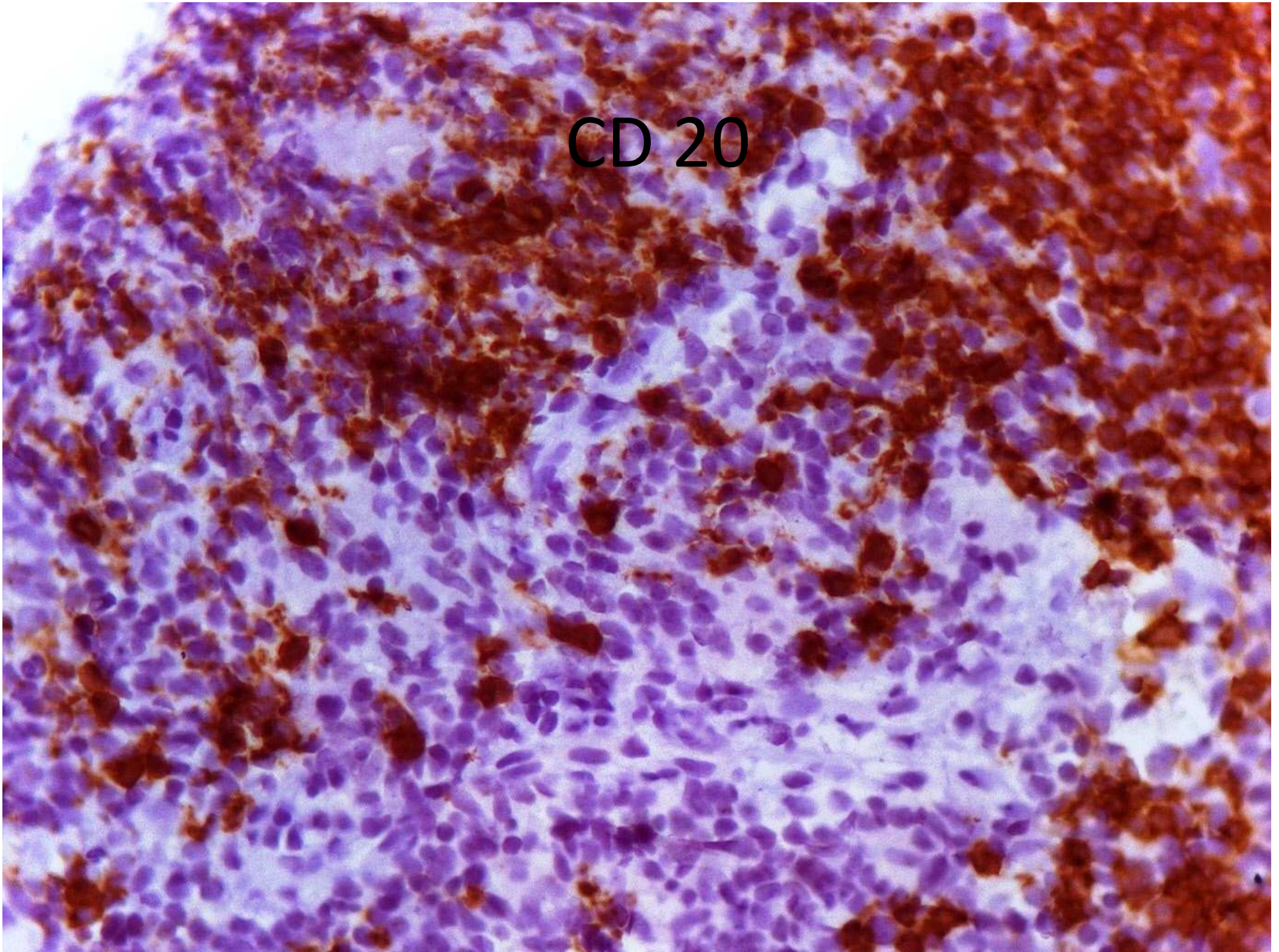


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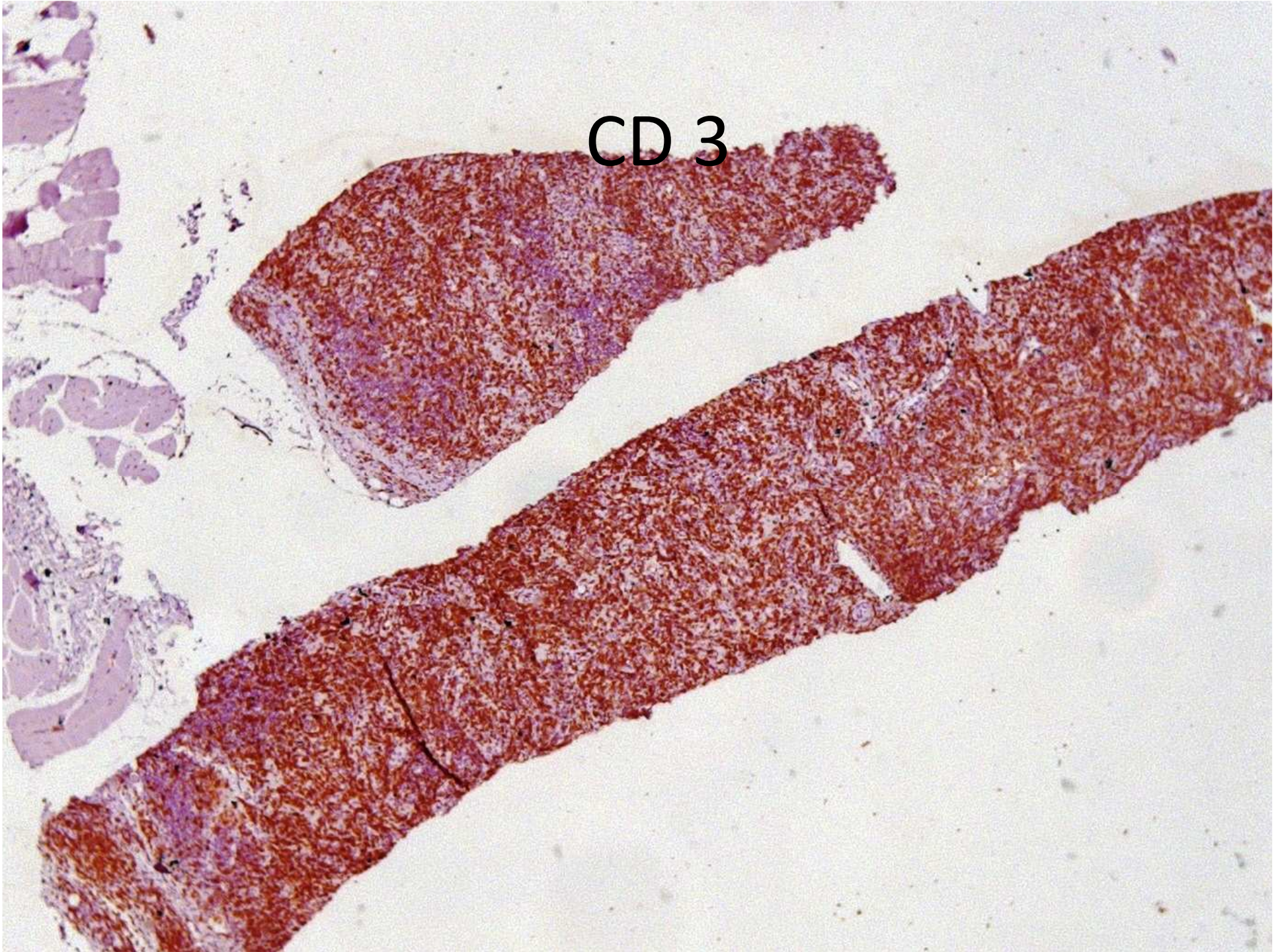


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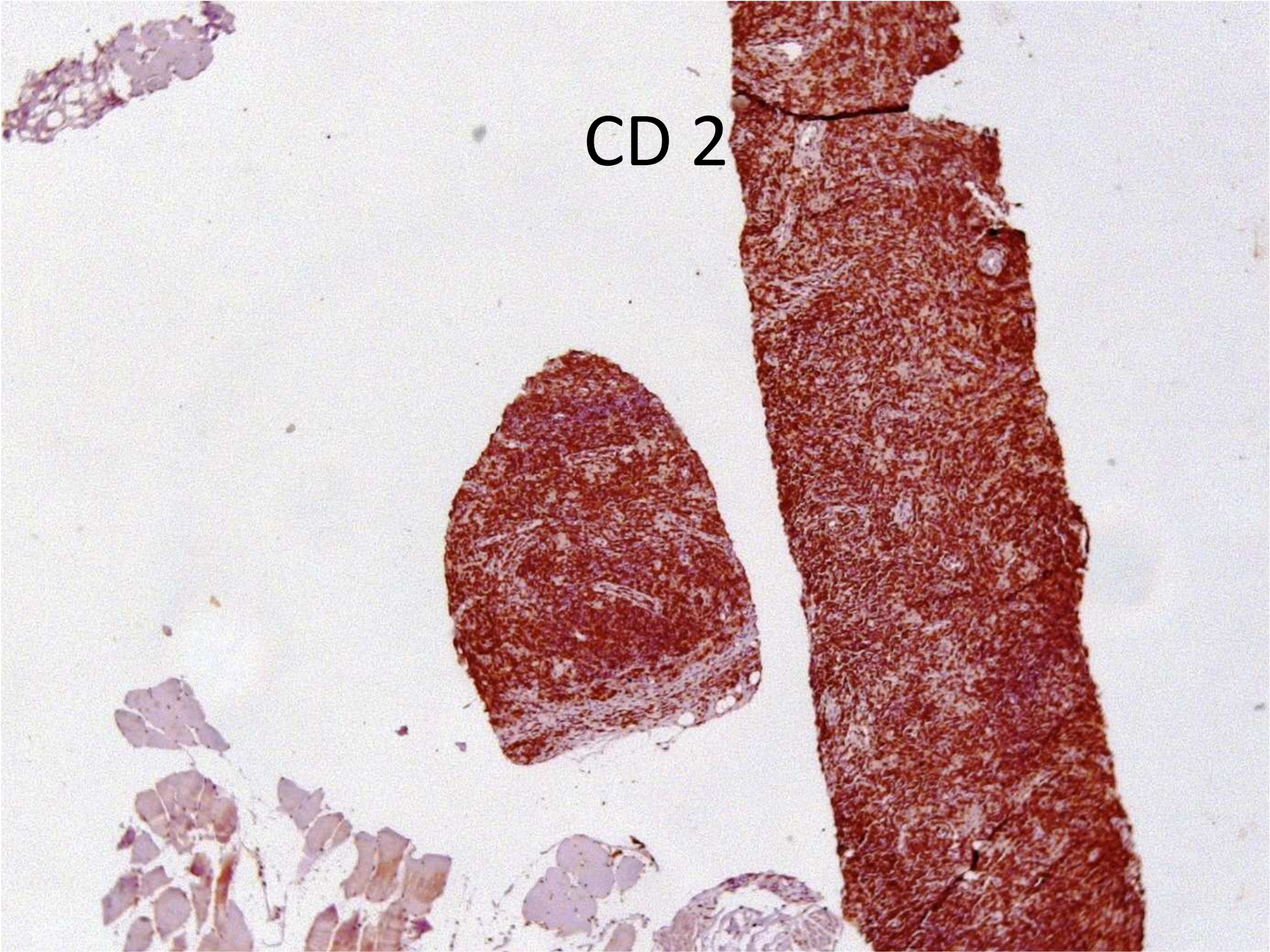


CD 3



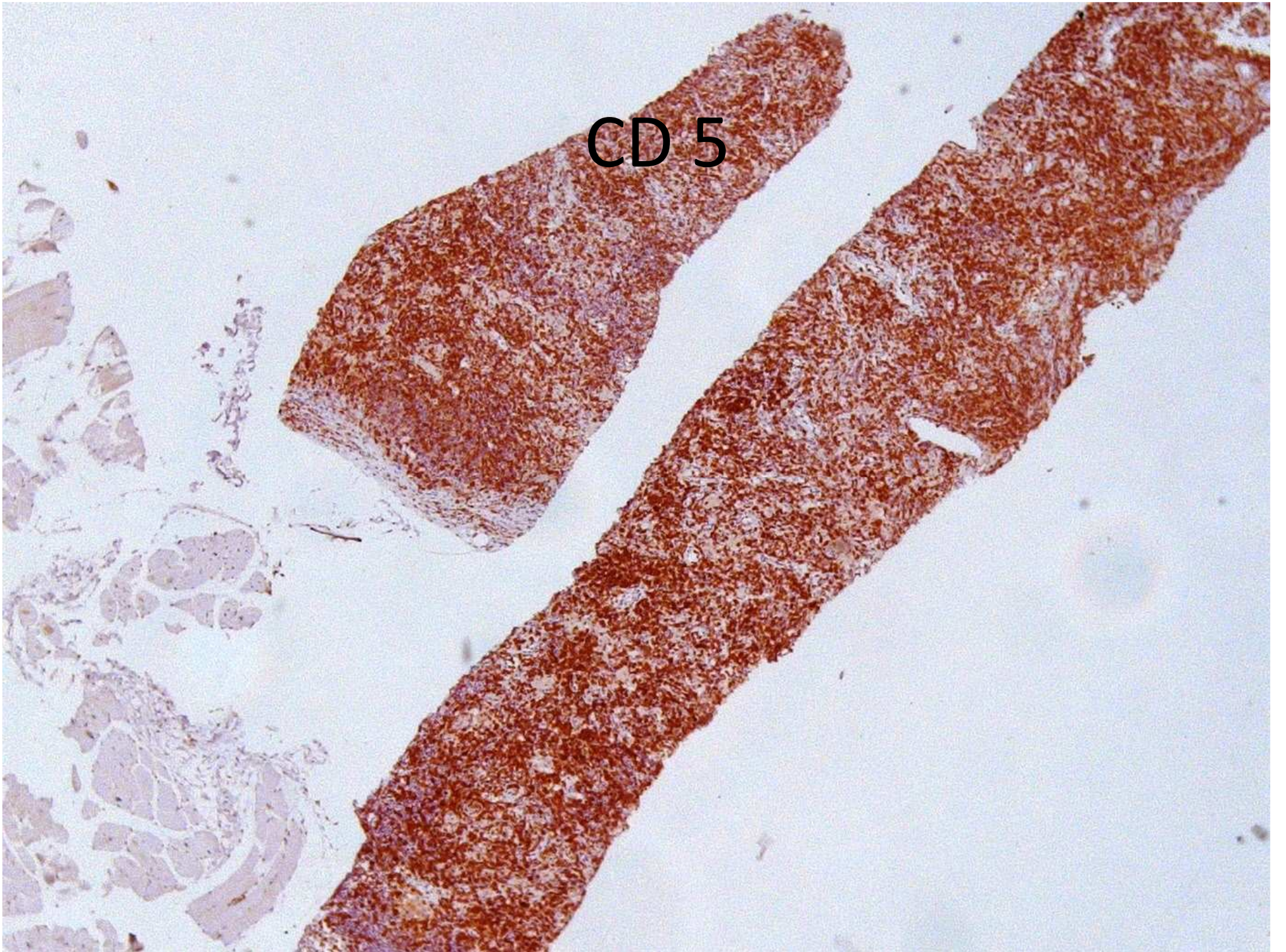


CD 2



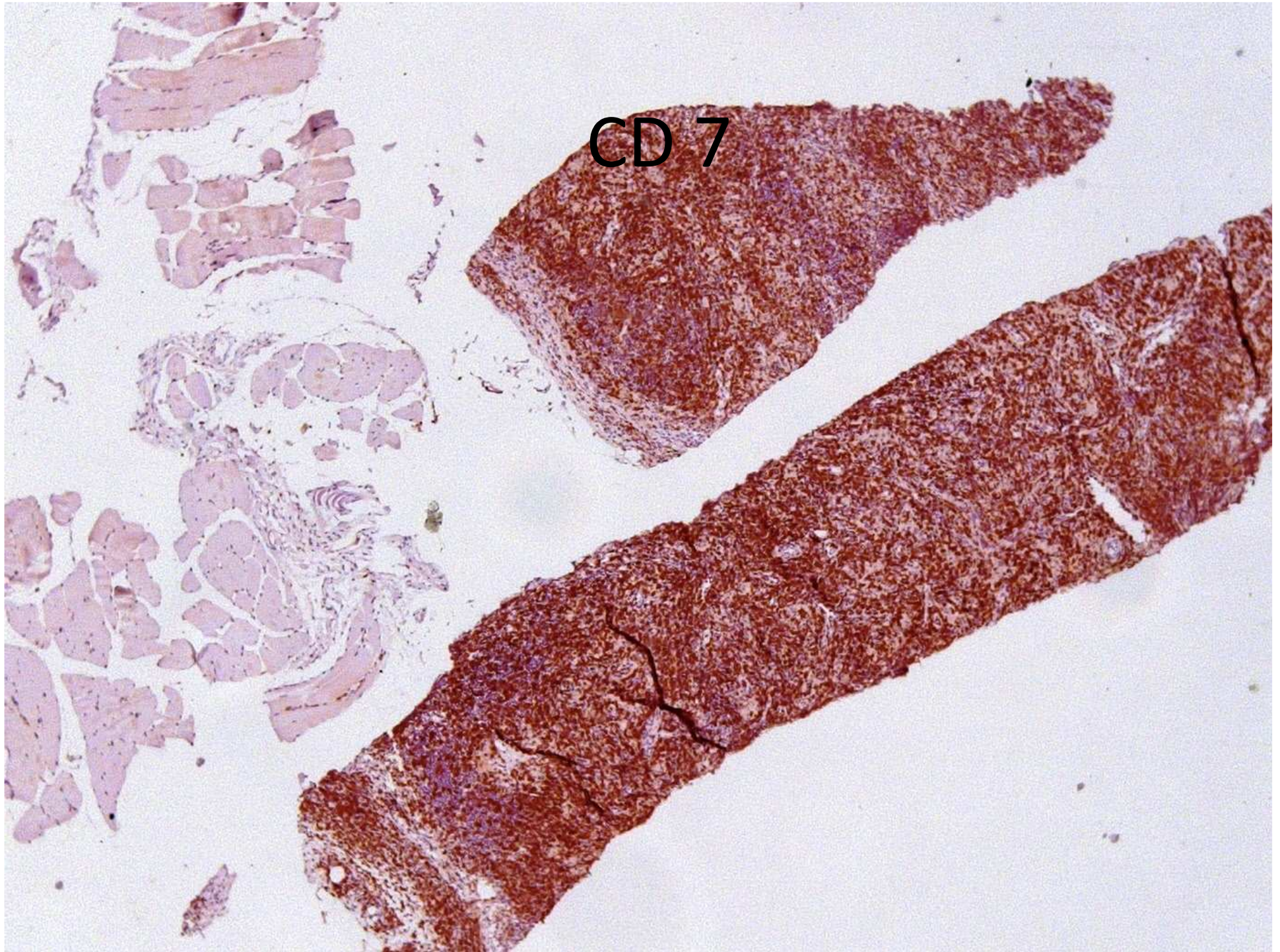


CD 5

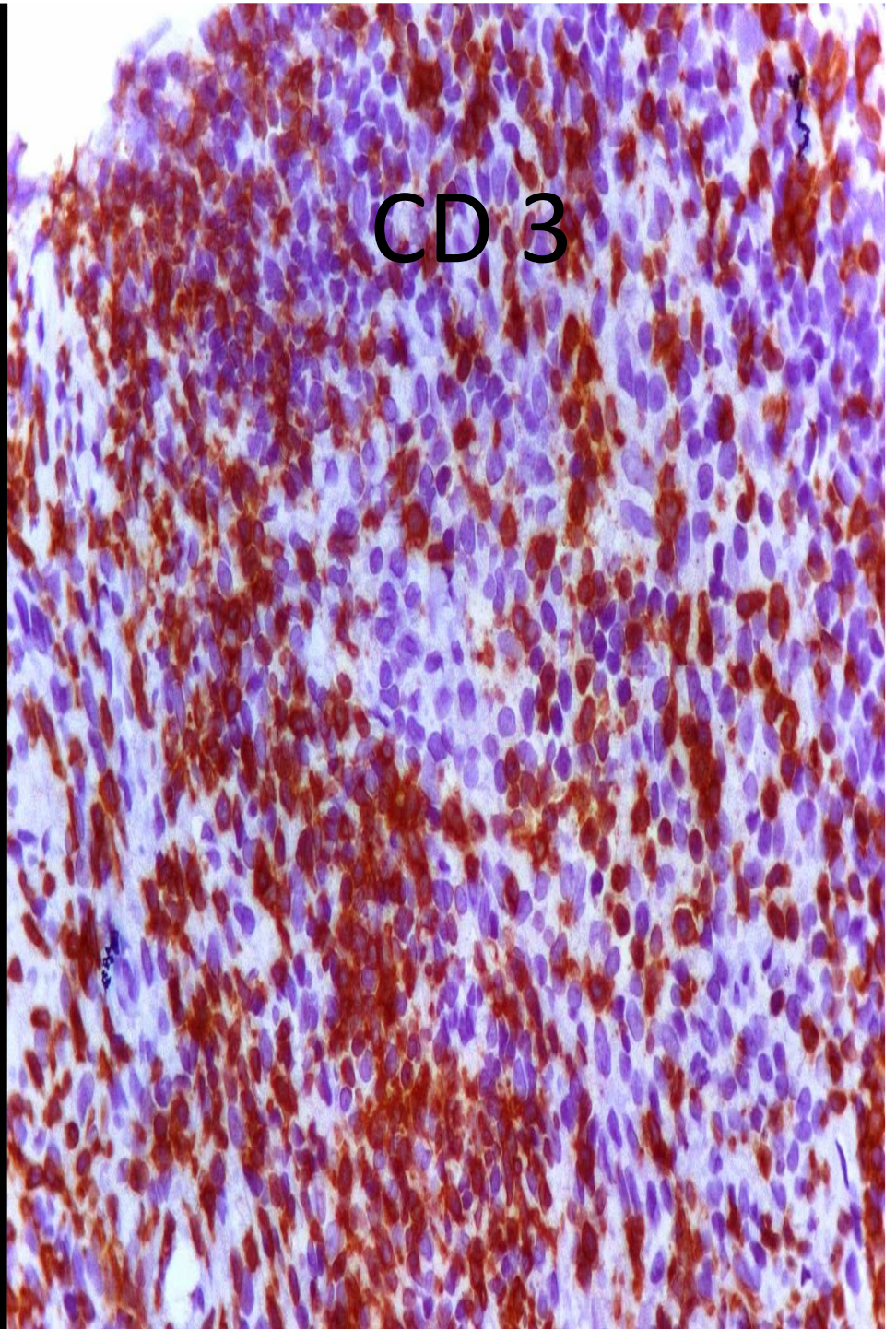
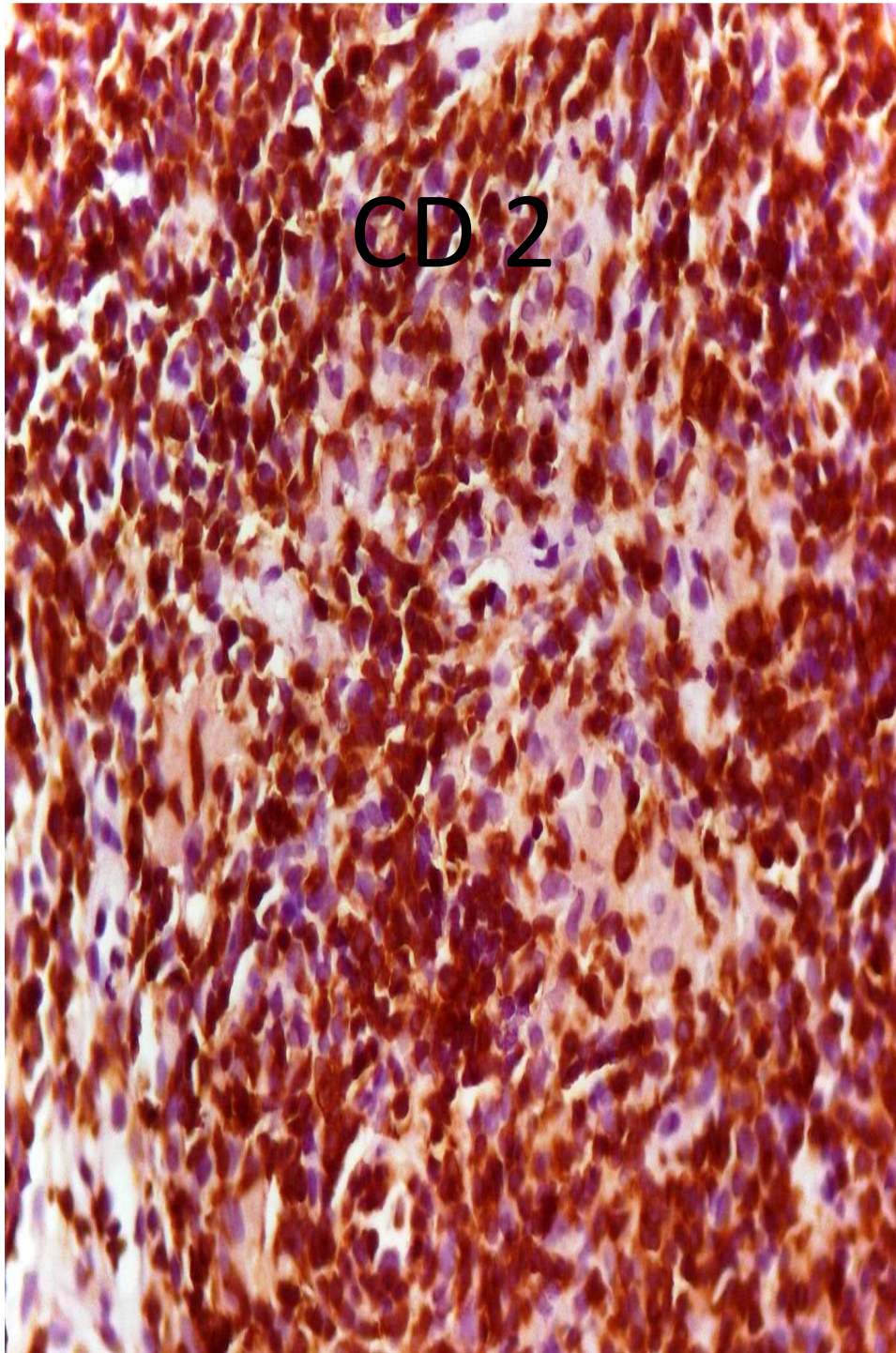




CD 7



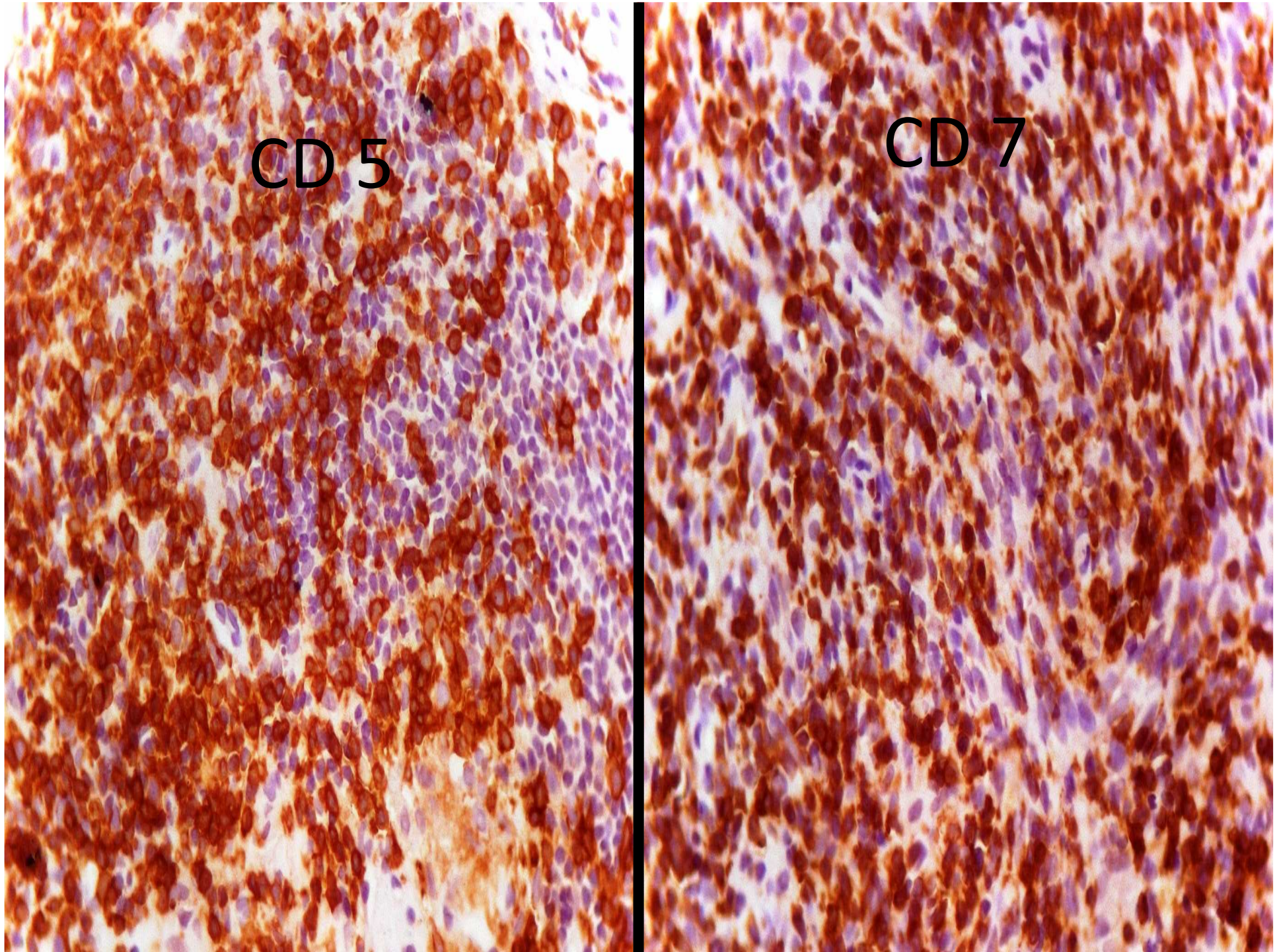






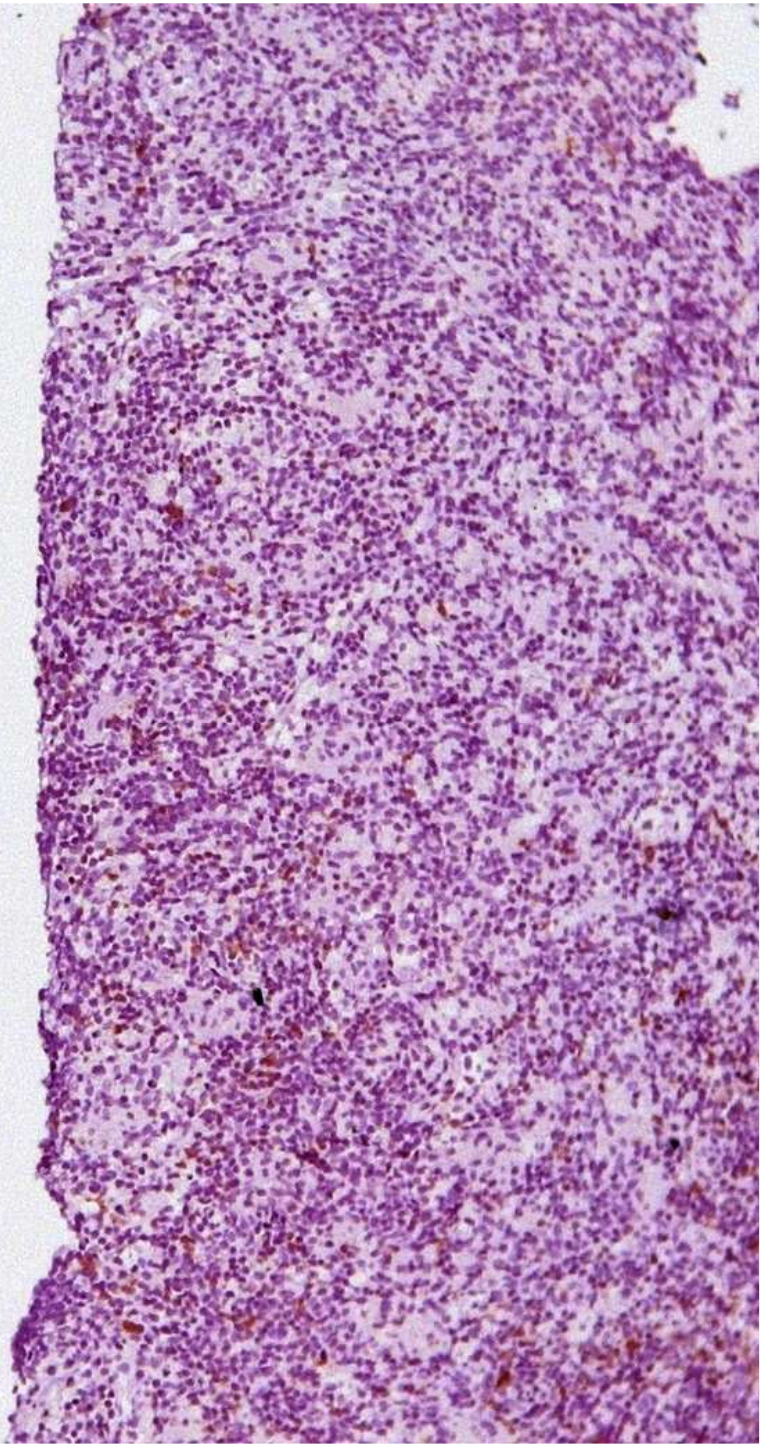
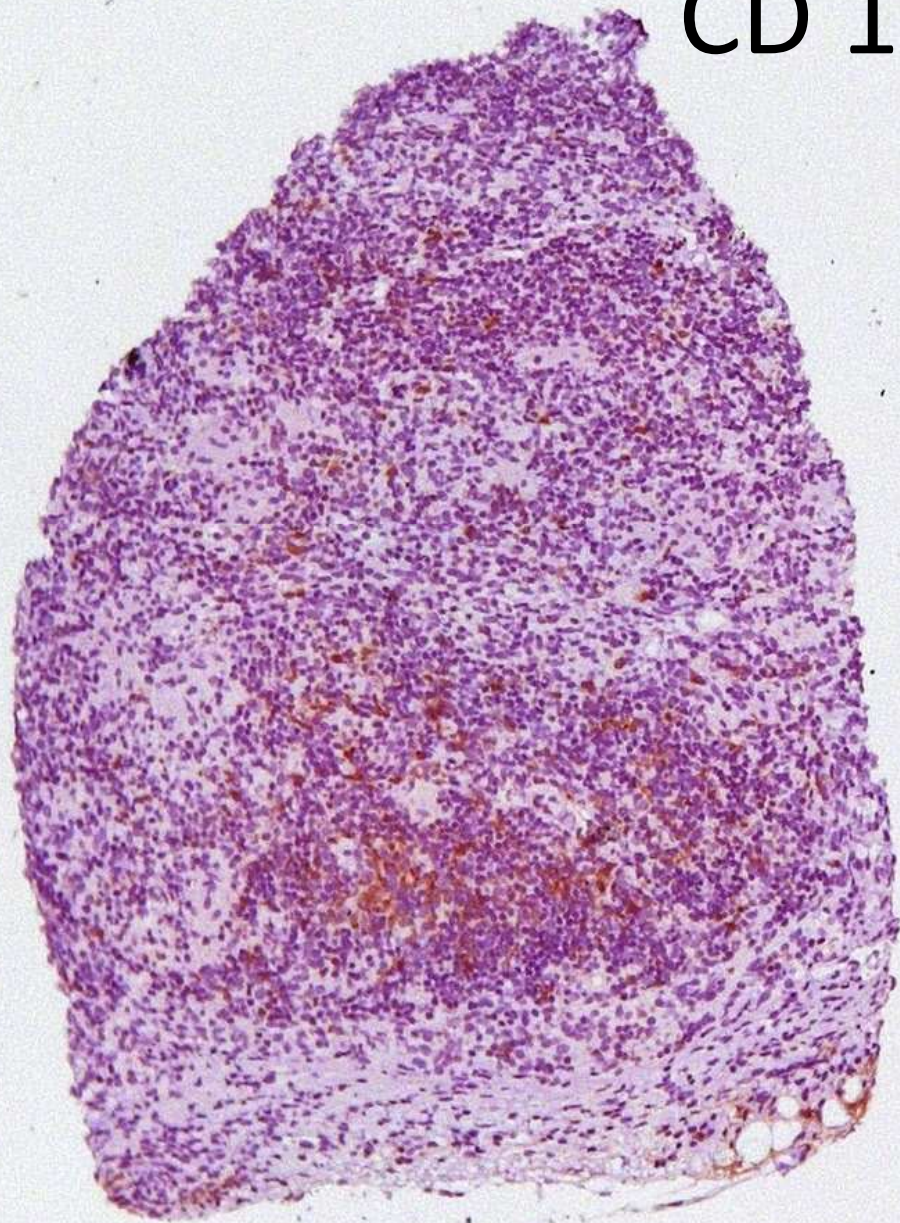
CD 5

CD 7



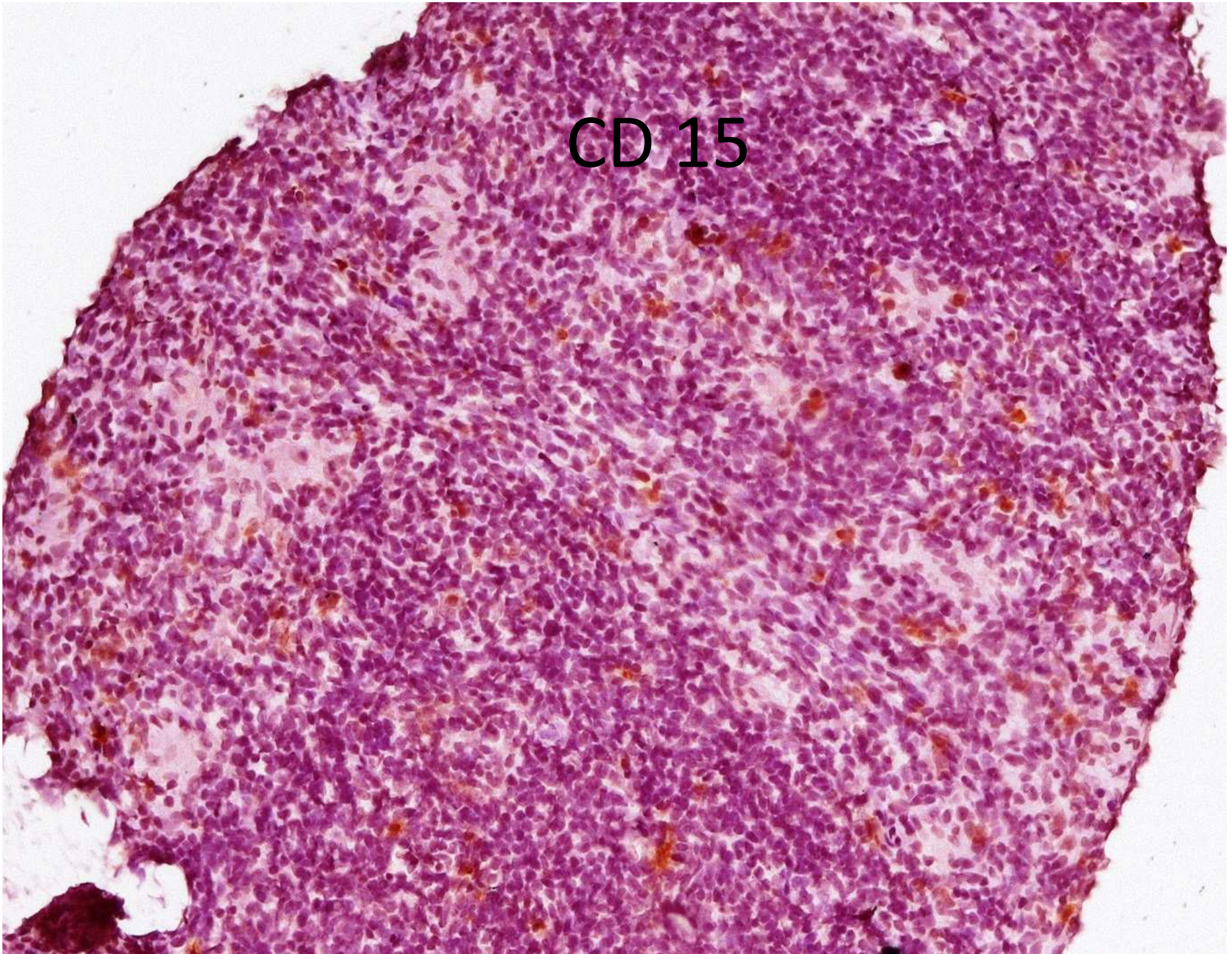


CD 10



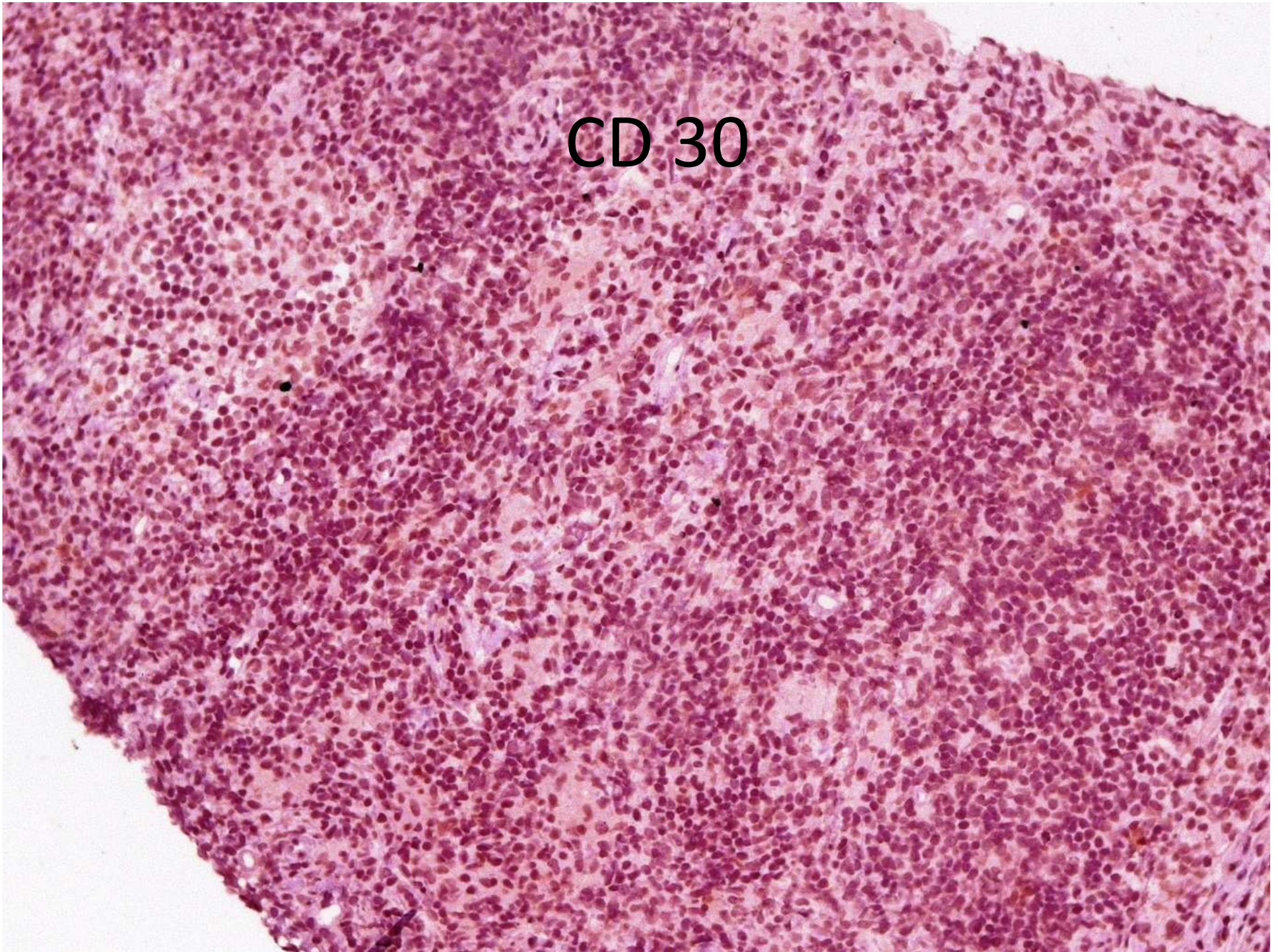


CD 15



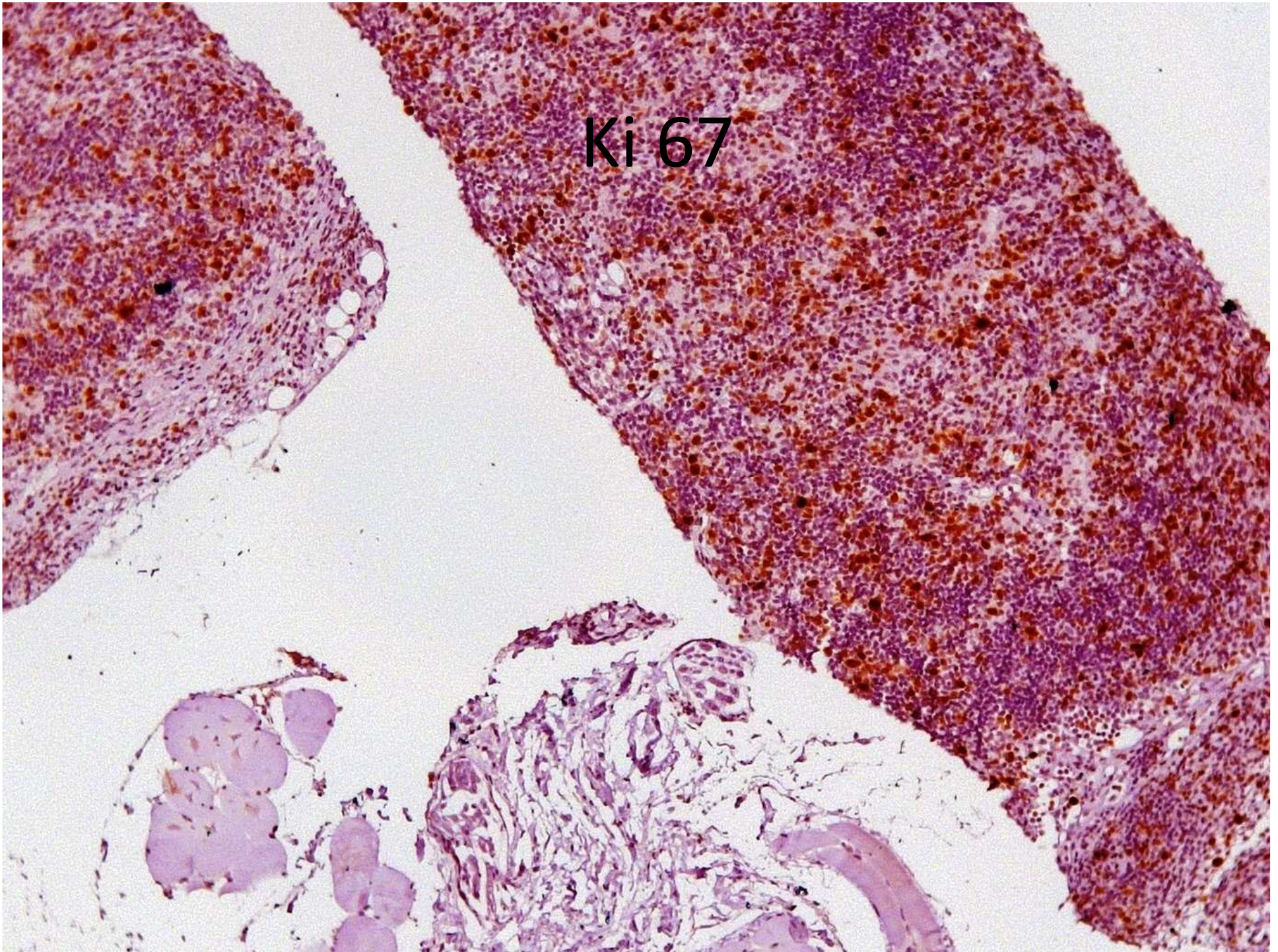


CD 30



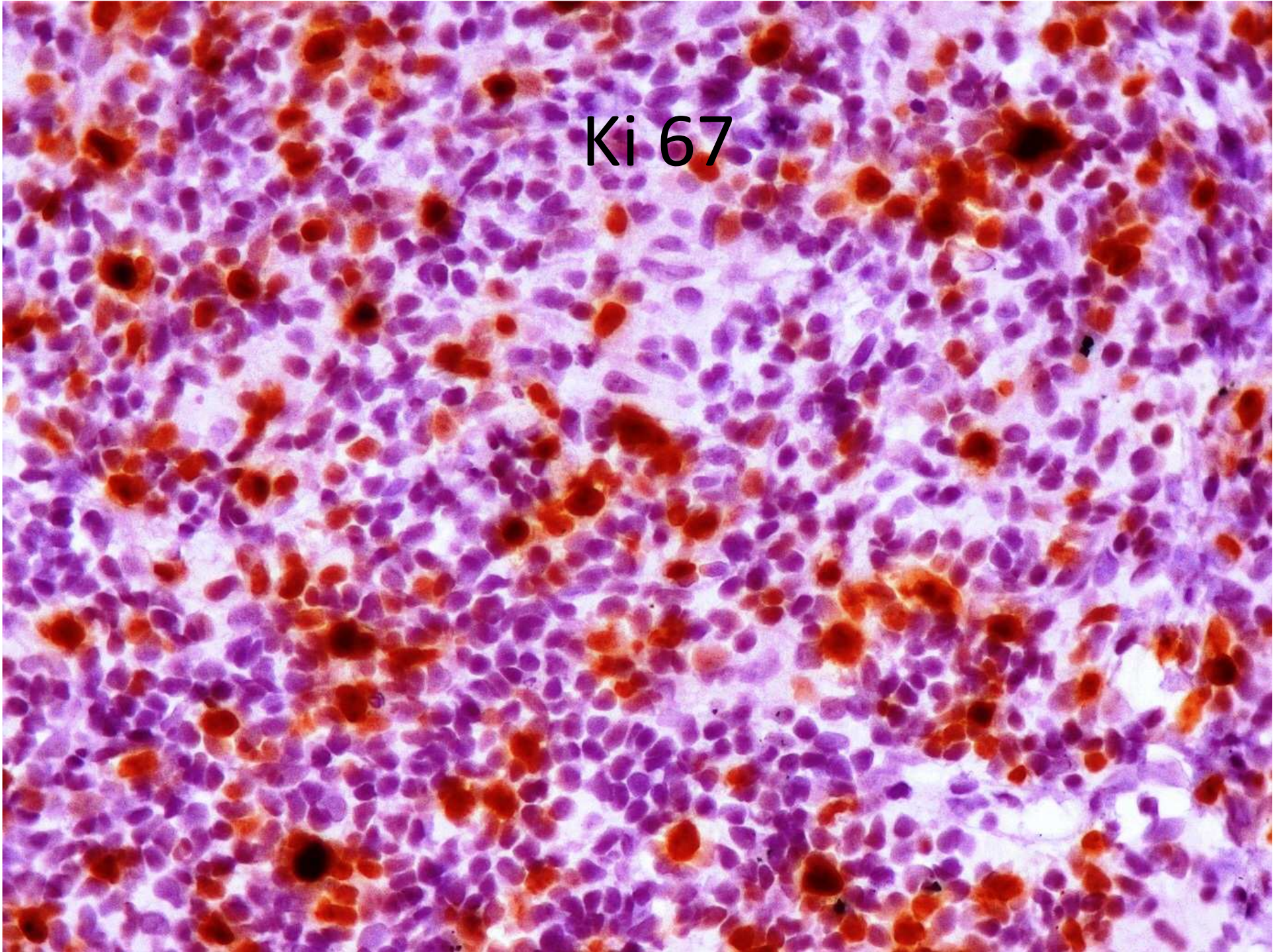


Ki 67



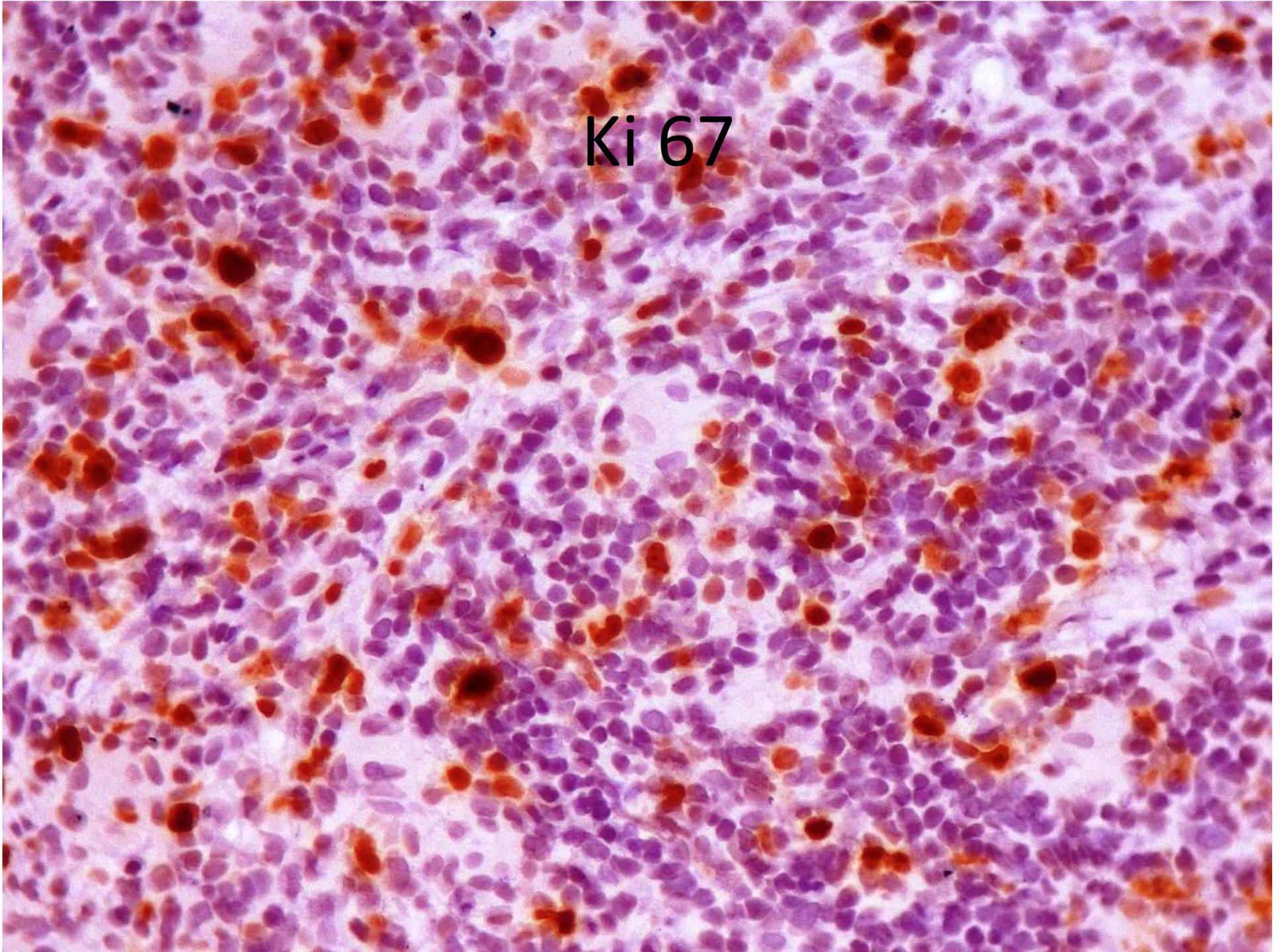


Ki 67





Ki 67





- **Biópsia de linfonodo cervical nível II**

- **Conclusão:** biópsia de linfonodo cervical nível II: - FRAGMENTOS COM ESCASSA REPRESENTAÇÃO DE TECIDO LINFÓIDE (LINFONODO), NÃO VISUALIZADO CÉLULAS COM CARACTERES DE REED-STERBERG.

- **Laudo de exame Imuno-histoquímico**

- CD 3: POSITIVO NOS LINFÓCITOS DA ZONA PARACORTICAL; CD 20: POSITIVO NOS NÓDULOS LINFÓIDES; CD 15: POSITIVO EM ALGUNS GRANULÓCITOS; CD 30: NEGATIVO; CD 21: POSITIVO NAS CÉLULAS DENDRÍTICAS FOLICULARES; ANTÍGENO Ki-67: POSITIVO (focal)

- **Conclusão**

- O PERFIL IMUNOISTOQUÍMICO DEMONSTROU PRESENÇA DE POPULAÇÃO LINFÓIDE B E T, NÃO SENDO POSSÍVEL CARACTERIZAR LINFOMA NESTA AMOSTRA.



- Dezembro 2011: internação para compensação clínica. Iniciado primeiro ciclo de QT. Paciente com melhora do estado geral (ganho de 3Kg).
- Janeiro 2012: reinternação devido choque séptico de foco pulmonar. Alta para segundo ciclo de QT.
- Fevereiro 2012: admitido no Icesp em neutropenia febril; internado para compensação clínica.
- Abril 2012: realizada nova biópsia linfonodal



Mielograma (29/02/2012):

MORFOLOGIA: Prejudicada

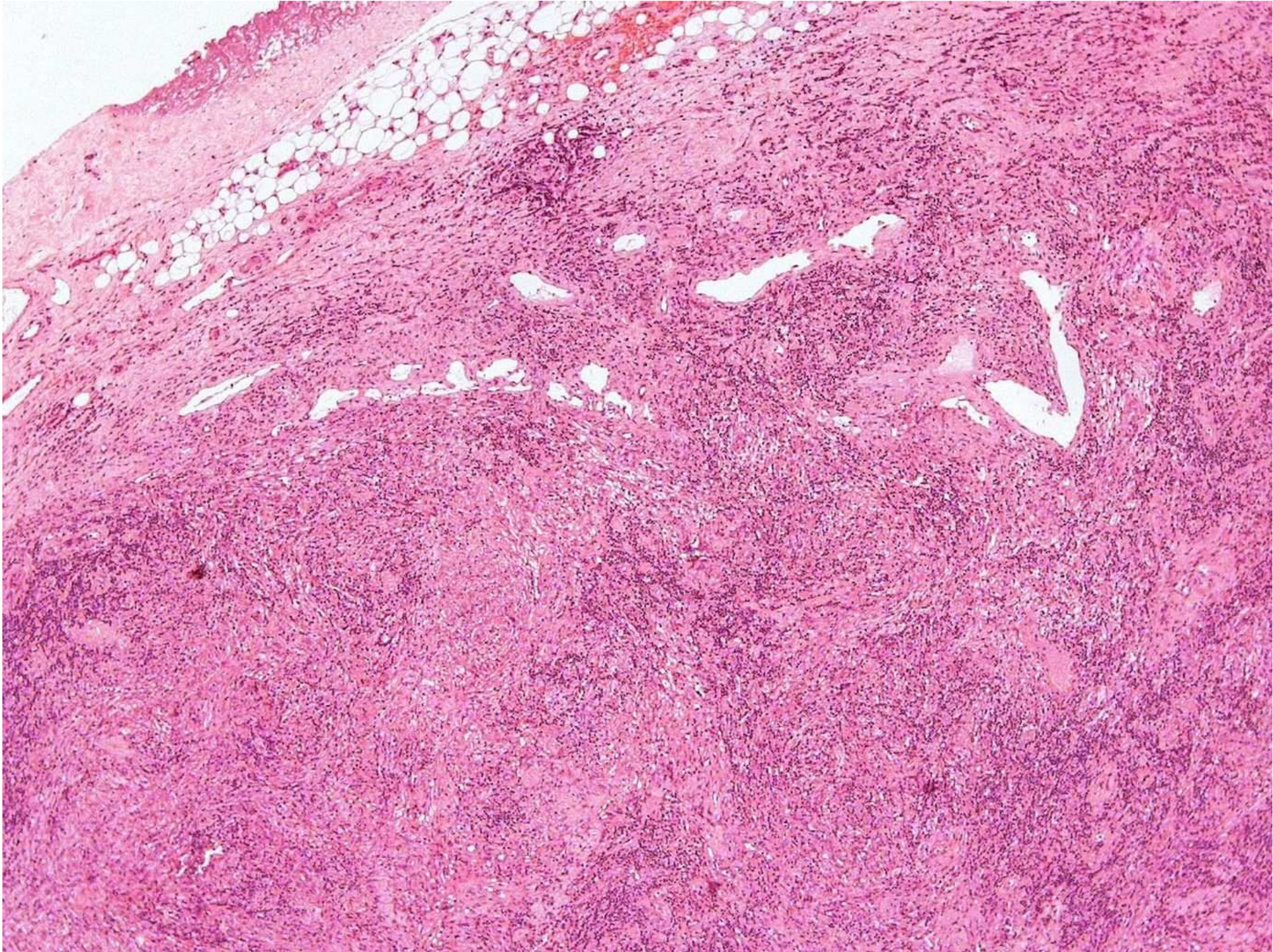
Presença de 77% de células CD3- que expressam os antígenos linfóides T CD4 e CD7. Quatorze por cento de linfócitos T CD3+, sendo 9% CD4 e 4% CD8. Dois por cento linfócitos B CD20+, CD19+.

CONCLUSÃO: presença de população anômala T (CD3 negativo, CD4+, CD7+). Em relação ao exame anterior ocorreu aumento da população anômala (30% para 77%) e redução da população linfóide T normal (46% para 14%).

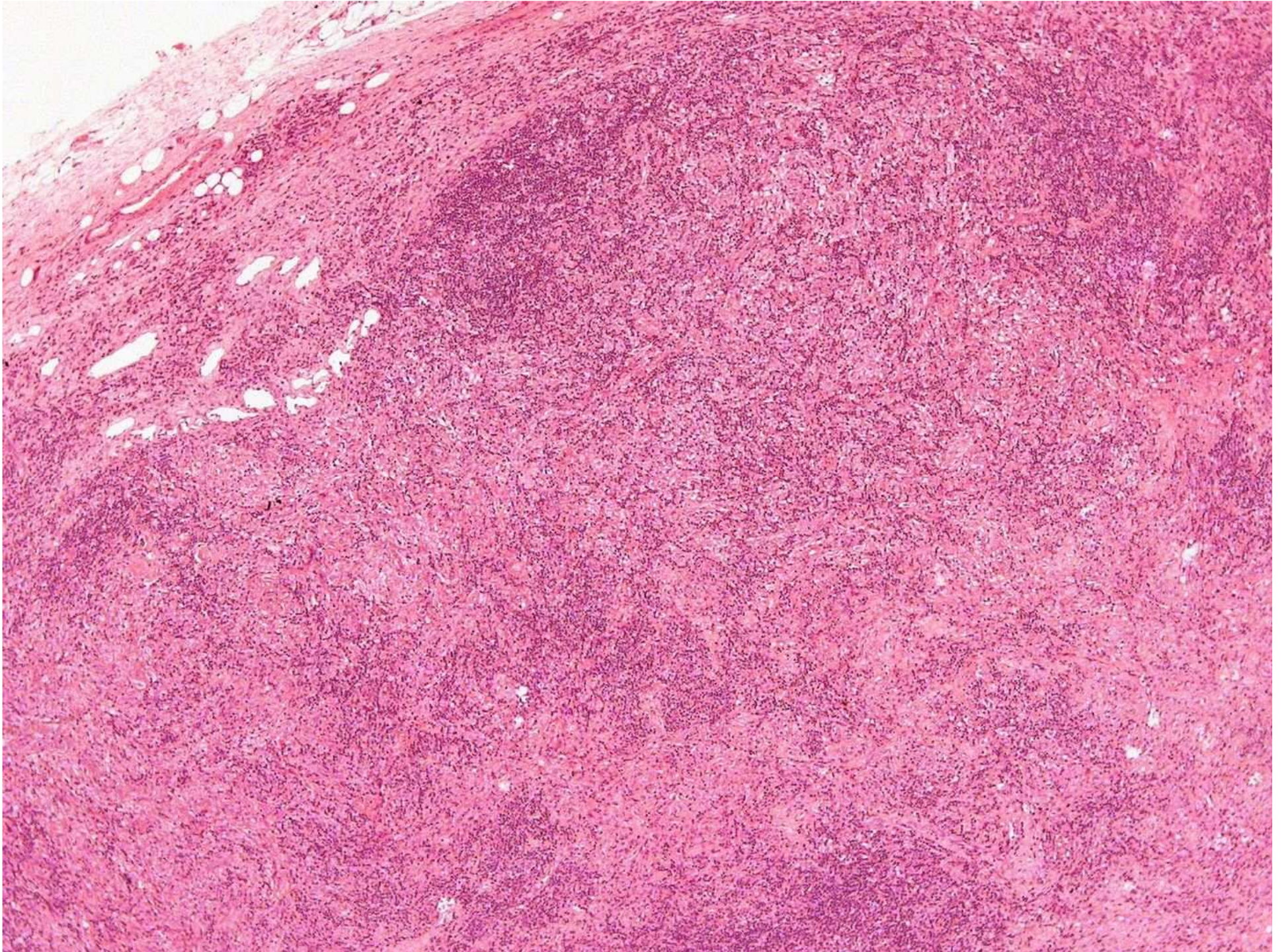


**Linfonodo – abril 2012**

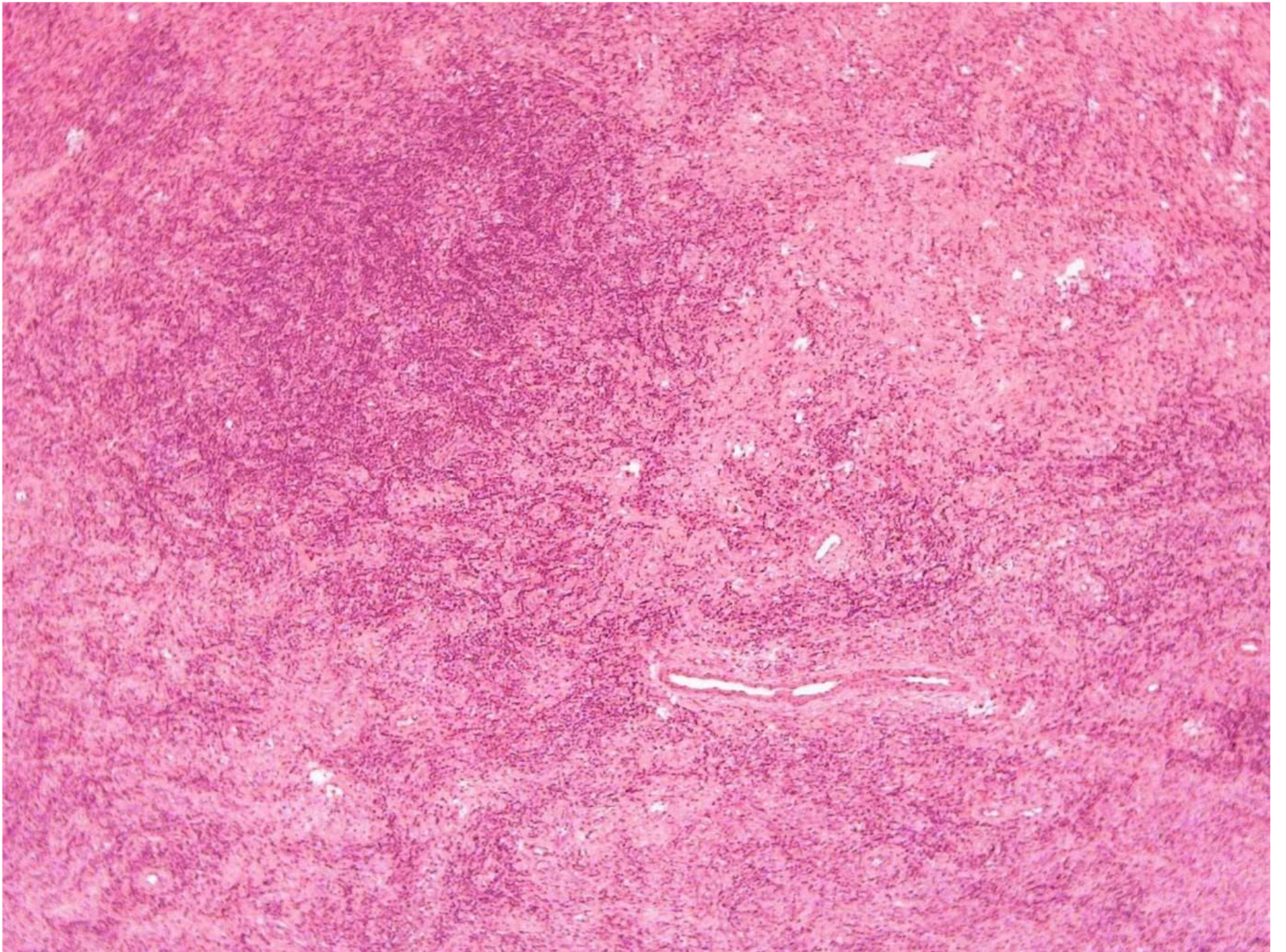




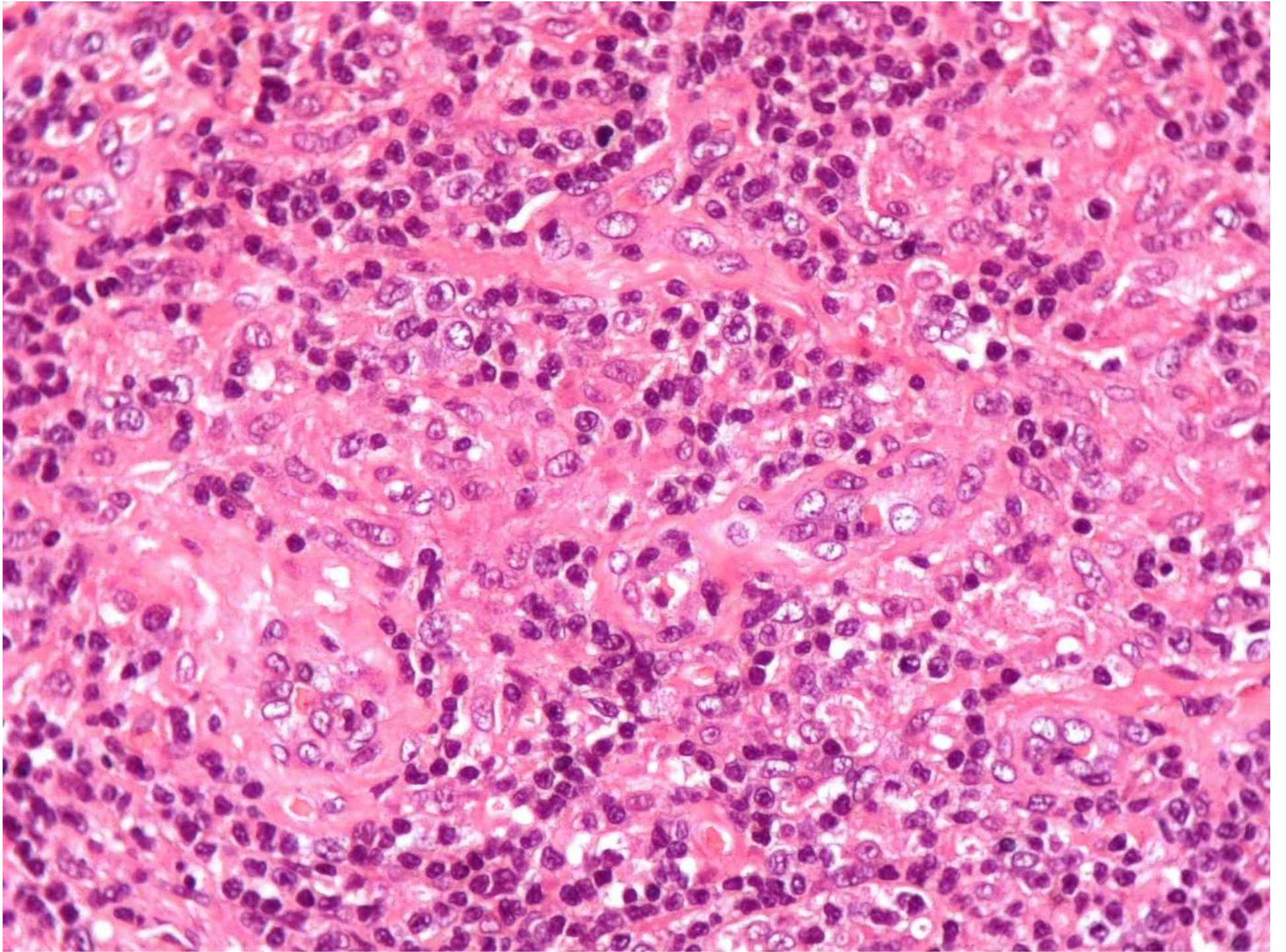




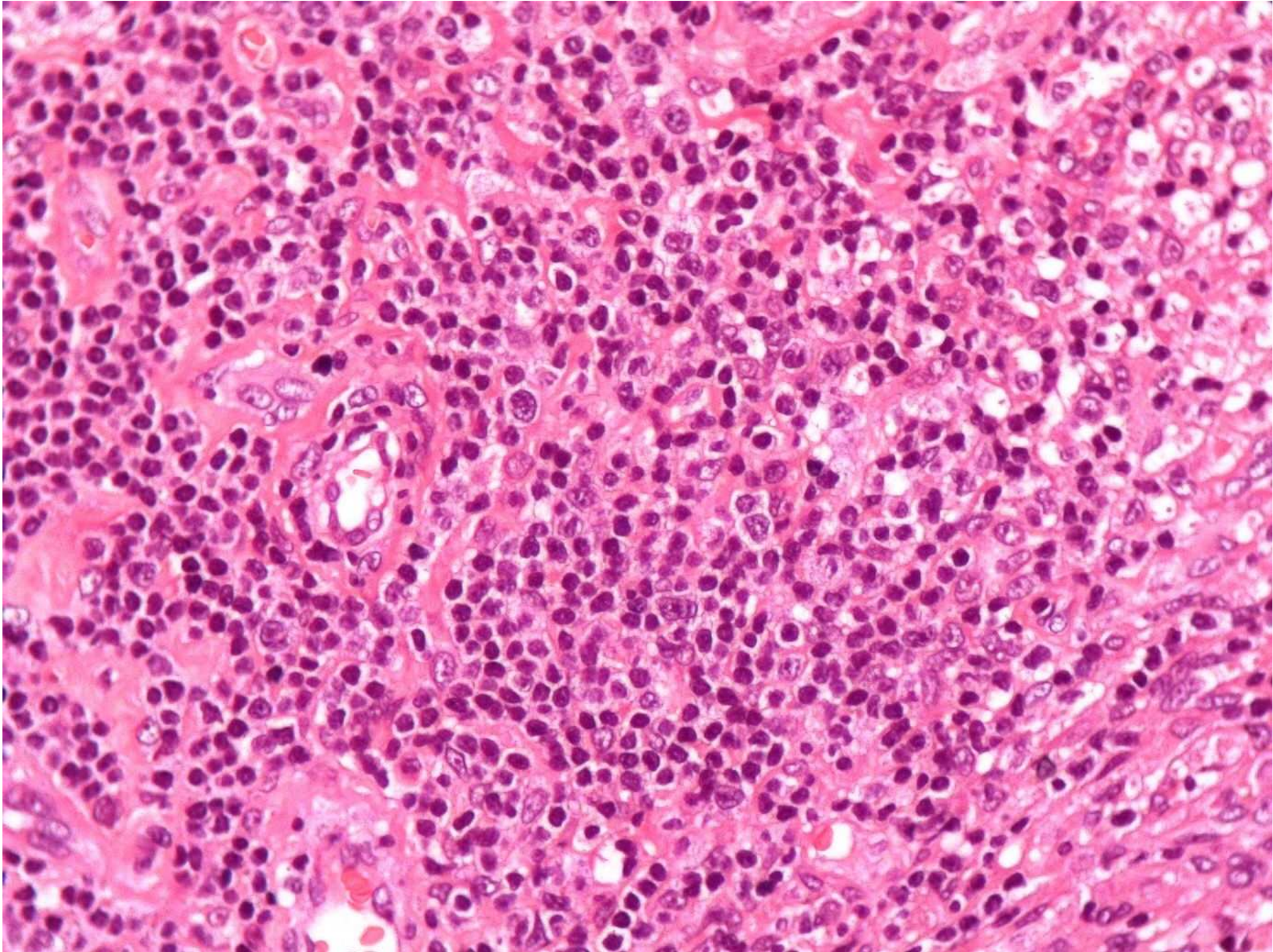




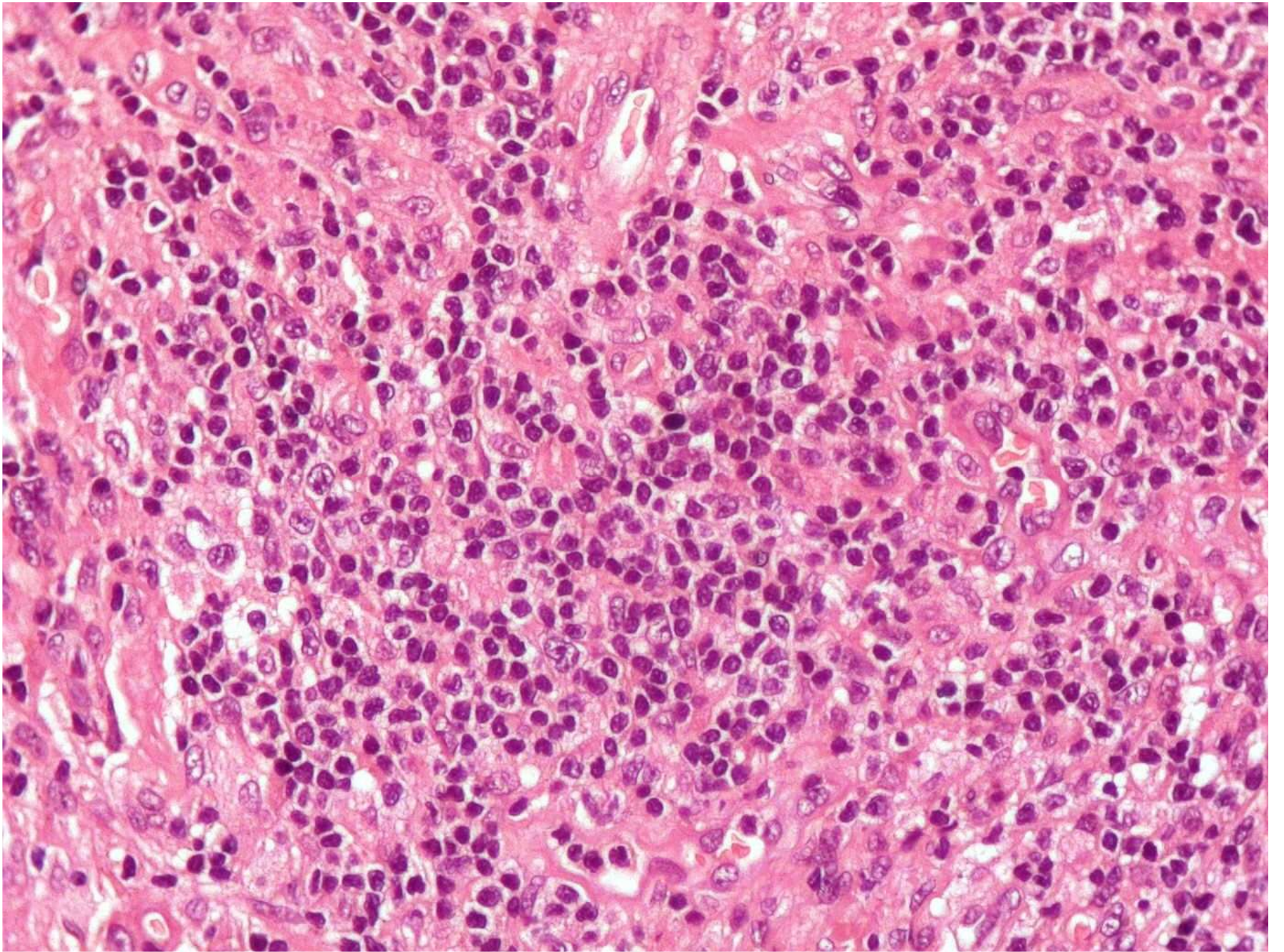






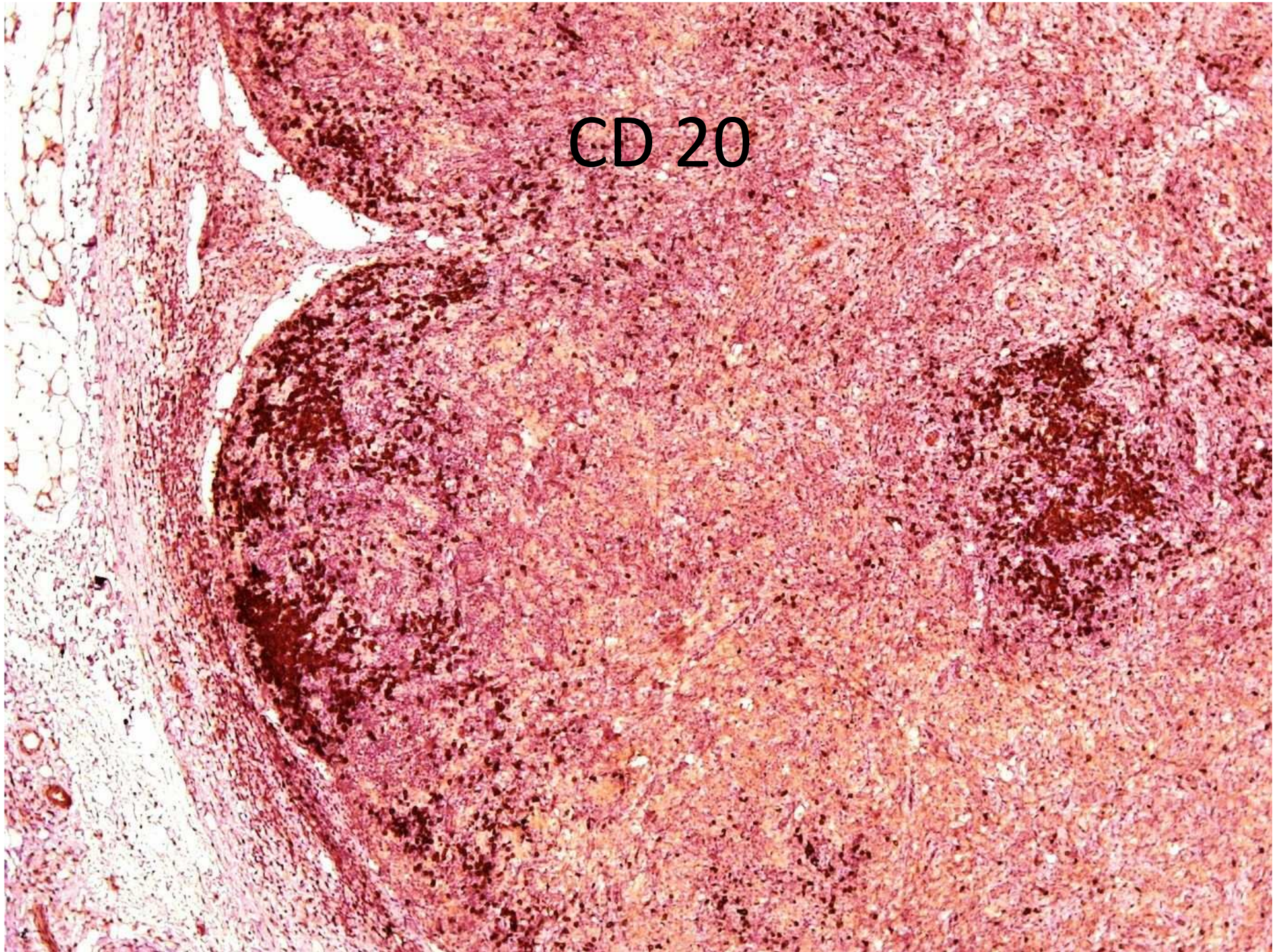






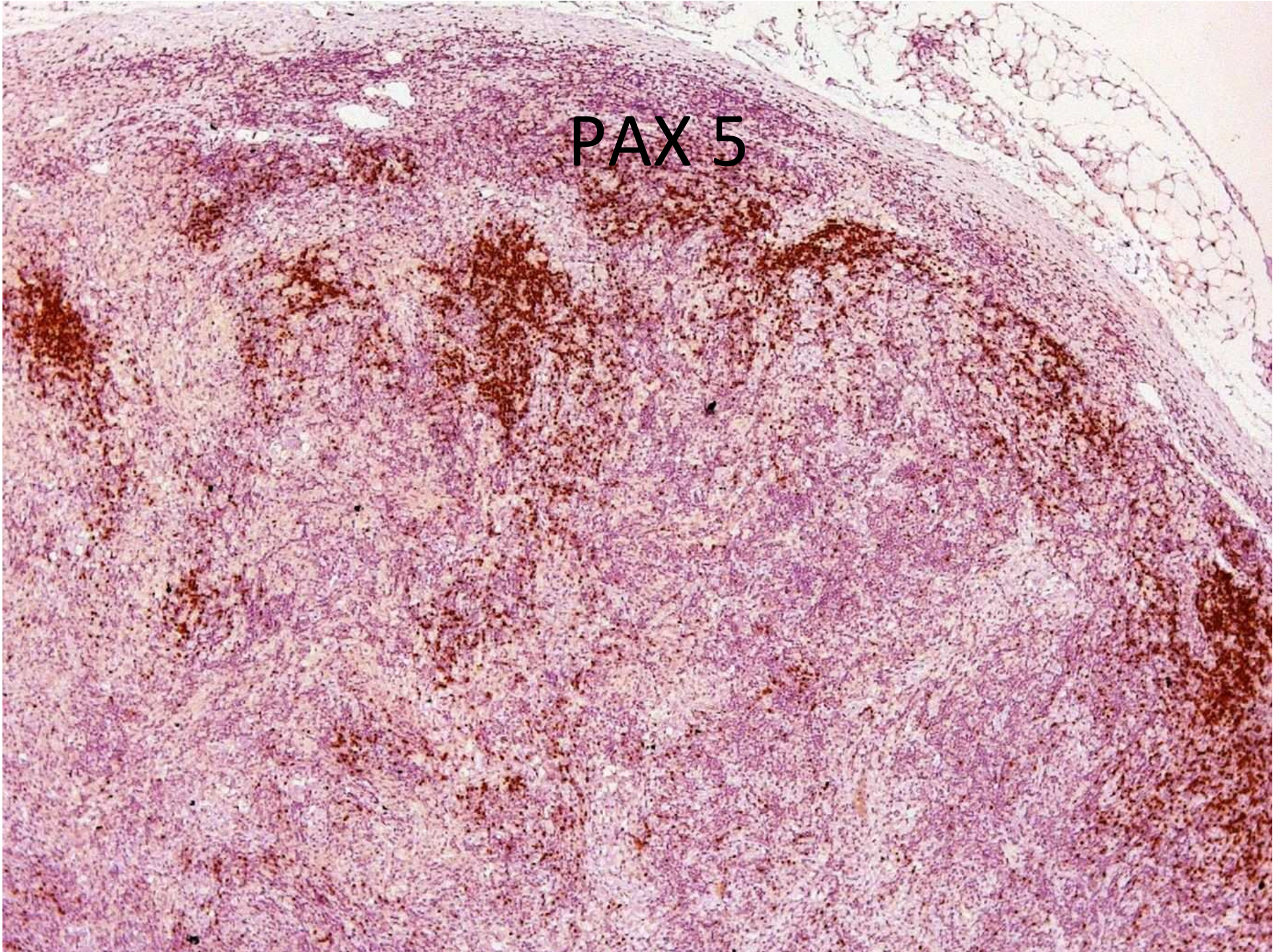


CD 20



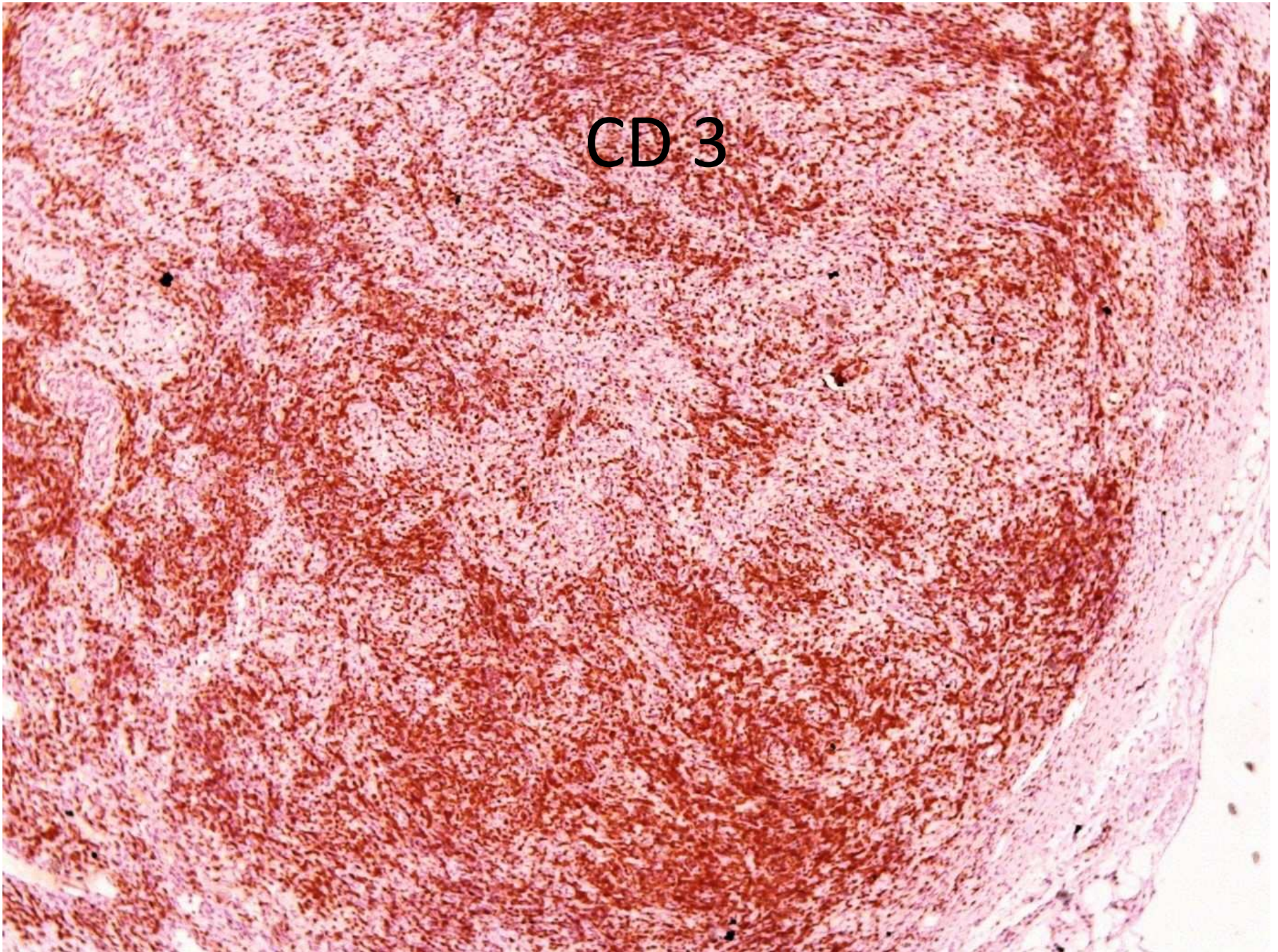


PAX 5



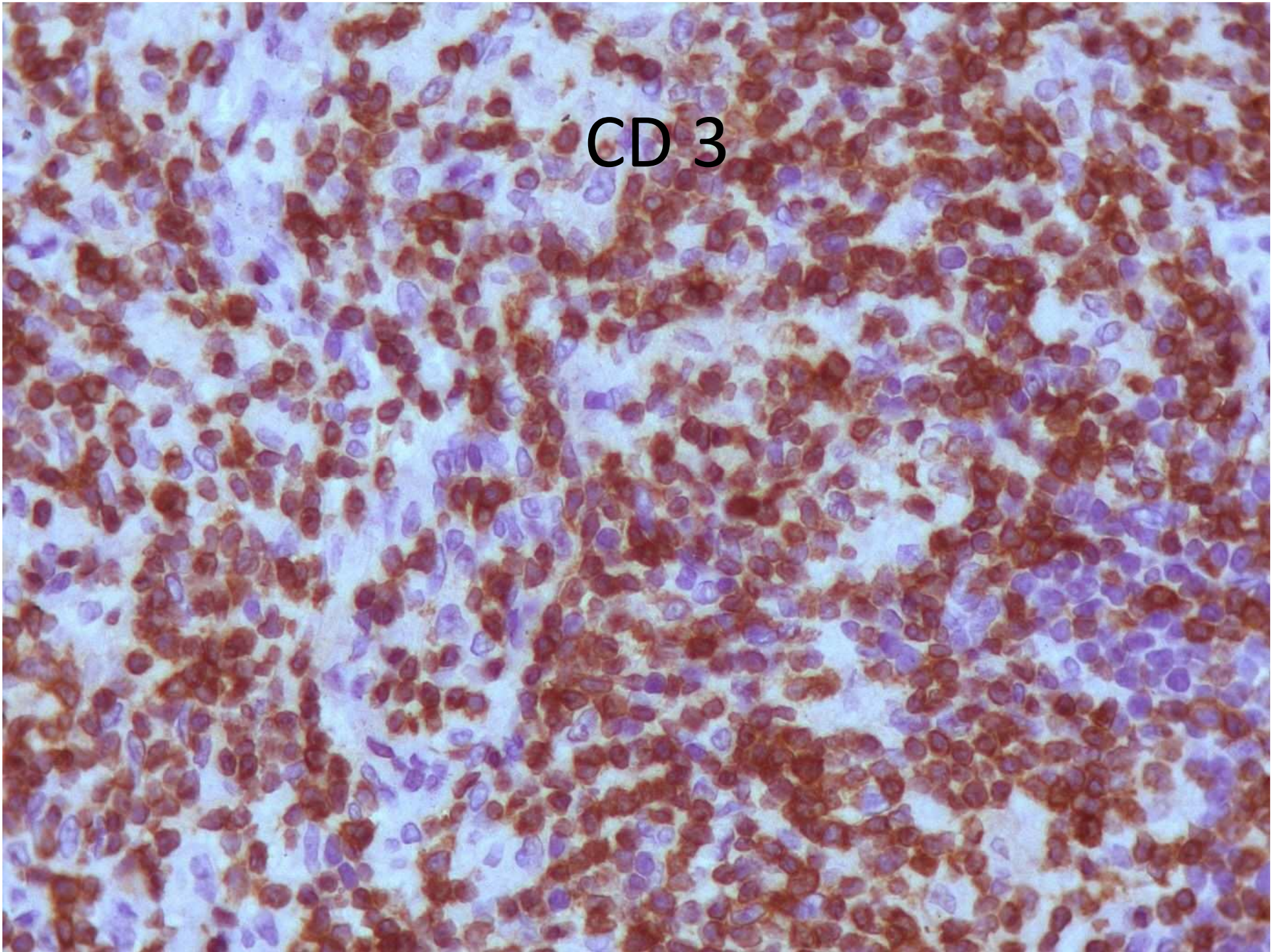


CD 3



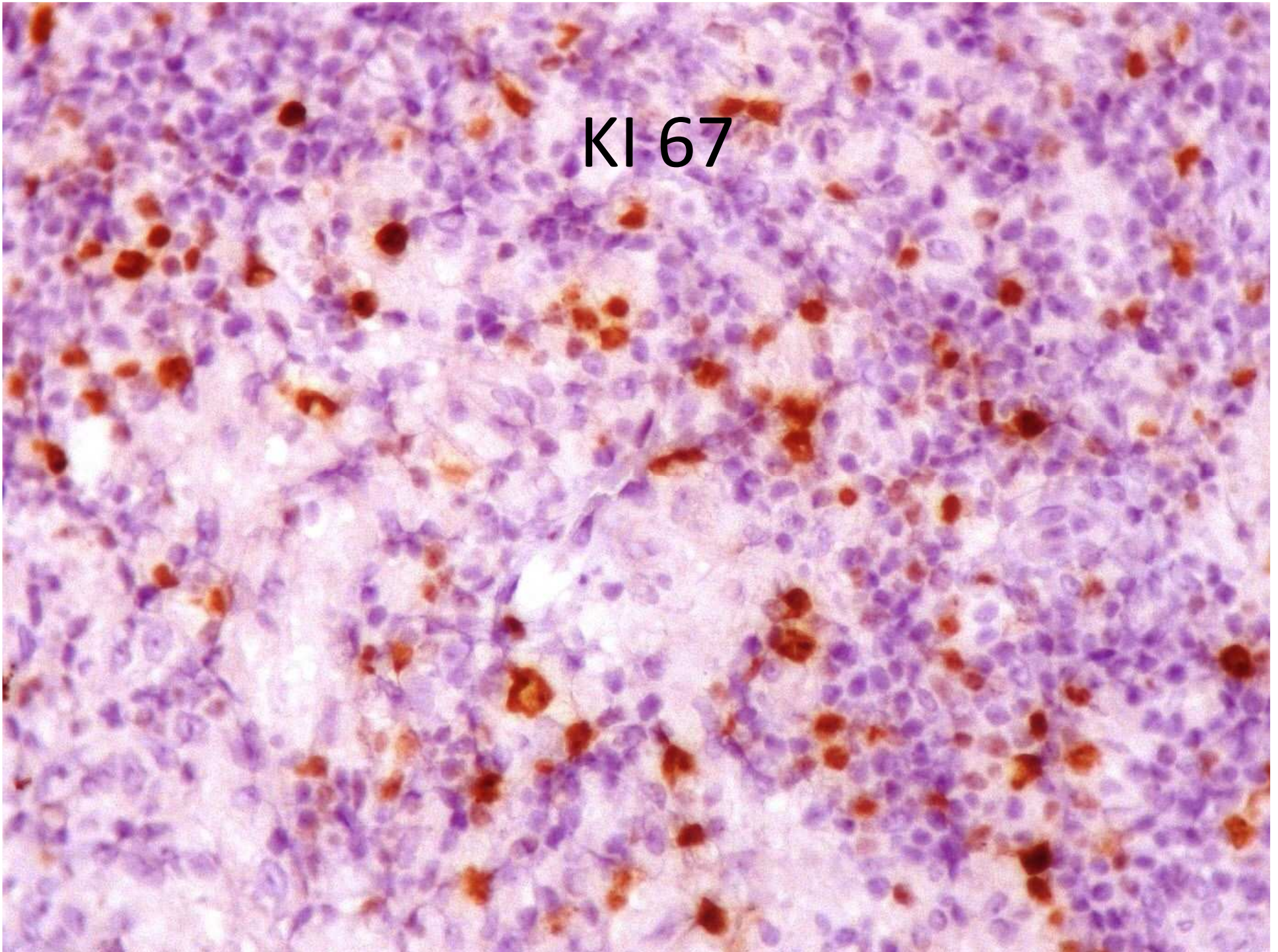


CD 3





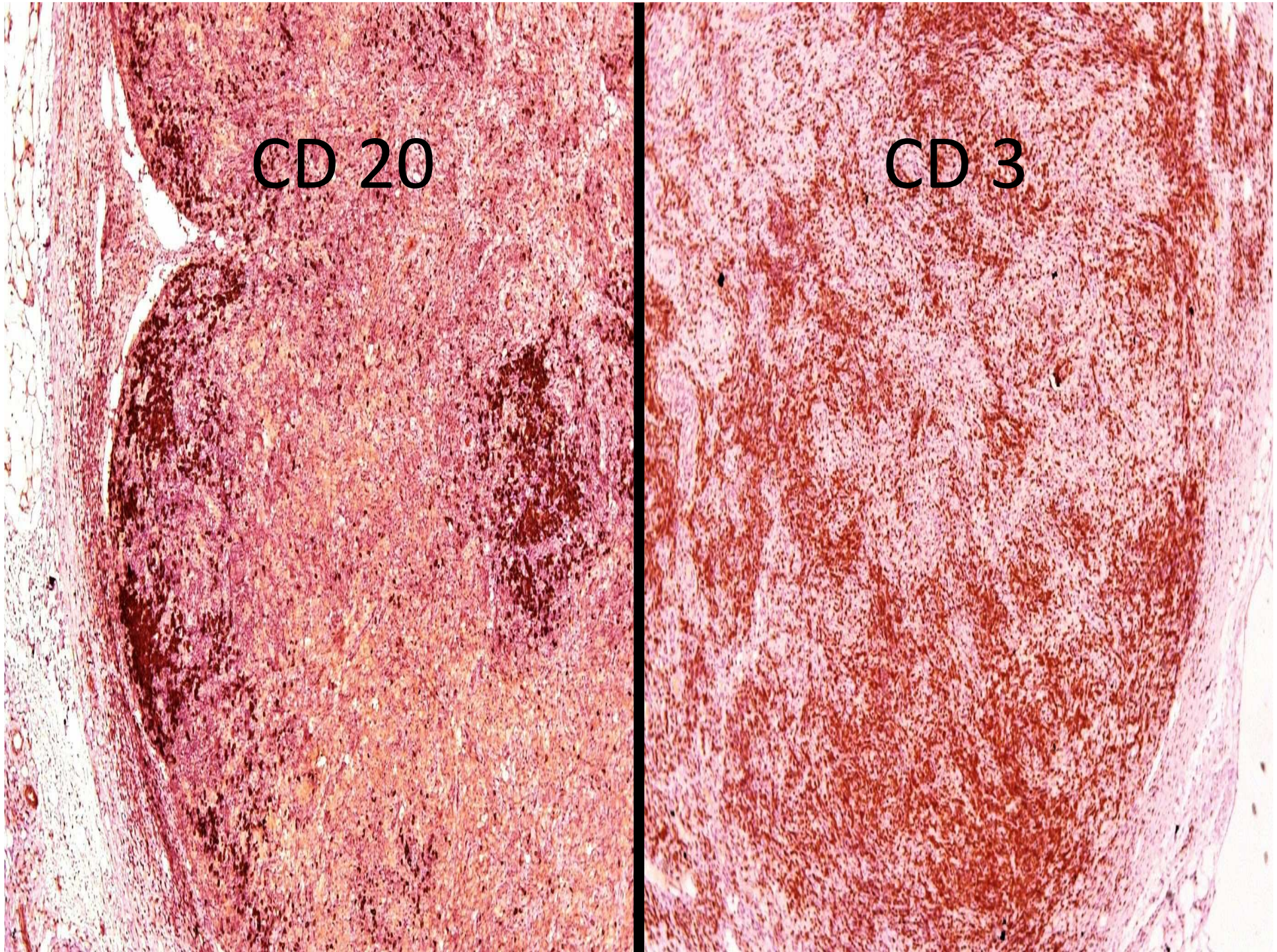
KI 67



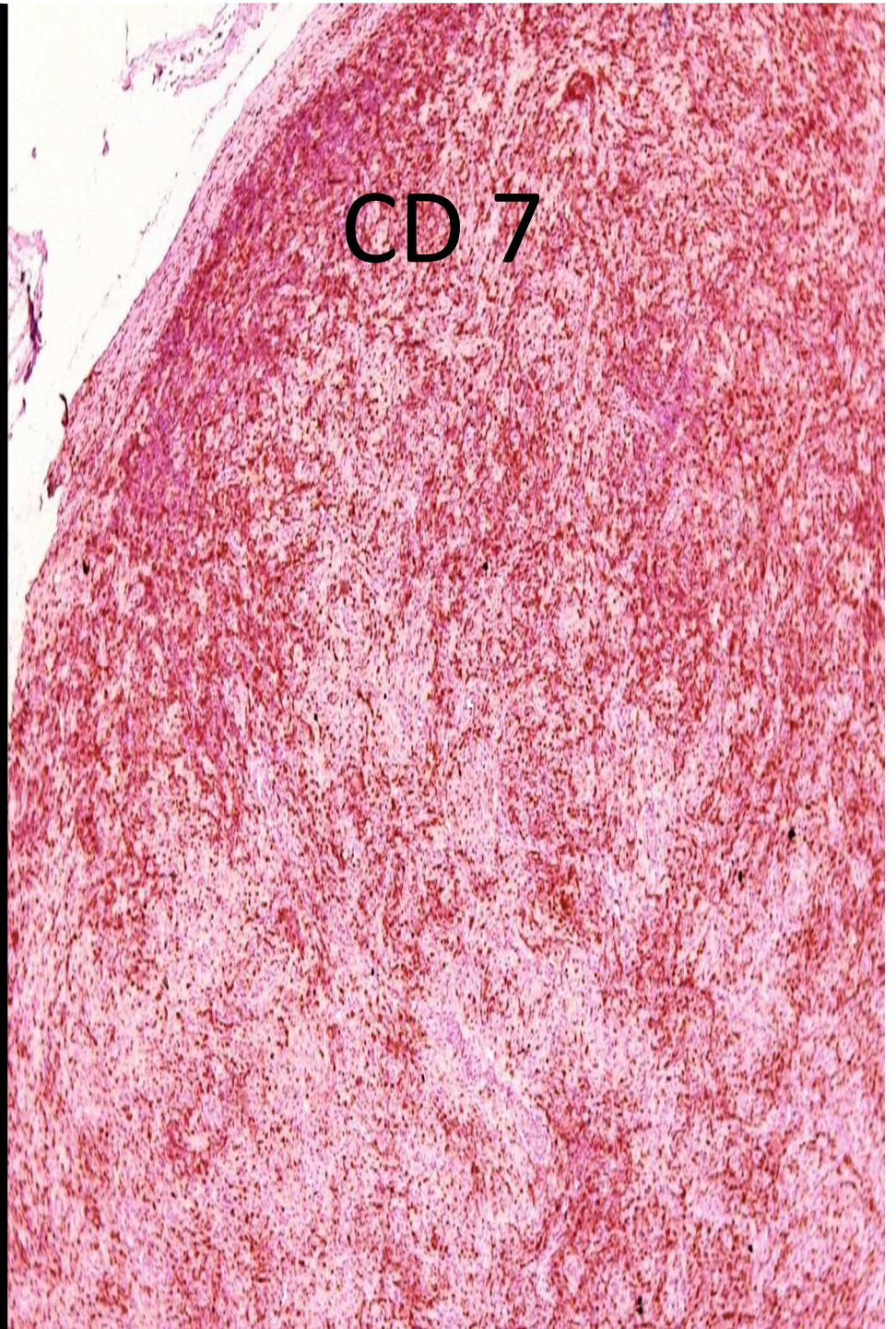


CD 20

CD 3

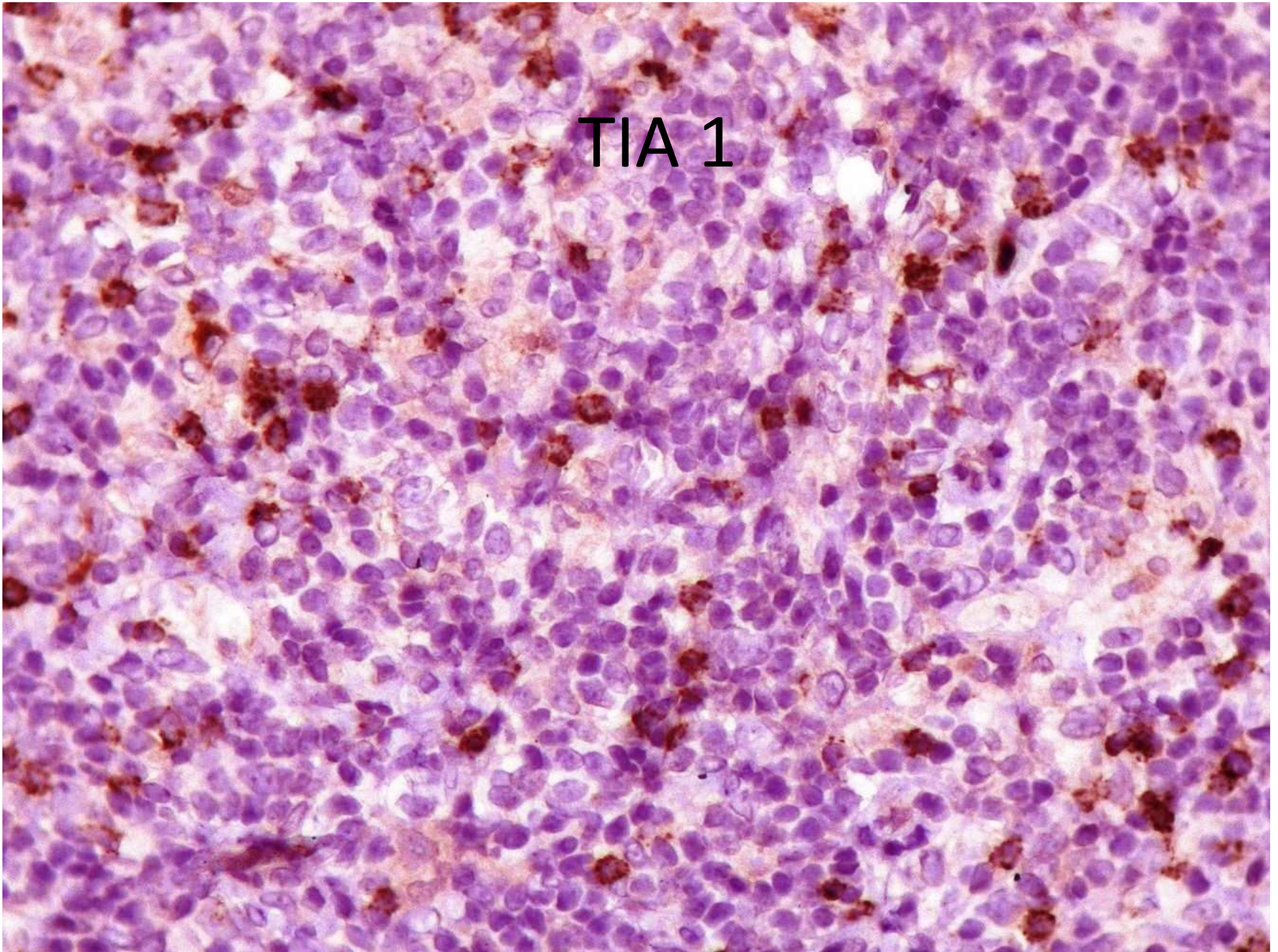






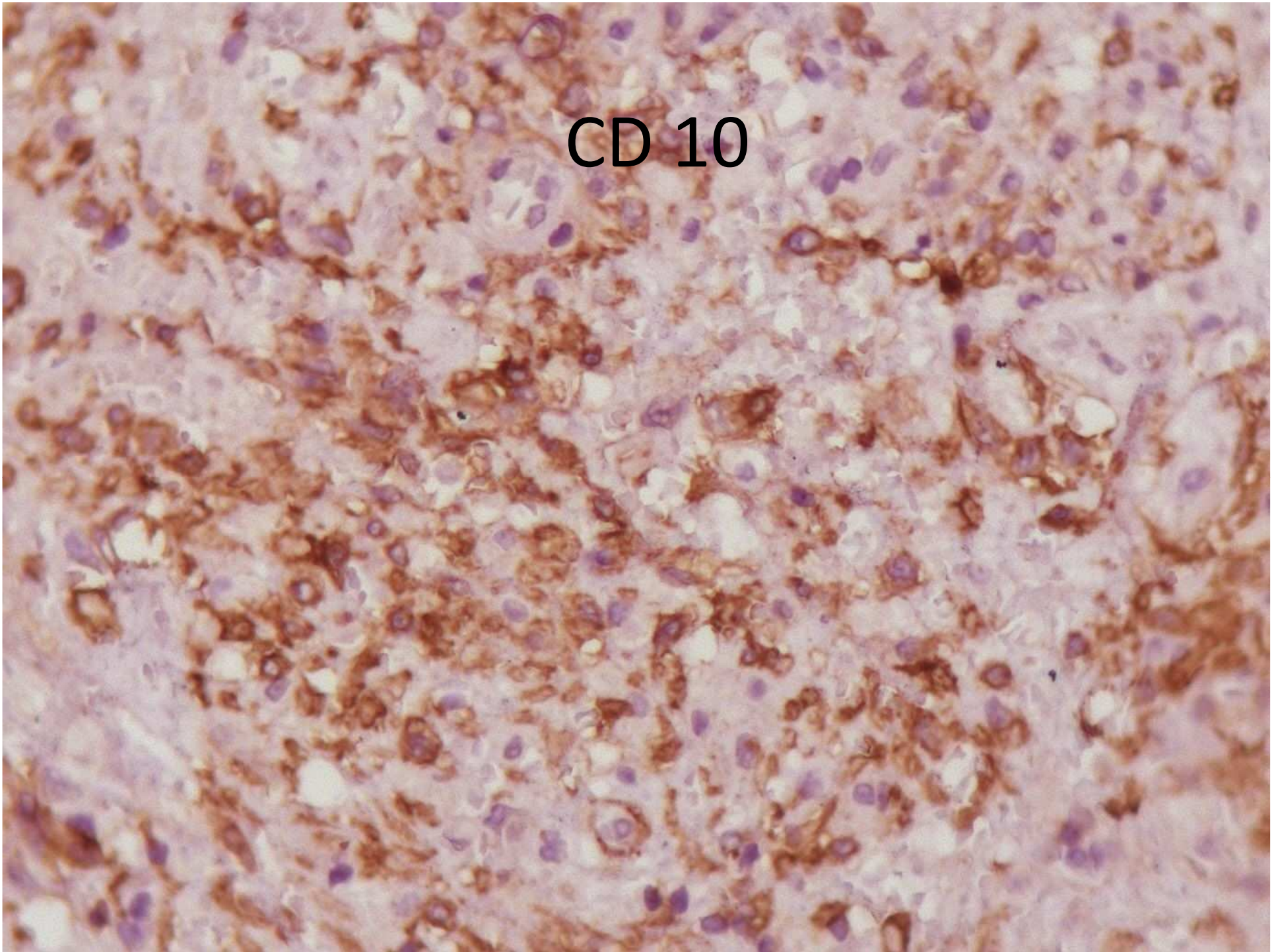


TIA 1



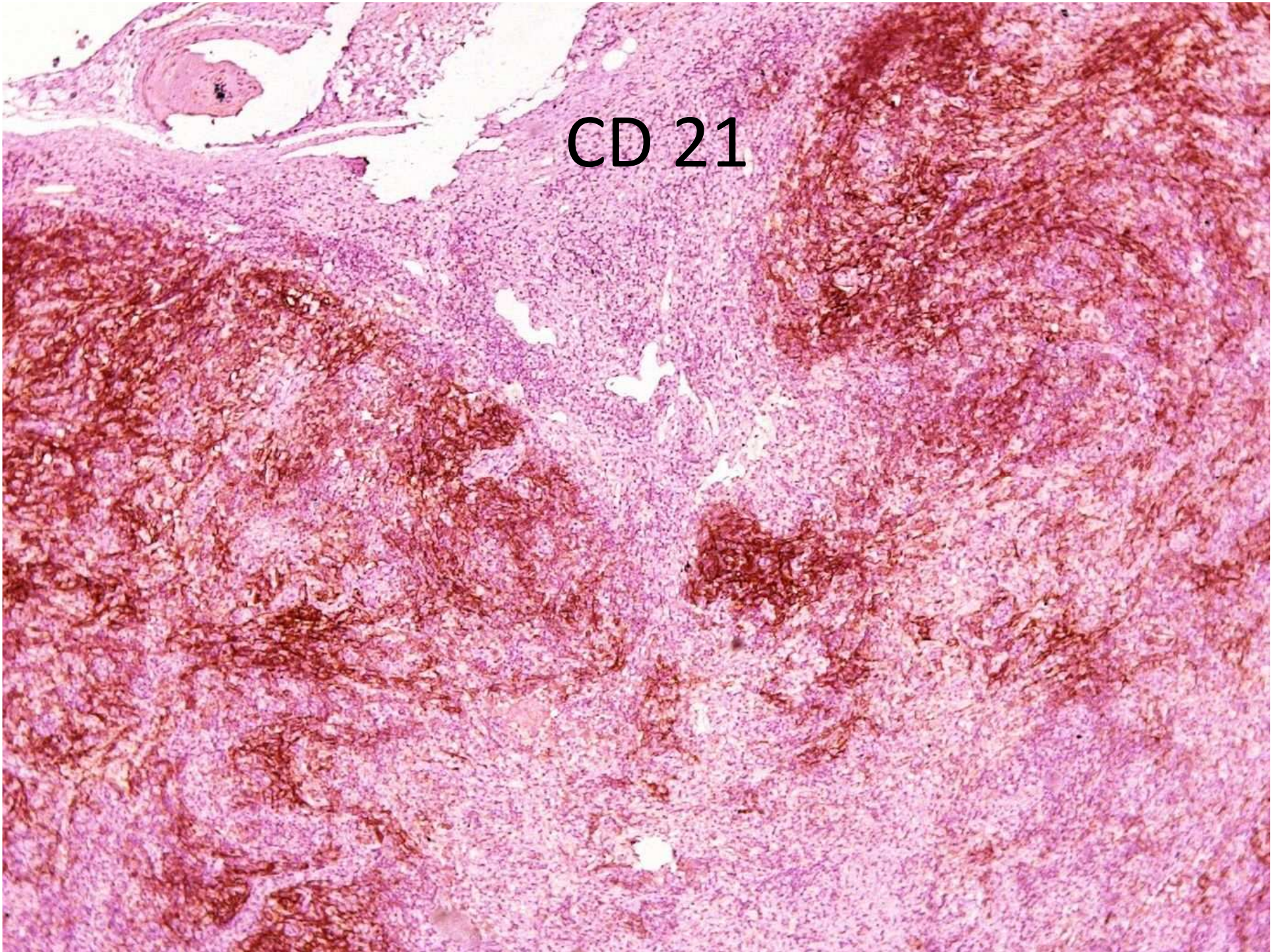


CD 10



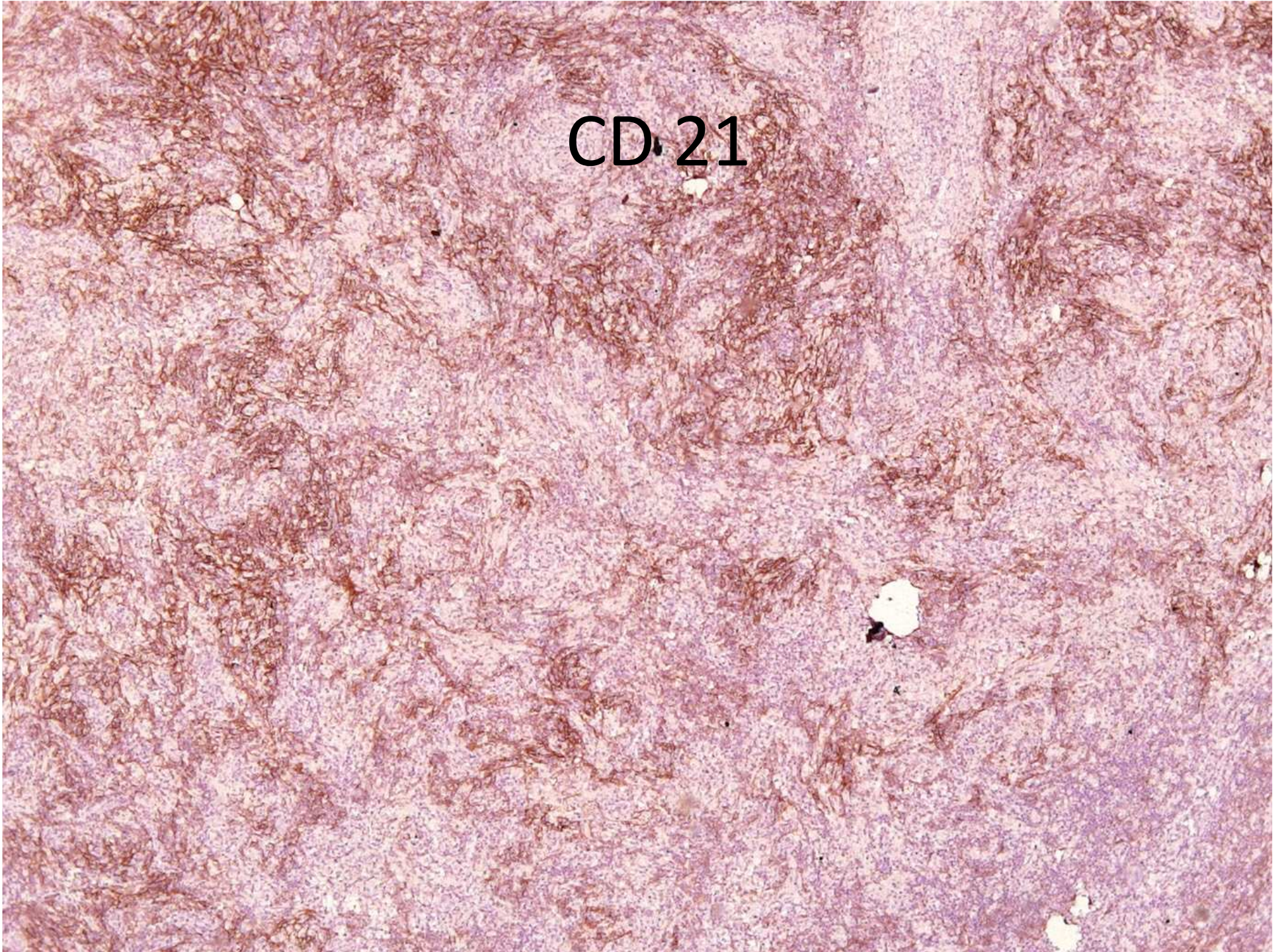


CD 21



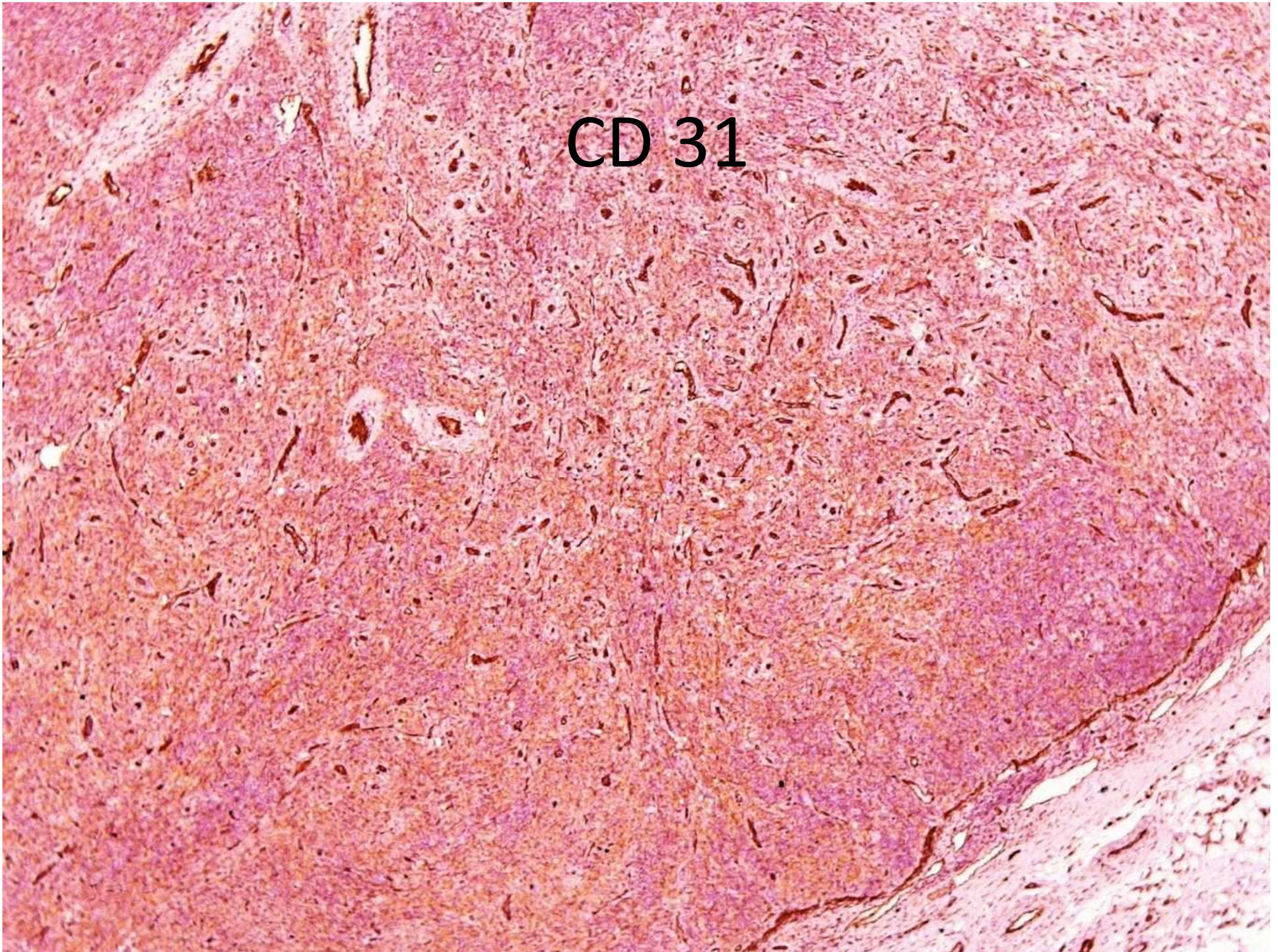


CD 21



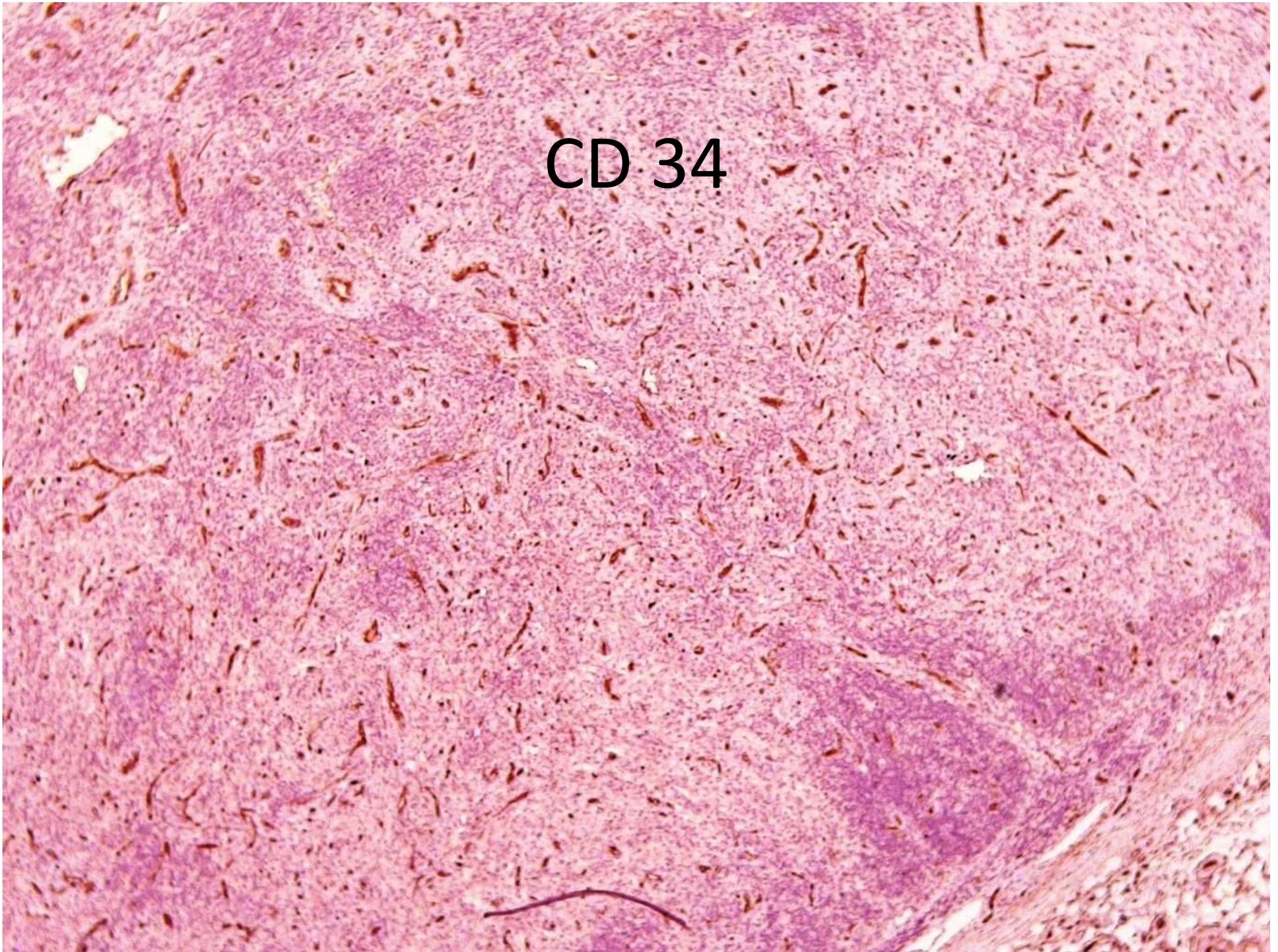


CD 31



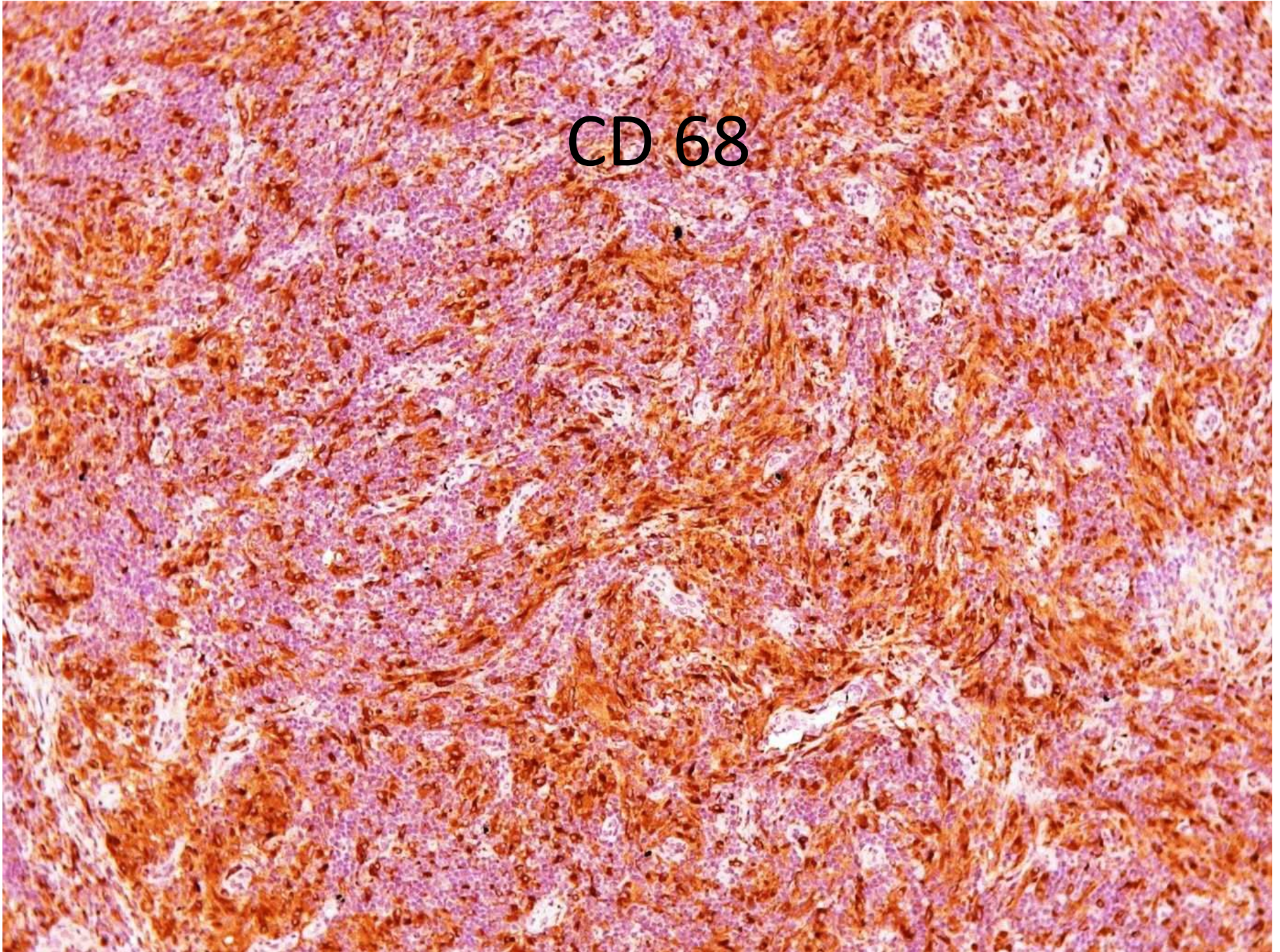


CD 34



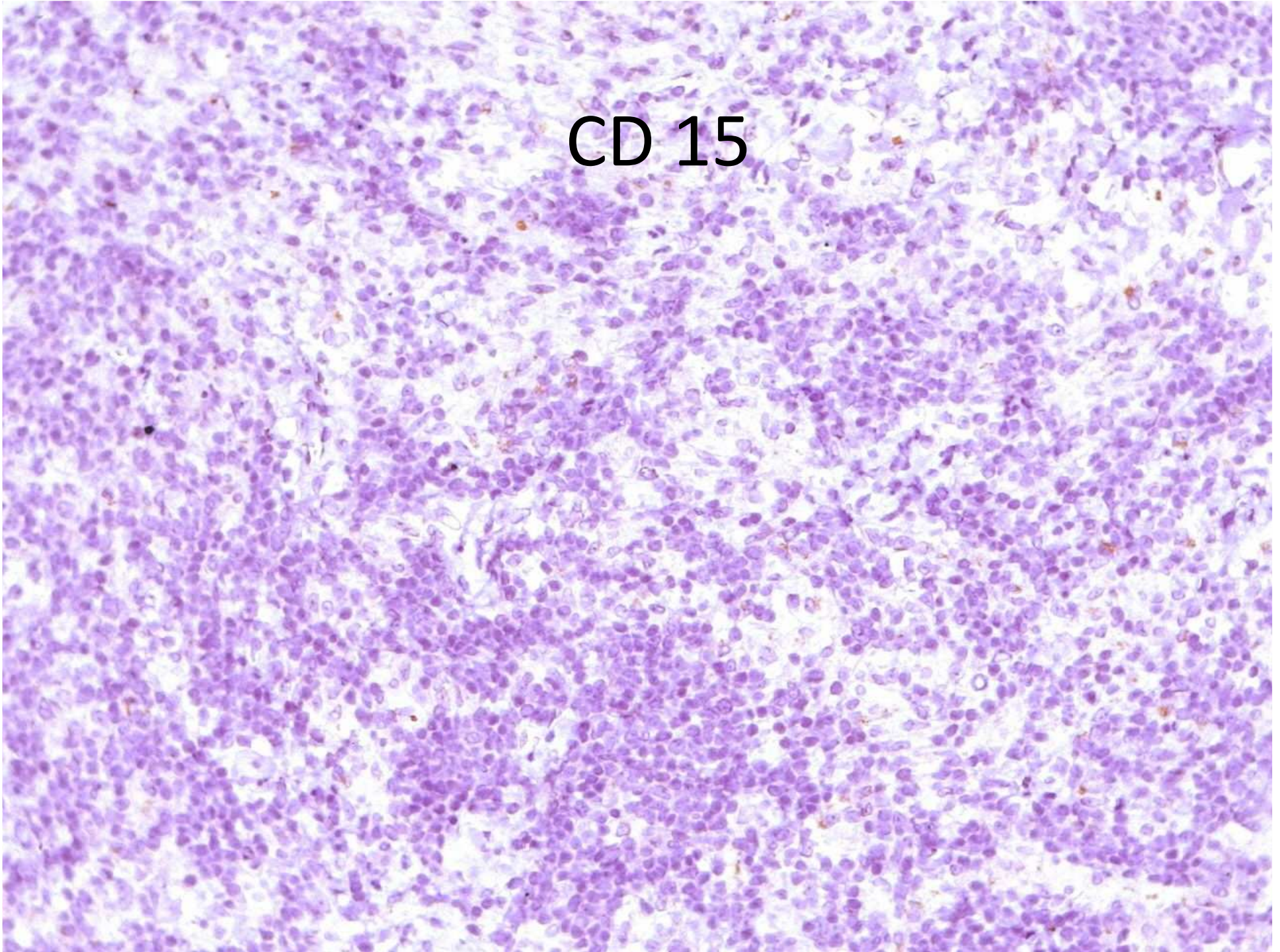


CD 68



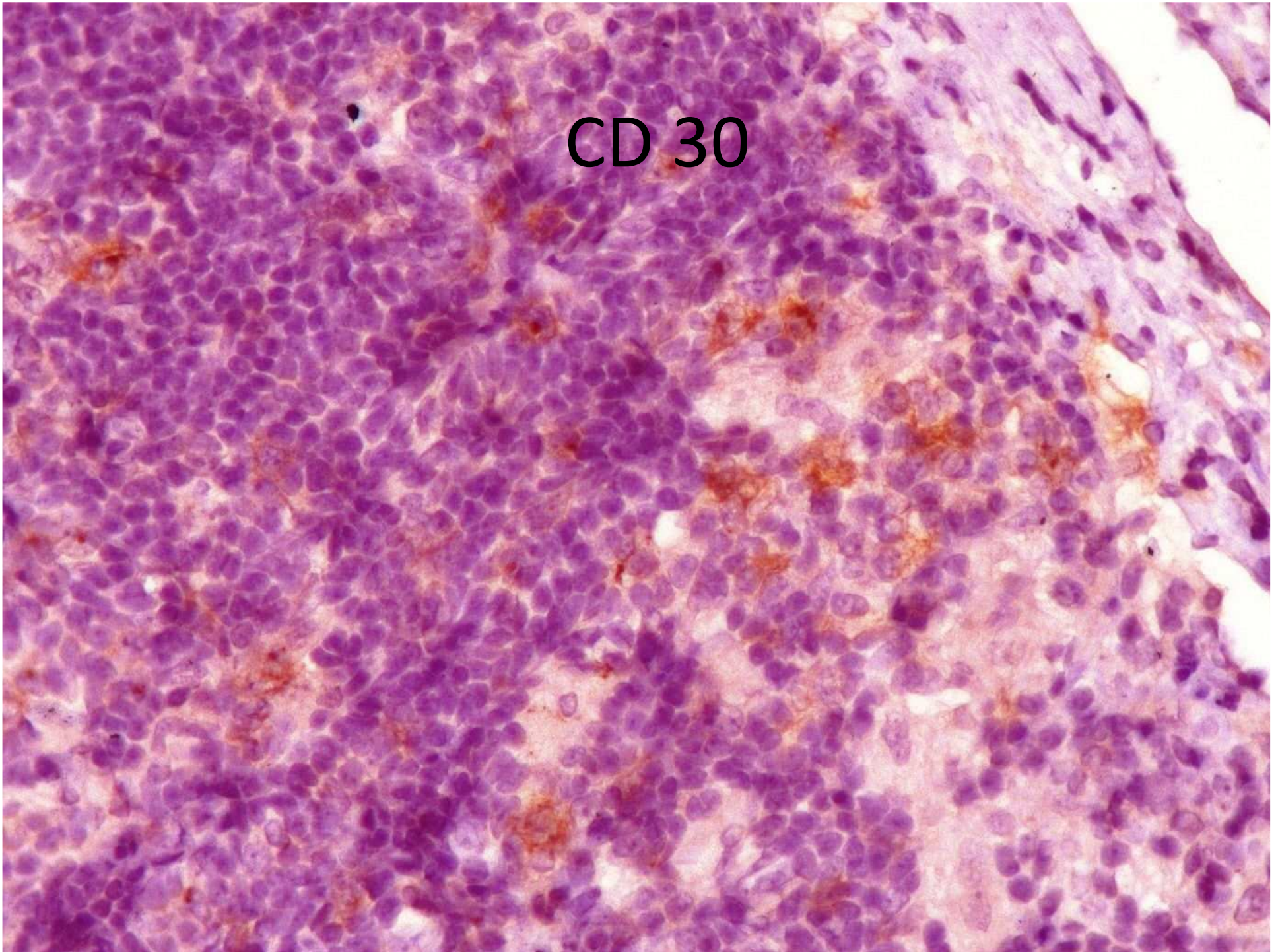


CD 15





CD 30





# LINFOMA T ANGIOIMUNOBLÁSTICO

**bjh** review

## Advances in the understanding and management of angioimmunoblastic T-cell lymphoma

Laurence de Leval,<sup>1</sup> Christian Gisselbrecht<sup>2</sup> and Philippe Gaulard<sup>3,4,5</sup>

<sup>1</sup>Department of Pathology, CHU Sart Tilman, University of Liege, Institute of Pathology B23, Liege, Belgium, <sup>2</sup>Department of Hemato-Oncology, AP-HP Hôpital Saint-Louis, Avenue Claude Vellefaux, Paris, France, <sup>3</sup>Département de Pathologie, AP-HP, Hôpital Henri Mondor, <sup>4</sup>INSERM U955, and <sup>5</sup>Université Paris 12, Faculté de Médecine, Créteil, France



# LINFOMA T ANGIOIMUNOBLÁSTICO

- Década de 1970: linfadenopatia angioimunoblástica com desproteïnemia
- Linfadenopatia imunoblástica
- Linfogranelomatose X
  - Reação hiperimune de células B ou um processo linfóide atípico
  - 1979: achados morfológicos de malignidade
    - LINFOMA T IMUNOBLÁSTICO
    - Década de 1980: clonacidade TCR, estabelecendo natureza neoplásica



# LINFOMA T ANGIOIMUNOBLÁSTICO

- Três padrões arquiteturais:
  - PADRÃO III
    - Mais comum, com perda arquitetural (perda de folículos)
    - Infiltração capsular
  - PADRÃO I
    - Arquitetura parcialmente preservada, com folículos hiperplásicos e manto pouco desenvolvido
    - Região paracortical com algumas células neoplásicas, tendendo à distribuição para-folicular
  - PADRÃO II
    - Depleção ocasional de folículos



# LINFOMA T ANGIOIMUNOBLÁSTICO

## *HALLMARK*

1. Infiltrado difuso polimórfico, com quantidade variável de células T, histiócitos, plasmócitos, eosinófilos, células epitelióides e imunoblastos
2. Acentuada proliferação endotelial (venular)
3. Proliferação irregular FDC
  - \* Padrões I e II têm FDC normais ou pouco aumentadas



# LINFOMA T ANGIOIMUNOBLÁSTICO

PATOGENESE – CÉLULA T *helper* folicular ( $T_{FH}$ )

Marcadores de  $T_{FH}$

- CXCL 3
- Bcl 6
- PD-1
- ICOS (*Inducible costimulator*)



# LINFOMA T ANGIOIMUNOBLÁSTICO

- Células de tamanho médio, com núcleo regular ou pouco irregular, citoplasma claro e abundante
- Tendência à formação de *cluster* perivenular
- Geralmente CD4+ CD8-
- Expressão anômala de CD 10 em 80%
- Um terço com expressão anômala CD 30

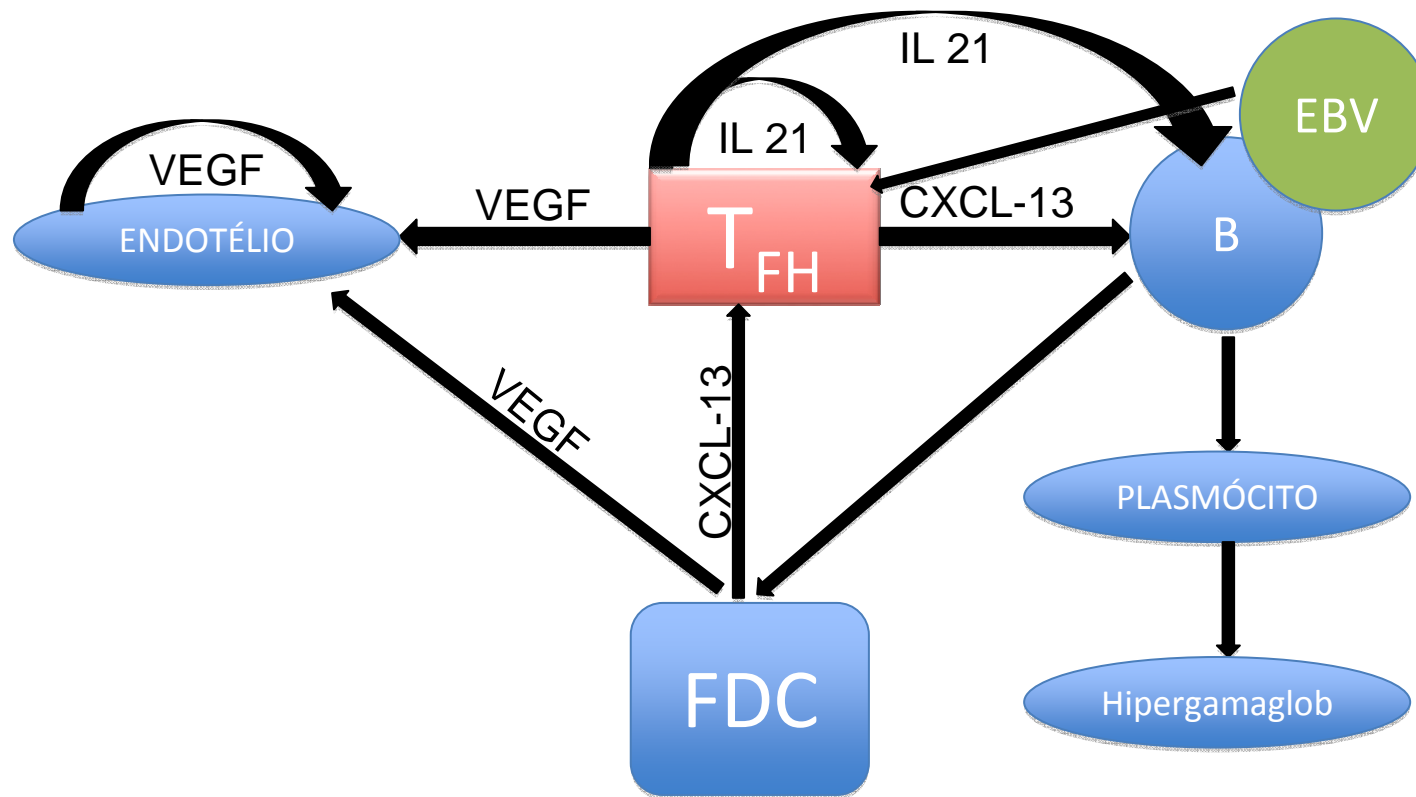


# LINFOMA T ANGIOIMUNOBLÁSTICO

- Presença de células B grandes (blastos), Reed-Sternberg like
- Geralmente infectadas por EBV
  - Infecção relaciona-se à imunodeficiência secundária



# LINFOMA T ANGIOIMUNOBLÁSTICO





# Medula óssea

## Março/2012







