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Case Report

An eerie presentation of lymphoma: a case report of non-Hodgkin

Cecil B. Harley, Monica Kotu*

Department of Otorhinolaryngology, University of Pretoria, Gauteng Province, South Africa

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***Correspondence:**
Monica Kotu,
E-mail: monicak@wol.co.za

ABSTRACT

Lymphomas are classified into Hodgkin and non-Hodgkin types according to the World Health Organisation classification of tumours of haematopoietic and lymphoid tissues. Hodgkin lymphoma arises from nodal sites, whereas non-Hodgkin lymphoma can originate from both nodal and extranodal sites.), NHL has multiple subtypes, with Diffuse large B-Cell lymphoma (DLBCL) being one of the most prevalent worldwide. We present a case of a 48-year-old female with well-controlled Retroviral disease (RVD), who presented with an isolated left ear lobule mass with final histology of Diffuse large B-cell lymphoma. This case underscores the rarity of extranodal lymphoma presenting in the ear lobule, an uncommon site for lymphoid malignancies.

Keywords: Diffuse large B-cell lymphoma, Extranodal sites, Ear lobule

INTRODUCTION

In the head and neck (HN) region, lymphomas may originate from various nodal and extranodal sites.[1] They are classified into Hodgkin and non-Hodgkin types according to the World Health Organisation classification of tumours of haematopoietic and lymphoid tissues.[2] Hodgkin lymphoma (HL) chiefly arises from nodal sites, whereas non-Hodgkin lymphoma (NHL) can originate from both nodal and extranodal sites.[1,3,4] The most common extranodal locations for non-Hodgkin lymphoma of the HN include Waldeyer's ring, ocular adnexa, sinonasal cavity, salivary glands, thyroid gland, oral cavity, and larynx.[1,3,4,5] NHL has multiple subtypes, with Diffuse large B-Cell lymphoma (DLBCL) being one of the most prevalent worldwide, accounting for approximately 30-40% of NHL cases.[6] While DLBCL frequently involves lymph nodes, extranodal manifestations, especially in the HN region, are observed in a substantial number of cases. However, isolated presentations in atypical locations, such as the ear lobule, are infrequent and may present significant diagnostic challenges for clinicians. We present a case of a 48-year-old female with well-controlled Retroviral disease (RVD), who presented with an isolated left ear lobule mass. The mass was initially treated as a cold abscess. There was no clinical response despite antibiotic therapy.

CASE REPORT

A 48-year-old female with controlled RVD infection presented with a three-month history of a left-sided earlobe mass and otalgia. The otalgia progressively worsened over time, prompting her to seek an ENT consultation. There was no history of trauma, otorrhoea, hearing loss or vertigo. There were no systemic constitutional TB or B-symptoms.

On physical examination, a firm, tender, non-fluctuant mass was observed on the left ear lobule, with signs of ulceration on the anterior surface (Figure 1). The external auditory canal was clear, and the tympanic membrane was intact and normal (Figure 2). There were no other abnormal systemic findings and no palpable cervical or generalised lymph nodes. At the follow-up appointment one month later, the lesion showed no improvement

(Figure 3). Due to the persistent and worsening swelling and ulceration, a biopsy was done and submitted for histopathological evaluation, which revealed DLBCL, an atypical presentation involving the earlobe.

Figure 1: Initial presentation, left auricle lesion.

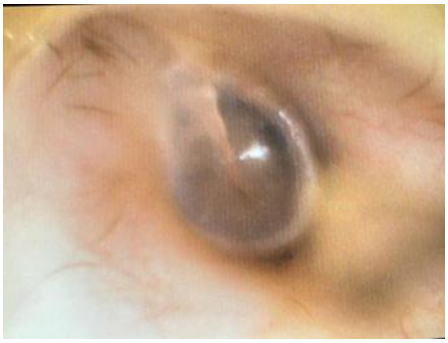

Figure 2: Normal external ear canal and tympanic membrane.

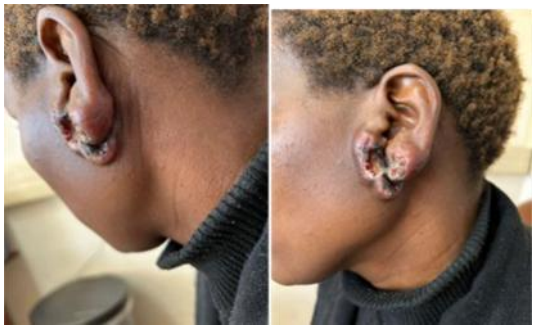

Figure 3: Follow-up visit 4 weeks later: worsening condition.

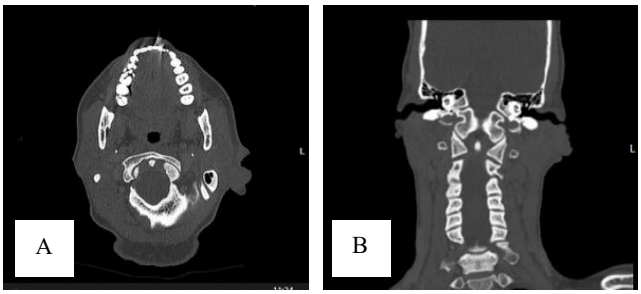

Figure 4 (A and B): CT scan of the head and neck shows a well-defined soft tissue mass in the left auricular region no evidence of local infiltration.

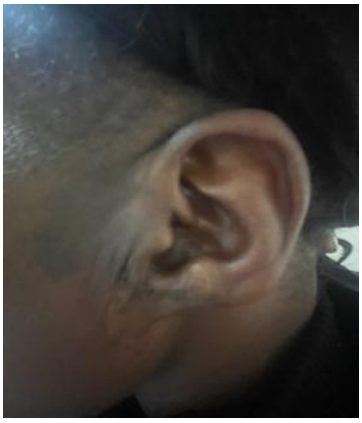

Figure 5: Post R-chop regime treatment (6 months later).

Investigation

CT Scan of the head and neck: Shows a soft tissue mass on the left earlobe that infiltrates the local soft tissues, with mild extension towards the subcutaneous layers; however, no bony erosion of the adjacent temporal bone or mastoid process. The external auditory canal and middle ear structures were not involved. No lymphadenopathy or distant spread was detected in the cervical region (Figure 4). Histopathology: The biopsy of the post-auricular mass showed diffuse infiltration by large, atypical lymphoid cells, consistent with DLBCL. Immunohistochemistry showed positivity for CD20, BCL-6, and MUM. The proliferation index (Ki-67) was high, further supporting the aggressive nature of the disease.

Treatment

The treatment options for NHL include radiotherapy, chemotherapy, immunotherapy, and radioimmunotherapy.[7] The selection of treatment should be based on the extent of tumour involvement and the availability of therapeutic agents. The treatment options vary between institutions. Surgery in non-Hodgkin lymphoma (NHL) is primarily used for diagnostic purposes rather than as definitive treatment. Our patient was subsequently referred to the oncologist for chemotherapy. She completed six cycles of the rituximab, cyclophosphamide, hydroxydaunorubicin, oncovin, and prednisone (R-CHOP) regimen with complete resolution of the lesion (Figure 5).

DISCUSSION

According to Storck et al, 76% of lymphoma cases present with cervical masses, particularly in both HL and NHL.[6] Several studies found that lymphadenopathy, mainly in the neck, was the most common presentation, occurring in 68.18% of HN lymphoma cases.[8] In a series by Pickard et al, they found that 85% of Extranodal NHL presented with a mass or symptoms related to the mass.[9]

Our patient presented with an earlobe mass with associated otalgia and no cervical lymphadenopathy. An isolated Lymphoma of the earlobe is exceedingly rare. The literature highlights only a few documented cases from Canada and America, both of which reported atypical presentations involving the ears.[10,11] However, the patient in the Cuartas et al, report, had a mediastinal mass, B-symptoms, and what appeared to be metastasis to the earlobe. The report by Do et al, showed histology consistent with small lymphocytic lymphoma (SLL), which has the same cell of origin as DLBCL but a different growth pattern.[12,13] SLL has a nodular growth pattern, whereas DLBCL has a diffuse growth pattern. Our patient was unique in that she had an isolated earlobe mass with no B-symptoms, no cervical lymph nodes, no other systemic findings, and DLBCL as histology. This case highlights the need to maintain a high index of suspicion for lymphoma in any persistent or unusual head and neck mass, particularly when typical treatments, such as antibiotics, fail to resolve the issue. Although lymphoma of the ear is sporadic, these cases highlight the broad spectrum of clinical presentations and the need for clinicians to include lymphoma in the differential diagnosis of head and neck masses in immunosuppressed patients.

CONCLUSION

This case underscores the rarity of extranodal lymphoma presenting in the earlobe, an uncommon site for lymphoid malignancies. Clinicians should maintain a broad differential diagnosis when dealing with persistent or atypical head and neck masses, especially when conventional treatments have failed. Lymphomas can present with various clinical manifestations, and an early, accurate diagnosis is crucial for proper management and improved patient outcomes. Importantly, if there is no response to initial treatment or the diagnosis remains uncertain, a biopsy should be pursued to obtain a definitive diagnosis. Timely diagnosis is key, as it not only enables appropriate treatment but can also significantly affect prognosis, especially in aggressive lymphomas, where early intervention can improve survival. The scarcity of such cases emphasizes the need for ongoing reporting and documentation to broaden clinical awareness and improve diagnostic accuracy.

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