Esophageal involvement by lymphoma is rare and represents approximately 1% of the cases of lymphomatous involvement of the gastrointestinal tract [1, 2]. Non-Hodgkin’s lymphomas account for most of the cases [2]. As with other digestive tract lymphomas, few of the esophageal lymphomas are of the primary type; esophageal location as the first site of Hodgkin’s disease is exceptional [2–5]. The radiographic manifestations of esophageal lymphoma have shown a diverse spectrum of abnormalities similar to those of lymphoma elsewhere in the gastrointestinal tract [6, 7], except for the aneurysmal dilatation pattern that, to our knowledge, has never been described previously. We report an exceptional case of primary Hodgkin’s lymphoma of the esophagus with a unique radiologic description of progressive aneurysmal dilatation.

Case Report

A 61-year-old man presented with odynophagia associated with dysphagia for solids and liquids. His history included a gastric ulcer and reflux esophagitis treated for 1 year. The findings at physical examination were normal. Complete blood cell count and routine serum chemistry levels were within normal limits. Findings of double-contrast esophagography showed an irregular luminal narrowing of the proximal two thirds of the esophagus due to multiple submucosal nodules. These nodules coalesced and presented as enlarged tortuous and ulcerated longitudinal folds (Fig. 1A) that mimicked esophageal varices. Varicoid carcinoma was considered, but this diagnosis was excluded after the biopsy analyses.

Endoscopic biopsies of the esophageal mucosa showed granulation tissue composed of a mixed lymphoplasmocytic–polynuclear infiltrate with neovascularity, associated with a fibrinonecrotic exudate containing bacteria, spores of Candida organisms, and mycelium filaments in large amounts with no sign of dysplasia or malignancy. CT of the chest showed a nonspecific circumferential wall thickening (Fig. 1B) of the proximal two thirds of the esophagus without mediastinal lymphadenopathy and showed incidentally a lung mass later found to be a poorly differentiated lung adenocarcinoma of the right upper lobe (stage T3 N0 M0 [8]), treated by right upper lobectomy. Mediastinal exploration during lung surgery showed no enlarged lymph nodes. All resected periesophageal lymph nodes were normal at pathologic examination.

For 6 months, the patient underwent several therapeutic trials for esophagitis of unknown origin. Ten additional esophagoscopic examinations were performed. Results of mucosal and deep submucosal biopsies showed non-specific inflammatory infiltrates and remained negative for malignancy. Results of repeated double-contrast esophagograms and CT scans of the esophagus showed a progressive aneurysmal dilatation of the diseased proximal two thirds of the esophagus with distal extension of the submucosal nodules (Figs. 1C and 1D). A fistula developed between the diseased esophagus and both the cavity of lobectomy and the right mainstem bronchus, leading to abscess formation of the right upper lobectomy cavity, right middle lobe pneumonia, and empyema, which was treated with antibiotics and pleural drainage (Fig. 1E). CT revealed enlarged lymph nodes in the gastrohepatic ligament.

The patient underwent esophagectomy. Findings of the pathologic examination (Fig. 1F) showed Hodgkin’s lymphoma of the esophagus (stage IIIE according to Ann Arbor classification [9]) with involvement of a single noncontiguous retroesophageal lymph node and of numerous perigastric lymph nodes. Septic shock developed postoperatively as a result of bronchopneumonia of the right middle and lower lobes.

The patient died on day 25 after esophagectomy. Autopsy showed numerous tracheobronchial lymph nodes involved by
Hodgkin’s disease and a single lymphomatous hepatic metastasis. No other gastrointestinal location of the disease was found.

**Discussion**

To our knowledge, Hodgkin’s disease involving the esophagus has been reported rarely in the literature. Most cases of supposed primary esophageal Hodgkin’s disease that were previously reported had concomitant peripheral lymphadenopathy at the time of lesion detection, arose secondarily by extension from involved adjacent lymph nodes or by contiguous spread from the gastric fundus, or recurred after a previously treated Hodgkin’s disease. On the basis of these findings, true primary Hodgkin’s lymphoma of the esophagus is exceptional, being reported in only four cases since the 1920s [2–5]. Lymphoma of the esophagus occurs more often in the distal esophagus [6, 7]; however, Hodgkin’s disease involves predominantly the upper or mid esophagus [2].

![Fig. 1.—61-year-old man with odynophagia and progressive dysphagia.](image)

A. At initial workup, double-contrast esophagogram shows submucosal nodules with confluent areas appearing as enlarged tortuous and ulcerated longitudinal folds that mimic varices in upper and mid esophagus.

B. CT scan shows marked circumferential thickening of esophageal wall (arrow).

C. Double-contrast esophagogram obtained 5 months after right upper lobectomy shows aneurysmal dilatation in proximal and mid esophagus.

D. Double-contrast esophagogram shows fistula to lobectomy cavity and right mainstem bronchus.

E. CT scan obtained at same level as B shows marked dilatation of esophageal lumen (e) with nodular thickening of esophageal wall, fluid–gas level with barium residue (arrow) in lobectomy cavity, and paraesophageal hypodense lymphadenopathy (arrowhead).

(Fig. 1 continues on next page)
Primary Hodgkin’s Lymphoma of the Esophagus

Fig. 1. (continued)—61-year-old man with odynophagia and progressive dysphagia.
F, Photograph of esophagectomy specimen shows ulcerated burgeoning masses partially covered by whitish fibrinous exudate. Diagnosis was Hodgkin’s lymphoma of mixed cellularity subtype.

Some authors stress the necessity of an early diagnosis because the response to local or systemic treatment is often good [2, 11]; therefore, clinicians and radiologists should be aware of this disease. Despite its rarity, primary esophageal Hodgkin’s disease and lymphoma in general should be included in the differential diagnosis of atypical lesions of the esophagus, even in the asymptomatic patient.

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