Methotrexate-Associated Lymphoproliferative Disorder Presenting As Oral Ulcers in a Patient With Rheumatoid Arthritis

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Abstract. Methotrexate-associated lymphoproliferative disorders are a heterogeneous group of lymphoid proliferations or lymphomas that develop in patients with autoimmune diseases treated using methotrexate. These lymphoproliferative disorders are often associated with Epstein-Barr virus infection and occasionally regress after the withdrawal of methotrexate therapy. The lymphoproliferative disorder in this case was diffuse large B-cell lymphoma, unusually presenting as oral ulcers in a 79-year-old woman on treatment with methotrexate for longstanding rheumatoid arthritis. Latent membrane protein 1 positivity was detected by immunohistochemistry and Epstein-Barr-virus encoded small RNA positivity by chromogenic in situ hybridization. Clonality was confirmed by immunohistochemistry (K light-chain restriction), polymerase chain reaction (monoclonal immunoglobulin H gene rearrangement), and capillary electrophoresis (GeneScan). Staging procedures were negative. Withdrawal of methotrexate therapy led to complete remission within 6 weeks, and the patient is alive and disease-free 18 months after the diagnosis was made. The oral cavity is not often involved in the initial presentation of methotrexate-associated lymphoproliferative disorders, and presentation with intraoral ulcers is very rare. We have performed a review of the literature on methotrexate-associated lymphoproliferative disorders presenting as ulcers in the oral cavity.

Key words: oral ulcers, diffuse large B-cell lymphoma, methotrexate, Epstein-Barr virus, rheumatoid arthritis.

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Introduction

The 2001 World Health Organization (WHO) classification of tumors of hematopoietic and lymphoid tissues recognizes 4 categories of lymphomas and lymphoproliferative disorders associated with immunodeficiency or immunosuppression: a) lymphoproliferative disorders associated with primary immunodeficiency, b) lymphomas associated with human immunodeficiency virus (HIV) infection, c) posttransplant lymphoproliferative disorders, and d) lymphoproliferative disorders associated with methotrexate therapy.1

This last category comprises lymphoid proliferations or lymphomas that affect immunocompromised patients treated with methotrexate for various autoimmune diseases (rheumatoid arthritis, psoriasis, dermatomyositis),1,2 and that can resemble large B-cell lymphoma, Hodgkin lymphoma, or a polymorphic posttransplant lymphoproliferative disorder. They are usually associated with Epstein-Barr virus infection and occasionally regress after withdrawal of methotrexate therapy.1

We describe a case of a lymphoproliferative disorder with the morphology of diffuse large B-cell lymphoma, positive for Epstein-Barr virus, in a patient with long-standing rheumatoid arthritis treated with methotrexate. The primary site was confined to the oral mucosa and the disorder presented as oral ulcers.

Case Description

The patient was a 79-year-old woman with a 20-year history of rheumatoid arthritis who had been receiving treatment with methotrexate for 17 years at a variable dose of between 5 and 12.5 mg/wk and who consulted for painful lesions in the oral cavity that had appeared 2 months earlier.

The lesions consisted of large ulcers covered with a grayish exudate, indurated on palpation, and located on the ventral surface of the tongue, the cheek mucosa, the floor of the mouth, and the lower lip (Figure 1). Histopathology identified a dense infiltrate composed of large lymphoid cells with irregular margins occupying the full thickness of the mucous membrane. The cells were arranged in sheets, with numerous mitotic figures (Figures 2 and 3). Immunohistochemistry showed the neoplastic cells to be positive for CD45, CD20, and CD79a, with numerous activated CD30+ cells (Figure 4), and negative for CD15, CD21, and CD23. The Ki-67 proliferation...
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mg/L). No changes in folic acid levels were observed. No other pathological findings or enlarged lymph nodes were detected on examination of the skin and mucosa, and analysis of tumor extension (computed tomography of the head and neck, thorax, abdomen, and pelvis) was negative. A diagnosis of methotrexate-associated lymphoproliferative disorder (Epstein-Barr-virus positive diffuse large B-cell lymphoma) was made and the drug withdrawn. Within 6 weeks complete epithelialization of the ulcers was observed. Remission of the lesions was confirmed histologically. Eighteen months after the diagnosis was made, the patient is in complete remission.

Discussion

Lymphoproliferative disorders affecting patients with autoimmune diseases treated with methotrexate can present varied histopathological patterns. Diffuse large B-cell lymphoma accounts for 35% of such cases. Less frequently, cases of Hodgkin lymphoma (25%), Hodgkin-like lesions (8%), follicular lymphoma (10%), Burkitt lymphoma (4%), and peripheral T-cell lymphoma (4%) have been reported. In 14% of patients polymorphous lymphocytic or lymphoplasmacytic infiltrates have been described. Approximately half of the patients are positive for Epstein-Barr virus. The rate of Epstein-Barr virus infection depends on histological type. Positivity for Epstein-Barr virus was detected in 50% of the cases of diffuse large B-cell lymphoma, in 75% of Hodgkin lymphomas and Hodgkin-like lesions, in 50% of lymphoplasmacytic infiltrates, and in 40% of follicular lymphomas.1

The proportion of cases that resolve following withdrawal of methotrexate is dependent on the presence of Epstein-Barr virus infection and on histological type. The majority of patients who respond to this measure are positive for Epstein-Barr virus. Forty percent of the cases of diffuse large B-cell lymphoma and 30% of the cases of Hodgkin lymphoma resolve following withdrawal of methotrexate. Patients who do not experience remission require chemotherapy. Overall survival is 50% in patients with diffuse large B-cell lymphoma and 75% in patients with Hodgkin lymphoma.1

Extranodal sites (gastrointestinal tract, skin, lung, kidney, soft tissues) have been reported in 40% of cases, although this figure depends on histological type. Thus extranodal involvement is observed in 50% of diffuse large B-cell lymphomas, 20% of Hodgkin lymphomas and Hodgkin-like lesions, 100% of lymphoplasmacytic lymphomas and atypical lymphoplasmacytic infiltrates, and 40% of follicular lymphomas.1 Methotrexate-associated diffuse large B-cell lymphomas presenting initially in the skin are extremely rare, and only a few cases of this disease have been reported.3-6
CD138+, BCL-6–) that corresponds to the terminal phases of B-cell differentiation. It is usually found in the oral cavity of HIV-positive patients, although it has been reported in transplanted HIV-negative patients as well, and is usually associated with a poor prognosis.4,12,13 Burkitt lymphoma is a highly aggressive B-cell lymphoma that can develop in the maxillofacial region and spread to the oral cavity with ulceration. It is characterized by a relatively uniform proliferation of medium–sized B-cells with the immunophenotype CD5–, CD10+, CD20+, Bcl-2– and translocation of the c-myc gene.14,15 Nasal-type natural killer-cell/T-cell lymphoma of the oral cavity is usually located on the palate or gums and is characterized by aggressive behavior and a diffuse angiocentric and angioinvasive infiltration of medium or large cells positive for CD3, CD43, CD45RO, CD56, and TIA-1.16

### Conflicts of Interest
The authors declare no conflicts of interest.

### References


