IS LYMPHOMA CURABLE?

SHORT ACCOUNTS OF INTERESTING CASES, SOME MEDICAL DISASTERS, INVOLVING PATHOLOGY AND CLINICAL PRACTICE, FROM THE RECOLLECTION OF PROF. ALBERT CILIA-VINCENTI.

This is early 1980s, a few years after I took up a consultant surgical pathologist post at the Royal Hampshire County Hospital in Winchester. I get a call from Dr Anthony Galea-Debono who is now a physician and neurologist in private practice in Malta. In the late 1970s, Tony and I used to meet often over lunch because we worked not far from each other in London, him at Queen's Square and I at The Middlesex in Mortimer Street.

The call from Galea-Debono is about a young woman in her early thirties who has been referred to him for management of a diagnosis of tuberculosis following an excision biopsy of an enlarged neck lymph node, and wishes the histology reviewed before he starts anti-tuberculous therapy. The lymph node histology, in fact, shows what I thought was a high grade large cell lymphoma with necrosis, the latter feature having been misinterpreted as tuberculous necrosis. The patient also complained of retrosternal pain on ingesting alcohol. I confirm the lymphoma diagnosis with Professor Dennis Wright, at the time a world figure in lymphoid pathology, and conveniently located in Southampton, just down the road from Winchester.

Galea-Debono says that the patient wishes to come up to UK to consult an oncologist and I recommend Professor Michael Whitehouse in Southampton, a jovial, moral-lifting doctor with great bed-side manner. The patient and her husband leave immediately for Southampton. By the time they get to UK, Dennis Wright has rung me to announce that his laboratory has tried their first immunohistochemistry diagnostic technique on this patient's lymph node using an antibody to epithelial membrane antigen (EMA), and that her tumour has stained positively, meaning he's changing his diagnosis to anaplastic carcinoma.

Next day I came across Michael Whitehouse and he explained how he was going to tackle the problem of two diagnoses, high grade lymphoma and anaplastic carcinoma. As no treatment regime existed for anaplastic carcinoma, he was going to try high grade lymphoma therapy in case it worked. He explained to the patient that she had a one in four chance of cure. She was given her first course of combination chemotherapy in Southampton, her hair fell out and returned to Malta with a suitable wig and with chemotherapy regime instructions for Galea-Debono to follow.

Back in Malta, the doctors' strike was still part of the medical services scene and Galea-Debono, probably assisted by oncologist Dr Victor Muscat, oversaw the completion of the patient's chemotherapy regime. I remember some feedback that the Southampton chemotherapy dosages were significantly higher than they had ever used in Malta. The patient did manage to complete the treatment course and her hair grew back. The couple had two small girls and they were struggling to set up a business.

Five years later the patient was fit and well, so I sent her lymph node paraffin block back to Dennis Wright to review his diagnosis of anaplastic carcinoma. Five years was a long time in evolution of immunohistochemistry and with newer antibodies to various diagnostic antigens, Dennis Wright now diagnosed a T-cell high grade lymphoma. We now know that some lymphomas stain positively with an epithelial membrane antigen antibody – this is only one of the many pitfalls in diagnostic immunohistochemistry interpretation. If Michael Whitehouse had not ignored immunohistochemical misinterpretation of anaplastic carcinoma, this patient would not have survived.

Almost 35 years later, this patient is a picture of health, as slim and attractive as ever, and a great success story of oncological chemotherapy. Michael Whitehouse always asks after her. The couple and their daughters have also been a success story in business, now owning and running three top local restaurants, outside-catering and a boutique hotel.