Most parvovirus infections are benign and self-limited and do not require specific therapy. Patients with parvovirus-induced fulminant hepatitis do better than those due to other etiology. In severe infection, immunoglobulins, anti-thymocyte globulins, and anti-lymphocyte globulins have been tried with some success. It is essential to perform serology to detect acute parvovirus infections among patients who present with pancytopenia, hemophagocytosis and acute liver dysfunction.

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**Primary esophageal T-cell non-Hodgkin’s lymphoma**

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Primary non-Hodgkin’s lymphoma of the esophagus is a rare disease. We report a 52-year-old man who had a polypoid mass in the esophagus at endoscopy. Histology was suggestive of non- Hodgkin’s lymphoma; immunohistochemistry was positive for CD3, CD45 RO, LCA. He was treated with 6 cycles of CHOP and is disease-free 14 months later. [*Indian J Gastroenterol* 2005;24:119-120]

Approximately 98% of esophageal malignant neoplasms are squamous cell carcinomas, with the remaining almost exclusively adenocarcinomas.
Lymphomas may involve the esophagus as part of extensive GI involvement, especially in mantle cell lymphomas, EATCL, and in the setting of immunodeficiency states. Most of the primary esophageal lymphomas reported are low-grade malomas, lymphoplasmacytoid lymphomas or aggressive diffuse large B-cell lymphomas. The aggressive lymphomas have been associated with immunodeficiency states like HIV infection, as second malignancy after chemotherapy, and after prolonged intake of immunosuppressive drugs like prednisolone or azathioprine. We did not find any report of primary T-cell lymphoma of the esophagus in an immune-competent patient.

Esophageal lymphomas may present with symptoms similar to those of squamous carcinoma. Systemic symptoms are uncommon in low-grade B-cell GI lymphomas, but may be present in aggressive T-cell variants. There is no typical radiologic pattern and barium studies may be non-specific or may mimic carcinoma. Endoscopy findings, which include polypoidal masses with or without ulceration, ulcerated stenosis, large intramural mass, narrow distal segment mimicking achalasia, varicoid pattern and multiple submucous nodules, are not diagnostic. Submucosal swellings may be localized or multifocal, resembling benign conditions like fibrotic strictures, leiomyoma, achalasia or varices. CT scans of the thorax and abdomen are needed for staging the disease and for evaluation of tumor mass after chemotherapy. Endoscopic ultrasound may also be a useful adjunct for assessing the local extent of the tumor and operability. Assessment of the Waldeyer’s ring, colonoscopy and bone marrow studies are required in addition to hematologic examination and serum LDH levels. Immunohistochemical studies are mandatory to distinguish lymphoma from poorly differentiated, anaplastic and small cell carcinomas of the esophagus and also to differentiate between B and T cell varieties, which differ in treatment and outcome.

Treatment of esophageal lymphomas may involve any of the three modalities, namely, surgery, chemotherapy or radiotherapy. Surgery has been recommended to avoid or treat obstruction, hemorrhage or perforation. Some authors report good results when complete surgery is followed by adjuvant radiotherapy or chemotherapy. Perforation and development of tracheoesophageal or aorto-esophageal fistulas have been reported at the initiation of chemotherapy or radiotherapy in advanced squamous carcinoma, small cell carcinomas of the esophagus and also in esophageal lymphomas.

In our patient, we achieved complete response using initial standard chemotherapy followed by external beam radiotherapy, conserving the esophagus.

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Cobalamine deficiency associated with neuropathy and oral mucosal melanosis in untreated gluten-sensitive enteropathy

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A 32-year-old woman was admitted with complaints of difficulty in walking and hypoaesthesia and tingling in her legs. She had short stature and brown-black hyperpigmentation, cheliosis, dental irregularities and scars in the axillary regions. Neurological examination revealed mild, symmetric, predominantly distal weakness of the legs; deep tendon reflexes were depressed. There was glove-and-stocking decrease in pinprick and temperature perception but proprioception and light touch were normal. Investigations established a diagnosis of celiac disease; her neurological features improved on gluten-free diet, but oral pigmentation persisted. [Indian J Gastroenterol 2005;24:120-122]