CASE REPORT

Polyarticular juvenile idiopathic arthritis treated with methotrexate complicated by the development of non-Hodgkin’s lymphoma

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A 10 year old boy with juvenile idiopathic arthritis is described. He was treated with methotrexate (MTX) for 2 years 8 months, and presented at routine review with hepatosplenomegaly and suspicious bilateral cervical lymphadenopathy, two months after discontinuing therapy. Magnetic resonance scan revealed significant lymphadenopathy around the upper abdominal aorta and coeliac axis. Lymph node biopsy was consistent with non-Hodgkin’s lymphoma, similar to that reported in several adults with rheumatic diseases taking low-dose MTX therapy. He was successfully treated with standard cytotoxic chemotherapy regime, but unfortunately his polyarthritis has subsequently flared some months after completion of his treatment.

CASE REPORT

Clinical findings
A 10 year old boy with a four year history of juvenile idiopathic arthritis (JIA) presented at routine review with bilateral non-tender but firm and suspicious cervical lymphadenopathy. He had hepatosplenomegaly. He had been treated with methotrexate (MTX) 7.5 mg per week, for 2 years 8 months; cumulative dose was 1042.5 mg. The MTX had been given by subcutaneous injection for four months prior to its discontinuation because of nausea associated with oral preparations. MTX had been discontinued two months prior to his presentation with lymphadenopathy as his arthritis had been quiescent for one year. He had also intermittently been treated with daily or alternate daily prednisolone throughout the period of his JIA, and with several intra-articular corticosteroid injections. There were no other co-morbid conditions.

He was admitted for urgent investigation. Full blood count, urea and electrolytes, and lactate dehydrogenase were normal. Serology indicated recent Epstein–Barr virus (EBV) infection, with IgG to EBV detected. Cytomegalovirus (CMV) IgG was not detected. Bone marrow aspirate and trephine revealed no evidence of malignant disease, and there were no malignant cells in his cerebrospinal fluid. Abdominal ultrasound confirmed hepatosplenomegaly and the presence of paraaortic nodes. Magnetic resonance scan revealed a diffusely enlarged spleen, 14 cm in length, with normal texture of liver, pancreas, and both kidneys. There was significant lymphadenopathy around the upper abdominal aorta and coeliac axis, with individual nodes measuring 2 cm in diameter. Computed tomography of the chest revealed evidence of bilateral cervical lymphadenopathy, extending to the sternoclavicular joints. There was no evidence of significant mediastinal or axillary lymphadenopathy, and no evidence of parenchymal lung disease.

Pathological findings
A tissue diagnosis of non-Hodgkin’s lymphoma was obtained. Histopathology of a lymph node biopsy revealed T cell rich B cell lymphoma. Most of the larger cells were positive for CD79A, CD20Y, and CD45RA (B cell markers), but negative for CD10, CD15, CD30, EBV, and T cell markers (including CD3, CD4, CD5, CD8, CD43, CD43RO), and dendritic reticulum cells (CD21).

Treatment
The patient was treated according to a standard treatment protocol (LMB89), which consists of six months of cytotoxic chemotherapy. This comprised vincristine, cyclophosphamide, prednisolone, MTX, doxorubicin, cytarabine, and intrathecal MTX. During this treatment programme his arthritis went into remission. At follow up six months after completion of chemotherapy his lymphoma is in remission, but unfortunately his arthritis has recurred, requiring careful consideration of treatment options.

DISCUSSION
The literature relating to lymphoma occurring in patients with rheumatoid arthritis treated with weekly low dose MTX has recently been reviewed; at least 50 cases have been reported. To the best of our knowledge, four children with JIA treated with MTX have developed Hodgkin's lymphoma. Two of these children had evidence of EBV infection associated with their lymphoproliferative disease. Table 1 summarises the characteristics of the cases.

The incidence of non-Hodgkin's lymphoma in the age group 5–9 years for the period 1968–95 was 6.5 per million per year. At present approximately 100 children at our institution with JIA are treated with MTX. Several other paediatric rheumatology units were contacted (Great Ormond Street, Birmingham, Nottingham, Leeds, and Newcastle). Any other cases of lymphoproliferative disease (LPD) occurring during treatment with MTX were sought, as it was acknowledged that since case reports were not the favoured format for most journals, other cases may exist. In fact only one other case was noted; this was in a child who also had Blackfan–Diamond syndrome and therefore was at increased risk of haematological malignancy (Professor Woo, personal communication).

Post-transplant lymphoproliferative disorder (PTLD) in an immunocompromised host following paediatric renal transplantation has been reported. Srivastava et al reported PTLD in six of 84 renal transplant recipients in one centre. In all of these patients PTLD was associated with EBV infection (primary in five, reactivation in one). All patients received therapeutic immunosuppression post-transplantation, with prednisolone and various combinations of mycophenolate.
Table 1 Characteristics of patients with juvenile arthritis developing lymphoma while treated with MTX

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Diagnosis</th>
<th>Cell type</th>
<th>Other therapy during treatment with MTX</th>
<th>Duration of MTX therapy</th>
<th>Outcome</th>
<th>Follow up</th>
<th>Cell type</th>
<th>EBV status</th>
<th>Other outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Systemic JIA Mixed cellularity</td>
<td>Hodgkin’s lymphoma</td>
<td>Not known</td>
<td>16 months</td>
<td>Late LPD relapse</td>
<td>12 months</td>
<td>CD30 CD15 EBV neg</td>
<td>Yes</td>
<td>Late LPD relapse</td>
</tr>
<tr>
<td>2</td>
<td>Systemic JIA Mixed cellularity</td>
<td>Hodgkin’s lymphoma</td>
<td>Prednisolone</td>
<td>16 months</td>
<td>Late LPD relapse</td>
<td>12 months</td>
<td>CD30 CD15 EBV neg</td>
<td>Yes</td>
<td>Late LPD relapse</td>
</tr>
<tr>
<td>3</td>
<td>Systemic JIA Nodular sclerosing</td>
<td>Hodgkin’s lymphoma</td>
<td>Not known</td>
<td>33 months*</td>
<td>Remission of LPD and JIA</td>
<td>12 months</td>
<td>Not known</td>
<td>EBV pos</td>
<td>Remission of LPD and JIA</td>
</tr>
<tr>
<td>4</td>
<td>Polyarthritis (RF positive)</td>
<td>Nodular</td>
<td>Prednisolone Cyclosporin A</td>
<td>30 months†</td>
<td>Death (respiratory failure secondary to legionella pneumonia)</td>
<td>12 months</td>
<td>CD30 CD15 CD20 LMP1</td>
<td>EBV pos</td>
<td>Death (respiratory failure secondary to legionella pneumonia)</td>
</tr>
<tr>
<td>5</td>
<td>Polyarthritis (RF negative)</td>
<td>Nodular</td>
<td>Sulphasalazine</td>
<td>21 months‡</td>
<td>Partial remission</td>
<td>12 months</td>
<td>EBV negative</td>
<td>Not applicable</td>
<td>Remission of LPD and JIA after 12 months</td>
</tr>
</tbody>
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*MTX discontinued for two months during episode of intercurrent pneumonia. †MTX discontinued after 20 months due to disease remission, and recommenced after one year due to relapse.

MTX interferes with the handling of EBV by T cells, and allows the subsequent proliferation of EBV infected lymphocytes.
REFERENCES