**Name of journal:** *World Journal of Gastroenterology*

**ESPS Manuscript NO: 28076**

**Manuscript Type: CASE REPORT**

**Hepatosplenic T-cell lymphoma in a 47-year-old Crohn’s disease patient on thiopurine monotherapy**

van de Meeberg MM *et al.* Hepatosplenic T-cell lymphoma in Crohn’s disease

Maartje M van de Meeberg, Lauranne AAP Derikx, Harm AM Sinnige, Peet Nooijen, Lucette Schipper, Loes HC Nissen

**Maartje M** **van de Meeberg, Lauranne AAP Derikx, Lucette Schipper, Loes HC Nissen,** Department of Gastroenterology and Hepatology, Jeroen Bosch Hospital, 5200 ME ’s-Hertogenbosch, The Netherlands

**Harm AM Sinnige**, Department of Hematology, Jeroen Bosch Hospital, 5200 ME ‘s-Hertogenbosch, The Netherlands

**Peet Nooijen,** Department of Pathology, Jeroen Bosch Hospital, 5200 ME ‘s-Hertogenbosch, The Netherlands

**Author contributions:** van de Meeberg MM is first author and composed the manuscript; Derikx LAAP and Nissen LHC contributed equally in writing the manuscript; Sinnige HAM, Nooijen P and Schipper L revised the manuscript; Schipper L also provided the case.

**Institutional review board statement:** This case report was exempt.

**Informed consent statement:** The patient gave verbal informed consent prior to composing the manuscript.

**Conflict-of-interest** **statement**: All the authors have no conflicts of interests to declare.

**Open-Access:** This article is an open-access article which was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

**Manuscript source:** Unsolicited manuscript

**Correspondence to:** **Maartje M van de Meeberg,** MD, Department of Gastroenterology and Hepatology, Jeroen Bosch Hospital, P/O Box 90153, 5200 ME ’s-Hertogenbosch, The Netherlands. [maartjevdm@gmail.com](mailto:maartjevdm@gmail.com)

**Telephone:** +31-73-5532000

**Fax:** +31-73-5538804

**Received:** June 26, 2016

**Peer-review started:** June 28, 2016

**First decision:** August 8, 2016

**Revised:** September 1, 2016

**Accepted:** September 28, 2016

**Article in press:**

**Published online:**

**Abstract**

Hepatosplenic T-cell lymphoma is a rare non-Hodgkin lymphoma with a high mortality rate. Higher incidence is reported in patients with inflammatory bowel disease, specifically in male patients that are younger than 35 years, and have been treated with thiopurine and tumor necrosis factor-α inhibitor combination therapy for over 2 years. In this case report we describe a 47-year-old patient with Crohn’s disease who developed hepatosplenic T-cell lymphoma after having been treated with thiopurine monotherapy for 14 years. To our best knowledge, only eleven cases exist of patients with Crohn’s disease who developed hepatosplenic T-cell lymphoma while on thiopurine monotherapy. We report the first patient with Crohn’s disease, older than 35 years, who developed hepatosplenic T-cell lymphoma while on thiopurine monotherapy. This emphasizes that hepatosplenic T-cell lymphoma risk is not limited to young men receiving both thiopurines and tumor necrosis factor-α inhibitors.

**Key words:** Hepatosplenic T-cell lymphoma; Thiopurine; Crohn’s disease; Immunosuppression

**© The Author(s) 2016.** Published by Baishideng Publishing Group Inc. All rights reserved.

**Core tip:** In this manuscript we provide an overview of all known cases in literature with Crohn’s disease who developed hepatosplenic T-cell lymphoma while on thiopurine monotherapy. In addition, we present our case of a patient with Crohn’s disease on thiopurine monotherapy who developed hepatosplenic T-cell lymphoma at a relatively old age. This emphasizes that hepatosplenic T-cell lymphoma may develop at all ages, even when the patient is solely on thiopurine monotherapy.

van de Meeberg MM, Derikx LAAP, Sinnige HAM, Nooijen P, Schipper L, Nissen LHC. Hepatosplenic T-cell lymphoma in a 47-year-old Crohn’s disease patient on thiopurine monotherapy. *World J Gastroenterol* 2016; In press

**INTRODUCTION**

Hepatosplenic T-cell lymphoma (HSTCL) is a rare subtype (1%) of peripheral T-cell non-Hodgkin lymphomas (NHL)[[1](#_ENREF_1)]. It is an extranodal and systemic neoplasm deriving from cytotoxic T-cells, usually with a gamma-delta (γδ)-T-cell receptor type[[2](#_ENREF_2)]. These atypical lymphocytes display global infiltration in the splenic red pulp and in the intrasinusoidal space in the liver and bone marrow[[3](#_ENREF_3)]. As a consequence, patients present with hepatomegaly (77%), splenomegaly (96%), constitutional symptoms (70%), anemia (85%), thrombocytopenia (89%), leukopenia (72%) and liver enzyme abnormalities (46%), in the absence of lymphadenopathy[[3](#_ENREF_3)]. HSTCL mainly affects male[[4](#_ENREF_4)] adults with a median age of 20 to 35 years[[1](#_ENREF_1),[3](#_ENREF_3)]. HSTCL has a rapidly progressive course with a mean overall survival less than 16 mo, regardless of the available treatment modalities (chemotherapy, splenectomy, bone marrow or stem cell transplantation)[[3](#_ENREF_3)].

The incidence of the highly lethal HSTCL is very low in the general population[[1](#_ENREF_1)]. However, at least 10% of HSCTL arises in inflammatory bowel disease (IBD) patients treated with immunomodulatory therapy (thiopurines and/or tumor necrosis factor (TNF)-α inhibitors)[[3](#_ENREF_3)]. This results in an increased HSTCL risk in IBD patients compared to the general population, although the absolute risk remains low[[1](#_ENREF_1),[5](#_ENREF_5)]. Especially men younger than 35 years with Crohn’s disease (CD) who are treated with thiopurines and TNF-α inhibitor combination therapy for at least two years are at increased risk[[4](#_ENREF_4)]. The estimated absolute risk to develop HSTCL in IBD patients treated with combination therapy is 1:22000 in general and 1:3534 for men younger than 35 years old. By contrast, IBD patients on thiopurine monotherapy had an estimated absolute risk of 1:45,000 and 1:7,404 in general IBD patients and men younger than 35 years old, respectively[[4-6](#_ENREF_4)]. IBD patients with HTSCL have a poor prognosis with a median survival of seven to eight months[[7](#_ENREF_7),[8](#_ENREF_8)].

In this case report, we present a 47-year-old male CD patient on thiopurine monotherapy. To our best knowledge, this is the first case report describing an IBD patient on thiopurine monotherapy who developed HSTCL at an age older than 35 years.

**CASE REPORT**

A 47-year-old Caucasian man with CD presented at our hospital with painless icterus, weight loss and malaise, without fever. He had a 33-year history of penetrating CD in the colon (Montreal Classification L2, B3+P) and was treated with thiopurine monotherapy at presentation. Initial CD treatment had consisted of budesonide and mesalamine which was followed by azathioprine 150-200 mg per day for 14 years. Subsequently, he received infliximab at the age of 33 (three doses, remission induction therapy) and 36 (maintenance therapy for one-and-a-half years, discontinued due to neurologic side-effects). During his course of CD, he underwent both right and left hemicolectomy (at the age of 18 and 30 years, respectively) and received a permanent ileostomy at the age of 41 due to active perianal fistulating disease in the three years before. CD had been in remission in the five years preceding presentation at our hospital.

Physical examination of our patient revealed hepatosplenomegaly in the absence of lymphadenopathy, which was confirmed by computed tomography and positron emission tomography (Figure 1). Laboratory testing indicated anemia, thrombocytopenia and liver test abnormalities (Table 1A). Imaging did neither reveal dilated bile ducts nor other (obstructive) abnormalities. Furthermore, viral causes of hepatitis, including Epstein-Barr virus, were excluded by serology. Based on these results, we suspected an hematological malignancy and performed a liver and bone marrow biopsy. Liver biopsy showed sinusoidal and portal infiltration of atypical lymphocytes (Figure 2). Immunophenotyping of both biopsies confirmed a T-cell population with the surface proteins listed in Table 1B. Based on these biopsies, γδ-HSTCL was diagnosed[[1](#_ENREF_1)].

Following the diagnosis of HSTCL, high dose corticosteroids (125 mg per day) were administered, followed by chemotherapy (CHOP regimen; cyclophosphamide, hydroxydoxorubicin, vincristine and prednisone). Despite this treatment, both clinical and biochemical parameters rapidly deteriorated and the patient died 21 d post-diagnosis due to massive esophageal bleeding, secondary to therapy-induced mucositis.

**DISCUSSION**

In this case report, we presented a male CD patient who developed HTSCL at the age of 47 years and after having been on thiopurine monotherapy during 14 years. Remarkably, this rare malignancy developed at an age older than 35, which is in contrast with previous cases in patients on thiopurine monotherapy. As HSTCL is very rare, and controlled cohort studies are lacking, this case report may contribute to the assessment of HSTCL risk and its relation with immunosuppressive therapies[[7](#_ENREF_7)].

IBD patients, especially CD patients, are twice more likely to develop any lymphoma, regardless of immunosuppressive treatment[[9](#_ENREF_9),[10](#_ENREF_10)]. The risk to develop HSTCL is also increased in auto-immune disorders like rheumatoid arthritis[[11](#_ENREF_11),[12](#_ENREF_12)], specifically in those patients, treated with TNF- α inhibitors, and in immunocompromised patients with, among others, renal or heart transplant[[3](#_ENREF_3)].

In IBD patients, thiopurine treatment is associated with a significantly increased overall risk (rate ratio = 1.41) of developing cancer[[13](#_ENREF_13)], specifically non-melanoma skin cancer (NMSC), urinary tract cancers and lymphoproliferative disorders (multivariate adjusted hazard ratio of 5.28)[[10](#_ENREF_10),[14](#_ENREF_14)].

More specifically, thiopurines promote development of lymphomas: a recent meta-analysis found an overall standard incidence ratio for lymphoma of 5.7 in IBD patients receiving thiopurines, but not in patients formerly treated with thiopurines or patients who had never used these drugs[[4](#_ENREF_4)]. The excess risk can be reversed by thiopurine withdrawal. Thiopurine cytotoxicity is mediated by the incorporation of 6-thioguanine during DNA replication in targeted cells, instead of guanine, which ultimately leads to apoptosis[[10](#_ENREF_10)].

Previous studies showed a higher absolute risk of developing HSTCL in patients receiving both thiopurines and TNF-α inhibitors, compared to patients on thiopurine monotherapy[[4-6](#_ENREF_4)]. Furthermore, a review including 25 IBD patients with HSTCL reported an increased HSTCL risk in those on thiopurine monotherapy compared to patients using TNF-α inhibitor monotherapy[[11](#_ENREF_11)].

Duration of immunosuppressive therapy may also influence the risk of developing HSTCL. For example, more than 80% of HSTCL cases occur in the first two years after initiation of combination therapy[[12](#_ENREF_12)]. Median time from initiation of thiopurines to HSTCL development did not significantly differ between patients on thiopurine monotherapy and combination therapy (5.5 *vs* 6 years, *P* = 0.39)[[4](#_ENREF_4)].

A review of the literature revealed 38 cases of γδ-HSTCL in patients with CD, including 27 patients on combination therapy and 11 on thiopurine monotherapy (Tables 2 and 3)[[7](#_ENREF_7),[15](#_ENREF_15)]. In contrast to these previous cases, our patient developed HSTCL after a longer period of thiopurine treatment (14 years *vs* a mean time of 5 years in the previously reported cases) and at an older age (47 years). HSTCL in general mainly affects men with a median age of 20 to 35 years[[1](#_ENREF_1),[3](#_ENREF_3),[4](#_ENREF_4)]. Only 7 CD cases are known to develop HSTCL at an age older than 35, all of them were receiving combination therapy (Table 2)[[7](#_ENREF_7),[15](#_ENREF_15)]. Time to HSTCL development following initiation of thiopurine treatment was reported in three cases, including 5.5, 7.3 and 13.5 years. In addition, all ulcerative colitis patients on thiopurine monotherapy (7 cases) developed γδ-HSTCL below the age of 35[[4](#_ENREF_4),[5](#_ENREF_5)]. Finally, our patient had a very short survival (21 d) in contrast to previous cases (Table 3) with a median survival of 7-8 mo.

The proven benefit of thiopurines in combination with TNFα inhibitors to maintain corticosteroid free clinical remission and mucosal healing should outweigh the risk of serious infections and secondary malignancies, such as untreatable lymphoma[[16](#_ENREF_16)]. Therefore, the recent published European Crohn´s and Colitis Organisation (ECCO) guideline recommends to limit the duration of combination therapy to 2 years, if possible[[10](#_ENREF_10)]. In addition, de-escalation of monotherapy (drug cessation or dose reduction) has to be considered to reduce risk of secondary malignancies. Several factors impact this decision, such as disease phenotype and extent, duration of remission, prior surgery, and a history of cancer. Given the prolonged clinical remission in our case, thiopurine withdrawal could have been considered to reduce HSTCL risk, although the extensive, relapsing disease course including surgery called for prolonged therapy[[17](#_ENREF_17)].

This case report presents the first IBD patient on thiopurine monotherapy for an extended period of time, who developed a γδ-HSTCL at an age older than 35 years. This highlights the clinical relevance of knowledge and awareness of HSTCL risk in patients with CD on immunomodulatory therapies.

**COMMENTS**

***Case characteristics***

A 47-year-old male with Crohn disease with painless icterus, weight loss and malaise.

***Clinical diagnosis***

Hepatosplenomegaly in the absence of lymphadenopathy and fever.

***Differential diagnosis***

Bile duct abnormalities, toxic hepatitis, viral hepatitis, liver cirrhosis.

***Laboratory diagnosis***

Anemia, thrombocytopenia and liver test abnormalities.

***Imaging diagnosis***

Hepatosplenomegaly, with increased metabolic activity in liver, spleen and bone marrow.

***Pathological diagnosis***

Hepatosplenisc T-cell lymphoma.

***Treatment***

Chemotherapy.

***Related reports***

There are only 38 known cases of hepatosplenic T-cell lymphoma (HSTCL) in Crohn’s disease of wich eleven were using thiopurine monotherapy. This is the first patient with Crohn’s disease, older than 35 years, to develop hepatosplenic T-cell lymphoma while on thiopurine monotherapy.

***Term explanation***

HTSCL is a rare and letal lymphoma with an increased risk by using thiopurines monotherapy or thiopurine TNF-α inhibitors combination therapy.

***Experiences and lessons***

Authors are emphasizing that hepatosplenic T-cell lymphoma risk is not limited to young males receiving both thiopurines and tumor necrosis factor-α inhibitors.

***Peer-review***

The literature is described also well, the authors report in detail information regarding the other patients affected from this rare condition. The review of the literature pertaining to HSTCL in inflammatory bowel disease is through.

**REFERENCES**

1 **Ferreri AJ**, Govi S, Pileri SA. Hepatosplenic gamma-delta T-cell lymphoma. *Crit Rev Oncol Hematol* 2012; **83**: 283-292 [PMID: 22047938 DOI: 10.1016/j.critrevonc.2011.10.001]

2 **Rosh JR**, Gross T, Mamula P, Griffiths A, Hyams J. Hepatosplenic T-cell lymphoma in adolescents and young adults with Crohn's disease: a cautionary tale? *Inflamm Bowel Dis* 2007; **13**: 1024-1030 [PMID: 17480018 DOI: 10.1002/ibd.20169]

3 **Thai A**, Prindiville T. Hepatosplenic T-cell lymphoma and inflammatory bowel disease. *J Crohns Colitis* 2010; **4**: 511-522 [PMID: 21122554 DOI: 10.1016/j.crohns.2010.05.006]

4 **Kotlyar DS**, Osterman MT, Diamond RH, Porter D, Blonski WC, Wasik M, Sampat S, Mendizabal M, Lin MV, Lichtenstein GR. A systematic review of factors that contribute to hepatosplenic T-cell lymphoma in patients with inflammatory bowel disease. *Clin Gastroenterol Hepatol* 2011; **9**: 36-41.e1 [PMID: 20888436 DOI: 10.1016/j.cgh.2010.09.016]

5 **Kotlyar DS**, Blonski W, Diamond RH, Wasik M, Lichtenstein GR. Hepatosplenic T-cell lymphoma in inflammatory bowel disease: a possible thiopurine-induced chromosomal abnormality. *Am J Gastroenterol* 2010; **105**: 2299-2301 [PMID: 20927075 DOI: 10.1038/ajg.2010.213]

6 **Mason M**, Siegel CA. Do inflammatory bowel disease therapies cause cancer? *Inflamm Bowel Dis* 2013; **19**: 1306-1321 [PMID: 23470503 DOI: 10.1097/MIB.0b013e3182807618]

7 **Selvaraj SA**, Chairez E, Wilson LM, Lazarev M, Bass EB, Hutfless S. Use of case reports and the Adverse Event Reporting System in systematic reviews: overcoming barriers to assess the link between Crohn's disease medications and hepatosplenic T-cell lymphoma. *Syst Rev* 2013; **2**: 53 [PMID: 23826928 DOI: 10.1186/2046-4053-2-53]

8 **Ochenrider MG**, Patterson DJ, Aboulafia DM. Hepatosplenic T-cell lymphoma in a young man with Crohn's disease: case report and literature review. *Clin Lymphoma Myeloma Leuk* 2010; **10**: 144-148 [PMID: 20371449 DOI: 10.3816/CLML.2010.n.021]

9 **von Roon AC**, Reese G, Teare J, Constantinides V, Darzi AW, Tekkis PP. The risk of cancer in patients with Crohn's disease. *Dis Colon Rectum* 2007; **50**: 839-855 [PMID: 17308939 DOI: 10.1007/s10350-006-0848-z]

10 **Annese V**, Beaugerie L, Egan L, Biancone L, Bolling C, Brandts C, Dierickx D, Dummer R, Fiorino G, Gornet JM, Higgins P, Katsanos KH, Nissen L, Pellino G, Rogler G, Scaldaferri F, Szymanska E, Eliakim R. European Evidence-based Consensus: Inflammatory Bowel Disease and Malignancies. *J Crohns Colitis* 2015; **9**: 945-965 [PMID: 26294789 DOI: 10.1093/ecco-jcc/jjv141]

11 **Deepak P**, Sifuentes H, Sherid M, Stobaugh D, Sadozai Y, Ehrenpreis ED. T-cell non-Hodgkin's lymphomas reported to the FDA AERS with tumor necrosis factor-alpha (TNF-α) inhibitors: results of the REFURBISH study. *Am J Gastroenterol* 2013; **108**: 99-105 [PMID: 23032984 DOI: 10.1038/ajg.2012.334]

12 **Parakkal D**, Sifuentes H, Semer R, Ehrenpreis ED. Hepatosplenic T-cell lymphoma in patients receiving TNF-α inhibitor therapy: expanding the groups at risk. *Eur J Gastroenterol Hepatol* 2011; **23**: 1150-1156 [PMID: 21941193 DOI: 10.1097/MEG.0b013e32834bb90a]

13 **Pasternak B**, Svanström H, Schmiegelow K, Jess T, Hviid A. Use of azathioprine and the risk of cancer in inflammatory bowel disease. *Am J Epidemiol* 2013; **177**: 1296-1305 [PMID: 23514635 DOI: 10.1093/aje/kws375]

14 **Beaugerie L**, Brousse N, Bouvier AM, Colombel JF, Lémann M, Cosnes J, Hébuterne X, Cortot A, Bouhnik Y, Gendre JP, Simon T, Maynadié M, Hermine O, Faivre J, Carrat F. Lymphoproliferative disorders in patients receiving thiopurines for inflammatory bowel disease: a prospective observational cohort study. *Lancet* 2009; **374**: 1617-1625 [PMID: 19837455 DOI: 10.1016/S0140-6736(09)61302-7]

15 **Falchook G**, Champlin R, Hagemeister F. Hepatosplenic T-cell lymphoma: clinical characteristics and treatment outcome. *Blood* 2006; **108:** 2460-2460

16 **Colombel JF**, Sandborn WJ, Reinisch W, Mantzaris GJ, Kornbluth A, Rachmilewitz D, Lichtiger S, D'Haens G, Diamond RH, Broussard DL, Tang KL, van der Woude CJ, Rutgeerts P. Infliximab, azathioprine, or combination therapy for Crohn's disease. *N Engl J Med* 2010; **362**: 1383-1395 [PMID: 20393175 DOI: 10.1056/NEJMoa0904492]

17 **Torres J**, Boyapati RK, Kennedy NA, Louis E, Colombel J-F, Satsangi J. Systematic Review of Effects of Withdrawal of Immunomodulators or Biologic Agents From Patients With Inflammatory Bowel Disease. *Gastroenterology* 2015; **149**: 1716-1730 [PMID: 26381892 DOI: 10.1053/j.gastro.2015.08.055]

18 **Fowler S**, Beyak M, Depew WT, Justinich C, Ropeleski MJ. W1212 Hepatosplenic T-Cell Lymphoma in Crohn's Disease. Where Does the Risk Lie? *Gastroenterology* 2010; **13** **Suppl 1**: S675 [DOI: 10.1016/S0016-5085(10)63105-8]

19 **Humphreys MR**, Cino M, Quirt I, Barth D, Kukreti V. Long-term survival in two patients with hepatosplenic T cell lymphoma treated with interferon-alpha. *Leuk Lymphoma* 2008; **49**: 1420-1423 [PMID: 18452073 DOI: 10.1080/10428190802087488]

20 **Zeidan A**, Sham R, Shapiro J, Baratta A, Kouides P. Hepatosplenic T-cell lymphoma in a patient with Crohn's disease who received infliximab therapy. *Leuk Lymphoma* 2007; **48**: 1410-1413 [PMID: 17613771 DOI: 10.1080/10428190701345433]

21 **Mittal S**, Milner BJ, Johnston PW, Culligan DJ. A case of hepatosplenic gamma-delta T-cell lymphoma with a transient response to fludarabine and alemtuzumab. *Eur J Haematol* 2006; **76**: 531-534 [PMID: 16548918 DOI: 10.1111/j.1600-0609.2006.00646.x]

22 **Navarro JT**, Ribera JM, Mate JL, Granada I, Juncà J, Batlle M, Millá F, Feliu E. Hepatosplenic T-gammadelta lymphoma in a patient with Crohn's disease treated with azathioprine. *Leuk Lymphoma* 2003; **44**: 531-533 [PMID: 12688327 DOI: 10.1080/1042819021000035662]

23 **Lémann M**, Gérard de La Valussière F, Bouhnik Y, Allez M, Touze Y, Bonnet J, Coffin B, Matuchansky C, Jian R, Colombel JF, Rambaud JC, Modigliani R. Intravenous cyclosporine for refractory attacks of Crohn's disease (CD): Long-term follow-up of patients. *Gastroenterology* 1998; **114: Suppl 1**: A1020 [DOI: [10.1016/S0016-5085(98)84151-6](http://dx.doi.org/10.1016/S0016-5085(98)84151-6)]

**P-Reviewer:** Gathungu G, Tana C **S-Editor:** Yu J **L-Editor:** **E-Editor:**

**Specialty type:** Gastroenterology and hepatology

**Country of origin:** Netherlands

**Peer-review report classification**

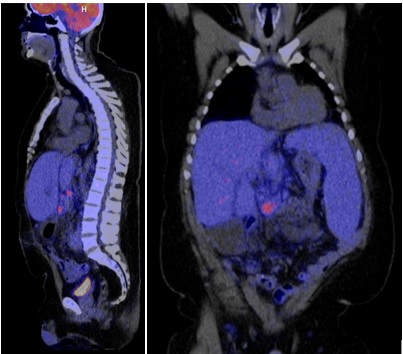
Grade A (Excellent): 0

Grade B (Very good): B, B

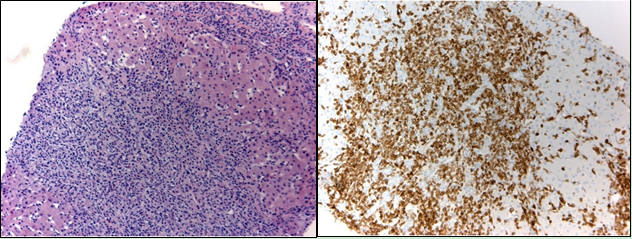
Grade C (Good): 0

Grade D (Fair): 0

Grade E (Poor): 0



**Figure 1 Positron emission tomography showing hepatosplenomegaly with increased metabolic activity in liver, spleen and bone marrow.** Left: coronal plane; Right: sagittal plane.



**Figure 2 Liver biopsy showing hepatosplenic T-cell lymphoma.** Left: Hematoxylin and eosin staining (magnification × 100) showing intrasinusoidal and portal infiltration of atypical lymphocytes; Right: CD3 staining (magnification × 100) showing neoplastic cells (appearing in brown colour).

**Table 1 Results of our patient**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| A |  |  | B |  |  |
| Analysis (Unit) | **Results** | **Reference value** | **Immuno phenotype** | **Results** | **Typical HTSCL[**[**1**](#_ENREF_1)**,**[**3**](#_ENREF_3)**]** |
| White blood cell count  (× 109/L) | 4.6 | 4,0 – 10,0 | CD 2, 3 | + | + |
| Platelet count (× 109/L) | 42 | 150 - 400 | CD 4 , 5 | - | - |
| Hemoglobin (mmol/L) | 7.7 | 8,5 – 11,0 | CD 7 | + | +/- |
| Bilirubin (µmol/L) | 175 | 0 - 17 | CD 8 | +/- | - |
| AF (IU/L) | 265 | 0 - 125 | CD 16 | - | +/- |
| GGT (IU/L) | 154 | 0 - 45 | CD 56 | + | + |
| ASAT (IU/L) | 250 | 0 – 34 | γδ-T-cell receptor | + | + |
| ALAT (IU/L) | 437 | 0 – 44 | TIA | - | + |
| LDH (IU/L) | 701 | 0 – 247 |  |  |  |

A: Laboratory findings; B: Immunophenotyping of liver and bone marrow biopsy. AF: Alkaline fosfatase; ASAT: Aspartate transaminase; ALAT: Alanine transaminase; GGT: γ-glutamyl- transferase; LDH: Lactate dehydrogenase; TIA: T-cell restricted intracellular antigen.

**Table 2 Number of Crohn’s disease cases with hepatosplenic T-cell lymphoma[**[**7**](#_ENREF_7)**,**[**15**](#_ENREF_15)**]**

|  |  |  |  |
| --- | --- | --- | --- |
| Age | Combination therapy | Monotherapy | Total |
| > 35 year | 7 | 0 | 7 |
| < 35 year | 20 | 11 | 31 |
| Total | 27 | 11 | 38 |

**Table 3 Cases of γδ-hepatosplenic T-cell lymphoma in patients with Crohn’s disease on thiopurine monotherapy**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Index | Age, sex | Years of thiopurine  treatment (type) | Presentation | Treatment | Survival (mo) |
| Index case | 47, M | 14 (AZT) | HSM, icterus, anemia, thrombocytopenia | Ch. (CHOP) | < 1 |
| Selvaraj *et al*[[7](#_ENREF_7)] 2013 (AERS 6751796) | 18, M | <1 (AZT, 6MP) | NS | NS | 7 |
| Selvaraj *et al*[[7](#_ENREF_7)] 2013 (AERS 7554658) | 13, M | NS (6MP) | NS | NS | NS |
| Fowler *et al*[[18](#_ENREF_18)] 2010 | 19, M | 6 (AZT) | SM, leucocytopenia | Ch. (NS) + splenectomy | 4 |
| Fowler *et al*[[18](#_ENREF_18)] 2010 | 22, M | 8 (6MP) | SM, night sweats, fever, abdominal tenderness | Ch. (NS) | Survival |
| Ochenrider *et al*[[8](#_ENREF_8)] 2010 | 18, M | 5 (6MP) | Fever, night sweats, SM, anemia, thrombocytopenia | Ch.(Pentostatin, ICE) + auto-SCT | 7 |
| Humphreys *et al*[[19](#_ENREF_19)] 2008 | 27, F | 5 (AZT) | Fever, nights sweats,  pancytopenia, HSM | Interferon-­α | > 31 |
| Zeidan *et al*[[20](#_ENREF_20)] 2007 | 31, M | 6 (6MP) a | Chills, SM, fever, pancytopenia | Ch. (CHOP, cytarabine, ESHAP) | 7 |
| Falchook *et al*[[15](#_ENREF_15)] 2006 | NS | NS (6MP) | SM | Ch. (NS) | NS |
| Mittal *et al*[[21](#_ENREF_21)] 2006 | 18, M | 6 (AZT) | Fever, pancytopenia, HSM | Ch. (IVE, ESHAP, alemtuzumab  fludarabine) + allo-SCT | NS |
| Navarro *et al*[[22](#_ENREF_22)] 2003 | 35, M | 5.6 (AZT) | Fever, night sweats, HSM, anemia, thrombocytopenia | Ch. (NS) + splenectomy | NS |
| Lemann *et al*[[23](#_ENREF_23)] 1998 | NS | 4 (AZT) | NS | NS | NS |

1Received one single gift infliximab 51 mo before presentation, therefore considered as TNF-α inhibitor naive. AERS: Adverse Event Reporting System; AZT: Azathioprine; Ch.: Chemotherapy; CHOP: Cyclophosphamide, hydroxydoxorubicin, vincristine and prednisone; EHSAP: Etoposide, methylprednisolone, cytarabin, cisplatin; ICE: Ifosphamide, carboplatin, etoposide; IVE: Ifosphamide, carboplatin and etoposide; NS: Not specified; (H)SM: (hepato)splenomegaly; SCT: Stem cell transplantation. 6MP: 6-mercaptopurine.