Lymphomas	Features	Behavior	Presentation	Therapy
Small lymphocytic lymphoma (SLL) Chronic lymphocytic lymphoma (CLL)	Naïve B-cells (prior to ag-driven differentiation w/in germinal center) IgM or IgD CD5 (T-cell)	Indolent Incurable	Increase in normal-appearing lymphocytes in peripheral blood and/or infiltration into nodes, spleen, solid organs	Early stages: radiation Later stages: observation to aggressive (chemo, auto HSCT, local radiation, retuxan vs CD20, interferon)
Follicular lymphoma	Germinal center lymphocytes T(14;18) involving *bcl-2* gene important in blocking apoptosis	Indolent Incurable	Follicles proliferate w/o respect for architecture Fewer mitotic figures (less turnover than hyperplasia)	Early stages: radiation Later stages: observation to aggressive
Large cell lymphoma	Diffuse large B-cell lymphoma (DLBCL)	Aggressive Curable	No follicles	Chemo, CNS prophylaxis
Burkitt's lymphoma	Origin in germinal center U.S.: distal small intestine Africa: head & neck (EBV) T(8;14) involving *c-myc* oncogene	Extremely Aggressive Curable	Abdominal pain/discomfort No follicles Starry sky pattern	Chemo, CNS prophylaxis
Mantle cell lymphoma	Diffuse lymphoma IgM or IgD CD5 (T-cell) T(11;14) involving *cyclin-D1* gene important for entry into cell cycle	Aggressive Incurable		
Marginal zone lymphoma MALT lymphoma	Small lymphocytes	Indolent Incurable	bean-shaped nuclei w/ abundant cytoplasm MALT: found in stomach, salivary & lacrimal glands, linked w/ h pylori	Abx for h pylori infec Early stages: radiation Later stages: observation to aggressive
Hodgkin's disease (HD)	*Reed-sternberg cells* derived from B-cells of germinal center Nodular sclerosis type Mixed cellularity type (no sclerosis) Lymphocyte depletion type (little inflammation) Nodular lymphocyte predominance type (distinct, like low-grade NHL)	Aggressive Curable	Anterior mediastinel mass on routine chest x-ray Inflammatory infiltrate w/ minority of cytologically distinct neoplastic cells (lacunar & hodgkin cells) Contiguous spread	Early stages: radiation, chemo, or both Later stages: combo chemo (ABVD) Salvage: chemo w/ auto HSCT

Dysproteinemia & plasma cell proliferation disorders	Diagnostic criteria	Presentation	Therapy
Multiple myeloma	10% plasma cells or plasmacytoma M protein in serum & urine (*bence-jones proteins*) Multiple lytic bone lesions	HyperCa (OAF), fractures, renal failure (lambda light chain deposits), hypervolemia & CHF (M prot causing hi osmotic pres in vasc), hypervisc (bulky M prot causing bleeding, retinopathy, neuro), cryoglobulinemia (M prot pcpt at low T), hemostatic (M prot interfere w/ platelet function & coag factors), anion gap (falsely low serum Na), amyloidosis (light chain deposits), infec (pneum)	No cure Palliative: chemo, auto/allo HSCT, radiation, interferon, pamidronate (prevent fractures), thalidomide, management of hyperCa, renal fail, pain etc.
Smoldering multiple myeloma		All criteria for multiple myeloma except no skeletal lesions, renal insufficiency or anemia	May be left untreated for yrs before it evolves
Solitary plasmacytoma of bone		Solitary lytic lesion, no marrow involvement Will eventually progress to MM	Radiation
Extramedullary plasmacytoma		Upper air passages (tonsil, palate, sinuses, orbit) No evidence of plasma cell neoplasm Broader age group Less likely to progress to MM than plasmacytoma	Radiation
Waldenstrom's macroglobulinemia		Low-grade lymphoma w/ secretes high amounts of IgM	Plasmapheresis if high viscosity Low-grade lymphoma chemo
Monoclonal gammopathy of uncertain significance (MGUS)			Observation No treatment