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Case Study

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INCIDENTAL FINDING OF CASTLEMAN'S DISEASE IN AN INGUINAL HERNIAL SAC LYMPH NODE - A CASE STUDY

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ABSTRACT

Castleman's disease (CD) is characterized clinically by lymph node hypertrophy, and histologically by angiofollicular lymphnode hyperplasia. Castleman et al first described it in 1956 in a group of patients with localized benign lymphadenopathy. This disease has two clinical types: Unicentric CD or localized and multicentric CD or systemic. It also has three histological types: hyaline-vascular variant, plasma-type variant, and mixed type. Castleman's disease in an inguinal lymph node is quite a rare location which is discussed in this case report.

KEYWORD: Castleman's disease, hyaline-vascular variant, plasma-type variant.

INTRODUCTION

Castleman's disease (CD), also known as angiofollicular lymph node hyperplasia, Castleman tumor, angiomatous lymphoid hyperplasia and giant lymph node hyperplasia,[1] is characterized clinically by lymph node hypertrophy, and histologically by angiofollicular lymphnode hyperplasia. Castleman et al first described it in 1956 in a group of patients with localized benign lymphadenopathy.[2] It potentially occurs across the lifespan from adolescence to the seventh decade[1], and has rarely been observed in childhood.[3,4] It manifests as a slow growing mass, commonly occurring in the neck (42%), mediastinum (31%), abdomen (18%), and retroperitoneum (5%).[5] Hernias comprise approximately 7% of all surgical outpatient visits.[6] About 75% of all abdominal wall hernias occur in the groin.[7] Inguinal hernia is a protrusion of abdominal cavity contents through the inguinal canal.[6] Inguinal and femoral hernias are the most common indications for surgical interventions. This is a rare case of inguinal CD in inguinal hernial sac.

CASE REPORT

A 38 year old male presented to the OPD with left inguinal lymph node swelling since childhood with increasing in size for past 2 years. On examination it was found the patient had left cryptorchidism. Left inguinal hernioplasty was done and clinically it was suspected? atrophic testis/ ? inguinal lymph node and sent for HPE.

Pahology

Gross: The specimen was a single grey white soft tissue which on cut section showed lymph node.

MICROSCOPY: Microscopy showed structure of lymph node with the capsule with partial loss of architecture. Some lymphoid follicles remained in the cortex and the architecture was altered. Paracortical and medullary areas showed several small, thick walled hyalinised blood vessels with prominent endothelial cells. There were also few small hyalinised nodules and occasional plasma cells.

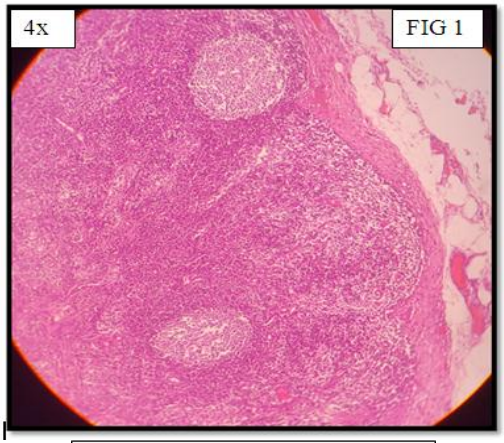

FIG 1: Shows lymph node with capsule with partial loss of architecture

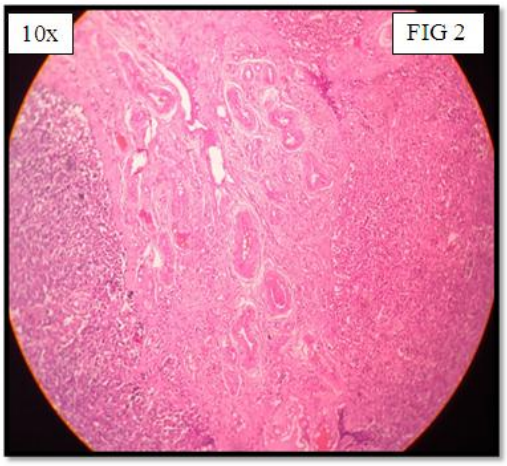

FIG 2: Shows thick walled hyalinised blood vessels

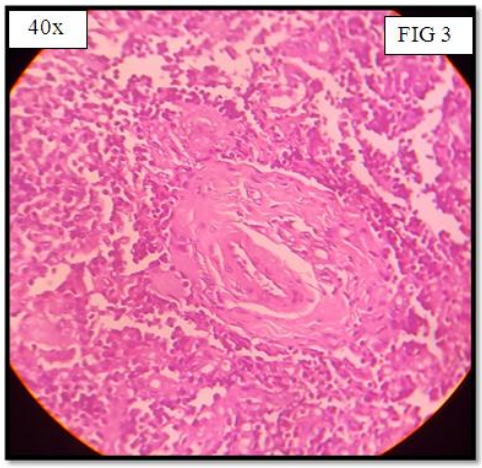

FIG 3: Shows thick walled hyalinised blood vessel

DISCUSSSION

Castleman's disease is a rare pathologic process, with undefined precise incidence and unknown etiology, characterized by lymph node hyperplasia. This disease has two clinical types: Unicentric CD or localized and multicentric CD or systemic. It also has three histological types: hyaline-vascular variant, plasma-type variant, and mixed type.[8,9] The hyaline-vascular variant [10] and it accounts for > 90% of cases and is characterised by small hyaline follicles and intrafollicular capillary proliferation. The plasma cell type variant which is less common. Histologically it is characterised by a spreading arrangement of plasma cells in the in lymph nodes. Irrespective from the histopathological type of the disease, the localized form always shows a benign behaviour. Complete surgical excision of the lesion after laparotomy or even laparoscopic approach provides cure of the disease, since there are no reported cases of recurrence after total excision of a solitary mass [11,12] . On the contrary, the multicentric form of the disease follows a more aggressive course and has poor prognosis and in some patients, multi-centric disease has been associated with both HIV infection and co-infection with human herpesvirus-8 (HHV-8).[13]

CONCLUSION

Although diagnosis of CD is based pathologically, a high degree of clinical suspicion is required for proper workup, diagnosis and management. If the mass is single, and important differential diagnoses such as inguinal hernia are ruled-out. Confirmation of the diagnosis should be based upon the combination of medical history, clinical findings, and histopathological evaluation. Complete surgical resection is a wise diagnostic and therapeutic work-up.

REFERENCES

1. Mohanna S, Sanchez J, Ferrufino JC et al: Characteristics of Castleman's disease in Peru. Eur J Intern Med, 2006; 17(3): 170–74
2. Castleman B., Iverson I., Menendez V.P. Localized mediastinal lymph node hyperplasia resembling thymoma. Cancer, 1956; 9: 822–830. [PubMed]
3. Salisbury JR: Castleman's disease in childhood and adolescence: report of a case and review of literature. Pediatr Pathol, 1990; 10(4): 609–15.
4. Fiel-Gan MD, Voytek TM, Weiss RG et al: Castleman's disease of the left triceps in achild suspected to be a small round cell tumor of childhood. Pediatr Dev Pathol, 2000; 3(3): 286–89

5. Danon AD, Krishnan J, Frizzera G: Morpho-immunophenotypic diversity of Castleman's disease, hyaline-vascular type: with emphasis on a stroma-rich variant and a new pathogenetic hypothesis. Virchows Arch A Pathol Anat Histopathol, 1993; 423(5): 369–82
6. Jenkins JT, O'Dwyer PJ: Inguinal hernias. BMJ, 2008; 336: 269–72.
7. Rutkow IM: Epidemiologic,economic, and sociologic aspects of hernia surgery in the United States in the 1990s. Surg Clin North Am, 1998; 78: 941.
8. Parez N, Bader-Meunier B, Roy CC, Dommergues JP: Paediatric Castleman disease: report of seven cases and review of the literature. Eur J Pediatr, 1999; 158(8): 631–37.
9. Klein WM, Rencic A, Munshi NC et al: Multicentric plasma cell variant of Castleman's disease with cutaneous involvement. J Cutan Pathol, 2004; 31: 448–52
10. Shroff VJ, Gilchrist BF, DeLuca FG et al: Castleman's disease presenting as a pediatric surgical problem. J Pediatr Surg, 1995; 30(5): 745–47
11. Williams MD, Eissien FA, Salameh JR, Ailawadi G, Sweeney JF. Laparoscopic approach to the management of intraabdominal unicentric Castleman's disease. Surg Endosc, 2003; 17: 1497.
12. Ushio T, Yoshimura K, Kojima A et al. A case of Castleman's disease that recurred nine years after initial surgical removal. Nippon Kyobu Shikkan Gakkai Zasshi, 1994; 32: 1175-1180.
13. Ifeoma S Izuchukwu, Kamal Tourbaf, Martin C Mahoney. An unusual presentation of Castleman's Disease:a case report, 2003; 3: 20.