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FOLLICULAR LYMPHOMA MASQUERADING AS CASTLEMAN'S DISEASE

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ABSTRACT
We report the case of a 59-year-old gentleman with no co-morbidities presented with palpable neck masses on either side of the neck since one month. Patient denied any history of fever, unintentional weight loss, night sweats, decreased appetite, or high-risk behavior. Enlargement of the bilateral cervical lymph node (LN), and axillary lymph node (LN) was found on physical examination.

Keywords: Bilateral cervical lymph node, Follicular Lymphoma, Castleman's disease

1. INTRODUCTION

Follicular Lymphoma (FL) is an indolent B-cell lymphoproliferative disorder of transformed follicular center B cells with multiple morphological variants.[1]
FL is the second most common subtype of non-Hodgkin's lymphoma (NHL) (20% of NHL) and the most common of the clinically indolent lymphomas. [2]
It usually presents in a patient's fifth to sixth decade with similar incidence in men and women.
Several morphologic variants of follicular lymphoma have been described. The most frequently encountered variant is follicular lymphoma with marginal zone differentiation, seen in approximately 10% of cases. [3]
Herein, we describe a case of FL with hyaline-vascular Castleman disease (FL-HVCD)–like features, a rare morphological variant.

CASE REPORT

We report the case of a 59-year-old gentleman with no co-morbidities presented with palpable neck masses on either side of the neck since one month.
He denied any history of fever, unintentional weight loss, night sweats, decreased appetite, or high-risk behavior.
Enlargement of the bilateral cervical lymph node (LN), and axillary lymph node (LN) was found on physical examination
His Chest x-ray, complete hemogram, renal & liver function test were within normal limits.
HIV, HHV8, ANA screening, and Gene-Xpert for tuberculosis were found to be negative.
Neck ultrasonography showed Multiple enlarged hypoechoic lymph nodes, the largest measuring 2.8 x 2.9 cm on the left side (level I) and 3.5 x 2 cm on the right side (level I)
A biopsy of the right cervical LN was done, and microscopic examination revealed varying-sized lymphoid follicles with germinal centres. The germinal centres showed hyalinised vessels along with centrocytes, centroblasts & dendritic follicular cells. Mantle zone was seen. Interfollicular areas showed small lymphoid cells and hyperplastic and hyalinised vessels. Focal pericapsular fibrosis and hemorrhage was noted. No granuloma was seen in the sections studied. Overall feature was suggestive of Castleman's disease - hyaline vascular type.
PET-CT scan confirmed homogenously enhancing enlarged lymph nodes in bilateral level II, bilateral level III, left level IV, both axillae, subaortic, subcarinal, paratracheal, prevascular paraaortic, aortocaval, mesenteric, periportal lymph nodes which were suggestive of lymphoma.
Immunohistochemistry was done, and BCL2 was diffusely positive with intense staining within the germinal center (GC); GC areas were also positive for CD20 BCL6, and CD10 with low Ki-67 proliferation index, features favoring Grade II FL.
The patient was diagnosed with FL Grade II, not satisfying GELF criteria[4], requiring no intervention, and was advised regular follow-up.

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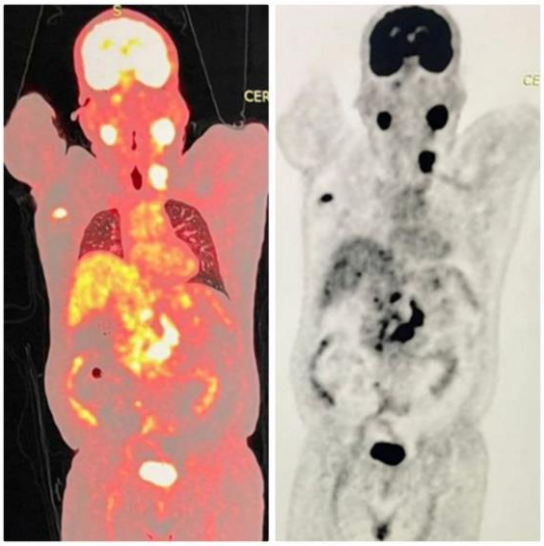

Figure 1: F-PET scan shows hypermetabolic lesions

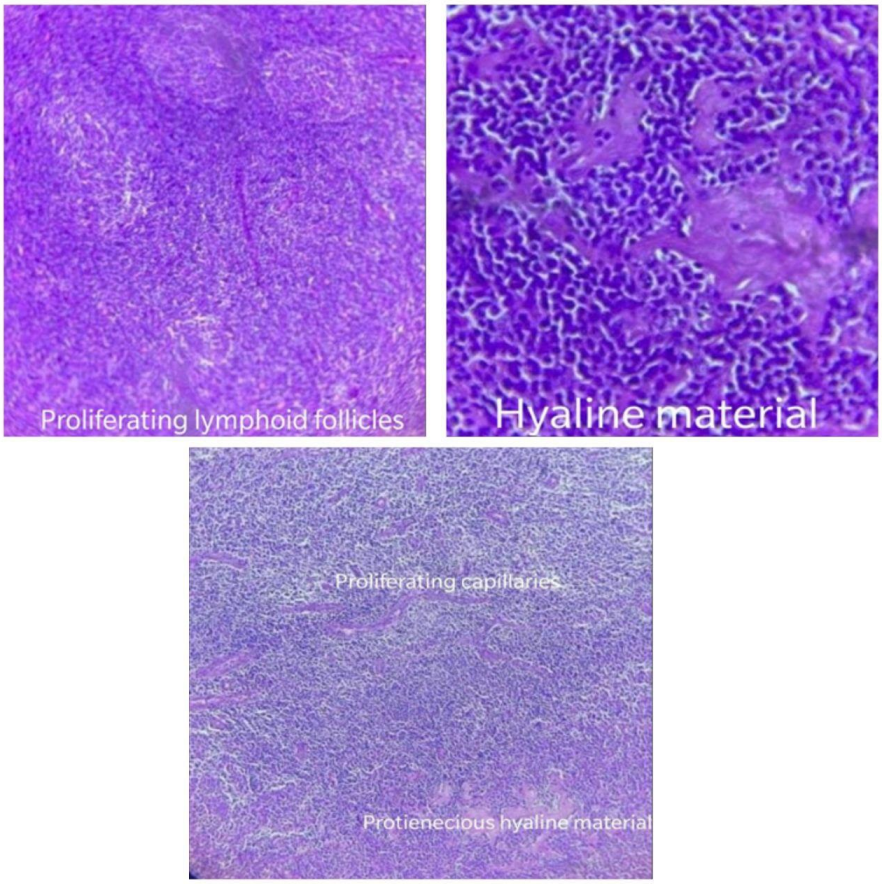

Figure 2: Microscopy

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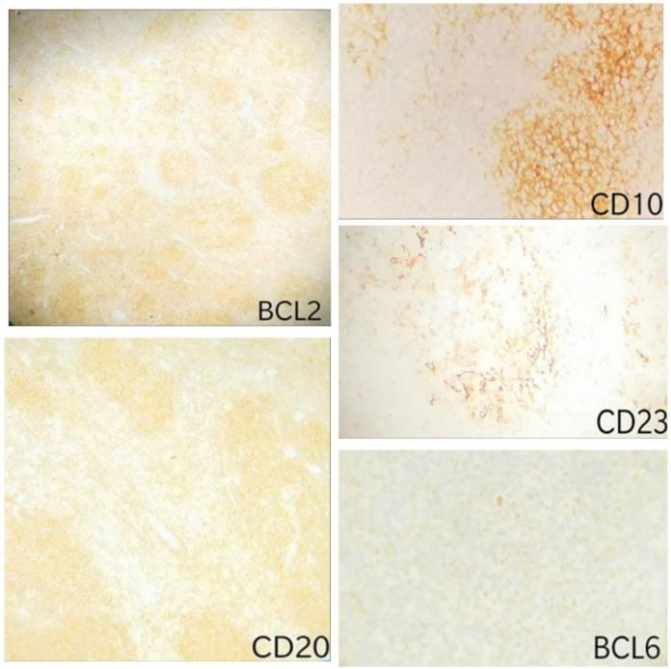

Figure 3: Immunohistochemistry

3. DISCUSSION

Although FL is usually easily recognized in lymph node biopsy specimens because of its distinctive follicular architecture, unusual morphologic variants of FL do occur. Although identification of most of these variants does not have a clinical impact in addition to the diagnosis of FL, these variants can be difficult to recognize, and therefore pathologists must be aware of the wide morphologic spectrum of FL.
A particularly uncommon morphologic variant of FL is FL with hyaline-vascular CD-like features. Distinction of FL-HVCD from CD is critically important, warranting systemic staging work-up upon diagnosis due to the indolent nature of the disease. Distinguishing this variant of FL from true hyaline-vascular CD is essential for proper patient management and has major prognostic implications.

4. CONCLUSION

We present this case to emphasize that the patients with FL present with a wide range of symptoms from asymptomatic, incidentally found lesion to generalized lymphadenopathy
Patients with symptomatic or advanced stage need therapeutic intervention. The possibility of FL-HVCD should be considered as a differential diagnosis when a specimen shows typical HVCD features.

5. BIBLIOGRAPHY

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