Kikuchis lymphadenitis: Is biopsy necessary in managing these patients

INTRODUCTION

Kikuchis-Fujimoto’s disease (KFD) or histiocytic necrotising lymphadenitis was first described by Kikuchis, simultaneously by Fujimoto’s et al. in 1972.[1,2] Since then, numerous cases have been reported in both Asian and western population. Though a self-limiting disease that resolves on its own within few weeks and months, it is known to recur in 3-4% of cases.[3] Though fine-needle aspiration cytology (FNAC) is diagnostic in most of these cases, histopathological examination of the excised node is usually done to confirm the diagnosis and differentiate from other causes of adenitis.

CASE REPORT

A 31-year-old female presented with fever (low grade, Intermittent), headache, edema, weight loss and pain in the right supraclavicular region of 3 month’s duration. There was no history of cough with expectoration/weight loss/skin rash/joint pain or any other swellings in the body. On examination, she was febrile, with multiple nodules in right supraclavicular region. A diagnosis of viral fever with supraclavicular lymphadenopathy was made, and laboratory workup was suggested. All her biochemical and hematological investigations were normal except an increase in erythrocyte sedimentation rate (80 mm at the end of 1st h). Antinuclear antibody test was negative.

An ultrasonography of right supraclavicular region revealed multiple nodes in upper and middle jugular areas largest measuring 1.4 cm across. A diagnosis of reactive lymph node enlargement was given.

Fine-needle aspiration cytology of the node was highly cellular with a heterogeneous population of lymphocytes, histioctyes, crescentic nucleated histiocytes [Figure 1] (histiocyte with crescentic nucleus and eosinophilic inclusions in the cytoplasm [Figure 2]), macrophages with engulfed karyorrhectic debris and monocytoid cells. Background showed karyorrhectic debris and erythrocytes. Ziehl Neelsen for tubercular acid-fast bacilli stain, periodic acid-Schiff stain, Grams-stain did not reveal any organisms.
A diagnosis of Kikuchis-Fujimoto’s Lymphadenitis in necrotizing stage was made. Patient was treated symptomatically along with a low dose of corticosteroid. After 3 weeks of treatment, her swelling subsided and there was no relapse or new symptoms even after 1-year of initial presentation.

DISCUSSION

Kikuchis Lymphadenitis is a rare, benign, self-limiting, immune mediated disorder occurring in young females that resolves on its own. Though Kikuchis Lymphadenitis can be diagnosed on fine needle aspiration many prefer Lymph node Biopsy for clinching the diagnosis.

Kuo proposed classification of the histopathological features of KFD into three stages-proliferative, necrotizing and xanthomatous stage. The most common stage is the proliferative phase which is characterized by numerous histiocytes, plasmacytoid monocytes, and a variable number of lymphoid cells, karyorrhectic nuclear fragments and eosinophilic apoptotic debris.

If any degree of coagulative necrosis is there, it is necrotic stage, while foamy histiocytes predominate in the xanthomatous stage. He also suggested that these types may suggest different stages of the disease or may reflect differences in cause or host reaction.

Fine-needle aspiration findings may vary depending on the stage of the disease. Most common presentation is the stage of necrotizing adenitis wherein presence of crescentic histiocyte (histiocyte with crescentic nucleus and eosinophilic inclusions in the cytoplasm), macrophages with abundant cytoplasm and phagocyctosed karyorrhectic or eosinophilia debris, plasmacytoid monocytes were consistent with Kikuchis lymphadenitis.

Although histopathology will help us to confirm the diagnosis, patient will be relieved of the burden of surgery, pain by making a definitive diagnosis on aspiration keeping in mind the above findings in India were tuberculosis is more common. However, a follow-up of these patients is absolutely necessary as these patients are known to have recurrences or known to develop Lupus.

CONCLUSION

Diagnosis of KFD is possible on FNAC. Keeping in mind the above cytological features it is possible to make a definitive diagnosis and avoid biopsy in these patients. However due to a higher incidence of recurrence and occurrence of Lupus in these patients, regular followup and serological testing is important.

REFERENCES


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