KIKUCHIS DISEASE

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Introduction

Kikuchi's Fujimoto's disease or Histiocytic Necrotising Lymphadenitis was first described in 1972 and is an uncommon clinical condition. It is a benign self limiting condition of unknown origin [1,2]. The disease usually presents in young women with cervical lymphadenopathy. We report such a case presenting in a young woman.

Case Report

A 27 year old woman presented with cervical lymphadenopathy of 3 months duration. The nodes were matted, 4 in number, non tender with the largest node measuring 1.5 cm in diameter. The skin over the nodes was normal. Low grade fever and malaise were the associated systemic symptoms, routine haematological and biochemical parameters revealed an elevated ESR (42 mm fall in the first hour). The chest X-ray was normal. The patient was referred for an FNAC which offered a diagnosis of necrotising lymphadenitis. Subsequently, the patient was placed on antibiotic therapy (Tab Supristol in a dose of 500 mg BD), for a period of 7 days. Since there was no perceptible decrease in the size of the nodes, a biopsy was done and the nodes sent for histopathological examination.

Cytological and Histopathological Findings

The FNAC revealed a cellular aspirate on a necrotic background. The cells showed a reactive population with small and large lymphocytes and occasional histiocytes. A number of neu-

trophils were also seen. A firm diagnosis of Kikuchi's disease however could not be offered because of the large number of neutrophils which goes against a diagnosis of Kikuchi's disease. The biopsy revealed a nodular lymph node which measured 1.5 cm in diameter. The node was grey white and homogenous on external and cut surfaces. No areas of haemorrhage or necrosis were seen. The H & E stain revealed a fragmented biopsy. Small follicles were seen at the periphery. The paracortical region showed a large number of transformed lymphocytes and histiocytes. Cellular debris was seen. As opposed to the FNAC, no neutrophils were seen (Figs 1 & 2).

Discussion

Kikuchi's Fujimoto's disease remains a poorly recognised entity and is still frequently confused with Malignant Lymphoma [3]. The FNAC diagnosis is based on the presence of activated lymphoid cells, necrotic debris, karyorrhectic cells and prominent histiocytes [4]. FNAC is not an ideal method to diagnose this condition. However cell blocks of Fine Needle aspirates preserve architectural relations of different cell types and may provide a clue to the diagnosis [4]. Neutrophils, plasma cells and multinucleated giant cells are not a feature [5]. In this case however neutrophils were noted on the smear. Fragmentation of the biopsy is a feature and was noted in this case. The

Fig. 1 : x 100 low power view showing partially effaced nodal architecture. Neutrophilic debris can be seen

Fig. 2 : x 400 high power view of the same showing neutrophilic debris in the paracortical region

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classical histopathological features of patchy areas of necrosis with karyorrhexis and paucity of granulocytes were seen [3]. The presence of these features along with enlarged mottled T zones and residual lymphoid follicles as emphasised by Pai et al [6] confirms the diagnosis of Kikuchi's disease. The patient had been put empirically on ATT while the biopsy result was awaited. The ATT was continued. There was a mild decrease in the lymphadenopathy a month after treatment. The patient was then lost to follow up.

The disease is an unusual clinical entity and is difficult to diagnose by FNAC. In this case the presence of a large number of neutrophils on the smears made a firm diagnosis impossible. It is likely that there was a superadded inflammatory component which subsided with antibiotics. Thus no neutrophils were noted on biopsy.

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