To the Editors:

Interfollicular Hodgkin’s disease with histological features of Castleman’s disease

Ceylon Medical Journal, 2000; 45:138-139

Interfollicular Hodgkin’s disease (IHD) may present with histological features of Castleman’s disease (CD) (1,2). We describe such a case that was initially diagnosed as CD. The knowledge that IHD may present with CD-like features, and use of immunohistochemical techniques would have prevented this error.

A 23-year old man was seen with a lump in the neck of one year’s duration, difficulty in swallowing and low grade fever with chills for one month. He was found to be pale. A left-sided mass of matted lymph nodes measuring 8.0 x 5.0 cm was found. No other lymph node groups were enlarged. Apart from a low haemoglobin level (10.2 g/dl) and an erythrocyte sedimentation rate of 56 mm /1st hour, all other investigations were normal.

Microscopic examination of the lump removed at surgery showed prominent lymphoid follicles with central hyalisation of capillaries. The follicle centre cells were concentrically layered, giving the follicles an “onion skin” appearance. There was paracortical expansion by plasma cells, occasional eosinophils and large mononuclear cells with prominent nucleoli. However, typical Sternberg-Reed (SR) cells were not found, a diagnosis of Castleman’s disease was made (intermediate / mixed type). But since the mononuclear cells were worrying, an interim report was issued while awaiting immunohistochemical staining. The immunohistochemistry revealed that these cells were positive for CD15 (Leu M1) and CD30 (Ber-H2), but negative for B and T cell markers, confirming the presence of interfollicular Hodgkin’s disease (IHD). The patient was lost to follow up.

Castleman initially recognised an unusual pattern of reactive hyperplasia in lymph nodes and subsequently described two histological types – hyaline vascular (HV) and plasma cell types (PC) (3). Since then an intermediate variant with overlap of histological features of these two types has been described (4), suggesting the possibility that PC transforms into HV via these intermediate types (4,6). Many histological features of CD may be found in reactive conditions (5) such as immunodeficiency syndrome, sepsis, systemic illness, Wiskott-Aldrich syndrome and rheumatoid arthritis.

Similarly, IHD is characterised by striking follicular hyperplasia and the scarcity and diffuse interfollicular distribution of RS cells (1). The importance of IHD rests on its misdiagnosis as a reactive condition. It is not included as a sub-type in any of the current classifications for Hodgkin’s disease.

It is thought that interleukin 6 (II-6) produced in the follicle centre is responsible for the histological and clinical findings of CD and many other reactive conditions (6). Similarly, II-6 secretion by SR cells and Hodgkin’s cells may explain the occurrence of CD-like histological features in lymph nodes of Hodgkin’s disease.

We thank Professor Kevin Gatter of the Department of Cellular Science, University of Oxford, for his assistance.

References
2. Maheswaran PR, Ramasay AD, Norton AJ, Roche WR.


S J De S Hewavisenthī1 and A N Wedysinghe2, 1Senior Lecturer and 2Demonstrator, Department of Pathology, Faculty of Medicine, University of Kelaniya.