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Dermatopathic Lymphadenitis Without Skin Manifestation: A Rare Case Report

KEYWORDS: Dermatopathic lymphadenitis, lymph node biopsy, No skin manifestation, Melanin pigment

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ABSTRACT *A 50 year old female of tropical spleenomegaly on tab chloroquine presented with pedal edema and lymphadenopathy with no skin manifestation .Her haemoglobin was low and peripheral smear showed anisopoikilocytes. Bone marrow was done which was normoblastic. Lymph node biopsy showed dermatopathic lymphadenitis. It is a rare entity in patients without skin manifestations.*

INTRODUCTION

DERMATOPPATHIC LYMPHADENITIS (OR Pautirier- Woringer) is a histopathological diagnosis of reactive lymph node hyperplasia which is characterised by increased reticulum cells, langerhans cells and histiocytes with lipid and melanin deposits. DL is associated with exfoliative and eczematoid inflammatory erythroderma. The incidence of DL without skin disease is estimated 12.5-34%.1,2

Case Report:

50 yr old female patient k/c/o tropical splenomegaly on tab. Chloroquine came with c/o Pain & distension of abdomen since 3 months Pedal edema since 3 months

On examination:

Pt is conscious, well oriented to time place & person.

Pulse- 84/min

BP- 150/84 mmHg

Pallor (+)

Pedal edema (+)

Lymph nodes- cervical lymphadenopathy (+) b/l symmetrical 0.5*0.5cm in submandibular triangle

- Posterior triangle single lymph node 0.5*0.5cms, soft, mobile. Not fixed to the underlying structures

- Inguinal lymph node b/l multiple lymph node largest size 1.0*0.7cm soft mobile not fixed to the underlying structures.

Skin examination- no e/o any skin lesion.

Respiratory system- clear, AEEBS

CVS- S1-S2- normal

P/A- liver- palpable 3cms below costal margin, non tender, firm

Spleen- palpable upto rt iliac fossa, firm, moves with respiration, non- tender.

Investigations-

Hb- 6gm%, TLC- 4500

Platelets- 2.4lacs

LFT, KFT- WNL

Peripheral smear- anisopoikilocytes, microsites (+) no parasites.

Bone marrow- normoblastic maturation.

FNAC inguinal lymph nodes- reactive lymphadenitis.

Lymph node biopsy- LN with part of capsule with underneath hyperplastic lymphoid follicles, sinuses filled with histiocytes and melanin pigments- s/o Dermatopathic Lymphadenitis.

CXR- WNL

ECG- WNL

USG- A/P- multiple enlarged LN are seen in peri pancreatic, para and pre aortic regions, largest of size 3.1*2cms.

e/o multiple diffuse sub cm size hypoechoeic lesion seen is entire spleen s/o spleenic infarct.

Abd/pelvis (iv/oral contrast CT) – mild hepatomegaly 16.5cms,

Spleen- gross spleenomagaly 20*8.2cms,

LN- multiple homogenous enhancing lobulated nodal masses largest size- 2.1* 1.4 cms seen in precaval, preaortic, aortocaval, peripancreatic, lesser sac.

Discussion-

DL is a morphologically distinct form of reactive lymphoid herplasia which often involves regional lymph node in pa-

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tients with benign exfoliative or eczematoid chronic dermatoses, toxic shock syndrome ,pemphigus, psoriasis, neurodermatitis, eczema and atrophic senilis.[2,3]. DL without skin disease is estimated at 12.5-34%.[1,2]

DL most often involves axillary and inguinal lymph nodes and rarely head and neck.[4] The duration of skin manifestation preceding a positive biopsy of DL varies from 6 months to 6 years.[3]

DL has characteristic histopathology with marked paracortical expansion by irregularly shaped, pale staining patches of interdigitating reticulum cells, langerhans cells, and phagocytic histiocytes. Some phagocytic histiocytes may contain cytoplasmic lipid and appear foamy and others are heavily laden with pigment mostly melanin and occasionally hemosiderin.[3]

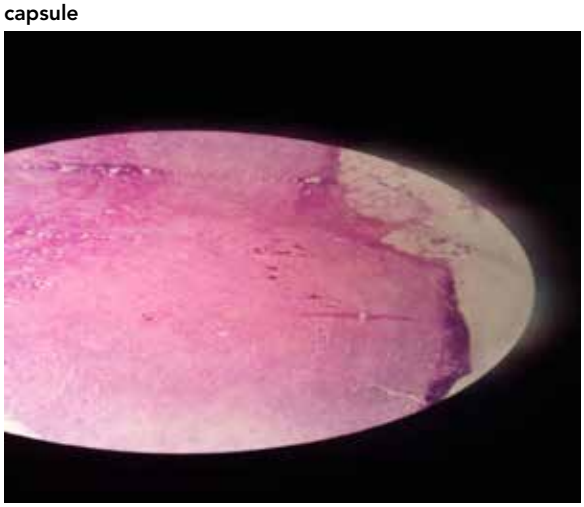
There are no consensus guidelines for treating DL.[4] Since DL is a benign reactive disease, controlling skin disease is prudent.

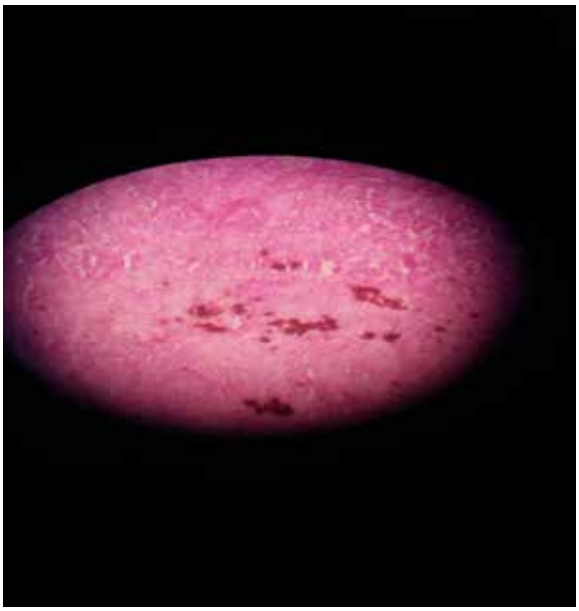
We report a new case of DL without skin manifestation. A similar study was done by Gould E et al which concluded that dermatopathic lymphadenitis may represent one end of a normally occurring histologic spectrum that maybe found in the absence of dermatitis.[2]

R.C.Nairn et all described 13 cases all showing lymphadenopathy with characteristics of dermatopathic reaction in the nodes have in common a pruritic skin disorder with exfoliation at some stage.[5]

In our case report patient presented without skin manifestation making it a rare finding.

capsule





Section shows lymph nodes with a part of capsule with underneath hyperplastic lymphoid follicles. Sinuses are filled with histiocytes and melanin pigment suggestive of dermatopathic lymphadenitis.

Conclusion

Dermatopathic lymphadenitis presents with skin manifestation with lymph node enlargement. In our case it presented with lymph node enlargement with massive spleenomegaly without skin manifestation which is a rare finding.

Thus we will like to publish this case report.

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