A rare cause of axillary lymphadenopathy: Kikuchi's disease

Gurdeep Singh Mannu,[1] Farid Ahmed,[1] Giles Cunnick,[2] Katharine Sheppard[3]

[1]Department of Breast Surgery, Wycombe Hospital, Buckinghamshire, UK
[2]Department of General Surgery, Bucks NHS Trust, Buckinghamshire, UK
[3]Department of Pathology, Bucks NHS Trust, Buckinghamshire, UK

Correspondence to
Dr Gurdeep Singh Mannu, gurdeepmannu@gmail.com, mannu@doctors.net

Accepted 16 January 2014

DESCRIPTION

A healthy 19-year-old woman presented to her general practitioner with a 2-month history of a right axillary lump. There were no breast lesions and a general clinical examination was unremarkable. The lump was thought to be an enlarged lymph node so the patient was given several courses of antibiotics with little benefit. Tests for lymphoma and systemic lupus erythematosis (SLE) were negative. The patient was subsequently referred to the breast clinic where an ultrasound scan showed two lymph nodes of indeterminate appearance. As fine needle aspiration of one of these demonstrated reactive changes, an excision biopsy was performed. This showed the necrotising histiocytic lymphadenitis (figure 1) seen in Kikuchi's disease. The patient's symptoms subsequently resolved with conservative management.

Kikuchi's disease, otherwise known as Kikuchi's histiocytic necrotising lymphadenitis, is a rare self-limiting condition presenting with cervical lymphadenopathy and fever.[1] It is unusual for it to present with axillary lymphadenopathy as in this case. It is more common in young women and in people of Asian ethnicity.[1] Laboratory findings are usually unremarkable other than leukopenia or a raised erythrocyte sedimentation rate in some cases. Although it is a self-limiting condition, lymph node biopsy is required to exclude other causes of lymphadenopathy such as lymphoma or viral infections.[2]

Microscopically, the affected lymph nodes show a histiocytic infiltrate with discrete foci of paracortical necrosis and abundant karyorrhectic debris.

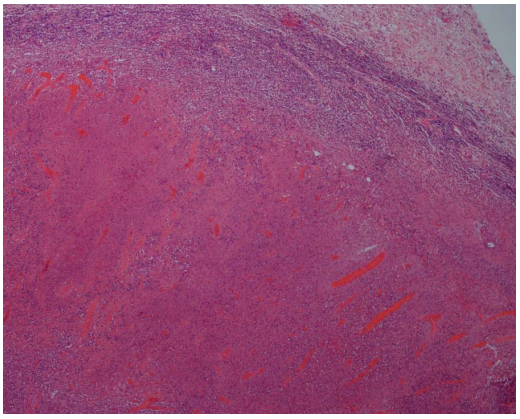

Figure 1 Well circumscribed focus of paracortical apoptotic necrosis with perinodal inflammation.

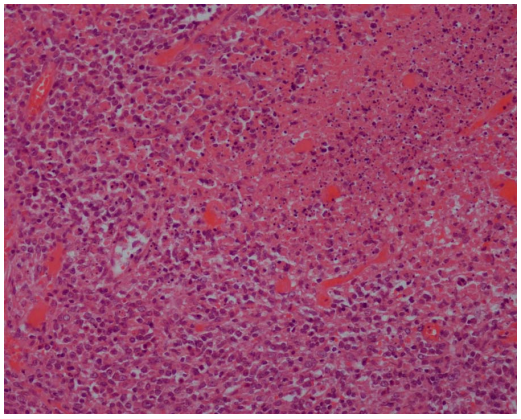

Figure 2 Apoptotic necrosis, comprising karyorrhectic nuclear fragments and eosinophilic fibrinoid material. There is a prominent histiocytic infiltrate consisting of tingible body macrophages and plasmacytoid monocytes with scattered surrounding immunoblasts. Note the absence of neutrophils.

Neutrophils and plasma cells are virtually absent[3] (figure 2). The condition can be difficult to distinguish from SLE and so serological tests are helpful. The treatment is supportive and symptoms commonly resolve within a few months.

Learning points

- Kikuchi's disease is a rare self-limiting condition that commonly presents with lymphadenopathy.
- Lymph node excision biopsy is helpful to exclude other causes of lymphadenopathy.
- Treatment is conservative and symptoms commonly resolve within a few months.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

1 Hutchinson CB, Wang E. Kikuchi-Fujimoto disease. *Arch Pathol Lab Med* 2010;134:289–93.
2 Weiss LM, O'Malley D. Benign lymphadenopathies. *Mod Pathol* 2013;26(Suppl 1):S88–96.
3 Hsi E. *Hematopathology. Expert consult*. Saunders, 2012:140–2.

To cite: Mannu GS, Ahmed F, Cunnick G, *et al*. *BMJ Case Rep* Published online: [*please include* Day Month Year] doi:10.1136/bcr-2013-203100