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View Abstract

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TITLE: Case Report of a Rare disease: Castleman Syndrome

CURRENT CATEGORY: Hospital-based Medicine

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ABSTRACT BODY:

Learning Objective 1: Learn about the diagnosis criteria of Castleman Syndrome and make a differential diagnosis with other disease

Learning Objective 2: Learn about the treatment strategy of Castleman Syndrome

Case: A 34-year-old male was admitted to the hospital due to headache and multiple nodes in the neck for 3 months, fever and pharyngeal discomfort for more than 10 days. The patient had a feeling of fullness in the head due to no obvious incentives before 3 months, accompanied by a sense of oppression, pulsating pain in the forehead, mild in the morning, severe in the afternoon, no dizziness, no nausea, vomiting, no rotation of objects, bilateral neck, multiple swellings behind the ear, 10-20 mm in size without tenderness. Fever occurred more than 10 days ago, mainly in the afternoon, the highest body temperature was 38.3 C, no chills, throat discomfort, hoarseness, chest tightness, shortness of breath, palpitations, no chest pain, loss of appetite, fatigue, no night sweats, no abdominal pain, diarrhea. He was seen a local hospital.

Chest CT: Scattered patchy cord-like density increased in both lung fields. Tuberculosis cannot be excluded. Mediastinal lymph nodes are enlarged. EEG: borderline abnormal brain topographic map. Blood cell analysis: platelets 93×10^9/L. Urine analysis: blood 1+. ESR: 120mm/h. CRP 98 μg/L. Giving levofloxacin and glucocorticoid. For further diagnosis and treatment, he came to our hospital for treatment. Admission physical examination: vital signs were stable and normal. The thinking is clear and to the point, and several enlarged lymph nodes can be touched in the neck, armpits, and under the clavicle, flattened, smooth surface, clear boundary, good range of motion, no tenderness, max 2cm×2.5cm. The thorax was symmetrical and no deformity was found. The respiratory movement of both lungs was symmetrical. The tactile sense of speech was normal. There was no pleural friction. The lungs were voiceless to percussion. The breath sounds of both lungs were weakened and no obvious dry or wet rales were heard. The rest of the physical examination was normal without obvious abnormalities.

Tuberculosis antibody: negative. PPD negative. Immunofluorescence: CD4+ 25.1%, the rest are generally normal. HCV antibody: negative. Abdominal ultrasound: mild fatty liver, double renal parenchyma echogenicity, right renal cyst, splenomegaly. Enhanced CT of the chest: enlarged mediastinal lymph nodes, enlarged axillary lymph nodes. Lymph nodes show no lymphatic tuberculosis characteristic ring enhancement. Pathology of lymph node biopsy: diffuse hyperplasia of plasma cells in lymph nodes, considering Castleman's disease.

Discussion: CD can occur at any age, both children and adults can suffer from CD, but it is found that most of the onset time is 10-45 years old, with no racial or gender differences. Frizzera proposed diagnostic criteria for CD: (1) Diagnostic criteria for LCD: lymphadenopathy at a single site; histopathologically, characteristic and proliferative changes can be seen and other primary diseases that may cause lymphadenopathy should be excluded. Except for the plasma cell type, it is often accompanied by anemia, fatigue, increased erythrocyte sedimentation rate, elevated immunoglobulin and other systemic multi-system dysfunction. Long-term survival after tumor resection. (2)MCD Diagnostic criteria: obvious lymphadenopathy with invasion of peripheral lymph nodes, multiple system involvement. Characteristic hyperplastic changes can be seen on histopathology. Exclude other disorders known to cause swollen lymph nodes. (3) Pathological diagnosis is the gold standard for CD diagnosis.

Chest CT has an important value. It can be seen that many lesions have clear boundaries, and they are round, oval, or shallowly lobulated. Larger masses often compress adjacent tissues and organs, causing them to misplace.

In the analysis of this patient, he was misdiagnosed as lymphatic tuberculosis and the treatment was ineffective. Lymphatic tuberculosis usually has clinical manifestations such as low-grade fever, fatigue, and night sweats. It is a solitary nodule at the initial stage, which is smooth and movable. As the disease progresses, the nodules fuse into lumpy and irregular with poor mobility. Take the lesion tissue for PCR detection, which can be positive. Most of the lymph nodes on CT scan have circular enhancement, and anti-tuberculosis treatment is effective. Pathological biopsy can confirm the diagnosis.
The treatment of CD is mainly surgical resection, and complete resection can usually achieve a curative effect. Its long-term metastasis and recurrence rate are low, and most patients can survive for a long time. Intrathoracic localized and some multicentric CDs undergo complete surgical resection of enlarged lymph nodes, and the clinical symptoms can disappear quickly and the prognosis is good. For unresectable or incompletely resectable LCD, radiation therapy and chemotherapy should be applied.

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Accuracy: I affirm
Policy Verification: I affirm
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