https://doi.org/10.29289/259453942022V32S1016

8 - CASTLEMAN DISEASE IN A PATIENT WITH AXILLARY LYMPH NODE ENLARGEMENT

Alicia Marina Cardoso[1], João Bosco Ramos Borges[2], Caroline Gomes de Almeida Rocha[3], Laura Alejandra Matulevich Santana[2]

[1]Universidade Estadual de Campinas – Campinas (SP), Brazil.
[2]Faculdade de Medicina de Jundiaí – Jundiaí (SP), Brazil.
[3]Hospital A. C. Camargo Cancer Center – São Paulo (SP), Brazil.

Castleman disease represents a group of polyclonal lymphoproliferative entities. Based on clinicopathological associations, the disease can now be clinically divided into two subtypes: unicentric disease and multicentric disease. The multicentric Castleman disease (MCD) involves multiple lymph nodes from different anatomical sites and represents the other 25% of cases, occurring in 5 out of 1 million patients. MCD is multifactorial and can be subdivided according to its clinical association. It is known that interleukin 6 (IL6) plays an important role in the constitution of iMCD symptoms. The cause of the increase in IL6 is unknown. MCD is commonly associated with constitutional symptoms such as night sweats, weight loss, ascites, and pleural effusion. The treatment for MCD is based on the use of IL6 inhibitors. Consideration should be given to the severity of symptoms present to determine the intensity of targeted therapy. Cytotoxic chemotherapy may be a possibility in cases of the disease with severe organ dysfunction. Data from a systematic review published in 2012 of 404 cases of surgery in DC and demonstrated that there was no long-term benefit if patients in the MCD group underwent resective surgery. New prospective research data are needed to further assess the role of surgery in MCD. A female patient, 25 years old, born in Várzea Paulista, SP, came to the mastology outpatient clinic of the University Hospital of Jundiaí in May 2021 with a complaint of the appearance of a hardened nodule in the left breast for 9 months, with progressive increase, pain on palpation, daily afternoon fever, and weight loss of 6 kg in 2 months. A breast ultrasound showed lymph node enlargement in the left infraclavicular region. Physical examination showed good general condition, conscious, oriented, left axilla with the presence of hardened, enlarged, and mobile lymph nodes of approximately 8 cm. She was tested for HIV, syphilis, and hepatitis B and C negative. B2 microglobulin: 2.4. Core biopsy and immunohistochemistry (IHC) were performed on lymph node enlargement, and the result was inconclusive. Computed tomography of the thorax and abdomen: supraclavicular and infraclavicular and axillary lymph node enlargement on the left, measuring the largest 5.7×2.5 cm and 5.9×4.4 cm, some compressing the subclavian vein on the left; paraortic and prevascular mediastinal lymph node enlargement; and presence of inguinal adenomegaly. The patient was undergoing an excisional biopsy in October 2021, whose IHC showed histological aspects of atypical proliferation of epithelioid cells in the context of chronic lymphadenopathy with regression of germinal centers. Fungal research and BAAR were negative. Such lymphoid features are similar to those identified in Castleman disease, hyaline-vascular form. The association of histopathology data, IHC, clinical picture, and the exclusion of other differential diagnoses allowed us to obtain the diagnosis of iMCD. Because of its primordial manifestation in the left armpit, it was essential to differentiate between lymphoma and occult breast carcinoma, since these are more common diagnoses in clinical practice and have a similar initial clinical picture.