

Kikuchi's Disease: A Case Report

¹N Archana, ²L Gayatri, ³RK Ipsita, ⁴S Naorem

Department of General Medicine Regional Institute of Medical Sciences, Imphal

Abstract: Kikuchi's disease, also known as Kikuchi Fujimoto Disease or histiocytic necrotising lymphadenitis is a rare idiopathic, usually self-limiting cause of lymphadenitis. It was first described in in 1972 in japan. Clinically Kikuchi's Disease most commonly presents as cervical lymphadenopathy with or without systemic signs and symptoms and is usually self-limiting. Clinically and histologically, the disease can be mistaken for lymphoma or systemic lupus erythematosus. Owing to its rarity we report a 27 year old female presenting with fever and cervical lymphadenopathy who was diagnosed to have Kikuchi's Disease and was confirmed by histopathological examination.

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I. Introduction

Kikuchi's disease or Kikuchi- Fujimoto Disease (KFD) or Histiocytic necrotising lymphadenitis is a rare idiopathic cause of lymphadenopathy, first described in 1972 in Japan by Kikuchi¹ and Fujimoto². It has a world-wide distribution with a higher prevalence among Asians³ with a possible viral or autoimmune etiology⁴. It is characterized by fever and upper respiratory tract symptoms with tender cervical lymphadenopathy⁶ and less frequently associated with weight loss, nausea, vomiting, sore throat and night sweats^{7,8} and is a self-limiting disorder⁵. In India, two cases have been reported in south India and one in northeast India at RIMS in 2014.¹⁰

History and examination:

A 27 year old female presented with fever for 2 weeks and multiple painful swellings in the neck for 1 week. There was history of similar complaints 3 years ago. No history of hypertension, tuberculosis, diabetes, bronchial asthma, surgery. Non-smoker.

On examination patient was alert and oriented. BP- 120/80mmHg, PR- 68/min. No pallor, icterus, cyanosis, clubbing, edema or jaundice. Right sided mobile tender cervical lymphadenopathy was present CVS- S1S2 +, Chest- B/L clear, P/A- soft, non tender, no organomegaly, CNS- within normal limits .

Investigations:

CBC: hb-10.4gm/dl, tlc- 5000/mm³, platelet- 1.7lacs/mm³, ESR- 40mm/1st hr, peripheral smear- normocytic normochromic

LFT: total bilirubin-0.3mg/dl, direct bilirubin- 0.1mg/dl, total protein- 6.5g/dl, albumin- 3.7g/dl, globulin- 2.8g/dl, SGOT- 118U/L, SGPT- 88U/L, ALP- 290U/L

KFT: urea- 24mg/dl, creatinine- 0.8mg/dl

RBS: 112mg/dl

PT: 9secs, INR: 1

HBsAg/AntiHCV/Rab: negative/non-reactive

Anti-CCP: 7IU/L (negative)

RF: <10.6IU/L (negative)

ANA: 0.4IU/L (negative)

Antids DNA: 23IU/L(negative)

Serum uric acid: 4.8mg/dl (normal)

Urine Routine: normal

FNAC of LN: features suggestive of reactive lymphadenitis

Histopathological examination of LN biopsy: patchy areas of necrosis with proliferation of histiocytes and increase in apoptotic cells, cellular debris and karyorrhexis.

II. Discussion

Kikuchi's disease is acute or subacute and usually evolves over 2 to 3 weeks. Most common presentation is tender cervical lymphadenopathy that mainly involves the posterior cervical triangle. Rarely, generalized lymphadenopathy can occur.⁶ Fever may occur in 30 to 50% cases of Kikuchi's disease along with

other less common symptoms like nausea, vomiting, weight loss, sore throat and night sweats.^{7,8} Kikuchi's disease may have a possible viral or autoimmune etiology. Role of Epstein-Barr virus and other viruses like HHV6, HHV8 and parvo virus B-19 remain controversial³ although clinical manifestations suggest a viral infection.⁴

Characteristic histopathologic findings of KFD include irregular paracortical areas of coagulative necrosis with abundant karyorrhectic debris, which can distort the nodal architecture, and large number of different types of histiocytes at the margin of the necrotic areas.⁹

III. Conclusion

Kikuchi's disease should be considered among the differential diagnosis for fever with cervical lymphadenopathy. A careful histopathological examination is necessary to come to a diagnosis. Recognizing the disease early and differentiating it from lymphoma or SLE is important to avoid unnecessary evaluations and treatments.

Reference

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