51st ANNUAL DIAGNOSTIC SLIDE SESSION 2010

CASE 2010 - 3

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Clinical History:
This 44-year-old woman presented to the Emergency Room with a two-month history of headaches, dizziness, and gait instability. The patient had a long-standing history of intermittent episodes of lymphadenopathies and fever that started in 1979 at age 15, when she was found to have an enlarged left axillary lymph node. This node was biopsied at an outside hospital and found to be "reactive/benign adenopathy". At age 25 she developed adenopathy in her right cervical area which was biopsied and found to be "reactive/benign". Throughout her adolescence and young adult life, she developed multiple upper respiratory tract infections and was found to have hypogammaglobulinemia, which has been treated, intermittently, with IV immunoglobulins. At age 41 she developed persistent fevers and night sweats, and she was hospitalized at an outside hospital and was found to have retroperitoneal and mesenteric hypermetabolic lymph nodes on CT/PET scans. She underwent numerous evaluations including bone marrow aspirate and laparoscopic lymph node biopsy. Flow cytometry analysis of the lymph node biopsy and bone marrow aspirate were negative for lymphoma. The lymph node biopsy showed a "non-specific/reactive lymphadenopathy". She opted for a second opinion/evaluation at another tertiary hospital where she underwent bone marrow aspirate and laparoscopic biopsy of periaortic nodes that showed "focally necrotizing lymphadenopathy negative for malignancy or infection". She also presented with a skin rash that was biopsied and was diagnosed as “lichen simplex chronicus”. She was seen and evaluated by rheumatology, and she was diagnosed with a specific rheumatological disease. She started treatment with hydroxychloroquine and prednisone with improvement of her symptoms. However, the patient discontinued her medications two months before the current admission at our institution because she was gaining weight. She also had problems getting her IV immunoglobulins due to insurance coverage. Her last treatment was 2 months prior to the current admission.

At admission the patient complained of headaches, dizziness and poor balance. She also complained about mild gradual decrease in vision, fatigue and anxiety about her condition. She was afebrile. An MRI revealed a 28 x 23 mm avidly enhancing, intra-axial lesion within the right occipital lobe with surrounding T2 prolongation. Clinical laboratory tests where within normal limits except for the immunoglobulin levels that showed low IgA and IgM. The patient underwent excisional brain biopsy of the lesion.

Material submitted: 1. One H&E section of the lesion.

Points for discussion: 1. Diagnosis
2. Differential diagnosis and follow up