Case report

Mutlicentric Castleman’s disease presenting in a young patient

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Abstract

Multicentric Castleman's disease (MCD) is a rare lymphoproliferative disease and its presentation in a young age population is unusual. Here, we report the case of a 28 year old Sri Lankan male who was evaluated for lower limb edema and sensory type neuropathy along with skin thickening and pigmentation. He was found to have generalized lymphadenopathy and hepatosplenomegaly. His investigations revealed evidence of demyelinating type sensory-motor polyneuropathy, pulmonary hypertension, hypothyroidism. However, studies conducted for HIV viruses and monoclonal gammopathy were negative. An excision biopsy of an Inguinal lymph node of his right side axila revealed changes supportive of a diagnosis of multicentric Castleman’s disease. Despite being a rare disease and even rarer in a young population, diagnosis of MCD/POEMS syndrome should be suspected in patients’ presenting with similar features described above. MCD is associated with many malignancies and has poor prognosis.

Key words: Castleman disease, Neuropathy, Edema, Pulmonary hypertension, Skin sclerosis

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Introduction

Castleman's disease (CD) is a rare group of lymphoproliferative disorders of unknown aetiology and pathogenesis. CD has no established clinical trials for treatment of the disease. Here, we report an unusual case of multicentric Castleman’s disease presenting in a young Sri Lankan patient.

Case Presentation

A 28-year-old male from Rathnapura, Sri Lanka was investigated for bilateral lower limb swelling and numbness for two years duration. He also complained of worsening breathing difficulty along with progressive skin changes of increased pigmentation and thickening. His clinical examination revealed generalized lymphadenopathy that was non tender, firm, non-matted with average size of 2-3 cm. He had increased skin thickening extending proximally up to mid arm. He had no evidence of acrosclerosis, hand edema, digit loss or features of Raynaud’s type phenomena. Abdominal exam revealed hepatosplenomegaly.

Among the extensive investigation workup that was performed on this patient, he was noted to have a persistently elevated erythrocyte sedimentation rate but negative results for anti nuclear, anti double stranded DNA, anti centromere and anti SCL 70 antibodies.
Nerve conduction study revealed demyelinating type sensory-motor polyneuropathy whilst serum protein electrophoresis studies revealed polyclonal hypergammaglobulinaemia. Examination of skin biopsy specimens was normal. He was also diagnosed with hypothyroidism.

Imaging studies with ultrasound scan and CT scan of the abdomen revealed hepatosplenomegaly and a haemangioma of the liver. There was evidence of pulmonary hypertension noted with echocardiography whilst normal results of imaging studies of the lung and spirometry study revealed only mild reversible obstruction. His bone marrow revealed normocellular active marrow, 2% plasma cells without evidence of malignancy infiltrating the bone marrow.

Table 1: Diagnostic criteria for POEMS syndrome

| Mandatory major criteria                  |
|------------------------------------------|
| Monoclonal plasma cell proliferative disorder |
| Polyneuropathy                           |
| Other major criteria (one required)       |
| Sclerotic bone lesions                    |
| CD                                       |
| Vascular Endothelial Growth Factor level elevation |
| Minor criteria (one required)             |
| Organomegaly – Splenomegaly, Hepatomegaly, Lymphadenopathy |
| Volume overload – Extravascular (Oedema, Pleural effusion, Ascities) |
| Endocrinopathy – Adrenal, Thyroid, Gonadal, Parathyroid, Pancreatic |
| Skin changes – Hyperpigmentation, Hypertrichosis, Plethora, Flushing, Acrocyanosis, White nails, Haemangioma |
| Papilledema                               |
| Thrombocytosis, Polycythaemia             |

An excision biopsy performed on a lymph node of the right axilla, revealed features supportive of a diagnosis of multicentric hyaline vascular variant of CD. The specimen revealed scattered large follicles (black arrowheads) showing vascular proliferation and hyalinisation of germinal centers surrounded by tight concentric layering of lymphocytes (onion skin appearance) but no evidence of dysplasia or malignancy (Figure 1). The patient however had undergone 3 separate biopsies of enlarged lymph nodes on separate sites that revealed non specific, reactive type changes prior to the above mentioned final fourth lymph node biopsy. He was thereafter referred to the oncology unit at National Cancer Institute Maharagama (NCIM) for further management but was recommended to be screened regularly for development of lymphoma or monoclonal gammopathy.

Discussion

CD may present with two types of disease states, namely, unicentric disease and multicentric disease (MCD). Both types of CD differ from their presentations and prognosis (1).

CD also has 3 different types of histological variants (2), namely, Hyaline vascular variant, Plasma cell variant and the HHV8 positive CD. Unicentric disease is associated with a benign lymphoproliferative disease of young adults.

Figure 1: Histology of the lymph node-biopsy of the patient; note the scattered large follicles (black arrowheads) showing vascular proliferation and hyalinisation of germinal centers.
There are no randomized clinical trials supportive of the treatment. Treatment options include Anti-CD20 monoclonal antibody therapy (eg; Rituximab), cytotoxic chemotherapy, glucocorticoids, IL-6-directed therapy and antiviral drugs. Rituximab therapy is now emerging as the treatment of choice for most patients including HIV positive patients (5).

**Conclusion**
CD is a rare disease. Further knowledge is required about its etiology, pathogenesis and treatment along with establishment of a registry of patients with CD.

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