RECURRENT KIKUCHI’S DISEASE: A CASE REPORT

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ABSTRACT
Kikuchi’s disease is a rare cause of cervical lymphadenopathy that is mostly seen in young women. This report describes the case of a 30 years old woman who presented with recurrent cervical lymphadenopathy. She had a history of enlarged cervical nodes about three years ago for which a biopsy was done that showed non-specific inflammation. She was given a course of antibiotics and the nodes subsided within a couple of months. She underwent excision biopsy of two lymph nodes for her current lymphadenopathy which were sent to two different laboratories; both reported it as a case of Kikuchi’s disease.

KEY WORDS: Cervical Lymphadenopathy, Kikuchi’s Disease, Histiocytic Necrotizing Lymphadenitis

INTRODUCTION

Kikuchi’s disease was previously known as subacute necrotizing lymphadenitis. It was first described by Kikuchi1 and Fujimoto et al2 in 1972, hence sometimes called as Kikuchi-Fujimoto disease. The first case reported outside Japan was reported in 1982.3 Most reports of Kikuchi’s disease have been published in the pathology literature. Very few reports have come from Pakistan and there appears to be a general lack of awareness about the condition among the surgeons.4,5

It is a self resolving, benign cause of cervical lymphadenopathy, usually posterior cervical, and is predominantly seen in young Asian women, who are in their late 20s or the early 30s. This report describes recurrent Kikuchi’s disease in a 30 year old woman.

CASE REPORT
A female aged 30 years, resident of Karachi, presented with the complain of enlarged glands on both sides of the neck. There were no other complaints like evening fever, chills, night sweats, cough, weight loss, fatigue and malaise apart from discomfort and occasional mild pain in one node near the angle of left jaw. There was also no history of sore throats, trauma, scalp or dental problems.

She was worried because she had enlargement of the glands on the right side of the neck about three years back for which a biopsy was done. She was told at that time that there was inflammation of the glands but nothing specific, and was given a course of antibiotics. The nodes subsided within two to three months.

On examination she had discrete enlarged lymph nodes in the posterior triangle on both sides of the neck. One large node at the angle of the left jaw was mildly tender. Examination of her throat, remaining head and neck, axillae, groins, chest and abdomen were unremarkable.

Investigations including complete blood picture, X-ray chest, ultrasound abdomen, RA factor, anti-nuclear antibodies (ANA) revealed nothing abnormal, except for mild rise in the ESR.

Excision biopsy of two lymph nodes was performed, one from each side of the neck. The node removed from the left side was the one causing discomfort to the patient. The nodes were sent to two different laboratories on the request of the patient as she was worried about the recurrence of the nodes.

The histopathology report from both the laboratories came back as necrotising lymphadenitis. One laboratory gave the conclusion as Kikuchi’s disease while the other
gave Kikuchi’s disease, collagen vascular disease and infectious aetiology as differential diagnosis. The patient was reassured and the nodes seem to be subsiding at two months follow-up.

**DISCUSSION**

Kikuchi’s disease was once thought to be an east Asian condition, predominantly Japanese. However, cases have been reported from other countries of Asia, USA and Europe, though in the latter many are of Asian descent. Women around 30 years of age are mostly affected; a female to male ratio of 4:1 has been described though recent studies quote a figure of 2:1 or even 1:1.

There are very few clinical findings apart from painless cervical lymphadenopathy, though occasionally pain and generalized lymphadenopathy has been reported. Cervical nodes are involved in around 80% cases (65-70% of the affected nodes are in the posterior triangle), axillary in 14% and supraclavicular in 12% cases. Other clinical features seen include fever, headache, nausea, vomiting, hepatosplenomegaly, skin lesions and rarely constitutional or neurological disturbances.

The disease may start insidiously like the lymphoma, with whom it may be clinically and pathologically confused. Other conditions to be differentiated include metastatic carcinoma, infectious mononucleosis, toxoplasmosis, Yersinia, tuberculosis, cat-scratch disease, AIDS, Kawasaki’s disease and Still’s disease in children.

Kikuchi’s disease may be associated with systemic lupus erythematous (SLE). It may represent an SLE like auto-immune disorder, or it may be a initial stage of patients who go on to develop SLE. Hence, patients with this condition should be followed long term for early detection of SLE.

There are no laboratory or radiological tests that can confirm the diagnosis of Kikuchi’s disease. However, complete blood picture, X-ray chest, ultrasound abdomen, ultrasound/CT neck, ANA, C-reactive protein, etc. may be done to exclude other conditions. The diagnosis is usually made on histopathology of the excised nodes or FNAC, though the former is preferable. Kuo has described three types of the disease on the basis of histopathology viz. proliferative, necrotizing and xanthomatous.

The exact cause of Kikuchi’s disease is unknown, though five years after its first reporting Kikuchi suggested an acute toxoplastic infection. Other infectious agents have been postulated due to the self-limiting nature of the condition like the Yersinia enterocolitica, cytomega-

lovirus (CMV), human herpes virus (HHV), varicella-zoster virus, parainfluenza virus and the Epstein-Barr virus (EBV), but none could be proven so far.

Kikuchi’s disease is a benign condition that usually resolves spontaneously within a few months. Hence, it does not require any treatment apart from symptomatic measures. Jang et al suggested using prednisolone in advanced cases to expedite resolution. Corticosteroids and immunosuppressant drugs have also been advocated in complicated cases. A recurrence rate of 3.3% and few deaths have also been reported. Our case was also probably that of recurrent Kikuchi’s disease as the patient has a similar lymphadenopathy three years ago.

**REFERENCES**


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