CASE REPORT

RARE KIMURA DISEASE: TWO CASE REPORTS

Ramesh Kumar Korumilli¹, S. Rama Chandra Reddy², G. Ramana Reddy³, D. Murali Krishna⁴, M. Siddarth Reddy⁵

HOW TO CITE THIS ARTICLE:

Ramesh Kumar Korumilli, S. Rama Chandra Reddy, G. Ramana Reddy, D. Murali Krishna, M. Siddarth Reddy. "Rare Kimura Disease: Two Case Reports". Journal of Evolution of Medical and Dental Sciences 2015; Vol. 4, Issue 36, May 04; Page: 6323-6326, DOI: 10.14260/jemds/2015/917

ABSTRACT: Kimura's disease is a rare chronic inflammatory disease characterized by multiple lymphadenopathy, blood and tissue eosinophilia and markedly elevated serum immunoglobulin E levels.

INTRODUCTION: Kimura disease is a rare chronic inflammatory disease characteristically manifests as enlargement of cervical lymphnodes and salivary glands with blood and tissue eosinophilia.^[1] It can present with other lymphnode enlargement also like axillary lymphnodes, inguinal, popliteal and medial epicondyle lymphnodes. Kimura's disease was first reported in china in 1937.^[2]

CASE 1: A 55 year old male patient presented to surgery out-patient with multiple lymphadenopathy - cervical, axillary and inguinal of one week duration, associated with low grade fever and itching. On Examination - Multiple lymphadenopathy present bilateral cervical, axillary and inguinal regions of sizes varying from 2-6 cms, non-tender, firm in consistency. (Figure 1)

FNAC was not conclusive. Excision biopsy of left cervical lymphnode done and histo pathological examination reported as Kimuras disease. The patient was managed conservatively with prednisone and cetirizine. After one month follow up revealed decreased size of other lymphnodes with no complaints.

CASE 2: A 40 year old male patient presented to surgery op with complaints of Bilateral post-auricular swelling of two weeks duration, no history of fever, no history of ear discharge. On Examination: Bilateral post-auricular lymphnode enlargement present of size 5×2 cm, non-tender, firm in consistency. (Figure 2)

FNAC was not conclusive, excision biopsy of bilateral post-auricular lymphnodes was done and histo pathological examination (Figure 3) reported as kimuras disease. Patient was on regular follow up with no recurrence.

DISCUSSION: We are here with reporting two cases of kimura's disease presented to surgical outpatient department involving post-auricular, axillary, cervical and inguinal lymphnodes. It is common to see tuberculous lymphadenitis, lymphomas and secondaries in lymphnodes but unusual to see kimura's disease.

These two cases of kimura's disease reported within a span of one month. Kimura's disease is more common in Asians with median age of onset being 28-32 years.^[3,4] Most commonly seen in males with M/F ratio of 3. 5:1 to 9:1.^[5] Etiology of which is unknown, allergic reaction and altered immune regulation lead to type 1 hypersensitivity (Ig E mediated) are suspected. Diagnosis is confirmed by Histo-Pathological Examination which shows proliferation of post capillary venules,

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lymphoid follicles with eosinophils and plasma cell infiltration. Histologically it should be differentiated with Angiolymphoid hyperplasia, Kaposi sarcoma, Dermatofibrosarcoma protruberans. Surgical excision of lesions is first line therapy.^[6] but recurrence is common after surgery. Oral corticosteroids (Methyl Prednisone) are used, disease recurs after cessation of steroids. Intralesional steroids can also be used for local disease. Cyclosporine 5 mg/kg/day was effective but lesions recur after stopping treatment.^[7] Other treatment modalities include Altrans retinoic acid, Imatinib, Pranlukast, Cetrizine and Intravenous Immunoglobulins. Radiotherapy 25-30 Gy is used for lesions where surgery is not possible and corticotherapy is refractory.^[8]

A rare possibility of kimura's disease also should be kept in mind where there is diagnostic difficulty.

Fig. 1: Axillary Lymphadenopathy

Fig. 2: Post Auricular Lymphadenopathy

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Fig. 3: Histopathological Examination Showing eosinophilic infiltration

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AUTHORS:

1. Ramesh Kumar Korumilli
2. S. Rama Chandra Reddy
3. G. Ramana Reddy
4. D. Murali Krishna
5. M. Siddarth Reddy

PARTICULARS OF CONTRIBUTORS:

1. Professor, Department of General Surgery, SVS Medical College, Mahabubnagar.
2. Professor, Department of General Surgery, SVS Medical College, Mahabubnagar.
3. Professor, Department of General Surgery, SVS Medical College, Mahabubnagar.

FINANCIAL OR OTHER

COMPETING INTERESTS: None

4. Post Graduate, Department of General Surgery, SVS Medical College, Mahabubnagar.
5. Post Graduate, Department of General Surgery, SVS Medical College, Mahabubnagar.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. Ramesh Kumar Korumilli,
Plot No.70, Gruhalaxmi Colony, Old Kakaguda,
Secunderabad-500015, Telangana.
E-mail: rameshkorumilli@gmail.com

Date of Submission: 08/04/2015.
Date of Peer Review: 09/04/2015.
Date of Acceptance: 22/04/2015.
Date of Publishing: 04/05/2015.