NECROTIZING LYMPHADENITIS AS A CAUSE OF PERIPHERAL LYMPHADENOPATHY IN A PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE REPORT

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BACKGROUND

Necrotizing lymphadenitis (NL) as an isolated manifestation of systemic lupus erythematosus (SLE) is a rare condition, especially in patients over 50 years of age, and must be differentiated from other causes of lymph node enlargement. We aimed to report a case of an adult patient with SLE and NL who had no additional active organ involvement.

CASE REPORT

A 59-year-old white female had been diagnosed with SLE 25 years before, with cutaneous (photosensitivity), articular, hematologic (lymphopenia and thrombocytopenia), and pulmonary (bronchiolitis) involvement. She had achieved disease remission 2 years earlier, with no current immunosuppressive therapy or hydroxychloroquine (because of preexisting maculopathy). She then presented with a 3-month history of bilateral enlarged cervical lymph nodes, which continued to increase in size, as well as night sweats, asthenia, and fatigue. The workup included negative anti-dsDNA antibodies, C3 and C4 levels of 135 and 13.3, respectively, and negative serologies (hepatitis, Epstein–Barr, cytomegalovirus, toxoplasma, and rubella). Her neck computed tomography (CT) scan showed bilateral enlarged lymph nodes, some of them globose and contrast-enhancing, with the largest one measuring 2.3 cm. Chest, abdomen, and pelvis CT scanning showed no abnormalities. Fine-needle aspiration (FNA) of the largest lymph node for cytology was performed and demonstrated reactive lymphadenitis with a negative acid-fast bacilli (AFB) smear and negative bacterial and fungal cultures. An excisional biopsy of a left cervical lymph node was then carried out and uncovered reactive follicular lymphoid hyperplasia associated with NL. Immunohistochemistry showed mixed populations of lymphocytes (BCD20+ / TCD3+), no AFB, fungi, or signs of malignancy; biopsy specimen cultures were also negative. The diagnosis of SLE-associated NL was thus considered. The patient was then started on azathioprine (1.5 mg/kg/day) and prednisone (5 mg/day) for her constitutional symptoms and increasing lymph nodes, in view of the contraindication to hydroxychloroquine. In addition, a follow-up appointment was scheduled.

CONCLUSION

Necrotizing lymphadenitis, even if presenting as the sole organ involvement, should be considered in the differential diagnosis of peripheral lymphadenopathy in patients previously diagnosed with SLE.

KEYWORDS

Case report, Necrotizing lymphadenitis, Lymphadenitis, Systemic lupus erythematosus.