9. McMillan A, Lee FD: Sigmoidoscopic and microscopic appearance

of the rectal mucosa in homosexual men. Gut 1981; 22:1035-

4. Drusin LM, Singer C, Valenti AJ, Armstrong D: Infectious syphilis

Anorectal syphilis should be suspected in any young male with a rectal mass, whether or not a history of anorectal sex is obtained, because the lesion histologically and clinically can mimic lymphoma. The physician should be aware of this unusual presentation of an old disease.

References

- Akdamar K, Martin RJ, Ichinose H: Syphilitic proctitis. Digestive Diseases 1977; 22:701-704
- Center for Disease Control Annual Summary 1979: Reported morbidity and mortality in the United States. Morbidity and Mortality Weekly Report 1980; 28:79–83
- Dorfman RF, Warnke R: Lymphadenopathy simulating the malignant lymphomas. Hum Pathol 1974; 5:519-550

Cancer Treat Rep 1982; 66:1391-1395

Intracranial Lesion Resembling Giant Lymph Node Hyperplasia

MARIE-JOSÉ LACOMBE, M.D., JACQUES POIRIER, M.D., AND JEAN-PIERRE CARON, M.D.

A 30-year-old woman, who, since the age of 20, had epileptic seizures, was hospitalized in 1972 because of frontal headaches, nausea, and vomiting. Clinical examination revealed a right cerebellar syndrome; gamma-encephalogram showed a focus of subtentorial hyperactivity; iodoventriculography showed a deformation of the aqueduct. At surgery, a posterior fossa tumor implanted on the dura mater and tentorium of the right cerebellar fossa was enucleated. The histologic features were those of giant lymph node hyperplasia. Postoperative craniospinal radiotherapy was administered. Ten years later the patient was in good health and neurogically normal. (Key words: Giant lymph node hyperplasia; Angiofollicular lymph node hyperplasia; Lymphoid hamartomata; Intracranial tumors; Castleman syndrome; Cercbral posterior fossa tumors) Am J Clin Pathol 1983; 80: 721-723

SINCE THE FIRST DESCRIPTION by Castleman,^{5,6} several cases of giant lymph node hyperplasia have been reported.^{1-4,7-14} The most frequent locations are the mediastinum, abdomen, neck, and axilla.

The present report concerns a woman who had a lesion resembling giant lymph node hyperplasia in the posterior cranial fossa, which was removed and treated postoperatively by radiotherapy. Ten years later the patient was in good health, with no sign of the tumor. As far as we Histologie "C" Institut Gustave-Roussy, Villejuif; Department de Pathologie (Neuropathologie), Hopital Henri Mondor, Creteil; and Service de Neurochirurgie, Hopital Henri Mondor, Creteil. Downloaded from http://ajcp.oxfordjournals.org/ at UIC Library, Collections Development on June 8, 2016

know intracranial giant lymph node hyperplasia has not been reported in the literature.

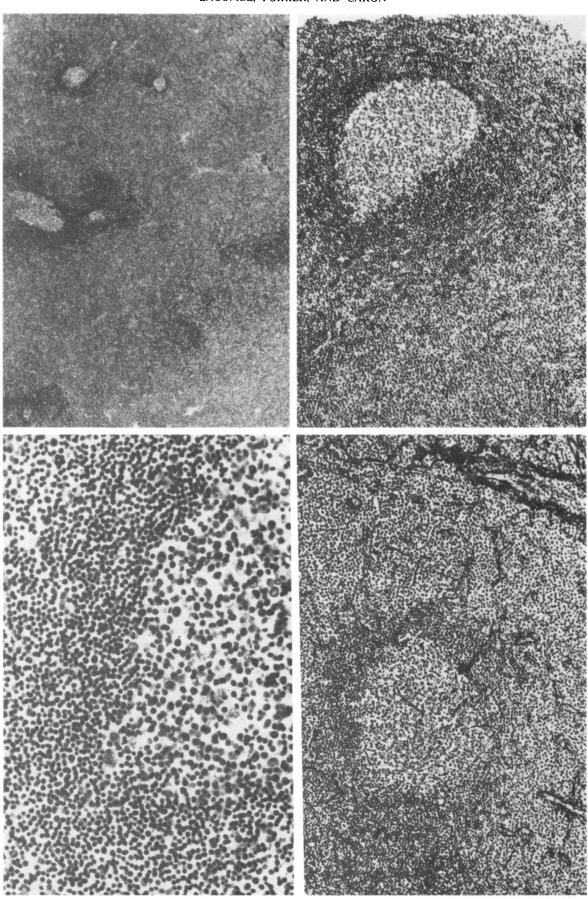
Report of a Case

Patient 1, aged 30, was hospitalized in January, 1972, for metrorrhagia. Gynecologic examination and biopsy of the uterus revealed atrophic endometrium. During her hospitalization she complained of epileptic fits since 1961 (about one per year) and headaches since December, 1971, with increasing intensity and duration, accompanied by nausea and vomiting. Neurologic examination revealed slight papilledema and a right cerebellar syndrome with lateral nystagmus. The cerabrospinal fluid contained 0.56 g/L protein, with 21% gamma globulins;13.4 leukocytes/mm³, 80% lymphocytes. Isotopic test showed a right subtentorial hyperactive focus. The iodine ventriculogram demonstrated that the fourth ventricle was displaced forward, laterally, and to the left. A vertebral angiogram showed a tumor in the right posterior fossa without injection of tumoral vessels. At operation (March 21, 1972), a reddish tumor was attached to the inner surface of the dura mater in the right posterior fossa, distinct from cerebellar tissue. It was removed entirely. Postoperative recovery was uneventful.

As a consequence of the initial erroneous histologic diagnosis of desmoplastic medulloblastoma (or cerebellar circumscribed arachnoidal sarcoma), the patient was irradiated. Irradiation consisted of 30 grays over the whole brain, 50 grays over the posterior fossa, 33 grays over the cervical spinal cord, 33 grays over the thoracic cord, and 33 grays over the lumbar cord.

Received November 29, 1982; received revised manuscript and accepted for publication May 25, 1983.

Address reprint requests to Dr. Poirier: Service d'Histologie, Hopital Henri Mondor, F 94010 Creteil Cedex, France.



- FIG. 2 (upper, right). A lymphoid follicle with its germinal center. Haematoxylin and eosin (×200).
- Fig. 3 (lower, left). High-power view of a lymphoid follicle with (right top corner) its germinal center. Haematoxylin and eosin (×500).
- Fig. 4 (lower, right). Reticulin stain showing numerous vessels around a follicle and an artery entering within it. Gordon-Sweet (×200).

Four months after the operation, clinical examination revealed no neurologic signs. The last neurologic examination on January 30, 1980, revealed no abnormalities.

Microscopic Findings

The tumor was lymphoid in appearance with a follicular architecture (Fig. 1). The follicles, which were distributed evenly throughout the tumor looked like large germinal centers, although some of them had a concentric arrangement of the germinal center cells and an epithelioid appearance (Figs. 2 and 3). Each follicle was penetrated by a vessel; the wall of which was not hyalinized.

It was not possible, even using reticulin stains, (Fig. 4) to distinguish true lymph node architecture with cortex medulla, and sinuses. The interfollicular areas consisted of mature lymphoid cells associated, in some areas with numerous mature normal plasma cells and, in other areas, with capillary proliferation and prominent endothelial cells. No malignant histologic features were observed.

The final diagnosis was giant lymph node hyperplasia.

Discussion

Clinically the present case resembles those previously described: 90% of the published cases are asymptomatic and 10% of the patients have symptoms due mostly, as in our patient, to direct compression by the tumor.

Microscopically, two distinct histologic patterns of this tumor type have been described: the hyaline-vascular type and the plasma cell type. The plasma cell type has prominent follicular hyperplasia and a great number of mature plasma cells in the interfollicular areas; it is associated typically with fever and with hyperglobulinemia, anemia, low serum iron, and elevated sedimentation rate. The hyaline-vascular type, most frequently observed, is characterized by prominent interfollicular vascular proliferation and hyalinization; it is usually asymptomatic. Some in-between cases have been reported,9 and our case falls in this intermediate histologic category, although it is closer to plasma cell type cases. However, our case did not include fever, anemia, or laboratory abnormalities, except a slight increase of the cerebrospinal fluid γ globulin (21%). Clinical symptoms related to cerebellar compression and to intracranial hypertension were observed. There have been no recurrence ten years after surgical excision followed by radiotherapy.

The cause of this lesion is uncertain. Though it has

been considered reactive, no cause for an inflammatory reaction was discovered. It may be a hyperimmune reaction. The abnormal vascular pattern and the absence of normal sinuses are consistent with either a benign tumor or with a hamartoma. In other reported cases, such lymphoid masses appeared in regions normally without lymph nodes, such as muscles or soft tissues. Because lymph nodes are not normally present in the cranial cavity, the development of a lesion resembling giant lymph node hyperplasia in the posterior cranial fossa seems to be important evidence in favor of the hamartoma hypothesis.

Acknowledgments. The authors thank Martine Favolini for technical assistance, Sylvie Daude and Aurore Feyfant for typing drafts of the manuscript, and Professor Serge Duckett for kindly reviewing this text.

References

- Anagnostou D, Harrison CV: Angiofollicular lymph node hyperplasia (Castleman). J Clin Pathol 1972; 25:306-311
- Ballow M, Park BH, Dupont B, Caldweel RR, Lonsdale D, Good RA: Benign giant lymphoid hyperplasia of the mediastinum with associated abnormalities of the immune system. J Pediatr 1974; 84:418-429
- Bartoli E, Massarelli G, Soggia G, Tanda F: Multicentric giant lymph node hyperplasia. A hyperimmune syndrome with a rapidly progressive course. Am J Clin Pathol 1980; 73:423-426
- Buchanan GR, Chipman JJ, Hamilton BL, Daughaday WH: Angiomatous lymphoid hamartoma: Inhibitory effects on erythopoiesis, growth, and primary hemostasis. J Pediatr 1981; 99:382

 388
- Castleman B, Towne VW: Hyperplasia of mediastinal lymph nodes. Case 40.011. N Engl J Med 1954; 250:26-30
- Castleman B, Iverson L, Menendez VP: Localized mediastinal lymph node hyperplasia resembling thymoma. Cancer 1956; 9:822–830
- Gaba AR, Stein RS, Sweet DL, Variakojis D: Multicentric giant lymph node hyperplasia. Am J Clin Pathol 1978; 69:86-90
- Karcher DS, Pearson CE, Butler WE, Hurwitz MA, Cassel PF: Giant lymph node hyperplasia involving the thymus with associated nephrotic syndrome and myelofibrosis. Am J Clin Pathol 1982; 77:100-104
- Keller AR, Hochholzer R, Castleman B: Hyaline-vascular and plasma-cell types of giant lymph node hyperplasia of the mediastinum and other localizations. Cancer 1972; 29:670-683
- Lattes R, Pachter R: Benign lymphoid masses of probable hamartomatous nature. Analysis of 12 cases. Cancer 1962; 15:197– 202
- Moir DH, Choy T, Dalton WR: Giant lymph node hyperplasia: Persistence of symptoms for 15 years. Cancer 1982; 49:748-750
- Weisenburger DD, De Gowin RL, Gibson DP, Armitage JO: Remission of giant lymph node hyperplasia with anemia after radiotherapy. Cancer 1979; 44:457-462
- Wong SL, Rao U, Takita H: Angiofollicular lymph node hyperplasia. NY State J Med 1977; 77:2220-2223
- Yu G, Carson JW: Giant lymph node hyperplasia, plasma-cell type, of the mediastinum, with peripheral neuropathy. Am J Clin Pathol 1976; 66:46-53