SHORT COMMUNICATION

ANGIOLYMPHOID HYPERPLASIA WITH EOSINOPHILIA (ALHE) VERSUS KIMURA'S DISEASE : CHANGING CONCEPTS

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The clinico-pathological differences between Kimura's angiolymphoid hyperplasia with eosinophilia are presented to emphasize that they are two separate disease entities which until now were considered as the same disease.

Key words : Kimura's disease, Angiolymphoid hyperplasia with eosinophilia

Introduction

Kimura's disease (KD) is a rare disease of unknown aetiology. The disease affects the subcutaneous tissues, major salivary glands, and lymph nodes, chiefly in the head and neck region. It is often accompanied by peripheral blood eosinophilia and elevated serum IgE. [1-4] Angiolymphoid hyperplasia with eosinophilia (ALHE) is characterized by multiple, small dermal papular or nodular eruptions, which occur in older patients and have a shorter duration. They are less frequently associated with peripheral eosinophilia.[1-4] The two terms have been used interchangeably in the earlier Indian literature. [5-7] Current evolving concepts suggest that the two conditions are distinct entities. We present two cases, each representing either of the two conditions and the relevant differentiating features to help in diagnosing them.

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Case Reports

Case 2: A 32 -year-old-male presented with a subcutaneous nodule on the outer canthus of eye, which

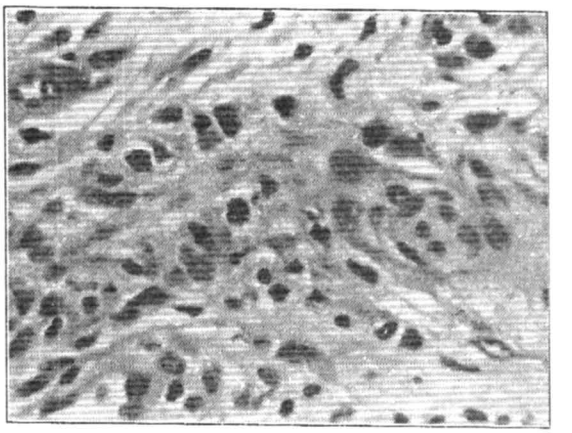

Fig. 1. ALHE: Higher magnification showing "histiocytoid" like endothelial cells (H&E X250).

grew rapidly and attained the size of 3x 2cm. The swelling was freely mobile, and non-tender. Eosinophilia in the peripheral blood was present. An incisional biopsy was performed with a provisional diagnosis of basal cell

carcinoma. Microscopy revealed lymphoid follicles in

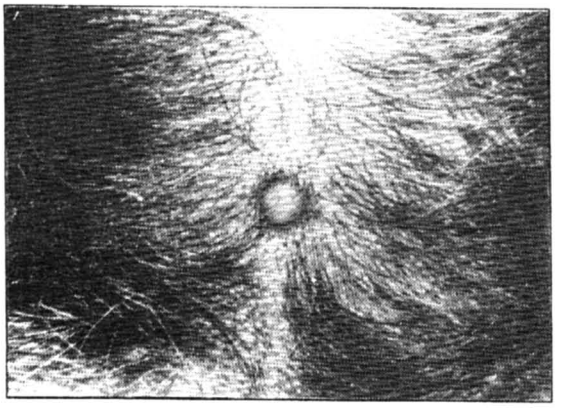

Fig.2. Nodular swelling over scalp

the deep dermis and subcutaneous tissue. Some of the lymphoid follicles had active germinal centers with infiltration of lymphocytes, plasma cells and cosinophils,

Table I. Clinicopathological comparison of Kimura's disease and Angiolymphoid hyperplasia with eosinophilia

Clinico-pathological features	Kimura's Disease	Angiolymphoid hyperplasia with Eosinophilia
Clinical features :		
Age of onset.	Younger age	old people
Duration of Disease	Longer	Shorter
Clinical appearance	Deep seated large soft tissue mass	Multiple small dermal papular or nodular eruptions
Overlying skin	Normal	Normal or ulcerated
Blood Eosinophilia	++	+/-
Lymphadenopathy	+/-	+/-
Elevated Serum IgE	+/-	-
Blood vessels	Thin walled	Thick walled and concentric
Plump histiocytoid endothelial cells	-	++
Lymphoid follicles with active germinal centers	+	+/-
Folliculolysis by eosinophils and lymphocytes	++	-
Fibrosis	+	-

+ = Present
- = Absent

causing partial destruction. Interfollicular areas also showed proliferation of thin walled small blood vessels and fibrosis (Fig.1). It was diagnosed as Kimura's disease. There was no recurrence after a follow up period of one year.

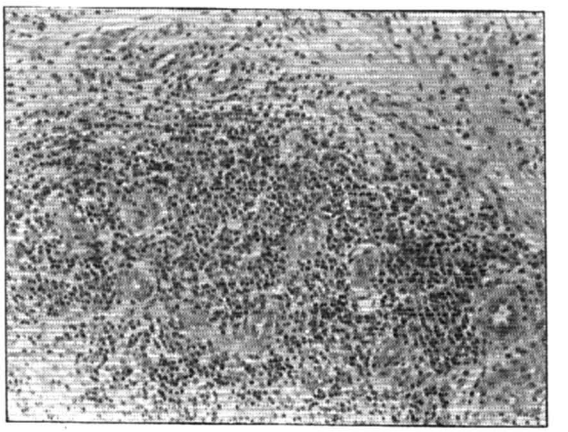

Fig.3. ALHE: thick walled vessels with prominent lymphoid follicles. (H & E X 125).

Case 2: A 55-year-old woman presented with multiple swellings on the scalp (Fig. 2), face and neck for the past 3 months which were progressively increasing in size and were non tender. No blood eosinophilia was present. An excisional biopsy of neck nodule revealed histological picture similar to the above case, with the important morphological difference of presence of thick-walled blood vessels and prominent plump "histiocytiod" endothelial cells (Fig 3). Lymphoid follicles with active germinal centers were seen but the eosinophilic infiltration was not marked. A diagnosis of ALHE was made. Injections of triamcinolone acetonide (40 mg) were given intramuscularly at interval of three weeks. A total of just three injections were given, as there was no recurrence thereafter during the following year.

Discussion

Kimura's disease was first described in China by Kim and Szeto in 1937 as an angiolymphoid proliferative

disorder of soft tissue.[2,3] It is very similar to ALHE but is no longer used synonymously.[4] Features common to both include male predominance as seen in Case-I, predilection for head and neck (both our cases) and infiltration in dermis by lymphocytes and eosinophils. The differences between the two entities are shown in table -I.

The histiogenesis of the lesion is still obscure and it is thought to be chronic inflammatory condition of unknown etiology.[1] The demonstration of granular deposits of IgA and C3 around small blood vessels suggests an immune reaction.[8] The vascular proliferation may be so bizarre that it may even mimic angiosacrcoma.[9] The multicentric form of both Kimura's disease and ALHE runs a benign course. The neoplastic nature of these lesions is still debatable as they regess with corticosteroid therapy though our patient has been free of disease for the last one year. It is important to differentiate between the two diseases so as to know about the course of the disease and it's prognosis.

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