

Cavitation of mesenteric lymph nodes without celiac disease

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A 49-year-old female, who suffers from insulin dependent diabetes, presented with a 6-month history of central post-prandial abdominal pain, associated with weight loss and occasional bloating. There were no other related abdominal or bowel symptoms. Clinical examination revealed no general features of note, but the presence of a central, easily palpable abdominal mass, the size of a small orange. The mass was partly mobile, non-tender and non-pulsatile. A range of hematological and biochemical investigations were all normal, as was autoimmune profile. Only serum magnesium was slightly low at 0.67 mmol/L (0.8-1). Abdominal ultrasound demonstrated a rounded soft tissue mass to the left of the umbilicus with computed tomography scanning, showing the presence of internal calcification. A small bowel enema was normal as was gastroscopy while a small bowel biopsy showed a normal villous pattern. A provisional diagnosis of intestinal lymphoma was initially made and laparotomy was carried out. A solid well-circumscribed entirely white mass measuring approximately 7 cms in diameter was present at the root of the small bowel mesentery; the small bowel appeared otherwise normal. There was no other abnormal finding in any of the other abdominal viscera and no lymphadenopathy. The mass was removed entirely, without compromising the blood supply of the adjacent small bowel and the patient made an uneventful recovery. On macroscopic assessment, the mass was formed of thick walled cyst 7x6x6.5 cm containing white chalky material with a wall up to 1.8 cm thick, and the cavity is up to 5 cm in diameter (Figure 1). Two possible lymph nodes measuring 2 cm and 1 cm are attached to one pole, the larger of these also having a central cystic cavity. Histological assessment showed that the wall is formed of poorly cellular fibrous tissue with extensive collagenisation and hyalinisation. Collection of chronic inflammatory cells, including plasma cells were scattered through the fibrous with hemosiderin-laden macrophages and lymphocytes. The central portions were necrotic. An attached lymph node showed reactive changes only. There was no evidence to suggest tuberculosis, and stains for amyloid were negative.

The cavitation of mesenteric lymph nodes is a rare complication of coeliac disease that was reported in a series of 17 cases in total.¹ All articles and case reports quoted on Medline, containing the text word cavitation of mesenteric lymph node were



Figure 1 - Cavitation of mesenteric lymph node

reviewed. From our extensive search, cavitation of mesenteric lymph nodes without coeliac disease has not been reported in the English literature. The gross and histological appearance of the mesenteric lymph node in our case matched those associated with coeliac disease. These included enlarged lymph node with central cystic cavitation containing white chalky material. However, there was no evidence of malabsorption or splenic atrophy in our patient to suggest coeliac disease. Coeliac disease was excluded by a normal small bowel mucosa biopsy, negative results of anti-glidian, anti-reticulin and anti-endomysial tests. The pathogenesis of mesenteric lymph node cavitation is unclear, but it has been suggested that damaged intestinal mucosa antigenic bombardment of the immune system over a prolonged period, causing depletion of the cellular components of the lymph node, and so cavitation.² It is possible with the increased use of imaging techniques in the diagnosis of intestinal disease, that more cases of this kind will be recognised.

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