Epithelioid Hemangioma (Angiolymphoid Hyperplasia With Eosinophilia) Of Left Supraclavicular Lymph Nodes: A Case Report

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Abstract: Background: Angiolymphoid hyperplasia with eosinophilia (AHE) is a benign process of unknown origin that tends to mainly affect the skin and subcutaneous tissue. A case is presented of AHE arising in a lymph node in the absence of dermal or subcutaneous involvement. The unusual location and histologic characteristics of the lesion prompted an initial diagnosis of lymphoma . Follow-up and review of the biopsy at a later date disclosed the characteristic features of AHE. The present case illustrates the ubiquitous nature of this process. AHE should be included in the differential diagnosis in lymph nodes showing effacement of their architecture by a diffuse, predominantly eosinophilic cellular infiltrate. [Mohammed A SEAJCRR 2017; 6(1):21-22]

Key Words: Hemangeoma, Lymph Nodes, Supraclavicular

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Case presentation: Thirty year old male without significant past medical history presented with few weeks history of painless left supraclavicular swelling. No other relevant history.

By examination there is 3*3 cm firm, non tender and mobile left supraclavicular swelling with no skin changes over it. Laboratory test were within normal.
CT scan showed multiple left supraclavicular lymph nodes with largest one 53*43 mm .The stomach was empty with mild increment of circumferential wall thickness. FNAC of swelling showed highly atypical cells suspicious for malignancy. Excisional biopsy showed Epithelioid hemangioma (angiolymphoid hyperplasia with eosinophilia).

Discussion: Angiolymphoid hyperplasia with eosinophilia is a benign, self-limited condition of uncertain origin most commonly observed in the dermis, subcutaneous , and mucous membranes but that has also been described in skeletal muscle, salivary glands, bone, and orbit. The histogenesis of this lesion is still a matter of debate, and, although it has been regarded by most authors as a hyperplastic, reactive process, a neoplastic angiogenic mechanism has been proposed by others. Histologically, AHE may present with a spectrum of changes that may vary, depending on the stage of development of the lesions. In cases of lesions of long duration, such as in those situated deeper in the subcutaneous tissue, a tendency for the formation of well-defined lymphoid follicles has been observed, whereas in cases showing the earlier stages of the process the lymphoid infiltrates may be minimal and will be neither nodular nor associated with reactive germinal centers.The degree of eosinophilia may also be quite variable,

Regional lymphadenopathy in association with AHE has been well recognized. However, histologic evidence of primary involvement of lymph nodes by this process has not been documented. The development of regional lymphadenopathy in patients with AHE has generally been regarded as a reactive phenomenon rather than involvement of the nodes by the primary disease process. The cases reported as "eosinophilic granulomas of lymph node and soft tissue" in China by Chang and Chen may represent an instance of such a reactive phenomenon as is attested by the lack of an endothelial proliferating component in their lesions.

A similar case to the one described here was reported by Wright and associates in a patient who presented with AHE simulating inguinal lymphadenopathy. However, the superficial location of the lesions and the absence of a subcapsular sinus led these authors to conclude that the lesions had originated in the subcutaneous connective tissue and came to resemble lymph nodal tissue as a result of the marked proliferation of lymphoid follicles.

Involvement of a lymph node by AHE as the initial form of presentation in the absence of dermal or mucosal involvement as illustrated by the present case introduces yet another element in the differential diagnosis. The partial or total effacement of the nodal architecture by sheets of small lymphocytes, eosinophils, and plasma cells in association with the presence of broad bands of connective tissue may create a histologic picture that closely resembles Hodgkin's disease. Attention should be focused in such instances on the vascular component of the lesion, and a search should be made for the

characteristic changes in the vessels that constitute one of the hallmarks of this process. The benign nature of this disease makes it of importance to distinguish nodal involvement by AHE from other inflammatory and neoplastic conditions amenable to specific therapy. The ubiquitous nature of this process has been previously emphasized by Rosai, who postulated that AHE is not a disease limited to the skin, subcutaneous tissue, and mucosal membranes, but rather one that can also occur at most sites where vessels are present. AHE should thus be added to the list of conditions included in the differential diagnosis in cases of eosinophilic lymphadenopathy.

Conclusion: Angiolymphoid hyperplasia with eosinophilia (AHE) presented as left supraclavicular lymphadenopathy is rare condition that should be considered in case of lymphadeopathy for proper evaluation and management.

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