Retroperitoneal pararenal Castleman's disease

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A 28-year-old man with no significant medical history presented with a 3-week history of abdominal discomfort and dyspepsia. No associated fever, vomiting, or localized abdominal pain occurred. Physical examination, routine hematologic, and blood biochemistry were normal. The patient was HIV 1-2 negative. CEA and CA 19-9 were in the normal range. Abdominal x-ray was considered normal, whereas upper gastrointestinal endoscopy revealed gastritis. Abdominal ultrasonography demonstrated a hypoechoic retroperitoneal mass, with 65 mm in size and with regular contour in the left anterior pararenal space. Computed tomography (Fig 1) was performed. At laparotomy, a 6 × 5-cm solid mass was found near the hilum of the left kidney (Fig 2). Through a midline abdominal incision, the mass was found near the hilum of the left kidney. However, it was not in contract with the kidney vessels. We performed complete resection of the mass and regional lymphadenectomy. Histologic examination of resected lesion revealed a hyaline-vascular type of Castleman's disease. The patient had an uneventful postoperative course, without any signs of sequelae or recurrence 3 years after the operation, on follow-up ultrasound examination.

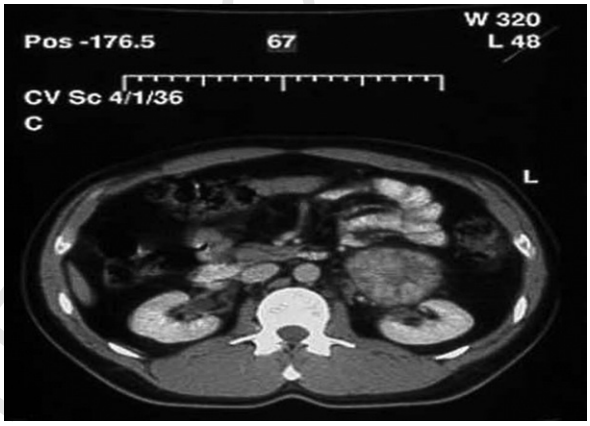

Fig 1. Computed tomography shows a retroperitoneal mass near the hilum of the left kidney.

COMMENTS

Differential diagnoses of such retroperitoneal lesion include benign or malignant neoplasms, cysts, hematomas, and abscesses, which arise from the kidney, pancreas, adrenal gland, stomach, spleen, retroperitoneum, and small and large intestine. Benign retroperitoneal tumors are relatively uncommon, comprising only about 20% of all primary retroperitoneal neoplasms, whereas the major malignant neoplasms found in the retroperitoneum are soft tissue sarcomas, vascular tumors, and lymphomas.[1]

Castleman's disease, or angiofollicular lymph node hyperplasia, is a relatively rare disorder characterized by the benign proliferation of lymphoid tissue related to chronic human herpes virus 8 infection.[2] Three basic histopathologic subtypes have been described: hyaline-vascular, plasma cell, and mixed variant.[3] Two clinical entities have also been described: a unicentric presentation with disease confined to a single anatomic lymph node, and a multicentric presentation characterized by generalized lymphadenopathy and a more aggressive clinical course.[3] Patients with localized hyaline-vascular type are usually asymptomatic, as in our case.

Abdominal ultrasonography and computed tomography are helpful in demonstrating the origin

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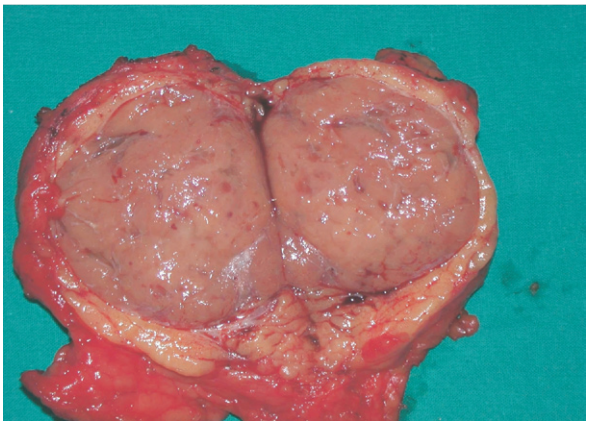

Fig 2. A cut-open specimen of the retroperitoneal mass after its removal.

of the mass. The usual appearance of this entity by ultrasonography is that of a hypoechogenic and homogenous mass with clear delimitation, whereas computed tomography may show a solid, homogenous, and well-delimited mass with microcalcifications.[4]

The standard therapy for localized, hyaline-vascular form of Castleman's disease is surgical excision, which is curative when resection is complete and en-block; the 5 years of survival is nearly 100%, and no recurrences have been reported.[5] The problem that is faced during resection is to resolve the differential diagnose between a malignant lesion and the Castleman's disease. Per-operative diagnosis by open biopsy is necessary because macroscopically it is nearly impossible to identify the diagnosis.

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