preponderance, with the male to female ratio being 10:1 to 3:1. Chondromas constitute about 72% of all cartilaginous tumors of larynx. Most common site of origin is posterior lamina of cricoid cartilage (78%), followed by thyroid cartilage (15-20%), epiglottis and arytenoid cartilage (2-5%) (Chiu and Rasgon 1996).

Laryngeal chondroma are usually slow growing and may present with slowly progressive airway obstruction if the mass is within the larynx, or gradual enlargement of neck mass if present externally. Hoarseness and dyspnoea are the commonest symptoms because of close proximity of the tumors to laryngeal airways. Rarely, they may present with dysphagia and cough besides presence of mass. Plain lateral soft tissue X-ray of neck suggests the diagnosis of laryngeal cartilaginous tumor in 75-80% of cases. CT and MRI are excellent methods to determine tumor origin, site and extent (Mata et al 1997).

Pathogenesis of the tumor is said to be due to metaplasia secondary to chronic inflammation. Histologically, the tumor is not different from normal chondroma. Behaviour of tumor is also similar. Surgical excision is the treatment of choice, with recurrence rate of about 10%.

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KIKUCHI'S DISEASE MIMICKING LYMPHOMA

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ABSTRACT : *Kikuchi's disease or histiocytic necrotizing lymphadenitis is an uncommon cause of cervical lymphadenopathy. Clinically it resembles tuberculosis or lymphoma. Although, this condition is well known to the pathologists, few ENT surgeons are aware of this entity.*

Key words : *Kikuchi, lymph node, lymphoma.*

CASE REPORT

A 27 year old female patient presented with a 5 day history of left sided neck swelling and mild fever. Although the fever subsided, the lump did not respond to antibiotics and progressed over next 2 weeks. Physical examination revealed 4x4 cm firm non tender upper deep cervical node and multiple small (1-2cm size) nodes in the posterior triangle of the left side of the neck. ENT, systemic, opposite neck, axillary and groin examination was normal. Fine needle aspiration cytology was inconclusive as only necrotic tissue was seen and chest X-ray was normal. Haematological investigations showed mild leukopenia with lymphocytosis and raised ESR. Clinical diagnosis of lymphoma was made and excision biopsy was planned. Excision biopsy of one of the posterior triangle nodes showed focal necrosis in the paracortex with abundant karyorrhectic debris. There was follicular hyperplasia in the non necrotic areas. No granulomas were seen and staining for acid fast bacilli was negative. Histological diagnosis of Kikuchi's disease (histiocytic necrotizing lymphadenitis) was made (Fig. I). The patient was reassured and no treatment was given. At 3 months follow up, she was well and the lymph nodes had resolved completely.

DISCUSSION

Kikuchi's disease was first described by Kikuchi and Fujimoto in 1972. (Kikuchi, 1972; Fujimoto et al, 1972).

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It is a rare, benign, self limiting disease of unknown aetiology affecting the cervical lymph nodes. Young adults, predominantly females are affected. Nodes are usually multiple, firm and mildly tender. Size of the nodes is usually 1-2 cm, in contrast to the large sized node seen in this case. Systemic symptoms like fever, fatigue, malaise, nausea & weight loss may be present (Nikanne et al, 1997; Garcia et al, 1993; Jayaraj et al, 1999). Most of these cases are clinically diagnosed as tuberculosis due to 2-4 weeks history of the neck swellings & systemic complaints. Acute onset of symptoms, progressive enlargement and the large size of the node, in our patient, prompted us to make the diagnosis of high grade lymphoma.

Mild neutropenia with lymphocytosis is seen in 50% of the cases. ESR is usually not raised, in contrast to our case (Kikuchi 1972). Diagnosis is based on the histopathological examination of the lymph nodes. Characteristic histologic features are patchy areas of

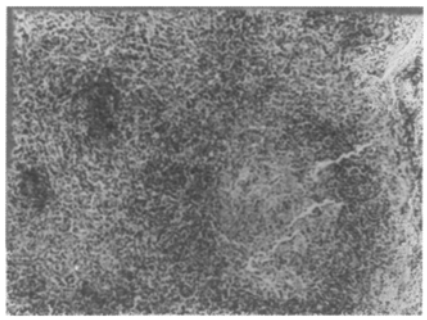

Fig. 1 : Section of lymph node showing large areas of necrosis with nuclear debris and absence of inflammatory cells. Haematoxylin and eosin x 120.

necrosis confined to the paracortical & cortical areas with karyorrhectic and karyolytic debris, and virtual absence of neutrophils. Areas of necrosis are surrounded by atypical mononuclear cells (plasmacytoid T-cells, phagocytic macrophages and foamy histiocytes). Plasma cells are sparse/absent. Rest of the lymph node usually contains immunoblasts. Histological differential diagnosis includes large cell NHL and lupus lymphadenitis (Unger et al, 1987; Chamulak et al, 1990).

The natural course of the disease is that the lymphadenopathy resolves spontaneously within a few weeks to few months (Kikuchi 1972). Small number of patients may develop systemic lupus erythematosis and therefore some clinicians suggest that long term follow up is needed (Dorfman & Berry 1988). There is no specific treatment for this disease. Symptomatic treatment with non-steroidal anti-inflammatory drugs is all that is needed. Severe systemic symptoms may require corticosteroids and immunosuppresive drugs. Our patient was not given any treatment and lymph nodes resolved completely in 3 months.

CONCLUSION

Kikuchi's disease should always be considered in the differential diagnosis of cervical lymphadenopathy especially in young females, to save the patient from unnecessary investigations and treatment. This case report is an endeavour to increase the awareness of this disease amongst the Otolaryngologists.

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