中文題目：巨大頸部淋巴結-感染性單核球增多症非典型表

英文題目：Massive Bilateral Cervical Lymphadenopathy-Atypical Presentation of Infectious Mononucleosis

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Abstract

Introduction

Patients with infectious mononucleosis most commonly present with a triad of fever, lymphadenopathy, and pharyngitis. However, an atypical clinical presentation occasionally results in a lymph node or tonsillar biopsy. The morphological features of Epstein–Barr virus (EBV)-infected lymphoid tissue can easily mimic lymphoma. Here, we present a case of massive cervical lymphadenopathy mimicking lymphoma using tools with tissue biopsy to diagnose infectious mononucleosis.

Case report

A 19-year-old man, a university student, presented to our hospital with progressive bilateral neck swelling with fever for one month, also complained of headache, general malaise with decreased appetite. Besides, insidious onset of painless swelling was noted on bilateral side of neck (right > left). He denied weight loss, night sweats, smoking habits, chewing betel nuts, travel history, animal exposure nor unprotected sexual behavior.

The predominant neck mass on right side (about 5x5 cm) was noted associated with tenderness, poor margin, poorly mobile, mild erythematous change without local heat nor open wound. The laboratory test data showed lymphocytosis (61%) with atypical lymphocytes (30.8 %), thrombocytopenia (103k/uL), acute hepatitis (AST: 219 U/L, ALT: 249 U/L) and elevated biliary tract enzymes (T-Bil: 1.7 mg/dL, ALK-P: 460 U/L). EBV IgG Ab was positive on viral markers (negative HIV, negative CMV) with positive EBV PCR load (7.83E3 EBV DNA copies/mL). Abdominal ultrasonography also revealed splenomegaly compatible with physical examination's finding. Nasopharyngeal biopsy via fiberscope was then performed and infectious mononucleosis was diagnosed from pathological report. The regressive lymphadenopathy was noted 3 weeks after admission with supportive care,

Discussion and Conclusion

The lymphadenopathy in infectious mononucleosis often peaks in the first week and then gradually subsides over two to three weeks. In this case, the cervical lymphadenopathy persisted for over 1 month, raising the possible differential diagnosis such as malignancy or abscess formation despite lack of clinical evidence from history nor physical examination. Further diagnostic tools including imaging

with head and neck computed tomography and tissue biopsy were then employed. In conclusion, clinical course of our case highlights the clinical dilemma in differential diagnosing between infectious mononucleosis and lymphoma. Besides thorough history taking and physical examination, further diagnostic tools including computed tomography and tissue biopsy with EBER in situ hybridization and CD markers should be exploit. To our knowledge, this case report is by far associated with the largest cervical lymphadenopathy in infectious mononucleosis. This better understanding of atypical presentation of infectious mononucleosis may help to avoid misdiagnosis with lymphoma.