Communications to the Editor:

Cardiac Tamponade Secondary to Giant Lymph Node Hyperplasia: Castleman's Disease

To the Editor:

We read with great interest the case report by Nicolosi et al., which appeared in the February 1994 issue of Chest, concerning the association of giant lymph node hyperplasia (Castleman's disease) and cardiac tamponade. The authors report a case of multicentric Castleman's disease of mixed histologic type in a patient with massive pericardial effusion. While pericardial effusion has been previously reported in conjunction with Castleman's disease, the association of cardiac tamponade with this disorder is a rare phenomenon. We too have recently treated a patient with multicentric giant lymph node hyperplasia of the plasma cell type. However, the clinical course of our patient was marked with rapid deterioration and death within 10 months after diagnosis.

In sharp contrast to Dr. Nicolosi's statement that "... surgical excision ... is uniformly curative ..." and "... the disease is not considered premalignant ...," a careful review of the literature shows that surgical extirpation is curative only in the "localized" type of Castleman's disease and not always possible in the multicentric form. In a clinicopathologic study of 16 cases, Weisenburger et al. reported a median survival of 26 months (range, 8 to 170 months). They also noted development of malignant lymphoma in four of their patients (25%), an association that has also been reported by others.

Further, since histologic findings of Castleman's disease are nonspecific, diagnosis can only be made when other causes of lymphadenopathy, including acquired immune deficiency syndrome (AIDS), is investigated and excluded. While the localized type of Castleman's disease is often amenable to surgery, the management of the multicentric variety—the subject of the case report—is not clear. Though a variety of chemotherapeutic regimens have been used, as yet none have consistently been effective. The role of surgery in disseminated disease, however, is limited to local relief of symptoms and treatment of organ compromise. In view of its premalignant potential, we believe this clinical entity requires close and long-term observation for neoplastic transformation.

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REFERENCES


To the Editor:

We appreciated very much the comments of Drs. Shahidi and Kvale regarding our case report, “Cardiac Tamponade Secondary to Giant Lymph Node Hyperplasia (Castleman’s Disease)” (Chest 1994; 105:637-39). Since this report was published, we too have become aware of the literature that suggests the striking clinical and prognostic differences between the localized and multicentric forms of Castleman’s disease. It is also now apparent that other diseases or syndromes can, at certain stages of their course, exhibit lymph node changes very similar to Castleman’s disease. In fact, many of these other entities, including AIDS, are associated with the development of malignant changes such as Kaposi’s sarcoma and lymphoproliferative states. Drs. Shahidi and Kvale make the point that the diagnosis of multicentric Castleman’s disease can only be made when these other entities are specifically excluded. In light of these facts, one must question whether the localized and multicentric forms of Castleman’s disease actually represent variants of the same disease state. Since its etiology is unknown and both the histologic and clinical patterns of the multicentric form are nonspecific, perhaps the name of “Castleman’s disease” should not be applied to the multicentric form until it can be definitively linked to the localized variant, which seems better defined in both the histologic and clinical sense. As far as our patient is concerned, she continues to do well.

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To the Editor:

Regarding the article by Harland et al. and our Communications to the Editor, Dr. Victor L. Roggli brought to my attention...