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4.5 × 3.0 cm, situated under the pectoralis major muscle [Figure 1]. Mammography did not show any lesion in breast parenchyma and fine needle aspiration cytology (FNAC) of the mass was inconclusive. The patient was submitted to excision of the nodule and during surgery, the lesion was found to be interpectoral. Gross examination of the specimen revealed a lesion measuring 4.3 × 3.5 × 3.1 cm with an undulated, gray external surface and a compact, whitish-gray cut surface. Histology revealed an altered lymph node architecture resulting from follicular lymphoid hyperplasia, most of the follicles presenting central capillaries with a deposit of hyaline material, surrounded by small, uniform, mature lymphocytes, forming concentric circles, all of which characterize the hyaline-vascular variant of Castleman’s disease [Figure 2]. Serology for HIV was negative and diseases like lupus, rheumatoid arthritis, and lymphoma were excluded.

Castleman’s disease is a rare, benign form of hyperplasia affecting lymphoid tissue. Its etiology is unknown; however, hyperplasia or hamartomatosis resulting from chronic inflammation has been suggested.[4] The majority of the multicentric cases are of the plasma cell variant, the type that is more frequently associated with malignancy and significant morbidity and mortality.[2,3] The hyaline-vascular form on the other hand, is the most common variant, usually unicentric, generally affecting the abdomen and mediastinum and is associated with local compressive clinical symptoms, rarely presenting systemic manifestations.[1-4] However, interpectoral location mimicking mammary gland neoplasia has not yet been reported.

The diagnosis of Castleman’s disease is based on clinical and histopathological criteria. [1,2] The principal differential diagnoses, depending on the localization, include tuberculosis, lymphadenitis, lymph node metastasis, lymphoma, and other neoplasia.[1-4] Treatment of the unicentric forms of the disease, both the hyaline-vascular and the plasma cell variants, consists of surgical resection of the lesion. Patients are cured in almost 100% of cases and there are few recurrences.[2,3] In the present case, the patient is being followed-up and there are no signs of recurrence in 2 years following the treatment.

References


Bacterial endocarditis due to Group C streptococcus

Sir,

*Streptococcus dysgalactiae* subsp *equisimilis* (GCSDE) which occurs as normal human flora, is found in approximately 2-6% of cases of pharyngitis but rarely causes serious infections.[1] Endocarditis caused by GCSDE is infrequently reported and it is associated with a high mortality rate. A 35-year-old male with a bicuspid aortic valve, was admitted with fever of one week duration, arthralgia, dyspnea and chest pain. On physical examination, his blood pressure was 160/50 mm Hg, his pulse rate 120 per min and body temperature was 100°F. Pallor, splenomegaly, petechiae and unilateral scrotal swelling with desquamation were
also noted. His white blood cell count was 12,400 cells/mm³ with 86% neutrophils, 10% lymphocytes and 4% eosinophils. The hemoglobin level was 14.0 g/dl, the platelet count was 1,10,000/mm³ and erythrocyte sedimentation rate was 32 mm for 1 h. The electrocardiogram revealed sinus tachycardia, incomplete left bundle branch block and left ventricular hypertrophy (poor R-wave progression and ST-T interval abnormalities). The transthoracic echocardiogram demonstrated a large vegetation attached to the left ventricle and mild aortic stenosis. Three samples of blood were drawn for culture after which antibiotic treatment was started which consisted of intravenous regimen of penicillin G (4 x 10⁶ IU every 6 h) and gentamicin (80 mg twice daily).

Blood cultures processed by standard protocols grew beta hemolytic streptococci which was serogrouped as a Group C streptococcus using specific antisera by latex agglutination tests (Remel Diagnostics Europe). The isolate was identified as Streptococcus dysgalactiae subsp equisimilis using the Rapid ID 32 Strep System (BioMerieux, USA).

Antimicrobial susceptibility testing was performed by the Kirby-Bauer disc diffusion method according to CLSI (formerly NCCLS) recommendations. The isolate was found to be susceptible to penicillin G, ampicillin, ceftriaxone. The patient responded well to treatment with penicillin and gentamicin and was afebrile within 72 h after initiation of therapy. Antibiotic treatment was continued for four weeks. The blood cultures were negative when repeated after four weeks. The patient had an uneventful recovery and was discharged from hospital.

Streptococcus dysgalactiae subsp. equisimilis can colonize the throat, skin and the genitourinary tract. From these sites, the organisms frequently invade soft tissue and other deep structures. Endocarditis due to GCSDE is an infrequent clinical entity and the predisposing conditions are rheumatic heart disease, bicuspid aortic valve, mitral valve prolapse, congenital heart disease (as in this case), calcific aortic stenosis and aortic valve insufficiency. Endocarditis due to Streptococcus dysgalactiae subsp. equisimilis infections has been reported in the literature. This patient had a congenital heart disease in the form of a bicuspid aortic valve. However, we were unable to identify the source of infection. Mohanty et al., has reported Group C streptococcal bacteremia in a patient with aplastic anemia without endovascular involvement. To the best of our knowledge, this is the first report of Streptococcus dysgalactiae subsp. equisimilis endocarditis from India.

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