Clinical History
This 44 year old woman presented to the Emergency Room with a two month history of headaches, dizziness and gait instability.

The patient had a long history of intermittent episodes of fevers with lymphadenopathy that started when she was 15 years old. An enlarged left axillary lymph node was biopsied and read as "reactive/benign adenopathy". At age 25 she developed right cervical adenopathy area which was also biopsied and found to be "reactive/benign". Throughout her adolescence and young adult life, she developed multiple upper respiratory tract infections, and was found to have hypogammaglobulinemia, treated intermittently with IV immunoglobulins.

At age 41 she developed persistent fevers and night sweats and was found to have hypermetabolic retroperitoneal and mesenteric lymph nodes on CT/PET scans. Flow cytometric analyses of lymph node and bone marrow were negative for lymphoma. The lymph node biopsy showed "non-specific/reactive lymphadenopathy". She opted for a second opinion/evaluation. Laparoscopic biopsy of periaortic nodes showed "focally necrotizing lymphadenopathy, negative for malignancy or infection". She also developed a skin rash that was biopsied and diagnosed as “lichen simplex chronicus”. She was evaluated by Rheumatology and diagnosed with a specific rheumatological disease. She started treatment with hydroxychloroquine and prednisone with improvement of her symptoms. However the patient discontinued her medications two months before the current admission because she was gaining weight. She also had problems getting IV immunoglobulins due to problems with her insurance coverage. Her last treatment was 2 months prior to the current admission.

In addition to her chief complaints of headaches, dizziness and poor balance, she also reported mild gradual decrease in vision, fatigue, and anxiety about her condition. She was afebrile. An MRI revealed a 28 x 23 mm avidly enhancing, intra-axial lesion within the right occipital lobe with surrounding T2 prolongation. Clinical laboratory tests were normal except for low IgA and IgM levels. The patient underwent excisional brain biopsy.

Material Submitted
H&E stained section
Virtual Slide (click here)
Points for Discussion
1. Differential Diagnosis
2. Follow-up