



Kimura's disease: A diagnostic dilemma



Fig. 1. Pre-treatment image showing right-sided face and parotid region painless and progressively increasing swelling (arrow).

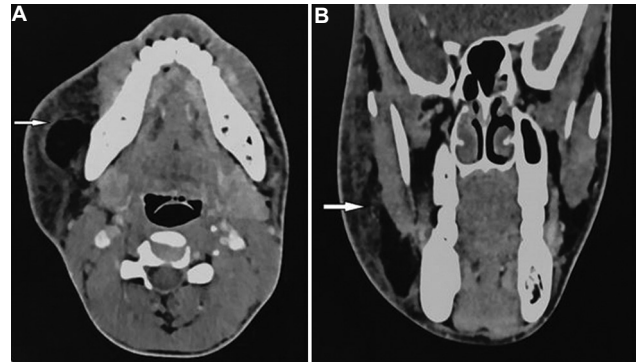


Fig. 2. Axial (A) and coronal (B) contrast-enhanced computed tomographic scan images showing subcutaneous oedema and fat reticulations (white arrows) in the right parotid region with an irregular outline of the right parotid gland.

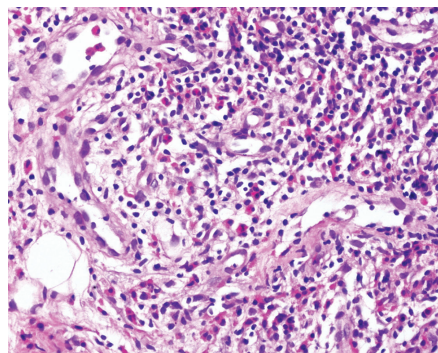


Fig. 3. Core biopsy showing fibroadipose tissue with lobules of inflammatory cells, *i.e.* lymphocytes, eosinophils and interspersed small vascular channels lined by plump endothelial cells, suggestive of angiolymphoid hyperplasia with eosinophilia (H and E, ×40).

A 19 yr old male[†] patient presented to the Surgical Oncology outpatient department, All India Institute of Medical Sciences (AIIMS), New Delhi, India, in December 2018, with the chief complaints of painless progressive swelling of right-sided face for

seven years. On clinical examination (Fig. 1), there was a solitary large soft cystic swelling measuring 16 ×16 cm in the right parotid region. Computed tomographic scan revealed subcutaneous oedema and fat reticulations in the right parotid region

[†]Patient's consent obtained to publish clinical information and images.

(Fig. 2). Core biopsy histopathology was suggestive of Kimura's disease (KD)/angiolympoid hyperplasia (Fig. 3). The patient was treated with neoadjuvant radiotherapy (50.4 Gy, 28 fractions, six weeks) followed by surgical excision of the mass lesion and superficial parotidectomy with pectoralis major myocutaneous flap reconstruction. Final specimen histopathology rendered lymphoid hyperplasia. After nine months of follow up, the patient was disease-free.

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Conflicts of Interest: None.

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