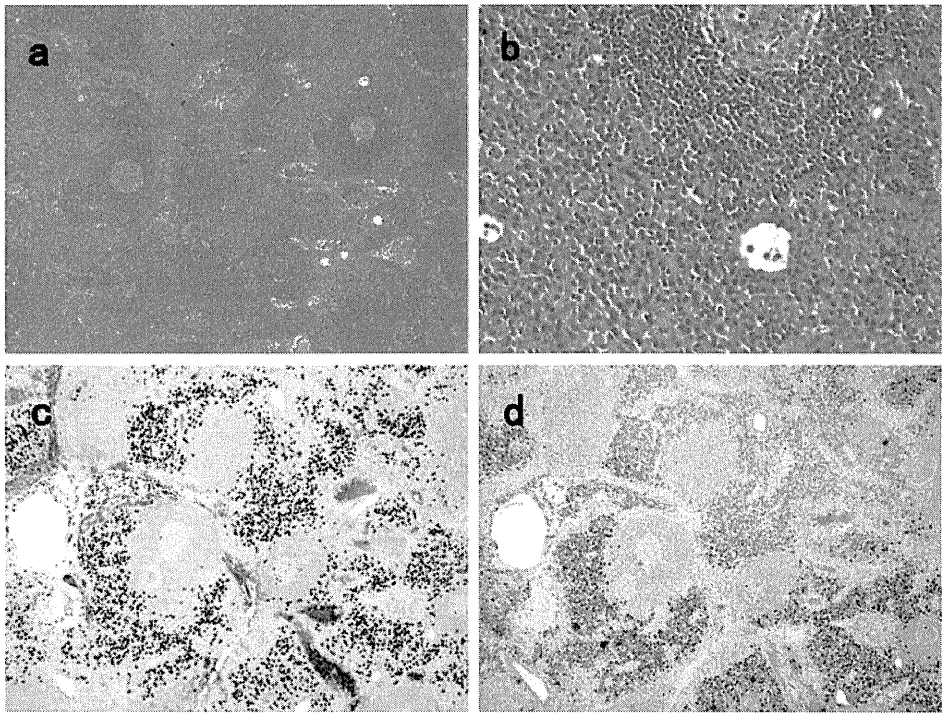

Figure 2 Histopathological findings of patient no 2. Small germinal centres and expansion of the interfollicular area were observed (A). Sheets of proliferating mature plasma cells were observed in the interfollicular area (B). (C) Immunostaining of IgG4. Immunostaining of (D) IgG. The IgG4-/IgG-positive cell ratio was 54.7%. The serum IgG4 level was elevated, but the serum IgG4/IgG ratio was not increased. (A, B) H&E staining; (A) ×40, (B) ×200, (C, D) ×40.

Interestingly, patient no 6 showed a good response to anti-human IL-6 receptor monoclonal antibody (tocilizumab), with disappearance of lymph node swelling and multiple lung nodules. Therefore, the case of this patient was considered to be that of a hyper-IL-6 syndrome, that is, MCD.

Patient no 1 showed an increased IgG4-/IgG-positive cell ratio, but serum IgG4 level was not elevated. Thus, this case indicated that the IgG4-/IgG-positive cell ratio and serum IgG4 level are not always correlated.

According to recently reports, IgG4-related diseases are characterised by elevated serum IgE level and eosinophil infiltration in the affected tissue,[8 16 19 26] probably due to upregulated T helper 2 (Th-2) cytokine production.[27] In our series, eosinophil infiltration in the affected tissue was not observed, but two patients examined showed elevated serum IgE levels. As mentioned above, IL-6 polyclonally increases Ig level [20–24] and is related to IgE synthesis.[21] Thus, we suggest that the elevated serum IgE levels in two patients were due to IL-6. Previous reports have described that serum IgE level is elevated in MCD and idiopathic plasmacytic lymphadenopathy with polyclonal hypergammaglobulinaemia.[17 18]

On the basis of immunohistochemical findings, Cheuk *et al*[9] reported the diagnostic criterion for IgG4-related lymphadenopathy to be an IgG4-/IgG-positive cell ratio of >40%.

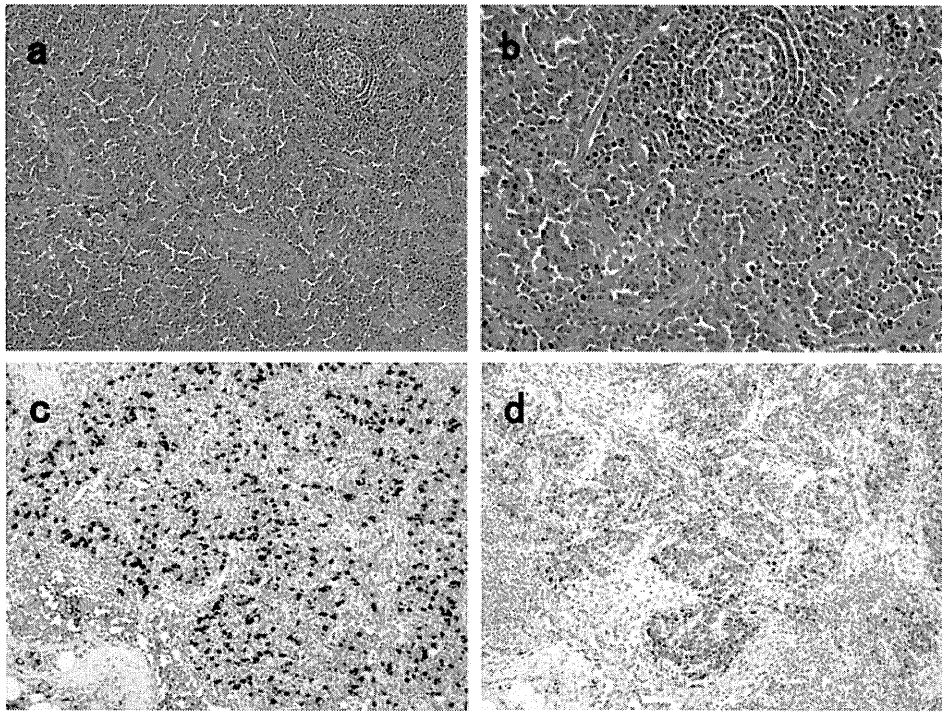

Figure 3 Histopathological findings of patient no 6. Small germinal centres, moderate increase in vascular proliferation and sheets of proliferating mature plasma cells were observed (A, B). (C) Immunostaining of IgG4. (D) Immunostaining of IgG. The IgG4-/IgG-positive cell ratio was 43.4%. The serum IgG4 level was highly elevated (789 mg/dl), but the serum IgG4/IgG ratio was only 11.5%. Moreover, a good response to tocilizumab was observed. (A, B) H&E staining; (A) ×40, (B) ×100, (C, D) ×100.

Take-home messages

- In Japan, idiopathic plasmacytic lymphadenopathy with polyclonal hypergammaglobulinaemia is considered identical to multicentric Castleman's disease (MCD).
- We examined six patients with MCD with the presence of abundant IgG4-positive cells.
- MCD and systemic IgG4-related lymphadenopathy cannot be differentially diagnosed by immunohistochemical staining alone.
- Histologically, MCDs usually showed small and regressive germinal centres, and this finding were different from IgG4-related lymphadenopathy.

However, our results of immunohistochemical staining showed IgG4-/IgG-positive cell ratios of >40% in MCD. Therefore, we concluded that in some cases, differential diagnosis of IgG4-related lymphadenopathy and MCD is difficult only by immunohistochemical staining of lymph node lesions.

Moreover, recently report have mentioned that pancreatic carcinoma and cutaneous Rosai–Dorfman disease show an increased number of IgG4-positive cells and elevated serum IgG4 level.[28–30] Therefore, it is not appropriate to diagnose IgG4-related diseases only by immunohistochemical staining.

In conclusion, MCD sometimes occurs with abundant IgG4-positive cells and elevated serum IgG4 levels. Therefore, MCD and systemic IgG4-related lymphadenopathy cannot be differentially diagnosed only by immunohistochemical staining. Clinical features and laboratory data, especially IL-6 level, CRP level and platelet count, are important for a differential diagnosis of the two diseases.

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ORIGINAL PAPER

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Immunoglobulin G4-related lymphadenopathy with inflammatory pseudotumor-like features

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Abstract Immunoglobulin (Ig) G4-related disease has been recently described. This disease affects various organs, including lymph nodes. We describe the case of a 52-year-old Japanese man with IgG4-related lymphadenopathy with inflammatory pseudotumor (IPT)-like features. Five years ago, the patient noticed a painless mass in the mandible but did not consult a doctor. Recently, he noted that the mass had increased in size and consulted an oral surgeon in the hospital. Excisional biopsy was performed for diagnosis. Histopathological examination revealed that most of the enlarged lymph node was occupied by the hyalinized tissue. A few residual lymphoid follicles with hyperplastic germinal centers and infiltration of plasma cells and eosinophils were observed. Most of the plasma cells expressed IgG4, and the ratio of IgG4-positive cells to IgG-positive cells was 57.1%. These findings were consistent with IgG4-related lymphadenopathy. In conclusion, pathologists should consider IgG4-related lymphadenopathy when diagnosing a lesion with IPT-like features.

Key words IgG4-related disease · Lymph node · Lymphadenopathy · Inflammatory pseudotumor · Histopathology

Introduction

Recently, autoimmune pancreatitis and its related disorders, such as sclerosing cholangitis, sclerosing sialadenitis (Küttner tumor), retroperitoneal fibrosis, and Mikulicz's disease, have been shown to be associated with immunoglobulin (Ig) G4-related abnormalities.[1–6] Such abnormalities include the elevation of serum IgG4 levels and the infiltration of the affected tissue with numerous IgG4-positive plasma cells. These autoimmune pancreatitis-related disorders, therefore, are classified as IgG4-related disease.[3–6] Interestingly, patients with IgG4-related disease respond well to steroid therapy, and many cases have been reported in Western countries and Japan.[1–7]

Hyalinized fibrosis is one of the specific findings of IgG4-related disease; in addition, some inflammatory pseudotumors (IPTs) are recognized as IgG4-related disease.[6] However, no detailed reports on IgG4-related lymphadenopathy with features of IPT are available.

Here, we report a case of inflammatory pseudotumor (IPT)-like IgG4-related lymphadenopathy and have described its clinical and pathological findings.

Case report

A 52-year-old Japanese man noticed a painless mass in the mandible 5 years ago, but he did not consult a doctor. He recently noted that the mass had increased in size, and he consulted an oral surgeon in the hospital. A computed tomography (CT) scan identified that the mass as a single lymph node swelling 4 × 2 cm in size. No other peripheral lymphadenopathy and no exocrine organ swelling were detected, and the patient did not have any B symptoms such as fever, fatigue, and night sweats. Lymph node excisional biopsy was performed for diagnosis.

The biopsied specimens of the lymph node were fixed in 10% formaldehyde and embedded in paraffin. Serial sections (4 μm) were cut and stained with hematoxylin and eosin and immunohistochemical stains.

Immunohistochemical staining was carried out using the BenchMark XT automated slide stainer (Ventana Medical Systems, Tucson, AZ, USA). Before the immunohistochemical

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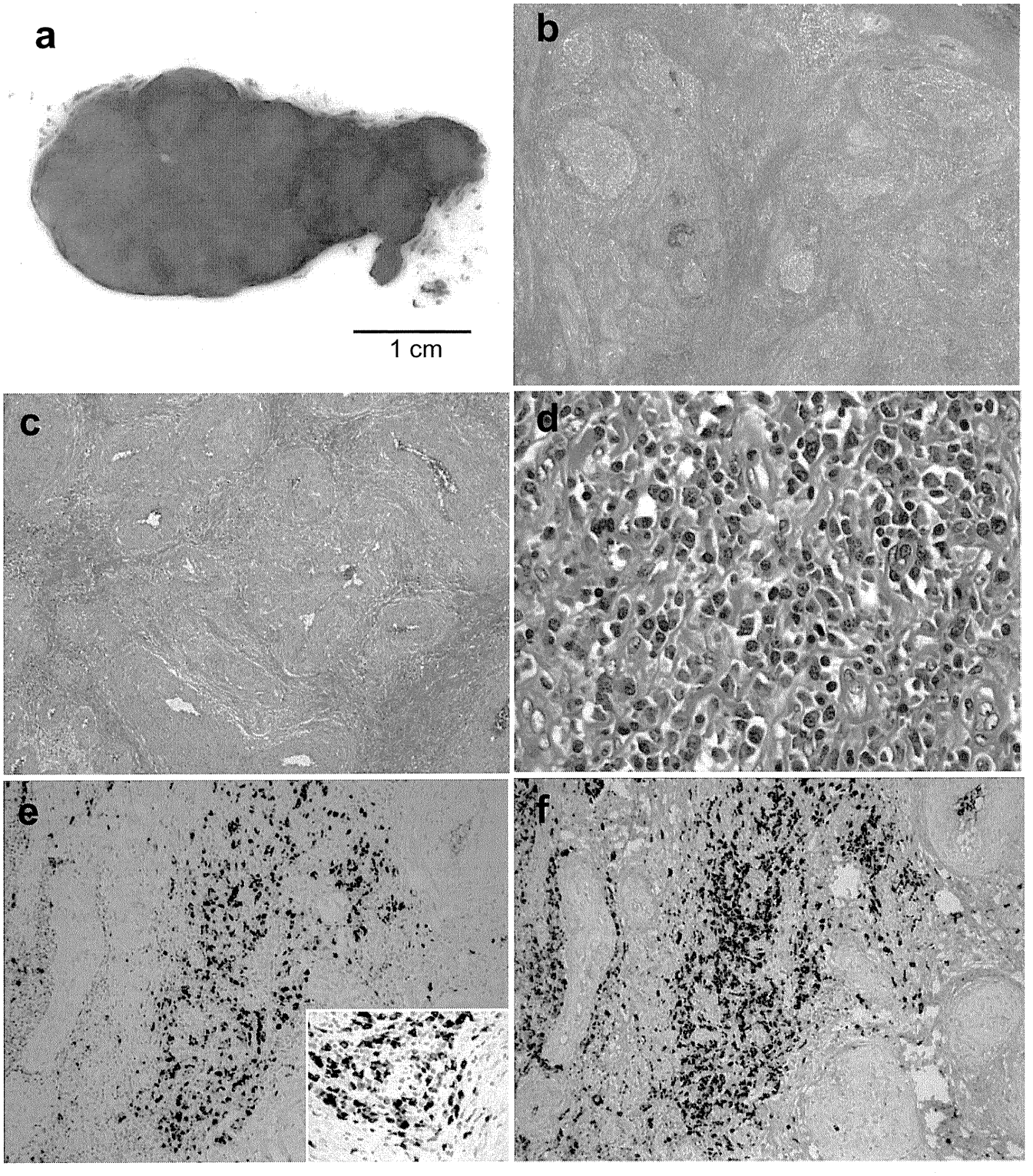

Fig. 1. **a** Most of the enlarged lymph node comprised hyalinized tissue [hematoxylin and eosin (H&E) stain, gross finding]. **b** A few residual lymphoid follicles with hyperplastic germinal centers and focally dense lymphoid infiltrate were observed (H&E stain). **c** Increased vascularity that predominantly comprised thickened vessels with perivascular fibrosis and hyalinization (H&E stain). **d** Infiltration of plasma cells, plasmacytoid cells, small lymphocytes, and eosinophils (H&E stain). Immunostaining for IgG4 (**e**) and IgG (**f**). Infiltration of many IgG4-positive cells was observed. **b** ×20; **c** ×40; **d** ×400; **e**, **f** ×100 (inset in **e**, ×400)

procedures, the tissue sections were subjected to standardized heating pretreatment for antigen retrieval. The following primary antibodies were used: cluster of differentiation (CD) 20 (L26, 1:200; Novocastra, Newcastle, UK), CD3 epsilon (PS1, 1:50; Novocastra), CD10 (56C6, 1:50; Novocastra), B-cell lymphoma (Bcl)-2 (3.1, 1:200; Novocastra), IgG (polyclonal, 1:20,000; Dako), IgG4 (HP6025, 1:400; Binding Site, Birmingham, UK), kappa light chain (kp-53, 1:100; Novocastra), lambda light chain (HP-6054, 1:200; Novocastra), and alpha-smooth muscle actin (1A4, 1:50; Dako).

The number of IgG4- or IgG-positive cells was estimated in areas with the highest density of these cells. In each section, five different high-power fields (HPFs; eyepiece, 10×; lens, 40×) were examined, and the average number of IgG4- or IgG-positive cells per HPF was calculated.[7]

Pathological findings

Microscopic findings

The enlarged lymph node was 3.8 × 2.8 cm in size (Fig. 1a). The histological findings revealed that most of the lymph node was occupied by hyalinized tissue and had increased vascularity that predominantly comprised thickened vessels with perivascular fibrosis and hyalinization (Fig. 1a–c). A few residual lymphoid follicles with hyperplastic germinal centers and focally dense lymphoid infiltrate were observed in the lymph node (Fig. 1b). Plasmacytoid cells, small lymphocytes, plasma cells, and eosinophils infiltrated the dense sclerotic tissue, with the latter two being particularly predominant (Fig. 1d).

Immunohistochemical findings

The cells that contained germinal centers and mantle zones were found to express CD20. The germinal centers expressed CD10 but not Bcl-2. CD20-positive B cells were scattered among CD3-positive T cells in the interfollicular areas. The B-cell population in both the follicles and the interfollicular areas exhibited polytypic expression of Ig light chains. The hyalinized connective tissue in the interfollicular area was negative for alpha-smooth muscle actin. The plasma cells and plasmacytoid cells predominantly expressed IgG4, and the ratio of IgG4-positive cells to IgG-positive cells was 57.1% (Fig. 1e,f). This IgG4-/IgG-positive cell ratio is consistent with IgG4-related lymphadenopathy.[6–8]

Discussion

The term IPT has been used to describe inflammatory/fibrosing tumoral processes of an undetermined cause that may involve a variety of organ systems, including the lungs, spleen, liver, skin, and soft tissues.[9–11] IPTs are clinicopathologically similar to inflammatory myofibroblastic tumors. However, recent evidence shows that inflammatory myofibroblastic tumors are actually neoplastic processes that often harbor balanced chromosomal translocations involving the anaplastic lymphoma kinase (*ALK*) gene.[11]

Concomitant lymphadenopathy is common in IgG4-related diseases. In recent times, several studies on the morphology and immunohistology of lymph node lesions have been reported.[6,7] These studies show that IgG4-related lymphadenopathy exhibits histological diversity. In addition, IgG4-related lymphadenopathy is frequently associated with clinical features of systemic lymphadenopathy such as hypergammaglobulinemia, especially elevated levels of IgG and IgE, and expression of various autoantibodies.[6,7]

The pathogenesis of IgG4-related disease remains unclear. A recent study reported that T helper (Th)-2 cytokines [interleukin (IL)-4, IL-5, and IL-13] and regulatory cytokines [IL-10 and transforming growth factor (TGF)-β] were upregulated in the affected tissue of the patients with IgG4-related diseases.[12] Th2 cytokines activate eosinophil infiltration and IgE production. Moreover, IL-4 and IL-10 induce B-cell differentiation into IgG4-positive cells, and TGF-β is a powerful fibrogenic cytokine. Although the presence of IgG subclasses in the serum was not examined in our patient, we considered that the pathological findings were consistent with IgG4-related lymphadenopathy.

Moran et al.[10] reported that IPTs of the lymph node can be histologically classified into three different stages: stage I, small nodules with partial involvement of the lymph node; stage II, infiltration of inflammatory cells and fibroblastic proliferation causing marked distortion of the lymph node connective tissue framework, including the hilum, trabeculae, and capsules, with secondary spread into the lymph node parenchyma and extranodal adipose tissue; and stage III, almost complete sclerosis of the lymph node with scant residual inflammatory elements. The histological findings in our case were similar to those of patients with stage III IPT; however, the clinical findings differed. Patients with IPT of the lymph node usually exhibit symptoms that are suggestive of lymphoid malignancy such as fever, fatigue, and night sweats.[9,10]

In conclusion, if the relationship between IPTs of the lymph node and IgG4 is examined in detail, it is possible that the lesions previously identified as IPTs of the lymph node are actually IgG4-related lymphadenopathies. Therefore, a misdiagnosis of IgG4-related lymphadenopathy as IPT should be avoided, especially in stage III, because the two diseases are clinically different.

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Review Article

IgG4-related disease: Historical overview and pathology of hematological disorders

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IgG4-related diseases comprise a recently recognized systemic syndrome characterized by mass-forming lesions in mainly exocrine tissue that consist of lymphoplasmacytic infiltrates and sclerosis. There are numerous IgG4-positive plasma cells in the affected tissues, and the serum IgG4 level is increased in these patients. The present study describes the history, autoimmune pancreatitis (AIP), IgG4-related lymphadenopathy and lymphomagenesis based upon ocular adnexal IgG4-related disease. Lymphoplasmacytic sclerosing pancreatitis, a prototypal histological type of AIP, is now recognized as a systemic IgG4-related disease. Lymph node lesions can be subdivided into at least five histological subtypes, and systemic IgG4-related lymphadenopathy should be distinguished from multicentric Castleman's disease. Interleukin-6 and CRP levels are abnormally high in multicentric Castleman's disease, but are normal in the majority of systemic IgG4-related lymphadenopathy. Ocular adnexal IgG4-related disease frequently involves bilateral lacrimal glands swelling, and obliterative phlebitis is rare. Moreover, some malignant lymphomas, especially mucosa-associated lymphoid tissue lymphoma, arise from ocular adnexal IgG4-related disease. In addition, IgG4-producing lymphoma also exists.

Key words: autoimmune pancreatitis, IgG4, lymph node, mucosa-associated lymphoid tissue lymphoma, ocular adnexa

IgG4 is a minor component of the four subclasses of IgG in serum. Sporadic examples, such as IgG4 autoantibodies present in patients with autoimmune bullous skin diseases[1–3] and deposition of IgG4 seen in membranous nephropathy,[4] had indicated that IgG4 might be pathogenetically related to some diseases. But little attention has been paid to this minor component of IgG since Hamano *et al.* found elevated serum IgG4 level in patients with autoimmune pancreatitis (AIP).[5] This was the beginning of the use of IgG4 as a serological marker for a specific disease, and nowadays serum IgG4 is acknowledged as an important serological test for making a diagnosis of AIP and other related diseases. The same group also reported that numerous IgG4-positive plasma cells were characteristically observed in pancreatic tissues with AIP.[6] This perception facilitated the identification of numerous extrapancreatic diseases that were potentially related to AIP pathogenetically, and more importantly triggered a reclassification of pre-existing entities. These diseases are now grouped together and called IgG4-related diseases, and the number of constituents in this category is still increasing.

This review article first focuses on how the concept of IgG4-related diseases emerged by reviewing the history, and debates the pathology of AIP, with special references to the lymph nodal lesion and lymphomagenesis of the ocular adnexal region.

HISTORICAL PERSPECTIVES OF AUTOIMMUNE PANCREATITIS AND IgG4-RELATED DISEASES

Pathology of AIP and its relationship to IgG4

The concept of AIP was proposed by Yoshida *et al.* in 1995.[7] According to their description and other reports mainly from Japan, AIP is common in elderly men. The chief complaint is usually mild abdominal symptoms or obstructive jaundice. Diabetes mellitus is commonly associated with this. Some patients are asymptomatic. Severe abdominal pain is exceptional. Radiologically, the affected pancreas has diffuse or focal swelling and irregular narrowing of the main pancreatic

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duct. Thus from the clinical standpoint, it is difficult to distinguish AIP from pancreatic carcinoma, and many resections had been performed for suspected carcinoma before this entity was recognized. Serology often indicated hypergammaglobulinemia, elevated IgG level and the presence of various autoantibodies, such as antinuclear antibody and rheumatoid factor. Characteristically, serum IgG4 level is often elevated. Notably, corticosteroid treatment is effective, and its effect is usually evident in a few weeks. From these observations, autoimmune mechanism has been considered to play a role in this condition, which led to the term AIP.

The histological feature of AIP is diffuse lymphoplasmacytic infiltration and fibrosis. It is pathologically so peculiar among inflammatory conditions of the pancreas that, indeed, there had been some sporadic reports on pathology dealing with this topic even before the concept of AIP was proposed, such as chronic inflammatory sclerosis of the pancreas,[8] lymphoplasmacytic sclerosing pancreatitis (LPSP),[9] non-alcoholic duct destructive chronic pancreatitis[10] and inflammatory pseudotumor.[11] As the concept of AIP had been gradually accepted among clinicians, and it has become recognized that lymphoplasmacytic infiltration with fibrosis was a histological characteristic of AIP, these pathological concepts were regarded as equivalent to AIP. It should be noted, however, that there are some differences among these reports. For example, patients with chronic inflammatory sclerosis complained of severe abdominal pain and died of cachexia, which is unusual for the current concept of AIP.[8] According to studies of non-alcoholic duct destructive chronic pancreatitis, neutrophilic infiltration in interlobular ducts was common, although this is not a feature of LPSP.[5,10]

After 2000, some groups argued that what was clinically diagnosed as AIP was not pathologically a single entity, but consisted of at least two different groups. A group from Mayo Clinic conducted a retrospective study with resected pancreata with a diagnosis of pancreatitis, and concluded that, in addition to a group that corresponded to LPSP, there was a group designated as idiopathic duct-centric chronic pancreatitis (IDCP).[12] A similar observation was also reported from Europe and Massachusetts General Hospital.[13–15]

LPSP is a histologically unique lesion that was proposed by Kawaguchi *et al.* in 1991.[9] It consists of diffuse lymphoplasmacytic infiltration and fibrosis that focally gives rise to a swirling pattern (storiform fibrosis; Fig. 1a). Eosinophils can be observed, but neutrophils are absent. Pancreatic lobules are relatively well preserved compared to alcoholic chronic pancreatitis, but focal destruction of pancreatic acini and replacement with fibrosis are commonly seen. The same inflammatory process is characteristically observed around the main and interlobular ducts, leaving the duct epithelium and lumen intact (Fig. 1b). It appears as if the duct wall is thickened with inflammation. Veins are almost always obliterated by the same inflammatory process (obliterative phlebitis; Fig. 1c). Splenic vein and even portal vein may be involved, which makes surgeons suspect that they are dealing with an inoperative carcinoma. The common bile duct is also often inflamed. This is the main cause of jaundice seen in patients with AIP. Numerous IgG4-positive plasma cells are identified in LPSP (Fig. 1d).[16,17]

Another group, designated as IDCP, is characterized by inflammation centered on the duct epithelium.[12,13,15] Neutrophilic infiltration in the main and/or interlobular ducts is characteristic, and is seen within the epithelium and lumen (Fig. 2). This finding is called 'granulocytic epithelial lesion' by the European group.[13] Duct epithelium shows destructive and regenerative changes, and, due to the inflammation, the lumen looks stenotic or tortuous. A band of lymphocytes and plasma cells surrounds the lumen but, in contrast to LPSP, the ductal lesion lacks the appearance of a thickened wall. Sometimes the entire duct appears to be entrapped within an aggregate of inflammatory cells (Fig. 2a). When the inflammation is severe, pancreatic lobules are also inflamed with neutrophils, lymphocytes and plasma cells. Microabscesses may be encountered. Although there is fibrosis around pancreatic lobules, inflammatory cells are scarce within fibrosis itself, in contrast to LPSP, in which inflammatory cells are numerous within fibrosis. Obliterative phlebitis is rare, and inflammation of the common bile duct is less common compared to LPSP. IgG4-positive plasma cells are usually few in IDCP.[17]

The clinical features of LPSP are concordant with those of AIP reported from Japan, described previously.[12] Serum IgG4 is elevated in 80% of AIP patients in Japan, which correlates well with numerous IgG4-positive plasma cells seen in LPSP. In contrast, patients with IDCP are younger than LPSP patients, and many of them are younger than 40 years.[12] There is no gender preponderance. Obstructive jaundice is less common in IDCP than in LPSP. The association of inflammatory bowel disease (IBD) is found in IDCP, but extrapancreatic manifestations seen in LPSP, which are described in the following section, are rare. Notably, IDCP is rare in Japan.[18]

Both LPSP and IDCP share some clinicopathological features. There has been a debate therefore on whether these two pathological groups are different manifestations of a single entity of AIP, or whether they are different clinicopathological entities. The controversy is due to the variety of AIP diagnostic criteria proposed by different groups. The diagnostic criteria from Japan,[19] Korea,[20] Asia[21] and Mayo Clinic[22] define LPSP as the pathological entity of AIP, but other groups include both LPSP and IDCP in AIP.[13,15,23] Considering the demographic and clinical differences as well as different immunoreactivity for IgG4, however, the idea that LPSP and IDCP are different is gradually gaining acceptance. Recently, new terms, type 1 and type 2 AIP, which correspond to LPSP and IDCP, respectively, have been proposed from the West.[24] It is important to note that, among these two groups, only

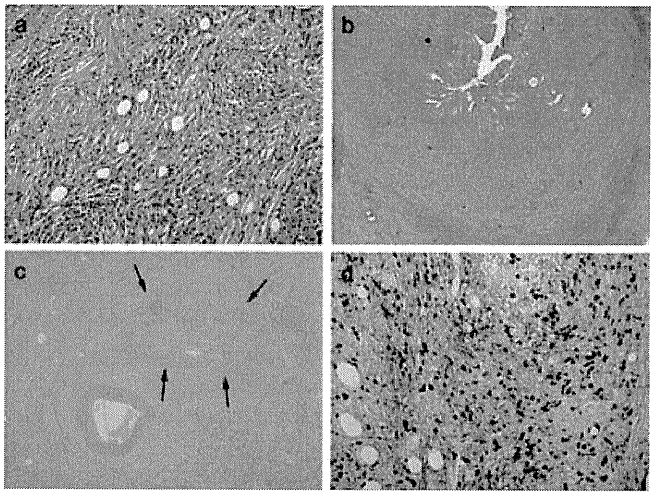

Figure 1 Lymphoplasmacytic sclerosing pancreatitis. (**a**) Lymphoplasmacytic infiltration and fibrosis giving rise to storiform fibrosis. (**b**) Ductal inflammation around the intact epithelium. The duct wall appears to be thickened with the inflammation. (**c**) Obliterative phlebitis (arrow). (**d**) Numerous IgG4-positive plasma cells are identified on immunostaining.

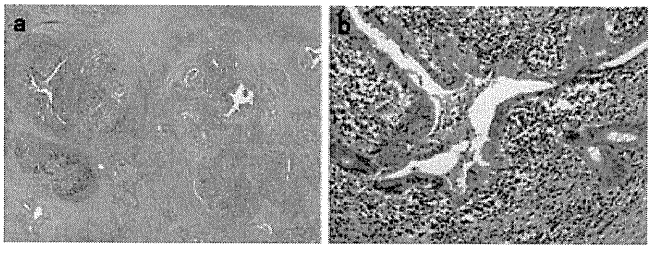

Figure 2 Idiopathic duct-centric chronic pancreatitis. (**a**) Duct-centric inflammation. Two ducts shown here are entrapped within an aggregate of inflammatory cells. (**b**) Neutrophilic infiltration in the duct lumen.

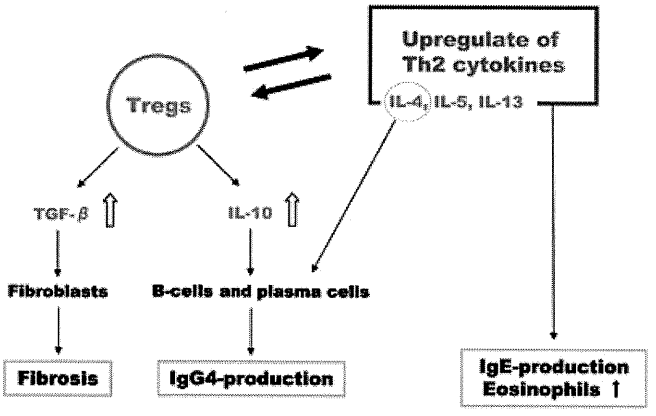

Figure 3 IgG4-related disease: hypothesis of the pathogenesis. The expression of T-helper cell 2 (Th2) cytokines (interleukin (IL)-4, IL-5, and IL-13) and regulatory cytokines (IL-10 and transforming growth factor (TGF)-β) was upregulated in the affected tissues of patients with IgG4-related diseases, suggesting that this disease might reflect an allergic mechanism in its pathogenesis. Tregs, regulatory T cell.

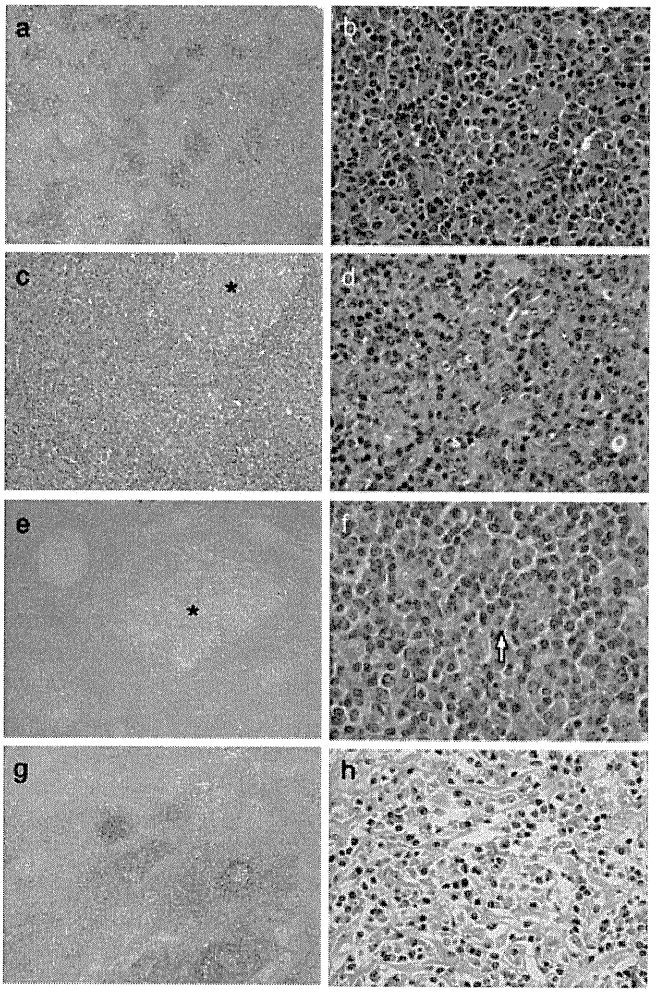

Figure 4 (**a**) Type I lesion. On low-power field, the lymph node demonstrated numerous lymphoid follicles with active germinal centers and distinct mantle zone and expansion of the interfollicular area. The interfollicular area contained a moderate number of capillaries. (**b**) Type I lesion. On high-power field, the interfollicular area was heavily infiltrated by mature plasma cells, plasmacytoid cells and small lymphocytes. Scattered medium-sized lymphocytes, transformed lymphocytes including immunoblasts and eosinophils were also present. (**c**) Type III lesion. On medium-power field, the lymph node demonstrated an active germinal center (*) with a distinct mantle zone, and expansion of the interfollicular area containing moderate vascularization. (**d**) Type III lesion. On high-power field, the paracortical area contained numerous mature plasma cells, plasmacytoid cells, immunoblasts, small and medium-sized lymphocytes and histiocytes. Note an eosinophil. (**e**) Type IV lesion. On low-power field a large early stage progressive transformation of germinal center (*) is surrounded by secondary lymphoid follicles. (**f**) Type IV lesion. On high-power field, a relatively large number of residual centrocytes, centroblasts and immunoblasts are present, in addition to the small mantle zone lymphocytes. Note a few mature plasma cells (arrow). (**g**) Type V lesion. On low-power field, the majority of the lymph nodes were occupied by the hyalinized tissue, and a few residual lymphoid follicles and a focally dense lymphoid infiltrate were observed. (**h**) Type V lesion. On high-power field, mature plasma cells, small lymphocytes and eosinophils focally infiltrated in the sclerosing tissue.

LPSP should be regarded as the pancreatic manifestation of IgG4-related diseases.

Concept of IgG4-related disease

Kawaguchi *et al.* suggested that LPSP was a systemic disease.[9] In addition to the pancreas, their patients had involvements in the extrahepatic bile duct, gallbladder and labial gland, and all lesions showed histological similarity to LPSP. They further noted that LPSP histologically resembled multifocal fibrosclerosis. Multifocal fibrosclerosis is an entity that includes systemic diseases, such as 'primary sclerosing cholangitis' (PSC), retroperitoneal fibrosis, Riedel thyroiditis and orbital pseudotumor. Association of 'pancreatic pseudotumors' has also been reported.[25] Notably, obliterative phlebitis, one of the unique features of LPSP, has been reported to occur in multifocal fibrosclerosis.[26–29] Ever since AIP was recognized as an entity, it has become well realized among clinicians that extrapancreatic lesions are common in AIP patients. According to a recent report, pulmonary hilar lymphadenopathy, bile duct lesions, lacrymal and salivary gland lesions, hypothyroidism and retroperitoneal fibrosis are commonly seen in Japanese patients with AIP,[30] suggesting the analogy of LPSP and multifocal fibrosclerosis. Curiously, an association with Riedel thyroiditis has been rarely reported in AIP, but the reason is not known.

On immunohistochemistry, Hamano *et al.* identified numerous IgG4-positive plasma cells in the retroperitoneal fibrosis seen in AIP patients.[6] Kamisawa *et al.* extended the observation, and reported that IgG4-positive plasma cells are increased systemically in patients with AIP.[31] They concluded that AIP patients have a systemic disease, and proposed the entity 'IgG4-related sclerosing disease'.[32] More recent entities, such as IgG4-related plasmacytic exorinopathy[33] and IgG4-positive multiorgan lymphoproliferative syndrome,[34] are synonymous.

The histological features and numerous IgG4-positive cells are unique to LPSP. Using these morphological and immunohistochemical features as a hallmark, Zen *et al.* proposed new concepts of IgG4-related diseases in various organs.[35–40] This is not merely a proposal of new concepts, but a reclassification of pre-existing entities. In addition, the recognition of these new entities is important from the clinical standpoint as well, because many of these lesions involve a mass that is clinically suspicious for malignant diseases, and nevertheless they are responsive to corticosteroid therapy. For example, IgG4-related sclerosing cholangitis had been diagnosed as PSC before this entity was recognized,[35] but the histological finding is different from classic PSC.[35] IgG4-related sclerosing cholangitis produces changes that are histologically similar to LPSP including numerous IgG4-positive plasma cells, while in classic PSC, the inflammation is centered on the bile duct epithelium, and IgG4-positive plasma cells are usually few. Importantly, IgG4-related sclerosing cholangitis is common in elderly men, in a similar fashion to LPSP. Classic PSC is well known to be associated with IBD, but such an association is rare in IgG4-related sclerosing cholangitis. The radiological features of the two are also different.[41] Corticosteroid treatment is effective for patients with IgG4-related sclerosing cholangitis, while there is no such indication for classic PSC, for which the only treatment option is liver transplantation.

Table 1 Previous reports of IgG4-related diseases

- Pachymeningitis
- Hypophysitis
- Lacrimal gland lesion (Mikulicz's disease)
- Sclerosing sialadenitis (Küttner tumor)
- Thyroid gland
- Pulmonary lesions
- Mastitis
- Autoimmune pancreatitis
- Hepatitis
- Sclerosing cholangitis
- Retroperitoneal fibrosis
- Prostatitis
- Inflammatory aortic aneurysm
- Tubulointerstitial nephritis
- Lymphadenopathy
- Skin Lesion

Since then, many entities that are related to IgG4 have been described from all over the world (Table 1), especially in Western countries, as well as in Japan.[36–57] They include sclerosing sialadenitis,[36] pulmonary plasma cell granuloma and other pulmonary lesions,[38,47,48] mastitis,[37,49] hepatitis,[39] tubulointerstitial nephritis,[50] prostatitis,[51]inflammatory aortic aneurysm,[40,43,44,52] lymphadenopathy,[53,54] pachymeningitis[55] and skin lesion.[54,56] Each of these diseases could occur separately, or in various combinations. It should be stressed, however, that the occurrence of numerous IgG4-positive plasma cells is not entirely specific for IgG4-related diseases. Suppurative granulation tissue, for example, may contain numerous IgG4-positive cells.[57] It is also well known that LPSP-like histology and numerous IgG4-positive plasma cells can be seen in association with pancreatic carcinomas, and some patients with pancreatic carcinoma have elevated serum IgG4.[58–60] A cautious approach is thus mandatory for pathologists to determine if each condition or each case is truly related to IgG4-related diseases.

The etiology of IgG4-related diseases is not well understood. The overall immune response seems to be mediated by T-helper cell 2 (Th2) reaction, and involvement of regulatory T cells is suggested (Fig. 3)[61]

Kawa *et al.* reported that the human leukocyte antigen DRB1*0405-DQB1*0401 haplotype is common among Japanese patients with AIP,[62] suggesting that a certain genetic preponderance is involved in the disease. IgG4 autoantibodies to various tissues have been found in the patients' sera,[63] and dense deposits have been identified ultrastructurally.[15] But IgG4 cannot activate the classic complement pathway, and it is unclear how IgG4 deposition can lead to tissue damage. Another unique feature of IgG4 is its ability to bind

other immunoglobulins through its Fc (Fragment, crystallizable),[64] but its relationship to IgG4-related diseases is still unknown.

IgG4-RELATED LYMPHADENOPATHY

Pathology and clinical findings of IgG4-related lymphadenopathy.

Concomitant lymphadenopathy is common in IgG4-related diseases.[39,53] Recently, several reports dealing with the morphological and immunohistological findings of the lymph nodal lesion have been published.[53,54,65,66] It appears that histomorphological findings of IgG4-related lymphadenopathy showed histological diversity.[53,54,65,66] Moreover, clinically, IgG4-related lymphadenopathy occasionally showed systemic lymphadenopathy, polyclonal hyperimmunoglobulinemia, especially elevation of IgG and IgE, and positivity of various autoantibodies.[53,54,65] Although some cases of lymphadenopathy were previously designated as atypical lymphoproliferative disorders,[67] mimicking malignant lymphomas, these cases lack immunoglobulin gene monoclonality, and are thought to be non-neoplastic.

We considered that there are five histological subtypes in IgG4-related lymphadenopathy (Table 2).

Type I: Castleman's disease- like morphology

The lymph node architecture is preserved. The lesion contains numerous lymphoid follicles (Fig. 4a). Cheuk *et al.* noted that the lymphoid follicles had a variable degree of regressive changes in the germinal centers, with decreased centroblasts, tingible body macrophages, and mitotic figures in some cases.[53] Hyalinized blood vessels frequently penetrate into the germinal centers. In some lymphoid follicles concentric files of small lymphocytes produced an onion skin pattern in the mantle zone. Other authors, however, reported that the lymphoid follicles had normal germinal centers with distinct mantle zone (Fig. 4a).[54,65,66] The interfollicular area contained mild–moderate increased vascular proliferation and moderate–large numbers of mature plasma cells with a few plasmacytoid cells and large transformed cells (immunoblasts) (Fig. 4b).[54,65,66] Occasionally, eosinophilic infiltration is observed in the interfollicular area (Fig. 4b). Immunohistology showed polytypic immunoglobulin in the plasma cells, and there was no human herpes virus type-8 (HHV-8) positive cells in 11 cases examined.[53,54,66]

Table 2 Histological subtypes and distribution pattern of IgG4-positive cells in IgG4-related lymphadenopathy

	Histological subtype	Distribution pattern of IgG4-positive cells
Pattern I	Castleman's disease-like morphology	Interfollicular
Pattern II	Reactive follicular hyperplasia	Interfollicular
Pattern III	Interfollicular plasmacytosis and immunoblastosis	Interfollicular
Pattern IV	Progressive transformation of germinal center-like	Intra-germinal center
Pattern V	Inflammatory pseudotumor-like morphology	Interfollicular

Type II: Reactive follicular hyperplasia

The lymph node shows reactive follicular hyperplasia, and small–moderate numbers of mature plasma cells in the interfollicular area.[53]

Type III: Interfollicular plasmacytosis and immunoblastosis

On low-power field, the lesion has paracortical hyperplasia with small vessel proliferation, and various numbers of lymphoid follicles with minimal sinuses (Fig. 4c).[53,54] The germinal centers were usually hyperplastic, although a few were atrophic. On high-power field, the paracortical area was diffusely infiltrated by a polymorphous population consisting of numerous mature plasma cells, plasmacytoid cells, large basophilic transformed lymphocytes (immunoblasts), eosinophils, small to medium-sized lymphocytes and histiocytes (Fig. 4d).[53,54] Immunostain demonstrates the mixed T- and B-cell nature of immunoblasts. The T cells in the interfollicular area were negative for CD10 and there was no extrafollicular proliferation of follicular dendritic cells using the anti-follicular dendritic cell antibodies, which are usually observed in angioimmunoblastic T-cell lymphomas (AITL). On immunohistochemistry, light chain immunoglobulin of the interfollicular plasma cells, plasmacytoid cells and B-immunoblasts is bi-modal and non-neoplastic.

Type IV: Progressive transformation of germinal center like

Progressive transformation of germinal center (PTGC) is characterized by the presence of large nodules of lymphocytes, often threefold to fourfold the size of other normal reactive germinal centers (Fig. 4e).[68] In PTGC, small lymphocytes migrate into the germinal center in a multifocal fashion, progressively accumulate and expand there, and then disrupt germinal centers.[68] In the early stage, germinal centers develop an unusual shape or break up without clear demarcation of the germinal center and mantle zone (Fig. 4e). These germinal center cell clusters contain centroblasts and centrocytes. Mitotic figures and tingible body macrophages are usually evident in the germinal center. In the late stage, PTGC are composed of large nodules with numerous small lymphocytes and centroblasts and centrocytes. In IgG4-related lymphadenopathy, early PTGC and normal

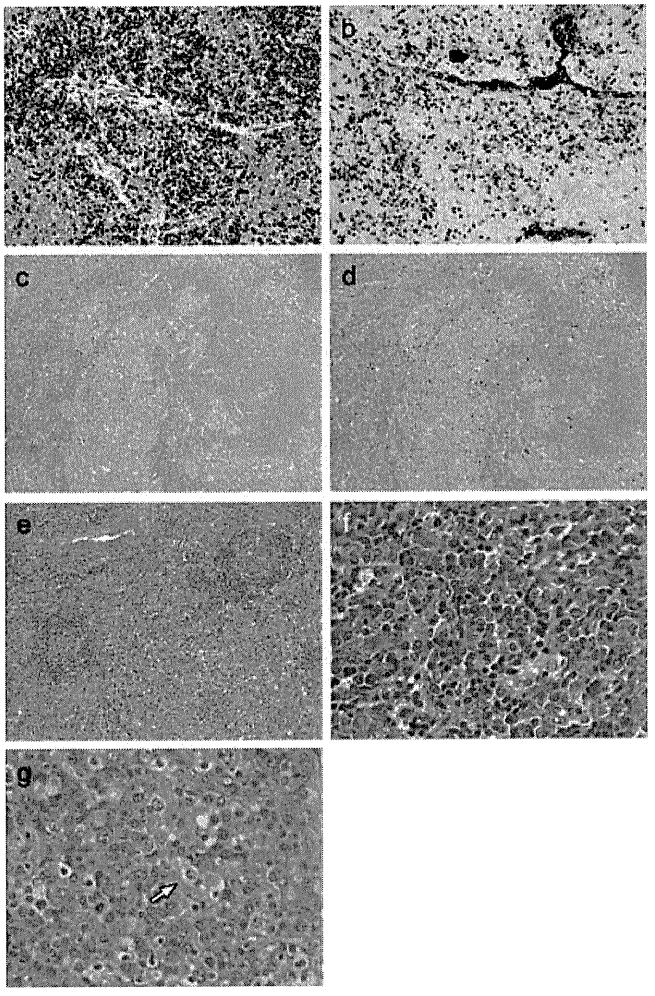

Figure 5 (**a**) Immunostaining for IgG and (**b**) IgG4. A large number of IgG4-positive cells infiltrated the type III lesion. (**c**) Immunostaining for IgG and (**d**) IgG4. IgG4-positive cells mainly infiltrated the type IV lesion of PTGC. (**e**) ALPIB. On low-power field, the lesion contained diffuse paracortical hyperplasia with small vessel proliferation and two small germinal centers. (**f**) ALPIB. On high-power field, the paracortical area contained numerous mature plasma cells, plasmacytoid cells, immunoblasts, small and medium-sized lymphocytes and histiocytes. (**g**) Angioimmunoblastic T-cell lymphoma. On high-power field, the lesion contained numerous plasma cells. Note scattered clear cells (arrow).

reactive germinal centers had scattered mature plasma cells (Fig. 4f) in the germinal centers.[54]

Type V: Inflammatory pseudotumor like

Inflammatory pseudotumor (IPT) of the lymph node develops in stages:[68,69] stage I, small nodules with partial involvement of the lymph node; stage II, inflammatory infiltrate and fibroblastic proliferation cause marked distortion of the connective tissue framework of the lymph node including hilum, trabeculae and capsule with secondary spread into the lymph node parenchyma and extranodal adipose tissue; and stage

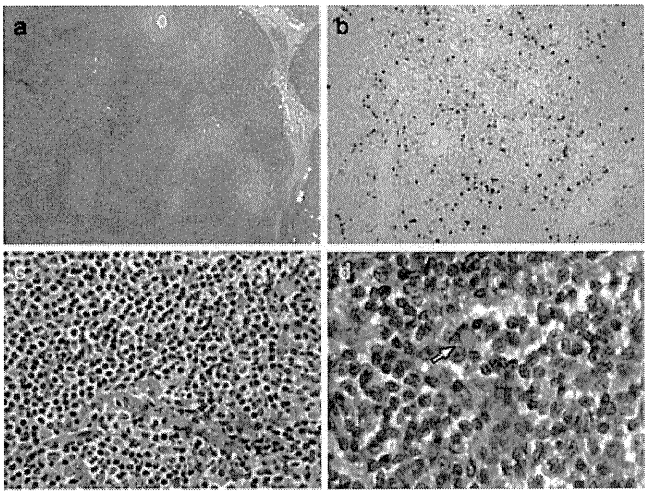

Figure 6 Ocular adnexal IgG4-related mucosa-associated lymphoid tissue lymphoma. (**a**) Diffuse dense infiltrate of lymphoid cells with lymphoid follicles and fibrosis band in lacrimal gland. (**b**) Numerous IgG4-positive plasma cells are identified (IgG4/IgG-positive cell ratio ≥ 50%). (**c**) The infiltrate consists of monocytoid B-cell-like cells, centrocytic cells and eosinophils. (**d**) Eosinophil infiltration and a few lymphoid cells exhibit Dutcher body (arrow).

III, areas of dense sclerosis of the lymph node with minimal inflammation. IgG4-related lymphadenopathy has similar histological findings to those of stage III of IPT (YS and MK, pers. comm., 2009). Histologically, the majority of the lymph nodes were occupied by the hyalinized tissue, and a few residual lymphoid follicles and focally dense lymphoid infiltrate were observed in the lymph node (Fig. 4g). Mature plasma cells, small lymphocytes and eosinophils focally infiltrate the sclerosing tissue (Fig. 4h).

The proportion of IgG4/IgG-positive plasma cells ranged from 40% to 99% in the literature.[53,54,66] We recognized two types of distribution pattern of IgG4-positive plasma cells, namely interfollicular and intra-germinal center type (Table 2).[54] In the interfollicular pattern, the majority of IgG4-positive plasma cells are located in the interfollicular area (Fig. 5a,b), whereas IgG4-positive plasma cells were observed more frequently in the lymphoid follicles in the intragerminal center type (Fig. 5c,d). Patterns I, II, III and V usually involved an interfollicular distribution, but pattern IV involved an intragerminal center distribution.

Clinically, three types of lymphadenopathy are recognized.[53] Group A involves enlarged regional and group B involves non-regional lymph node of organs affected by IgG4-related disease. Cases of unexplained lymphadenopathy were designated as group C. The characteristic clinical presentation of group B and C patients can be summarized as follows (Table 3):[53,54] (i) the patients are middle-aged to elderly with marked male predominance; (ii) usually systemic lymphadenopathy; (iii) the lymph nodes are not very large (usually up to 2 cm); (iv) the exocrine or extranodal lesions

Table 3 Clinical characters of systemic IgG4-related lymphadenopathy

Clinical presentation	(i)	Patients are middle-aged–elderly with marked male predominance
	(ii)	Systemic lymphadenopathy
	(iii)	Lymph node are not very large (usually up to 2 cm)
	(iv)	Exocrine or extranodal lesions may precede, follow, or present together with the lymph node swelling
	(iv)	Absence of fever
Abnormal laboratory findings	(i)	Polyclonal hyperimmunoglobulinemia
	(ii)	Raised serum IgG and IgE levels
	(iii)	Elevation of serum soluble interleukin-2 receptor
	(iv)	Presence of autoantibodies
Normal laboratory findings	(i)	Interleukin-6 level
	(ii)	Negativity of C-reactive protein
	(iii)	Lactate dehydrogenase level

may precede, follow, or present together with the lymph node swelling; and (v) despite the systemic nature of the disease, there is no fever or other B symptoms. The diagnostic laboratory clues to diagnosis are polyclonal hyperimmunoglobulinemia, raised serum IgG and IgE levels, elevation of serum soluble interleukin-2 (IL-2) receptor and presence of autoantibodies, whereas the IL-6, CRP and lactate dehydrogenase level were within normal limits in the majority of cases.

Differential diagnostic problems of IgG4-related lymphadenopathy

The present review demonstrates the histological variety of IgG4-related lymphadenopathy. Clinically, this disease frequently affected middle-aged and elderly patients, producing systemic lymphadenopathy associated with various immunological abnormalities.[53,54]

IgG4-related lymphadenopathy should be differentiated from various atypical and malignant LPD containing numerous and plasma cells.

Type I lesions had similar clinicopathological findings to multicentric Castleman's disease (MCD), including idiopathic plasmacytic lymphadenopathy with polyclonal hyperimmunoglobulinemia (IPL).[67,70] In Japan, HHV-8 appears to be unrelated to the etiology of MCD except for HIV type-1 infection as well as IgG4-related lymphadenopathy.[70,71] We (YS and MK) have seen numerous IgG4-positive plasma cells in the lymph nodal lesion of IPL, although the serum IL-6 level was within normal limits in the majority of type I lesions.[54,66] The abnormal clinical findings, such as general fatigue, anemia and polyclonal hypergammaglobulinemia, elevated CRP and thrombocytosis may be related to a high level of IL-6 in the MCD,[72–74] but there were no clinical characteristics of MCD in any of the IgG4-related lymphadenopathies.

Type I lesions also should be differentiated from lymph node lesions of autoimmune disease-associated lymphadenopathy, in particular rheumatoid arthritis (RA) and systemic lupus erythematosus (SLE).[75,76] The characteristic histological finding of lymph nodal lesion of RA is both reactive follicular hyperplasia and interfollicular plasmacytosis.[75] The lymph nodal lesion of SLE occasionally has similar histological findings to Castleman's disease,[76] but there is no evidence of definite autoimmune disease in any of the IgG4-related lymphadenopathies.

One of the most important differential diagnostic problems is atypical lymphoplasmacytic and immunoblastic proliferation (autoimmune-disease-associated lymphadenopathy).[77] Koo *et al.* reported an unusual lymph node lesion, namely 'ALPIB',[77] which is associated with various autoimmune disease including RA and SLE.[77,78] Histologically, the lesion is characterized by prominent polyclonal lymphoplasmacytic infiltration with various numbers of immunoblasts.[77] There is no evidence, however, of definite autoimmune disease in any of the IgG4-related lymphadenopathies.

When AITL contains a few tumor cells (clear cells) with numerous plasma cells and B-immunoblasts, it can be confused with type III lesions. In contrast to AITL, there are no cytologically atypical CD10+ T-cells and there is no extrafollicular follicular dendritic proliferation in type III lesions.[79] Moreover, AITL usually involves systemic symptoms such as fever.[79]

Type IV lesion has histological findings of early stage PTGC.[68] A portion of PTGC containing numerous plasma cells in the germinal center may be an IgG4-related lymphadenopathy.

Type V lesions have similar histological findings to those of the IPT of the lymph node. IPT of the lymph node, however, mainly affects the lymph node framework such as hilum, trabeculae and capsule,[68,69] whereas lesions of IgG4-related disease are usually located in the lymph node parenchyma.

The importance of recognition of this entity lies in the remarkable response to steroid therapy. The diagnosis requires awareness and a high index of suspicion for this entity, which could present as unexplained lymphadenopathy with numerous plasma cells and scattered eosinophils, or lymphadenopathy in patients with known pancreatitis, lacrimal gland lesion or salivary gland lesion.

OCULAR ADNEXAL IgG4-RELATED DISEASE

Clinical and pathological findings of ocular adnexal IgG4-related disease

IgG4-related diseases frequently involve the ocular adnexal region.[80,81] Ocular adnexal IgG4-related disease is also

called Mikulicz's disease or chronic sclerosing dacryoadenitis.[82–86] Clinically, the lacrimal glands are involved, and bilateral lacrimal gland swelling is frequently observed.[80] Though some patients do not show obvious lacrimal gland involvement clinically, lacrimal gland component was frequently detected histologically. This suggests that accessory lacrimal glands may be involved.

Mikulicz's disease is a unique condition that refers to bilateral, painless and symmetrical swelling of the lacrimal, parotid and submandibular glands. Although Mikulicz's disease has been considered a subtype of Sjögren syndrome, there are several differences between the two diseases. Patients with Mikulicz's disease lack anti-SS-A and anti-SS-B antibodies, but frequently have elevated serum IgG4 levels.[34,82–84] Infiltration of many IgG4-positive plasma cells into the lacrimal and salivary glands has been detected in Mikulicz's disease. Additionally, Mikulicz's disease has good responsiveness to steroids, and reversible of lacrimal and salivary gland function. Thus, it is important to distinguish Mikulicz's disease from Sjögren syndrome.[34,82–84]

The ocular adnexal IgG4-related disease is histologically uniform: marked lymphoplasmacytic infiltration and lymphoid follicles, admixed with dense fibrosis, and infiltration of many IgG4-positive plasma cells.[80] These findings are similar to those of previous reports of IgG4-related disease of other organs. The ocular adnexal IgG4-related diseases often are associated with ones of the salivary glands.[80]

As referred to here, obliterative phlebitis has been identified as a histological feature of IgG4-related diseases since Kawaguchi *et al.* reported on the histopathology of sclerosing pancreatitis in 1991,[9] and it has been easily and characteristically found in sclerosing pancreatitis and sclerosing sialadenitis. But obliterative phlebitis is usually not detected in ocular adnexal IgG4-related disease.[80] Therefore, we suggest that obliterative phlebitis may be organ specific, but not a common feature of IgG4-related diseases.

Interestingly, although serum IgG4 levels are often evaluated after treatment, it remains elevated even in remission.[80] This may be due to residual IgG4-secreting plasma cells located subclinically elsewhere.

Ocular adnexal IgG4-related disease and mucosa-associated lymphoid tissue lymphoma

Little is known about lymphomagenesis in the context of IgG4-related disease.[80,85,87] We recently first reported ocular adnexal mucosa-associated lymphoid tissue (MALT) lymphomas arising from IgG4-related disease, occurring in the same organ.[80]

MALT lymphoma is an extranodal lymphoma consisting of morphologically heterogeneous small B-cells including marginal zone cells.[88,89] The infiltrate is in the marginal zone of reactive B-cell follicles and extends into the interfollicular region. In epithelial tissues, the neoplastic cells typically infiltrate the epithelium, forming lymphoepithelial lesion. The presence of lymphoepithelial lesion is important when making a diagnosis of MALT lymphoma.[88,89]

In many cases of MALT lymphoma, there is a history of chronic inflammatory, often autoimmune disorders that result in accumulation of extranodal lymphoid tissue. These include *Helicobacter pylori*-associated chronic gastritis, Sjögren syndrome or Hashimoto thyroiditis.[88,89] Thus, we considered that patients with ocular adnexal IgG4-related disease may be at an increased risk of developing ocular adnexal MALT lymphoma. Another study has also described ocular adnexal lymphomas arising from IgG4-related disease.[85] Takahashi *et al.* reported that three patients with IgG4-related disease with or without autoimmune pancreatitis later developed B-cell non-Hodgkin lymphoma (two of whom developed diffuse large B-cell lymphoma).[87] In addition, Ochoa *et al.* reported on marginal zone B-cell lymphoma of the salivary gland arising in Küttner tumor.[90] It has previously been noted that autoimmune pancreatitis and Küttner tumor were considered to be IgG4-related disease. Therefore, these reports suggest that IgG4-related disease may be a risk factor for malignant lymphoma.

We experienced seven patients with the ocular adnexal MALT lymphomas arising from IgG4-related disease (IgG4-related ocular adnexal MALT lymphoma), occurring in the same organ. Six patients had localized disease (clinical stage IE or IIE; unpubl. data, 2009). Histologically, in this series of patients there was dense fibrosis subdividing the lacrimal gland, and marked lymphoid cell infiltration with lymphoid follicles. These histological findings were consistent with previous reports of IgG4-related disease. However, some infiltrated lymphoid cells showed centrocyte-like features, and Dutcher bodies were found in some of the cases (Fig. 6) in addition to histological finding of IgG4-related disease. All cases had immunoglobulin light chain restriction, and immunoglobulin heavy chain gene rearrangement on polymerase chain reaction and/or Southern blot hybridization. Interestingly, lymphoepithelial lesion was not found in any cases. Lymphoepithelial lesions usually are not found in ocular adnexal MALT lymphomas (especially in the lacrimal gland region).[90] Another report also noted that lymphoepithelial lesion was not found in ocular adnexal IgG4-related MALT lymphoma. It remains unclear whether the absence of lymphoepithelial lesion indicates biological differences in the lacrimal gland, or whether the epithelium may have been destroyed due to IgG4-related chronic inflammation.

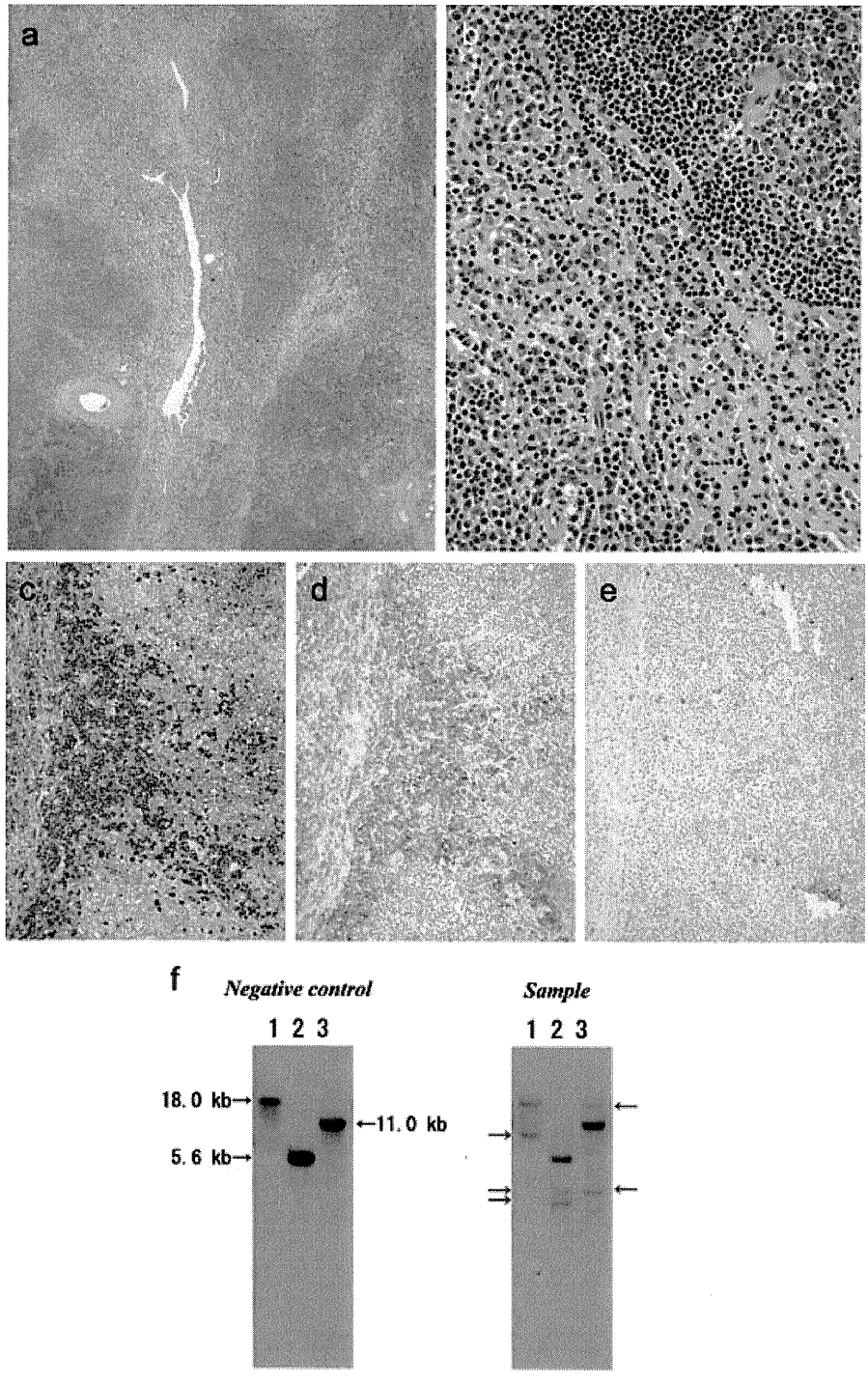

Figure 7 Ocular adnexal IgG4-producing mucosa-associated lymphoid tissue lymphoma. (**a**,**b**) Dense fibrosis and marked lymphoplasmacytic infiltration in the lacrimal gland. Histologically, this is compatible with previous reports of IgG4-related sclerosing disease. Immunostain for (**c**) IgG4, (**d**) kappa-light chain and (**e**) lambda-light chain. Most of the IgG4-positive cells exhibit kappa-light chain restriction. (**f**) Immunoglobulin heavy chain gene rearrangement was detected on Southern blot hybridization.

There have been many reports on ocular adnexal IgG4-related lymphomas at the annual meetings of the Japanese Society, but in IgG4-related disease of other sites, there is rare or absent IgG4-related MALT lymphoma. In the orbital region, the most common tumor is malignant lymphoma, especially MALT lymphoma.[91] In contrast, submandibular gland and pancreas have a low incidence of MALT lymphoma. Therefore IgG4-related MALT lymphoma may occur more easily in the ocular adnexa.

IgG4-PRODUCING LYMPHOMA

Little is known about IgG4-producing lymphoma.[85,92] We recently reported the first case of IgG4-producing marginal zone B-cell lymphoma of the lymph node.[92] The IgG4-positive tumor cells were lambda light-chain-restricted and CD138 partially positive, although the expression was fainter than that of the non-neoplastic cells. Additionally, the tumor cells were partially positive for CD20, which is normally

negative in non-neoplastic plasma cells, and had elevation of serum IgG4 level.[92] Therefore that case indicates that not only can malignant lymphomas occur in the setting of IgG4-related diseases, but that IgG4-producing cells can also be neoplastic.

Moreover, we encountered a case of ocular adnexal IgG4-producing MALT lymphoma (Fig. 7). The histology was compatible with ocular adnexal IgG4-related disease (Fig. 7a,b), and there was elevation of serum IgG4 level, serum IgG4/IgG ratio, and IgG4/IgG-positive cell ratio (≥50%). The lesion exhibited immunoglobulin light chain restriction of IgG4-positive cells (Fig. 7c–e) and immunoglobulin heavy chain gene rearrangement (Fig. 7f). Previously, Cheuk *et al.* also reported on ocular adnexal IgG4-producing lymphoma.[85] They concluded that it remains unclear whether ocular adnexal IgG4-producing MALT lymphoma arises from pre-existing IgG4-related disease, or de novo IgG4-postive MALT lymphoma. We suggest that it may clonal expansion of IgG4-positive cells occurring against a background of IgG4-related chronic inflammation. This is because the case showed marked lymphoplasmacytic infiltration and lymphoid follicles, admixed with dense fibrosis, and also detected elevation of serum IgG4 level. These findings are compatible with IgG4-related disease.

Clinicopathological features of IgG4-producing lymphoma should be clarified in the future by accumulation and evaluation of such cases.

CONCLUSION

IgG4-related diseases are a new clinicopathological systemic entity, but the pathogenesis and etiology remain unclear. IgG4-related diseases have a good response to steroids. Accordingly, accurate pathological diagnosis is very important.

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INTERNAL MEDICINE

□ CASE REPORT □

Idiopathic Duct-Centric Pancreatitis (IDCP) with Immunological Studies

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Abstract

A 65-year-old woman with elevated serum levels of pancreatic enzymes was referred to our hospital for further examinations. Abdominal US and contrast-enhanced CT demonstrated swelling of the pancreas body and tail. MRCP and ERCP revealed abrupt ending of the MPD in the pancreas body. Under the suspicion of malignancy, distal pancreatectomy and splenectomy were performed. The histopathological findings showed idiopathic duct-centric pancreatitis (IDCP) with granulocytic epithelial lesions (GEL). As most cases of Japanese autoimmune pancreatitis (AIP) are lymphoplasmacytic sclerosing pancreatitis (LPSP), the present case seems to be helpful to clarify the clinical findings of IDCP in Japan.

Key words: autoimmune pancreatitis (AIP), Idiopathic duct-centric pancreatitis (IDCP), lymphoplasmacytic sclerosing pancreatitis (LPSP), granulocytic epithelial lesion (GEL), IgG4

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Introduction

Since Sarles et al reported a case of idiopathic pancreatitis with hypergammaglobulinemia in 1961 (1), several investigators have reported that autoimmune mechanisms may be involved in the etiology of chronic pancreatitis. Yoshida et al first proposed the concept of "autoimmune pancreatitis" (AIP) in 1995 (2). Thereafter, many cases of AIP have been reported mainly from Japan until the disease concept was accepted worldwide. As previously reported, the characteristic features (3, 4) of the Japanese patients with AIP show (i) diffuse enlargement of the pancreas on US, CT and MRI, (ii) irregular narrowing of the pancreatic duct (sclerosing pancreatitis) on endoscopic retrograde cholangiopancreatographic (ERCP) images, (iii) histologically termed lymphoplasmacytic sclerosing pancreatitis (LPSP) with fibrosis, abundant infiltration of lymphocyte and IgG4-positive plasmacytes and obliterative phlebitis, and (iv) it is often associated with extrapancreatic lesions, such as sclerosing cholangitis similar to primary sclerosing cholangitis (PSC), sclerosing cholecystitis, sclerosing sialoadenitis, retroperitoneal fibrosis, interstitial renal tubular disorders, enlarged celiac and hilar lymph nodes, chronic thyroiditis, and pseudotumor of the liver (5-7). On the other hand, in Western countries, another type of AIP different from the AIP commonly observed in Japan has been reported. In a study performed by a group at the Mayo Clinic, it was demonstrated that there may be two histological types of AIP, LPSP and idiopathic duct-centric pancreatitis (IDCP) (6, 8). IDCP was characterized by lobular fibrosis and pancreatic duct damage mainly caused by infiltration of neutrophils without obliterative phlebitis (8). Zamboni et al also recognized a subtype of AIP occurring in a subset of patients who are younger and more commonly have ulcerative colitis and Crohn's disease, which is characterized by the presence of granulocytic epithelial lesions (GEL) (9). There are a number of similarities in the clinical and histopathological findings between AIP

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with GEL and IDCP, but not between AIP with LPSP and AIP with GEL or IDCP. Although Japanese AIP cases are almost all LPSP (4, 7), those concerning IDCP have been rarely reported from Japan (10). Therefore, it still remains unclear whether the clinical manifestations of the Japanese patients with IDCP are similar to those of Western countries or not. Herein, we report the first case of IDCP in Japan with full radiological and histopathological findings.

Case Report

A 65-year-old woman with elevated serum levels of pancreatic enzymes, as discovered by an annual health check, was referred to our hospital for further examination in the beginning of December 2004. She had no history of other illness or alcohol abuse. Furthermore, the symptom of inflammatory bowel disease including diarrhea was absent. Physical examination at the time of admission revealed no significant findings. Laboratory examinations showed the following values (normal range): peripheral white cell count, 4,600/μL; peripheral eosinocyte count, 690/μL; C-reactive protein, 0.04 mg/dL (<0.3 mg/dL); total bilirubin, 0.7 mg/dL; alkaline phosphatase, 313 IU/L (107-323 IU/L); γ-glutamyl transpeptidase, 13 IU/L (8-45 IU/L); asparate aminotransferase, 23 IU/L (12-31 IU/L); alanine aminotransferase, 18 IU/L (6-24 IU/L). Pancreatic enzymes were elevated: amylase 292 IU/L (32-112 IU/L), lipase 473 IU/L (16-60 IU/L), and elastase-1 950 ng/dL (100-400 ng/dL). Hepatitis B surface antigen and antibody to hepatitis C virus were negative. Serum γ-globulin, IgG levels were 1.43 g/dL (0.7-1.6 g/dL), 1,523 mg/dL (870-1,700 mg/dL), respectively. Serum autoantibodies were all negative, including antinuclear antibody, rheumatoid factor, anti-Ro antibody (SS-A), anti-La antibody (SS-B), and anti-mitochondrial antibody. Among tumor markers, CEA was 1.1 ng/dL (<5.0); DUPAN-2, 25 U/mL (<150); and CA19-9, 25.3 U/mL (<37). Abdominal US showed the partially enlarged pancreas body and tail with homogenous hypoechoic pattern (Fig. 1). Contrast-enhanced CT demonstrated moderate swelling in the body and tail of the pancreas with homogenous enhancement, but not capsular-like low density rim or swelling of peripancreatic lymph nodes (Fig. 2). MRI demonstrated the enlarged pancreas body and tail with no obvious intensity of change(Fig. 3A, B). MRCP revealed obstruction of the main pancreatic duct (MPD) in the body concordant with pancreas cancer tumors (Fig. 3C). ERCP demonstrated abrupt ending of the MPD in the pancreas body and irregular strictures of the pancreatic ducts in the pancreas head (Fig. 4). Transpapillary biopsy of the obstructive pancreatic duct and cytology of the pancreatic duct did not show malignancy. We were not able to identify a mass in the pancreas in the image, but also were not able to deny the possibility of the pancreatic cancer because we showed the disruption of the pancreatic duct. Therefore, we performed distal pancreatectomy and splenectomy. The postoperative course was uneventful and the patient was discharged after eight days. After hospital discharge, the patient had no recurrence to date.

The cut surface of the resected specimen showed swelling

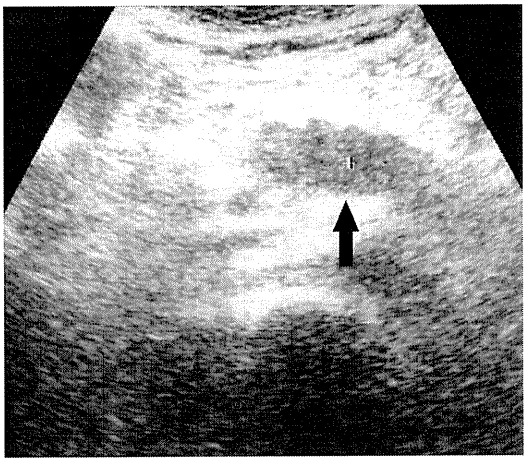

Figure 1. Abdominal ultrasonography (US) of the pancreas. US showed the partially enlarged pancreas body and tail with homogenous hypoechoic pattern (arrow).

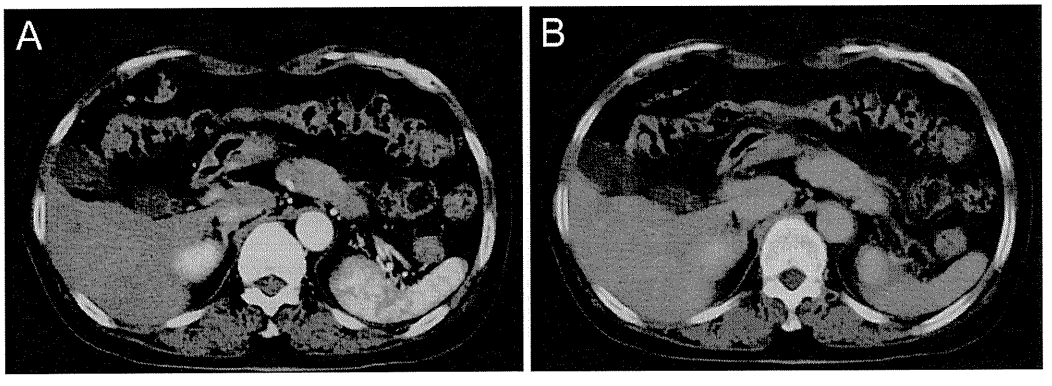

Figure 2. Contrast-enhanced computed tomography (CT) of the pancreas. Contrast-enhanced CT demonstrated moderate swelling in the body and tail of the pancreas with homogenous enhancement, but not capsular-like low density rim or swelling of peripancreatic nodes. (A) early phase (B) delayed phase.