Answer

Reactive Lymphoid Hyperplasia

The discovery of a macroscopic lymphoproliferative lesion in the liver is an uncommon occurrence, which evokes diagnostic difficulties for the pathologist. Differentiating reactive lymphoid hyperplasia (RLH) from low-grade lymphomas may not always be possible on histologic evaluation alone. Reactive lymphoid hyperplasia should not be confused with intrahepatic lymphoid follicles, sometimes seen with well-formed active germinal centers, that can occur in autoimmune hepatitis, primary biliary cirrhosis, and chronic hepatitis B and C infection. It is also difficult to differentiate from other rare entities, such as ectopic spleen, solitary plasmacytoma, or unicentric Castleman disease (angiofollicular hyperplasia) involving the liver.

Nonneoplastic nodules may include focal nodular hyperplasia, nodular regenerative hyperplasia, compensatory hyperplasia of the liver, pseudonodule of the liver demonstrable by angiography, partial nodular transformation, focal fatty change, cirrhotic large regenerative nodule with variable atypia, anoxic pseudolobular necrosis, intrahepatic bile duct adenoma, biliary and mesenchymal hamartoma, and mesenchymal nodular lesions, such as inflammatory pseudotumor and pseudolymphoma, pseudolipoma, peliosis hepatitis, solitary necrotic nodule, and so on. Some of these develop preferentially in noncirrhotic or cirrhotic livers, while others occur with similar prevalence in cirrhotic and noncirrhotic livers. Some occur multiply or diffusely and others singly. Inflammatory myofibroblastic tumors, or inflammatory pseudotumors or plasma cell granulomas, may manifest morphologic features similar to RLH.

Very few cases of RLH forming benign hepatic tumor–like masses have been reported. There are usually no associated systemic manifestations. These lesions are generally discovered incidentally and present as hypoechoic, hypervascular masses.

Hepatic involvement by lymphoma is considered to represent stage IV disease, unless the liver represents the primary and only site of disease. Primary lymphomas may present as a solitary mass in 60% of cases or as multiple masses in 35% of cases. These numbers have increased since the emergence of the AIDS epidemic. Cases of primary hepatic mucosa-associated lymphoid tissue lymphomas presenting as solitary or multiple nodules have been described as well. Hepatic involvement in Hodgkin disease can also manifest as large, irregular masses or as smaller, more diffusely distributed nodules. It is essential in such cases to identify Reed-Sternberg cells.

In contrast to RLH, primary lymphomas of the liver, if untreated, are associated with a poor prognosis, particularly if there is related cirrhosis. Therefore, it is important to recognize the occurrence of these benign hyperplastic lymphoid lesions so as not to erroneously diagnose them as low-grade lymphomas. For a definitive diagnosis, careful histologic analysis integrated with immunohistochemical and flow cytometric analysis, as well as molecular genetic methods, should prove helpful in making the correct diagnosis. The prognosis of RLH is good, as most patients treated by resection of the lesion have shown no ill effects, recurrence, or progression to lymphoma.

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Correspondence: Adolfo Beguiristain, MD, PhD, Donostia Hospital, Paseo Dr Beguiristain, 20014 San Sebastian, Spain (abegirl@cchdo.osakidetza.net).
Author Contributions: Study concept and design: Jiménez, Villar, and Medrano. Acquisition of data: Jiménez, Beguiristain, Ruiz-Montesinos, Villar, Garnateo, and Vaquero. Analysis and interpretation of data: Echenique Elizondo. Drafting of the manuscript: Echenique Elizondo. Critical revision of the manuscript for important intellectual content: Beguiristain, Medrano, Echenique Elizondo, and Vaquero. Administrative, technical, and material support: Ruiz-Montesinos, Villar, Medrano, and Garnateo. Study supervision: Echenique Elizondo.
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REFERENCE