7/27/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Adam **Case Discussants**: Alec (@ABRezMed) & Austin (@RezidentMD)

https://clinicalproblemsolving.com/present-a-case/

Scribing: Krishi+Lera

CC: 42F with **3 days** of rapidly enlarging L upper neck mass

HPI: Noted to be anxious, marked lethargy+unwell, concerned about mass and thus presented to ED, triaged to be seen in clinic later

ROS:
-moderate preceding sinusitis+congestion
-7 lbs unintentional weight loss over **2 months**
-denied fevers, night sweats, hemoptysis, chills, dyspnea, voice changes, odynophagia, rash, skin, changes

PMH: known HIV (loss to follow up, no ART for 15 years)

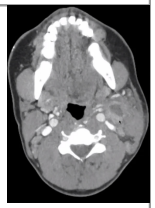
Meds: na

Social Hx: immigrated from south africa
-non smoker, minimal alc, no IVDU

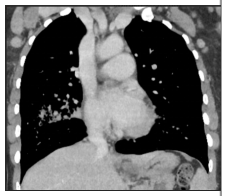
Health-Related Behaviors:
-last sexual encounter >6 years ago

Vitals: T: 37 **HR**: 97 **BP**: 120/78 **RR**: 16 **Sat**: 99% on RA **BMI**:
Exam: Gen: anxious, otherwise well appearing **HEENT**: L level II neck mass 3x4cm firm, non-fluctuant, non-painful, non erythematous + bilateral lymphadenopathy
CV: na **Pulm**: na **Abd**: na **Extremities/skin**: na

Notable Labs & Imaging:
Hematology: WBC: 8.1 [no diff] MCV: 88 Hgb: 11.4 Plt: 263
CD4=150 cell/microL, **HIV viral load** 87322 copies/mL
Chemistry: Na: 134 K: 4.3 Cr: .83 ALT: 54 ALP: 104 T. Bili: 0.3
T. protein: 10.9 Alb: 4.1 CRP: 12 LDH: 150
Flex nasal endoscopy: large mass occupying post-nasal space



CT: -head: symmetric prominence in midline posterior nasopharynx, L sphenoidal thickening
-neck: oval lesion w internal hypodense areas in the L level II neck- impression was large necrotic lymph node
-thorax: b/l scattered multiple nodular densities, concentrated on the R middle lobe, mediastinal and hilar lymph nodes observed
-abdomen/pelvis: no abnormalities
-FNA of cervical lymph node
-ID consult→ admission→
TMP-SMX started for PJP prophylaxis



Serology:
EBV, CMV, toxo prior exposure w IgG+, HCV, HBV, syphilis, TB negative
→ PT initiated on ART (dolutegravir, tenofovir, emtricitabine) +TMP-SMX
Tissue:
-US FNA result=macrophages, neutrophils, lymphocytes
Repeat US neck and core biopsy=slender cores of sclerotic lymphoid tissue, occasional small reactive-looking germinal centers, mixed interfollicular lymphoid infiltrate, mature plasma cells, no well-formed granulomas
-IHC: B cell markers of CD10, BCL6, NCL2 negative, CD3/CD5+ T cell in interfollicular areas, Ki-67 focally increased, HHV negative
-overall hematopathology impression= equivocal
Lymph node biopsy pending:
-no clonal B cell populations; T cell receptor studies= TRG and TRB rearrangement ;still equivocal, no aberrant immunophenotype but T-cell lymphoma could not be excluded
-post-nasal space mass biopsy= reactive lymphoid hyperplasia, no malignancy or granulomatous inflammation
Progression: cervical lymphadenopathy near completely resolved and CD4 rose to 200

FINAL DIAGNOSIS: HIV-associated reactive lymphoid hyperplasia involving cervical+nasopharyngeal lymphoid tissue (given negative biopsy and clinical improvement with ART)
→ patient's lymphadenopathy resolved with time, CD4 rose to 450 cells, no HIV viral load

Problem Representation: 42yo F with HIV not on ART presenting with rapidly enlarging L upper neck mass. Serologies and biopsies were negative and patient improved with ART suggesting HIV driven lymphoid hyperplasia.

Teaching Points (Sana <3)

Acute neck swelling:
- acute swellings → think inflammation (infections mcc)
- Isolated vs systemic?
- Other factors to consider - ptn factors like immune status, location of the sweling
- Firm swelling - mass forming lesion vs LN conglomerate (thorough examination for localized vs diffuse LAD)

Absence of local symptoms: early stage of pathology vs chronic issue?
Untreated chronic HIV: confirm w/ history and labs
- w/ leukocytosis→ possibility of falsely elevated CD4 count

Protein Gap: solely d/t HIV? Evaluate for hep B & C, spep, and sr. free light chain levels
Upper respiratory + lower respiratory findings: evaluate separately before considering a unifying dx
DDx for nasopharyngeal mass w/ HIV: ↑er r/o malignancy (NK B-cell lymphoma, SCC), infections
-ve Quantiferon: in 20-30% of ptns w/ TB (especially in ptns who cannot mount a sufficient immune response)
Resolution of LAD w/ immune reconstitution:
- Lowers the possibility of malignancy and AI conditions
- Infections - d/t to HIV alone vs better immune response against superimposed infection

Reactive lymphoid tissue: infection vs subtle malignancy?

Why has the patient presented now?