

As to toxicity, only one patient, who received a total anthracycline dose of 240 mg/m², developed a severe dilated myocardiopathy.

In conclusion our results confirm that some infants with ALL can be cured by conventional chemotherapy. Thus, we believe that careful stratification for prognosis is needed to treat these patients with adequate risk-adapted therapeutic strategies.

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Key words

Childhood, acute lymphoblastic leukemia

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Three cases of Kikuchi-Fujimoto disease

Sir,

Kikuchi-Fujimoto disease (KFD) is a benign form of necrotizing lymphadenitis of unknown cause, usually affecting young women^{1,2} and characterized by lymphadenopathy often associated with fever and leukopenia. Cervical nodes are usually involved, while generalized lymphadenopathy, hepato-splenomegaly and extranodal involvement are uncommon. Laboratory tests show only a raised ESR.³ The diagnosis is based on distinctive lymph node histologic features:^{4,5} focal necrosis in cortical and paracortical areas; karyorrhectic nuclear debris mixed with a polymorphous cell population including immunoblasts and histiocytoid cells. Polymorphonuclear leukocytes and B cells are characteristically absent. In early phases T-suppressor lymphocytes are predominant. Lesions in different stages of development may coexist; focally, the histologic pattern might be mistaken for lymphoma or other diseases.^{4,6} The disease resolves spontaneously within 2-3 months; relapse is not common. For unknown reasons, this disease is more frequent in Japan, where it was first described.

In a five-year period, we have observed three patients with KFD.

Case #1. A 36-year-old woman presented in January 1993 with fever and cervical lymphadenopathy, unresponsive to antibiotics and low dose prednisone. The ESR was 70 mm, all other laboratory tests were negative. Bone marrow examination was normal. Lymph node histology was typical of KFD (Figure 1). The patient recovered in three weeks with no other treatment.

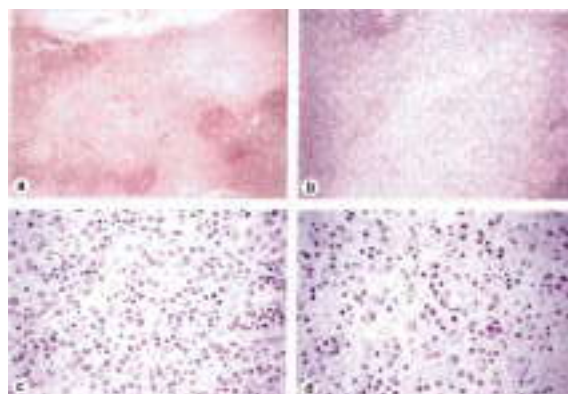
Case #2. A diabetic 53-year-old man was observed in December 1996 with a four-month history of fatigue, fever, and moderate cervical and axillary lymph node enlargement. His ESR was 88 mm, all other tests were normal. Bone marrow examination showed a normocellular marrow. Lymph node biopsy demonstrated KFD. He received antibiotic therapy after biopsy, and the disease resolved over four weeks.

Case #3. A 31-year-old woman was admitted in March 1997 because of fatigue, fever, night sweats, cough and cervical lymph node enlargement. Laboratory tests were all normal, including ESR. Lymph node biopsy showed necrotizing lymphadenitis of the KFD type. She recovered in six weeks with no treatment (Table 1).

The etiopathogenesis of KFD is still obscure. Some clinical and histologic features suggest a possible infectious etiology, particularly viral.^{3,7} It has also been supposed that KFD may have different etiologies, all provoking an abnormal cell-mediated immune response. This hypothesis is supported by the finding of cytoplasmic tubuloreticular structures; similar structures are observed in other diseases, particularly systemic lupus erythematosus (SLE).³ KFD and SLE may be associated and KFD may precede the onset of

Table 1. Clinical features.

Pts	Sex/Age	Involved Nodes	Symptoms	Abnormal laboratory test	Therapy	Time from diagnosis to recovery
1	F/36	Left, cervical	Fever	ESR	Antibiotic+steroids	Six weeks
2	M/53	Cervical, axillary	Fever, fatigue	ESR	Antibiotic	Four weeks
3	F/31	Cervical	Fever, fatigue, sweats, cough	-	-	Six weeks

**Figure 1 (left). Typical lymph node histology of Kikuchi-Fujimoto disease (case #1).**

a) lymphoid tissue with multiple nodular necrotic foci; b) a necrotic area adjacent to a normal follicle; c) a necrotizing lesion with karyorrhectic nuclear debris; phagocytizing histiocytes and a few lymphocytes; neutrophils are absent; d) a necrotic area containing lymphocytes, histiocytes and nuclear debris.

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SLE.^{3,8-9} Therefore, prolonged follow-up of patients with KFD to reveal possible connections with SLE is suggested. The prevalence of the disease may be underestimated, since the spontaneous regression of the symptoms may hinder the diagnosis in some cases. All our patients were resident in rural areas surrounding the city, 20-30 km away from each other. We have found only two other cases of KFD from Italy reported in the literature; one was a patient with AIDS.^{4,10} Thus, no estimate of the incidence of KFD in Italian populations can be attempted. We do not know whether the identification of three cases over a few years in a relatively restricted area is a casual event, possibly related to a greater attention to this disease, or whether it indicates the existence of local factors responsible for an endemic spread. Our patients recovered in about six weeks; neither relapse nor onset of other diseases has been observed with follow-ups of sixty-three, fifteen and thirteen months, respectively.

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