this peculiar situation is not always mentioned in piercing guidebooks for the public [9]. Therefore, midwives and obstetricians play an important preventive role. As soon as the first consultation, the parturient should be warned of the potential risks and know that she may have to remove her piercing within the next upcoming months. Fortunately, various retainers, such as intravenous catheter, can be placed to keep the hole open [7,10] if the parturient fears for a premature closing of the piercing hole. Of note, some body jewellery retainers are commercially available but may come apart more easily and are not encouraged in this context [7]. Such “issue” may appear trivial for some readers. However, the remaining scar may be disabling from an aesthetic point of view for any young woman, where as it could be avoided simply and easily.

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References

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Contribution of diffuse-weighted whole body imaging with background body signal suppression (DWIBS) in multisystemic Castleman’s disease

Contribution du Diffuse-Weighted Whole Body Imaging With Background Body Signal Suppression (DWIBS) dans la maladie de Castleman multicentrique

Castleman’s disease (CD) is a rare lymphoproliferative disorder divided into unicentric Castleman’s disease (UCD) which represents 90% of the cases, and Multicentric Castleman’s Disease (MCD), which represents the remaining 10%. Compared to UCD, MCD presents at a later age, is always symptomatic, shows an important association with HIV, is more difficult to treat and has a bleaker prognosis [1]. Almost all cases of MCD are symptomatic, albeit with symptoms of unspecified nature (fever, night sweats, weight loss, fatigue...). Possible complications of MCD include fulminant infection and malignancies, notably lymphoma and Kaposi sarcoma [2]. Enlarged lymph nodes have been shown to exist in multiple locations with multiple imaging methods. However, definitive diagnosis requires histological confirmation. The different imaging diagnostic modalities used are chest X-Ray, CT Scan or MRI [3–5]. 18F-Fluorodeoxyglucose positron emission tomography/computed tomography (FDG PET-CT) was also used in some instances [6]. The use of diffuse-weighted whole body imaging with background body signal suppression (DWIBS) for MCD has not been reported so far. DWIBS is a whole body MRI using diffusion sequences with a b factor of 1100 with reconstruction of the whole body in 3D using Mobi view software and Maximum Intensity Projection (MIP) after color inversion and fat signal suppression [7]. There is no consensus for the treatment of MCD. Multiple modalities have been attempted, including steroids [8], chemotherapy, antiviral agents [9], anti-CD20 antibody [10] and splenectomy [11] with variable efficacy.

Case

We relate the case of a 72-year-old woman who was admitted for fever, lethargy, paleness, decreased appetite and diffuse arthralgias. The physical exam showed a splenomegaly and adenopathies of elastic consistence. Initial workup showed normocytic anemia (Hb: 7.8 g/dL, MCV: 83 fl) and thrombocytopenia (PLT 90.10⁹/L). An extensive infectious workup, including HIV serology was negative. A research of autoimmune disease markers was also negative. Bone marrow aspirate
showed plasmocytosis at 14% and an “en rouleaux” disposition of RBC. CT scanner of the chest and abdomen showed multiple mediastinal adenopathies of 1–1.6 cm diameter as well as retroperitoneal adenopathies. A biopsy of a cervical lymph node was performed. The overall aspect of the histological study was reminiscent of plasmacytic type CD. In the immunohistochemical studies, CD3 marked interfollicular T lymphocytes and CD20 accentuated follicular architecture. HHV8 was positive in both the germinal centre and interfollicular space. Based on these results, MCD was diagnosed. The patient was treated with 1 mg/kg methylprednisolone with a good overall response and was discharged with tapering of steroids. However, 1 week later she stopped her treatment without medical advice. She was admitted 3 weeks later with high fever and severe anemia. The workup showed a reactive hemophagocytic syndrome that was successfully treated with VP16 and three bolus of 500 mg IV methylprednisolone. Treatment was continued with decreasing doses of steroids. Five years later, the patient was still alive and in good shape with a maintenance dose of 5 mg/d of prednisone, which was increased during periods of stress and illness. Her last admission dates to 8–9 months ago when she complained of fatigue and fever. An infectious workup was negative. She responded well to an increase in the doses of steroids. During this admission, a DWIBS was performed. The result is shown in the figure 1. The MIP reconstruction after color inversion (PET like) revealed multiple lymphadenopathies clustered in the retroperitoneal, axillary and iliac regions with nonspecific bone marrow changes. The Apparent Diffusion Coefficient (ADC) was 0.9. The patient died before any control by DWIBS could have been done. She passed away following a myocardial infarction after 6 years from the diagnosis.

**Discussion**

Diagnosis and treatment of MCD remain uncertain and guided by individual reports, mostly because of its rarity. This case report attempts to instigate a new diagnostic method, the DWIBS, into its diagnosis classification. The definitive cause of this disease remains to be proven. Our patient has an HIV-negative/HHV8-positive MCD. One of the known complications of MCD is its malignant transformation [2]. Hemophagocytic syndrome is a rare issue. All reported cases with HHV8-associated hemophagocytic syndrome in HIV-negative MCD patients were fatal [12–14]. This was not the case in our patient. In our study case, DWIBS was performed to evaluate its effectiveness in monitoring the extent of the disease, the response to treatment and early detection of transformation to lymphoma. Compared to conventional CT and PET scan, DWIBS is performed without any radiation exposure or contrast agent that can be useful in patients necessitating repeated follow-up imaging [7]. DWIBS with high resolution requires a shorter acquisition time than the former techniques (around 15 minutes) and is available at a lower cost in our local community. DWIBS is a valuable tool for the identification and characterization of lymph nodes; normal and pathologic lymph nodes have a relatively restricted diffusion because of their high cellular density with variability in the apparent diffusion coefficient (ADC) and are well visualized with the possibility of monitoring response to therapy. The ADC of 0.9 observed in our case may rule out a lymphoma complication: the reported values of ADC in lymphoma were significantly lower [15]. Conclusively, we suggest, when possible, the use of DWIBS to evaluate the extension of the disease (cartography of the lymph nodes, the liver and the spleen involvement) and to detect early the lymphomatous transformation. Finally, corticotherapy should always be tried to treat MCD HIV-negative patients because the chance of disease control is possible for many years.
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