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Subcutaneous inflammation mimicking metastatic malignancy induced by injection of mistletoe extract
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We describe the histological features of subcutaneous inflammation induced by mistletoe, a popular Christmas decoration, when used as an anticancer complementary therapy. We also outline the use of extract of mistletoe in this context.

Case report
A 61 year old woman attending a follow-up appointment two months after excision of tubular carcinoma of the breast complained of an abdominal wall mass. The lesion was subcutaneous, mildly tender, and had a nodular consistency. The patient was worried that the soft tissue mass might be a recurrence of follicular lymphoma, which had been diagnosed in April 2001, although her disease had been stable after five cycles of chemotherapy. The possibility of metastatic breast carcinoma was low considering the good prognostic features of tubular carcinoma.

The lesion was excised and the 4×2×2 cm mass of subcutaneous tissue seemed to consist solely of fibroadipose tissue. Microscopically, we identified a widespread infiltrate of plasma cells, lymphocytes, and eosinophils within the subcutaneous adipose tissue, in a septal and lobular distribution, indicating inflammation or panniculitis.

A large proportion of the inflammatory cells were eosinophils. The lymphocytes formed follicular aggregates, particularly adjacent to blood vessels (fig 1). The architecture of these aggregates was benign. The lymphocytes were normal and immunohistochemistry confirmed a normal distribution of T cells and B cells. We found no evidence of light chain restriction, and Bcl-2 immunoreactivity was negative within the follicle centres, confirming the morphological impression of a reactive lymphoid infiltrate with no evidence of follicular lymphoma.

In addition to the perivascular lymphoid aggregates and panniculitis, lymphocytes and eosinophils were seen within small blood vessel walls, indicating vasculitis (fig 2). In summary, we found no evidence of malignancy after the tissue was examined microscopically on multiple levels.

Ethical approval: Submitted to the institutional review board (IRB) but transferred for approval by the institutional beauty review (IBR), an ad hoc subcommittee of our institution.


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Local reactions have been documented previously, usually manifesting as erythema or pain. Two reports of histologically assessed inflammation induced by mistletoe exist in the medical literature. A 61 year old man with a T3NOM0 pancreatic adenocarcinoma who was treated with once weekly intratumoral and peritumoral injections of mistletoe for five weeks underwent diagnostic needle core biopsy on day 28 after starting treatment. The biopsy showed adenocarcinoma admixed with neutrophils and eosinophils. A further study documents the histology of seven patients with subcutaneous inflammation induced by whole plant mistletoe extract. The microscopic pattern was of a dense perivascular lymphoid infiltrate and increased monocytes. An infiltrate of plasma cells or eosinophils was not seen. Both accounts support the notion that the microscopic features of panniculitis in our case are caused by subcutaneous mistletoe administration. Ours is the first documented account of a combined pattern of a heavy infiltrate of eosinophils, perivascular lymphoid aggregates, and mild vasculitis.

This case taught us the importance of good communication. We may never have known the underlying cause of the inflammation without an honest working relationship between the pathologists and surgeons, and between the surgeon and his patient. This story also shows that patients sometimes withhold information from us. In this case, the patient may have assumed that alternative therapies have no relevance in conventional medical consultations.

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