Non-Specific Mesenteric Lymphadenitis

Non-Specific
Mesenteric Lymphadenitis

V. Tuchel
Surgeon of Hospitals, Bucharest

With a Preface by Prof. Ag. H. H. Mollaret, Paris

44 figures and 2 tables

Table of Contents

Preface by Prof. Ag. H. H. Mollaret, Paris VII

Introduction 1

I. Historical Account 4

II. Anatomy of the Mesentery and the Mesenteric Ganglia 8

A. Lymphatics of the Mesentery and Jejunoileum 8
B. Jejunal Lymphatic Pelvis 9
C. Ileac Lymphatic Pelvis 10
D. Cecoappendicular Lymphatics 10
E. Elements of Anatomy and Explanation of Certain Clinical Signs, In This Case Pain 11
III. Physiology and Physiopathology of the Mesenteric Lymphatic Ganglia 16

A. Normal Functions of the Lymphatic Ganglia and their Structural Evolution with Age 6
B. Physiopathology of the Mesenteric Ganglia in Non-Specific Mesenteric Lymphadenitis 6
C. Esenteric Invaginations and Adenopathies in Human Pathology 22
D. Physiopathology of Segmentary Ileitis 5
E. Disorders of the Resorption of Fats and their Consequences 6
F. Relation Between the Abdominal Sympathetic Ganglia and the Mesenteric Lymphatic Ganglia 7
G. Physiopathology of Pain in Mesenteric Lymphadenitis 8

IV. Histopathological Lesions in Mesenteric Lymphadenitis.......... 29

A. Acroscopic Lesions 0
B. Microscopic Lesions 2
C. Esenteric Lymphadenitis with Past, pseudotuberculosis 3
D. Microscopic Lesions in Mesenteric Lymphadenitis from Past, pseudotuberculosis 38
E. Histopathological Lesions in Crohn's Disease 5

VI Table of Contents

V. Etiology and Pathogenesis 47

A. Circumstances Favoring the Appearance of the Disease 47
B. Alimentary Factor and Allergic Conditions 50
C. Seasonal Nature and Role of Animals as Agents for Transmission of the Disease 51
D. Pathogenesis - Mechanism of Production in Mesenteric Lymphadenitis 51
E. Mesenteric Lymphadenitis Due to Past. Pseudotuberculosis 52

VI. Clinical Aspects of Non-Specific Mesenteric Lymphadenitis 61

A. Chronic Mesenteric Lymphadenitis 62
B. Acute Mesenteric Lymphadenitis 69
C. Mesenteric Lymphadenitis, Familial Epidemic Forms 83
D. Acute Mesenteric Lymphadenitis, Septicemic Form 88

VII. Mesenteric Lymphadenitis, Terminal Lymphoid Ileitis and Crohn's Disease. 92
The extremely high incidence of mesenteric adenitis - higher than that of appendicitis - has long 'made it commonplace without awakening interest in it', as G. Laurence has written. Regarded as a normal ganglionic reaction secondary to some lesion of the intestine, appendix etc. (although the theoretical primary lesion always escaped detection and was never found at operation), mesenteric adenitis viewed in this way posed no etiopathogenetic problem. The clinical aspect, at the same time vague and indistinguishable from that of acute appendicitis, like the latter, led to surgical intervention and appendectomy, the spectacular results of which served to assuage even the most enquiring mind. Of course, the extent of involvement of the ganglia was in striking contrast to the intact appendix and the absence of any other lesion to explain the lymphatic reaction, but the doctrine of adenitis preceding or even giving rise to the appendicitis was tacitly accepted. From 1934 onwards the work of J. Reilly led surgeons to abandon their ideas of secondary mesenteric adenitis in favour of primary mesenteric
adenitis, essential and autonomous; the etiology and pathogenesis remained nonetheless mysterious. They were to remain so until microbiologists and anatomopathologists had available the material essential to their investigations - sufficiently large series of mesenteric ganglia to culture, examine and compare. The long and legitimate conflict between the proponents and opponents of adenectomy denied biologists for many years the biopsies which could alone provide an etiological explanation.

In 1953, W. Masshoff and W. Dölle, at the University of Tübingen, in an investigation covering 800 ganglia, discovered in 41 cases specific lesions. This led them to define the anatomical and clinical entity of abscess-forming reticular lymphadenitis, the etiology of which was revealed the following year by W. Knapp with the isolation of the Malassez-Vignal bacillus (Yersinia pseudotuberculosis) from the mesenteric ganglia of three children undergoing operation with a diagnosis of acute appendicitis and presenting specific agglutinins in their sera.

The interest of surgeons being aroused by these results, abundant material was channelled to microbiologists enabling them to discover further etiological factors of bacterial, viral or parasitic nature: salmonellae, Y. enterocolitica, adenovirus, toxoplasma. These various agents account at present for about a third of all cases observed. This means that the essential cause or causes of mesenteric adenitis are still evading us, and that close cooperation between the operating theatre and the laboratory must continue.

Dr. Tuchel's work has been performed in this spirit. In 1963, Dr. V. Tuchel sent his first specimens to the Pasteur Institute. He then extended his collaboration to the Institut d'Hygiène in Geneva and the Faculty of Veterinary Medicine at Bucharest, never departing from his methodical insistence on complete investigation of each case. In this way, he has amassed a particularly rich collection of clinical, anatomical, radiological, histological, microbiological and epidemiological material. The present monograph is essentially the result of this long personal experience. It provides an indispensable review of an area which has suddenly expanded in the past few years. It will be read with advantage by physicians, surgeons, biologists and students.

Professeur agrégé H. H. Mollaret