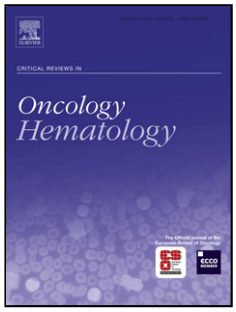

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TAFRO SYNDROME: CRITICAL REVIEW FOR CLINICIANS AND PATHOLOGISTS

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1. Abstract

TAFRO is an acrostic and includes thrombocytopenia (T), anasarca (A), fever (F), reticulin fibrosis (R) and organomegaly (O) (Takai K, et al 2013). TAFRO syndrome has been described firstly by Takai in Japanese patients. However TAFRO cases have been reported from US, Europe and other countries (Takai K, et al 2010; Iwaki N et al, 2016; , Abdo LA et al, 2014). Three major and at least one minor criteria and exclusion of infectious, rheumatologic and neoplastic diseases are required for the diagnosis of TAFRO. In fact TAFRO must be thought in clinically undiagnosed and unsolved problemmatic cases.

2. Differences and similarities of Castleman Disease and TAFRO syndrome

Castleman Disease (CD) has been described by Benjamin Castleman et al in 13 asymptomatic cases with mediastinal mass in 1956 (Castleman B, et al 1956). Today CD is a group of diseases showing several clinico-pathologic/serologic characteristics and should be considered in differential diagnosis of hematologic, oncologic, rheumatologic, and infectious diesease, . According to the involvement patterns, CD is classified as unicentric CD (UCD) and multicentric CD (MCD).

The etiologic factor in some cases with MCD is Human Herpes Virus-8 (HHV-8) or Kaposi Sarcoma associated Herpes Virus (KSHV-8). KSHV-8 is driver for hypercytokinemia in immunodeficent state and this is named as HHV-8 associated MCD. Idiopathic MCD (iMCD) term is used for HHV-8 negative cases and accounts for one third to one half of the cases with MCD. There is a significant overlap with malignant, autoimmune and infectious diseases